PROFESSIONAL DOCTORATE IN SOCIAL PRACTICE

DOCUMENT 5:

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Research Topic:

Examining safeguarding implications and perspectives for overcoming Female Genital Mutilation among Black Ethnic Minority Communities in the UK.

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Abstract

Female Genital Mutilation (FGM) is a deep-rooted socio-cultural practice that continues to pose major health and psychological issues to girls and young women in a significant number of communities around the world, but predominantly in about 27 countries in Africa.

This study principally aims at providing a critical assessment of the practice of FGM, and the safeguarding concerns it poses for black minority ethnic (BME) girls in the UK. The objective is to analyse and interpret data collected from research participants to determine if emerging themes can propound a case for overcoming FGM in the UK, and ostensibly beyond.

Two separate participant groups provided primary data for the research, namely, survivors of FGM, and professionals in social work and education. Qualitative research methodologies have been applied to explore safeguarding implications of FGM to survivors of the practice. Concurrently, lived experiences from social work and education professionals are also collected and assessed in terms of how professional culturally congruent or incongruent practice might influence the practice of FGM in the UK. Ideas about how to overcome the practice are also gathered from both participant groups.

In total, thirteen respondents took part in the study. They were identified from two different cities in England and the data were collected from them on various dates. Among the thirteen participants, seven were selected from the community of FGM survivors, and six respondents were social work and education professionals.

Emerging themes from analysing and interpretating the data suggested that FGM continues to present safeguarding concerns for BME girls in the UK. However, further ideas from the data also suggested that there are chances of significantly curbing the practice of FGM in the UK if there is a wider social behaviour change among practising communities and social institutions by adhering to the concept of social convention.

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APRs	Annual Performance Reviews
BME	Black Minority Ethnic
CAF	Common Assessment Framework
CamDoc UK	Cameroon Doctors in the UK
CSP	Compromised Safeguarding Practice
CVBs	Cultural Values and Beliefs
EDDiM	Education Drive by Diaspora Menfolk
FC	Female Circumcision
FC/FGM	Female Circumcision/Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
FGM	Female Genital Mutilation
FORWARD	Foundation for Women's Health Research and Development
HMIC	Her Majesty's Inspectorate of Constabulary
HM	Her Majesty's Government
HTP	Harmful Traditional Practices
IP	Interview Participant
ITSE	Ineptness in Transcultural Self-Efficacy
MUWO	Men for Uncut Women
NASW	National Association of Social Workers
NHS	National Health Service
NTU	Nottingham Trent University
NSPCC	National Society for the Prevention of Cruelty to Children
ORP	Obliviousness to Referral Procedures
R	Researcher
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RCPCH	The Royal College of Paediatrics and Child Health
SPAC	Selective Patriarchal Conformism
TSE	Transcultural Self-Efficacy

UK	United Kingdom
UN	United Nations
UNICEF	Originally called the United Nations International Children's Emergency Fund in full, now officially United Nations Children's Fund
UNUDHR	United Nations Universal Declaration of Human Rights
W.H.O.	World Health Organization

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To God be the Glory

1. Introduction

1.1 Statement of the problem

Justifying why Female Genital Mutilation (FGM) would be a suitable subject of research was one of the arguments articulated across by this researcher when invited to an admission interview for the Professional Doctorate programme at the Nottingham Trent University (NTU). A terse reasoned case was made as an interviewee about what FGM is all about, including especially, its safeguarding implications to BME girls in the UK. That proposition has subsequently developed to represent the statement of the problem for this research with a further argument that for over half a century now, FGM also referred to as Female Circumcision (FC) has attracted significant levels of attention within the circles of a good number of international organisations such as the World Health Organization (W.H.O.) and the United Nations Children's Fund (UNICEF) including governments, non-governmental organizations, religious and other civil society groups, and local communities UNICEF (2013).

This intense interest in the subject has grown mainly because the practice is generally considered to cause not only physical and psychological damage to young girls and women, but also because it 'is at its essence a basic violation of girls' and women's rights to physical integrity…[and] is performed primarily on children, who have no say in the matter' (Rahman and Toubia 2000, p.3). Above all, it has also been noted that 'despite concerted efforts to curb Female Genital Mutilation/Cutting FGM/C, it is still a contributor to the high morbidity and mortality rates among females in Africa' (Obiora, Maree and Nkosi-Mafutha 2020, p.1).

Arguably, outsiders to FGM could find the practice obnoxious, appalling, and horrific. It is a surgical process that results in the alteration of genital organs of young girls and women. Others have seen it as 'an irreversible reduction of human capacity in the absence of meaningful consent' (Mackie 2003, p.1) which, ostensibly leaves them with various health implications. Also, the procedure is unscientific and involves the use of traditional instruments that can be considered rudimentary and unhygienic. It has been further argued that the young girls and women who undergo the procedure live through unbearable painful experiences because 'the majority of the procedures are performed without anaesthetic' (W.H.O. 1998, p.26).

Yet, among practising communities it is endorsed as a natural and beneficial practice which is done out of love for their womenfolk and in the overall best interest of girls and women in their communities. Its practice is further justified by the fact that it is done in respect of cultural and traditional values and that it 'cements social and political cohesion among [practising] communities' (Lamb 1992, p.13).

Burrage (2015) has stated that members of the British communities who originate from African and other societies in which FGM is a part of culture have come along with that aspect of their culture. Hence, FGM occurs in the UK among migrant communities who have come along with the practice from their indigenous home countries. Logically, the effects of its practice can result in safeguarding implications for young girls and women in British communities. FGM can, therefore, be seen as a social problem that necessitates being researched into and ideas suggested that could help towards curbing its practise in the UK and beyond. One way of contributing a solution to the problem has been to research the subject through the Professional Doctorate programme at NTU.

1.2 Aims and objectives of this document.

This research has three overarching aims: the first aim is to explore the concept of FGM and reasons justifying its practice within practising communities; the aim is to examine the safeguarding implications of FGM for BME girls in the UK; and thirdly, to explore ideas on how FGM can be significantly curbed or possibly how to overcome the practice in the UK.

Three main objectives have been designed to address how the aims outlined above will be met. The first objective is to answer the following main and subsidiary research questions; namely:

Main research question:

How does the practise of FGM pose safeguarding concerns to BME girls in the UK, and what are the options for significantly curbing FGM in the UK?

Subsidiary research questions:

- *What does the phenomenon of FGM entail?*
- *How prevalent is FGM in the UK?*

- *How is FGM a form of child abuse, and what are the implications for safeguarding?*
- *How does the cultural value argument influence the prevalence of FGM?*
- *How can professional culturally congruent practice influence safeguarding linked to FGM and contribute to its eradication?*

The second objective is to re-state the previous findings that emerged from documents 3 and 4, respectively regarding safeguarding implications of FGM to BME girls in the UK.

The third objective of the study is to analyse and interpret the data collected from both FGM survivors on the one hand, and social work and education professionals on the other hand, to determine if emerging themes can propose ideas about curtailing and/or possibly overcoming the practice of FGM in the UK.

1.3 Contextualising document 5

Document 5 is core to the overall research. It involves the complex task of pulling across the various critical literature reviews in the previous documents and synthesising these in one place to inform a unique critical literature review for the overall study. It also comprehensively restates the various critical arguments that were developed, and the themes that emerged in all the previous documents. Suffice to mention at this early stage that this is a qualitative research project. A detailed justification for applying the qualitative research design will be presented in due course; however, as one of its strengths the qualitative approach is:

> flexible and [can be] continuously formulated as the information is collected. In the process …, if you find something interesting to your broad area of study, you add the aspect(s) and change the focus to accommodate the new vision (Kumar 2014, p.115).

Considering the view stated above, this study intends to examine beyond the themes that emerged out of the original research topic regarding safeguarding implications that are linked to FGM. Taking into consideration that document one presented the subject of the research; that document two proposed that FGM is a form of child abuse; and that data analyses and interpretations for documents three and four evidenced that FGM poses safeguarding implications to BME girls in the UK, this

document seeks to obtain ideas from participants' lived experiences about how to overcome FGM.

This explains why for document five, the original research topic has been modified from *Female Genital Mutilation and safeguarding implications for Black Minority Ethnic girls in the UK* to Examining safeguarding implications and perspectives for overcoming Female Genital Mutilation among Black Ethnic Minority Communities in the UK.

To give it a full context, it is important to re-emphasise that this document is principally concerned with exploring ideas about how to overcome FGM in the UK. To go about this first requires an understanding of what the whole concept of FGM is and the safeguarding implications it poses to BME girls in the UK. This research believes that re-stating these arguments will logically and meaningfully synchronise with the ideas on how to overcome the prevalence of FGM.

This research is principally concerned with examining the safeguarding implications of FGM for BME girls, and ideas on how FGM can be overcome in the UK. It is a criminal offence to practise FGM in the UK; hence, it is sanctioned by two Acts of Parliament in 1985, and 2003, respectively. In the UK 'if the offence occurs in respect of someone under 18, it, like all other harmful traditional practices (HTP), is recognised…as an illegal act of child abuse' (Burrage 2015, p.15). Therefore, in terms of the age range, the use of the word 'girls' in this study refers to girls from infancy up to the age of 18 years.

While social workers, health and educational practitioners are considered as key frontline workers for ensuring the health, safety, educational development, and well-being of children in general, child protection needs to be the concern of everybody. The UK government's policy clearly states that:

> Everyone who works with children has a responsibility for keeping them safe. No single practitioner can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns sharing information and taking prompt action (HM Government 2018, p.11).

However, this study has limited frontline workers to regulated practitioners in social welfare and education. By their roles either as social workers or education welfare

staff, their professions strategically position them to come into regular contact with children and their families through home visits or meeting children daily at school in the case of education welfare staff.

Although the FGM migrant population in the UK could have come from across the globe, this study concentrates on the African FGM practising migrant community. Also, the reference to BME girls in the UK in this study henceforth relates to girls within the BME communities in the UK with origins from FGM practising communities in Africa. But also suffice to make it clear that although the study blanketly alludes to the African practising migrant population, it recognises the heterogenous nature of the various populations because their 'lived experiences are differentiated by their histories, cultures, ethnicities, and social circumstances' (Bernard and Gupta 2008, p.477).

1.4 Structure

The structure of this document follows 'a pattern which is dictated largely by the need to present information in a logical order, with each new section building on information that has been provided earlier' (Denscombe 1998, p.326). In this regard, the opening part of the document logically progresses to part two which is the literature review section. This section coherently pulls across and synthesises together both the previous and an augmented critical literature review with an interest to underscore and justify the aims and objectives of the study.

The contentious subject of cultural influence as the principal factor for the prevalence of FGM is also explored in this section. Professional culturally congruent practice is equally discussed in this section of the research. The argument at the base of discussing professional culturally congruent practice is that if as a cultural practice FGM negatively impacts children, hence, is outlawed in the UK, then by duty social welfare and education professionals must ensure that all children in the UK but particularly BME girls are safeguarded against such a cultural practice.

This study contends that if professionals can evidence culturally congruent practice vis-à-vis the values of the BME communities in which they serve, child safeguarding against a cultural practice like FGM can arguably be safely managed. This notion is based on the claim that professionals can demonstrate the ability to prioritise child

safety without disrespecting indigenous cultural values. However, if professionals are culturally incongruent in their practice, the risks to child abuse can be higher and safeguarding implications can be become complex. This discussion is further explored in the literature review section of the study.

Part three focuses on the theoretical and methodological research approach. The qualitative research methodology will remain the one in use as has been the case in the previous documents. This is for many reasons, but most essentially for maintaining consistency in the methodological approach.

Part four discusses the methods used including most importantly data collection, analysis, and interpretation. The main data for this document would be on how FGM can be ended in the UK. Data would be collected from members of the local community who practise FGM on the one hand, and from social welfare and education professionals on the other hand. The emerging themes about how FGM can be overcome are fully explored in part four of the study. Such ideas can be more meaningful as these are derived from the lived experiences of the participants themselves. However, some of the key findings that came out from documents 3 and 4, respectively, will firstly be re-stated to foreshadow the arguments for how to achieve the ending of FGM.

Part five explores the perspectives for overcoming FGM in the UK. This section tries to address the second part of the main research question regarding ideas *on how FGM can be overcome*. The ideas are interpreted from data collected from both the survivor and the professional respondents, respectively.

Part six is the conclusion. The first part of the conclusion assesses the extent to which the aims, objectives and research questions set out for the study have been attained. Other aspects of the conclusion include how the research contributes to knowledge and professional practice, how knowledge from the research will be disseminated, and a list of recommendations for tackling FGM.

2. Literature Review

2.1 What this literature review is all about

This review presents a summary of the literature that has been gathered about the subject of FGM. It also attempts to illustrate not just how the literature is linked to the theme of FGM and safeguarding implications but also very importantly, how the literature ultimately contributes to creating new ideas from which further research can be built. But before examining the literature, it is worth underscoring some important limitations relevant to the subject of this research.

According to NHS FGM Digital Enhanced Dataset (2015) a total of 8,656 women and girls were recorded to have attended NHS Trusts and GP practices between the period April – March 2015. However, between the period 2015 and 2021, NHS FGM Digital Enhanced Dataset (2021) reported that the total number of women and girls who attended NHS Trusts and GP practices where FGM was identified rose to 67,795. These statistics are just for England and so, they still fall short of providing useful information that represents the whole picture of the practice in the UK.

Also, while undertaking this review, no literature is available on the views and experiences of BME men in the UK or the diaspora about FGM. Where this limited literature can be identified it has focused more on the psychological impact endured by men with partners who have undergone FGM. The painful experiences their partners are living during sexual intimacy tend to psychologically affect the men yet there is very little research available to evidence any salient contributions that men are offering to bring about the end of FGM.

On a positive note, Ali *et al.* (2020) have captured the views of twenty young people aged 13 – 15 years old where they have assessed how young people living in FGM affected communities in the UK, interpret and explain the phenomenon. Divergent views emerged among participants. Accordingly,

> whilst some perceived FGM as a historical tradition that was of very little, if any, relevance to them, others in contrast, perceived that the more archaic, cultural interpretation of FGM, more commonly shared by older generations, had been supplanted by a new form of FGM, which they believed to be a safe procedure, made so by the availability of highly

> trained, qualified doctors and better equipment in the UK (Ali *et al.* 2020, p.1).

It can be argued that little regard shown towards the phenomenon by some of the participants in the study above could be because of sheer lack of interest and knowledge in the subject or because their cultural worldview has become more dynamic and sophisticated beyond understanding of their indigenous cultural practices. It is also interesting to note that some of the participants are not categorically against the practice insofar as medicalization of the practice through highly trained, qualified doctors and advanced apparatuses can be used.

Whatever divergent views are articulated by the participants in the study above, an apparent significant gap in the literature has been narrowed, namely, that the voice of the child has been heard. This is noteworthy in the concept of child protection and safeguarding where curiosity necessitates that the voice of the child needs to be heard.

2.2 What is FGM?

FGM is referred to in different terms and remarkably varies both in its procedures and in their meaning. Gruenbaum (2001) refers to it as female circumcision and describes it as an act that entails the cutting and removal of tissues of the genitalia of young girls to conform to social expectations. This viewpoint highlights a socio-cultural perspective of the practice and situates the prevalence of the practice within cultural and traditional conformism.

For their part, Rahman, and Toubia (2000) describe the practice in joint terms - referring to it as female circumcision/female genital mutilation (FC/FGM). In their view, FC/FGM is a collective name given to several different traditional practices that involve the cutting of female genitals. While the element of an act of circumcision is upheld, universalists' perspectives of revulsion also reverberate as the definition suggests that the practice involves the mutilation of genitals.

Within practising cultures, a variety of terms are used in their local dialects to describe the practice which, Rahman and Toubia (2000) have suggested are often synonymous

with purification or cleansing hence, *tahara* is used in Egypt, *tahu* in Sudan and *bolokoli* in Mali.

According to the Home Office (2015) FGM is illegal in the UK and is considered a form of child abuse and violence against women. This research essentially intends to shed light on the safeguarding implications to children in the UK who have suffered or are likely to suffer harm resulting from FGM practices. It will then also explore ideas about how the phenomenon can be curbed in the UK.

It is, therefore, appropriate to choose a definition that reflects the setting within which the research is undertaken and how the practice is perceived and referred to in that setting. Accordingly,

> the term 'female genital mutilation/cutting' [FGM] (also called 'female genital cutting' [FGC] and 'female genital mutilation/cutting' [FGM/C]) refers to all procedures involving partial or total removal of the external female genitalia or other injuries to the female genital organs for non-medical reasons (World Health Organization 2008, p.1).

The definition above is considered holistic and deemed to represent both relativists and universalists perspectives about the FGM term. Additionally, it is widely recognised among many international organisations and thus, will be considered as the working definition for this study.

2.3 The practice of FGM in the UK

FORWARD (2007) has identified the practise of FGM in twenty-seven African countries, and three others in some parts of the Middle East and South-East Asia mainly Yemen, Iraq, and Indonesia. There seem to be difficulties in determining the exact number of girls affected globally by FGM. However, a study carried out by RCM *et al.* (2013) established that globally, 100 to 140 million girls and women have undergone FGM, and a further three million girls undergo FGM every year.

The World Health Organization (2024), however, estimates that more than 230 million girls and women alive today have undergone female genital mutilation (FGM) in 30 countries in Africa, the Middle East and Asia where FGM is predominantly practised.

Socio-political and economic events in the world and the colonial history of Britain have arguably contributed to the outlook of the diverse communities of today's British society. Based on a study by Ruiz *et al.* (2014) migratory movements and the current globalization processes have allowed FGM to be more and more known and practised in the most industrialized western regions. For her part, Burrage (2015) considers that members of the British communities who originate from the African societies and other societies in which FGM is a part of culture have come along with that aspect of their culture.

It can be argued that with its predominantly Western cultural characteristics the British society is still only slowly publicly acknowledging FGM as a problem just like it is with most other Western societies. This is understandable because, until the past few decades, African and other diasporas had only a small prevalence in most Western countries (Burrage 2015). The European Parliament has recognised that with increased migration, FGM is no longer restricted to Africa, the Middle East and Asia; hence estimates put the number of women who have been subjected to FGM living in Europe up to half a million, with a further 180,000 at risk (Brown, Beecham and Barrett 2015).

A recent study has reiterated the view that FGM has become a global trend. Accordingly, 'while FGM is traditionally practiced in North and Western Africa, Asia, and the Middle East, globalisation and immigration have led to an increasing number of cases in the western world' (Bradbury-Jones *et al.* 2022, p.3).

Statistics of women and girls affected, or at risk of FGM in the UK are not exactly known; however, a Macfarlane and Dorkenoo (2015) report estimated that an overall number of women aged 15 – 49 years old who were permanently resident in England and Wales alone, but who were born in countries where FGM was widely practised, increased from 182,000 in 2001 to 288,000 in 2011. Further estimates from the same report indicate that there were 137,000 women and girls across all age ranges with FGM, born in countries where it is practised, permanently resident in England and Wales with the consequences of FGM. The overall 137,000 comprised nearly 10,000

girls aged 0 - 14 years born in FGM practising countries who have undergone or are likely to undergo FGM.

Estimated statistics collected for women born in 28 FGM practising countries in Africa and who are resident in England and Wales show that for each estimated number of women with FGM per country there is a corresponding total enumerated number of women aged 15 - 49 with FGM (FORWARD 2007). The highest number estimated with FGM were from Somalia and Kenya. FGM is arguably becoming a very concerning problem in the UK with thousands of women being identified as victims every single year. Accordingly,

> Between September 2014 and January 2015, more than 2,600 new cases of FGM were identified. Forty-four of these were children under eighteen. More than 9,500 women were deinfibulated. And…these are only the women and girls who have sought medical treatment – many more (could) be suffering in silence (Wadere 2016, p.190).

NHS Digital (2017) has stated that between January and March 2017, there were 1,236 newly recorded cases of FGM reported in England. The report further states that over 1,200 newly recorded women and girls with FGM were recorded every quarter since April 2015. Accordingly, newly recorded refers to women and girls who have had their FGM information collected in the NHS enhanced dataset for the first time. If 1,200 women and girls are recorded every quarterly, then about 4,800 girls and women are recorded annually with FGM procedures in England. Therefore, between April 2015 to the end of 2017, there would have been over 9,000 newly prevalent cases of FGM in England alone.

NHS Digital (2020) April 2019 to March 2020 period updates that 6,590 individual girls and women had an attendance where FGM was identified. Overall, for this period, a total of 11,895 attendances were reported at NHS Trusts and GP practices where FGM was identified. NHS Digital (2020) further reports that since the Enhanced Dataset was opened and started collecting data 5 years ago at the time of capturing these statistics, information has been reported by NHS Trusts and GP practices recording 24,420 individual women and girls, who have – between April 2015 to March 2020 –

had a total of 52,050 attendances where FGM was identified. The total number of prevalent cases could be quite concerning if total UK statistics were assembled.

The HMIC (2015) completed research on characteristics of FGM practitioners in the UK. Evidence found that girls can be taken abroad, usually ahead of the six-week or other long school holiday, to undergo FGM. Alternatively, FGM may be conducted in the United Kingdom by people known as 'Cutters' usually female, although, in rare cases, they can be male (HMIC 2015). Additionally, families in the UK are now holding what are referred to as 'FGM parties' whereby relatives club together to invite the cutter to the UK. For the organizers, this not only minimises the costs of sending a group of girls back to villages in their parents' original FGM practising communities where they will be mutilated but it also evades the scrutiny of Border Agency staff (Wardere 2016).

The exact data on locations in the UK with the highest incidence of girls and women at risk of FGM is not yet clear. However, Burrage (2015) presumes that the cities in England and Wales which displayed campaign posters in the summer of 2014 against FGM initiated by Theresa May the then serving Home Secretary, were deemed to contain the highest prevalence of FGM in the UK. These included 17 London boroughs, and outside London, other cities included Birmingham, Manchester, Leicester, Bristol, Sheffield, Liverpool, and Cardiff. However, the findings of Macfarlane and Dorkenoo (2015) included additional cities to the ones targeted by former Home Secretary, May's campaign posters. These include Slough, Milton Keynes, Coventry, Reading, Thurrock, and Northampton. Flicklearning (2016) for their part have identified 11 cities as the known FGM 'Hot spots' of the UK. The only exceptions noted which have not yet been cited from both sources above include Glasgow, Crawley, Oxford, and Edinburgh.

The significant risks associated with the practice will arguably, make FGM one of the most current burning safeguarding and child abuse issues in the UK. As such, FGM has been criminalised by the Female Circumcision Act 1985 (Prohibition of Female Genital Act 1985). In England, Wales and Northern Ireland, the practice is illegal under the Female Genital Mutilation Act 2003 and in Scotland, it is illegal under the

Prohibition of Female Genital Mutilation (Scotland) Act 2005 (National FGM Centre 2015). Furthermore, since 31st October 2015, it has now become a mandatory professional duty for all regulated professionals in the UK (health workers, teachers, and social workers) to report known cases of FGM or disclosed cases of FGM directly to the Police (Serious Crime Act 2015). The Act refers to 'girls' though it is also applicable to women. Failure by professionals to perform this duty is an offence if not proven otherwise under Sections 70 – 75 of the Serious Crime Act 2015.

The good intentions to prohibit and criminalise FGM notwithstanding, the idea that culture can be the main driving force behind its practise suggests that it might still be a long way before survivors both in practising communities in Africa and the UK are risk-free. This, therefore, makes FGM not only a significant safeguarding problem for girls with roots back in African FGM practising communities but it has also made FGM increasingly become 'a very British problem' (Wardere 2016, p.190).

2.4 The historical context of FGM

FGM has existed for centuries now, yet it is still a polarised debate among medical and social scientists as to its historical/cultural origins, and its geographical locations. Slack (1988) asserts that it has been practised for nearly 2500 years, before either Islam or Christianity. Research has linked historical prevalence among tribes in Eastern Mexico, Peru, and Western Brazil. Its historical prevalence has also been reported in Europe among the Romans and the 18th century Tsarist Russia with the Skoptsy sect. Huelsman (1976) reports that in Berlin in 1882 a fourteen year 'idiotic' patient was 'declitorized' and cured of her 'excessive masturbation and nymphomania' which, then led her to thrive both physically and intellectually (see Gruenbaum 2001, p.9). Similarly, a famous 17th-century French surgeon, Dionis was highly esteemed for being the first person to recommend excision as a remedy against female lasciviousness (Lionnet 2005). Prevalence of the practice has also been known in Middle and Far Eastern Asia among the Phoenicians and Hittites.

Africa has, however, been mainly associated with the historical and geographical location of the origins including a 40% current prevalence level (Lamb 1992). Abdalla (1982), cites Greek geographer and historian Strabo, who in 25 BC noted that 'one of

the customs most zealously observed among Egyptians is...that they rear every child that is born...circumci[sing] the boys and excis[ing] the girls' (see Anon 1. n.d., p.1). For her part, (Gruenbaum 2001) has stated that several authors report scattered references to the existence of female circumcision in the Nile Valley at least since the times of the ancient civilisations of Egypt and Sudan. A myth also holds according to Huelsman (1976) about an ancient Pharaoh who, due to being less endowed with a sexual organ had demanded that women be infibulated to enhance their sexual pleasure (see Gruenbaum 2001, p.46).

A study among the Nile Valley people who practised infibulation found that a greater proportion of them asserted that infibulation originated during the reigns of the pharaohs, hence giving rise to the term 'pharaonic circumcision'. Sanderson (1981) (see Gruenbaum 2001, p.43) also refers to a statement from Herodotus, a Greek historian of the fifth century BC, that Egyptians and Ethiopians among others practised female excision five hundred years BC.

The historical accounts reviewed so far have been predominantly propounded by western scholars who have invested more interest and time to research on the subject. There is, therefore, a western stance albeit unclearly stated which, essentially locates the origins of FGM if not centrally but at least within the peripheries of African corridors.

However, a significant body of literature also argues in favour of FGM being a recurrent phenomenon throughout history (Anon 1. n.d.). It is a tradition unbeknown to when and where it originated from (FGM National Clinical Group 2015). From Verzin's (1975) point of view, it is practised on every continent, although it would be most prevalent in Africa and the Middle East (see McFalls Jr., McFalls 1984, p.459). Although Worsley (1938) suggests that infibulation was a great ancient times practice known to the people of ancient Egypt he, however, also surmises that it prevailed among Arabs in general in pre-Islamic times. Worsley (1938) also highlights the prevalence of the practice among the Romans, who fastened fibulae, or fastening devices, through the prepuce, to enforce chastity and virginity, hence the name infibulation. McLean and Graham (1983) further elucidate that in ancient Rome it was common for female slaves

to have 'one or more rings put through their labia majora to prevent their becoming pregnant' (see Anon.1 n.d., p.2).

Historically loaded as it is 'there is no way of knowing the origins of FGM' (Golloher 2012) (See Lorenzi 2012, p.1) because the origins of FGM are a mystery (Nour 2008). This debate may not be ending soon. FGM practising cultures remain patriarchally dominant in today's modern society in semblance to the ancient times. As can be recalled, the Romans fastened fibulae, or fastening devices, through the prepuce, to enforce chastity and virginity in women. Arguably, these two practices can generally be seen as acts of oppression to women in ancient times, but which continue to occur in modern times.

A direct correlation between the historical background of FGM and the main theme of this study may seem not to be strikingly evident; however, its presentation is still deemed to be relevant to the overall research. Understanding the historical/cultural and geographical backgrounds arguably help in situating the concepts inherent in the FGM phenomenon within context, namely, the BME African communities in the UK who have continued with this generational practice. Girls and women continue to undergo FGM today. It is an indication that the same types of FGM that prevailed in primitive society continue to flourish in today's modern world. One can, therefore, posit that there is a baseline safeguarding concern that has remained customary since primitive to modern society regarding FGM.

Also, this research will be disseminated to a wider audience when it is completed. Any audience, professional or researcher who does not identify with this cultural value may be overwhelmed by being exposed to it for the first time. The likely question to ask is: how or where did FGM come from? Understanding this background can arguably settle this curiosity and enhance the development of qualitative ideas for overcoming FGM.

2.5 Forms of FGM

The W.H.O., UNICEF, UNFPA (1997) provided a technical classification of four different types of FGM. Summarily, the various types range from the removal of the prepuce (Clitoridectomy/*sunna*) to the more severe procedures that entail the removal of the

clitoris (excision), to infibulation, which involves the removal of the clitoris, the labia minora, and the labia majora. In pharaonic circumcision, the remaining flesh is stitched together leaving a small aperture (Korieh 2005). Clitoridectomy, and particularly excision are the most practised forms across a large representation of the African practising communities (Lamb 1992).

Hosken (1989) has explained that excision and infibulation continue to be practised in large parts of Africa, from the Red Sea Coast to the shores of the Atlantic. While this certainly raises serious concerns, suffice to also recognise that it is about three decades ago since Hosken's research report. Some attempts have been ongoing to try to curb the prevalence of FGM within international and national circles and a more substantive discussion around steps towards eradication will be developed in later parts of this research.

2.6 Why does FGM occur? Conceptualising the practise of FGM within the concept of culture and cultural relativism

The argument can be made that the FGM phenomenon befits the definition of culture in terms of the attitudes, behaviours, and patterns that characterise the societies that practise it. Whatever sub-categories that explain the reasons for the prevalence of FGM these all amount to the main subject of culture. It may be helpful to have a quick insight into what can be described as culture, cultural relativism, and how cultural relativism embeds into the reasons that inform the prevalence of FGM.

2.7 What is culture?

The word culture is debatably a complex word to define. Diller (1999) attests that it is 'a difficult concept to grasp' (see Connolly, Crichton-Hill and Ward 2006, p.16). Additionally, Hays (2001), and Eisenhart (2001), not only individually think it is a difficult word to define, but each sees it respectively, as 'the most inclusive term but also the most general', and also 'meanings change over time, place and context' (see Connolly, Crichton-Hill and Ward 2006, p.16).

Williams (1976), believes that culture broadly has three connotations, as being 'the process of intellectual and aesthetic development; culture as [an] intellectual and artistic activity (for example, film, art and theatre), [and]; culture as a way of life of

people including values and norms' (see Connolly, Crichton-Hill and Ward 2006, p. 17). For their part, Harrison, Harvey, and Maclean (2010) think that culture is essentially about a shared understanding with others of the same values. For NASW (2001) culture is the 'totality of ways being passed on from generation to generation' (see Harrison, Harvey and Maclean 2010, p.13).

The third perspective of Williams' (1976) definition and the preceding definitions are more relevant to this study. FGM is a practice which, defines a way of life for the communities that practise it. It can also be recalled that in the historical background section of this research, FGM is established as a generational practice among practising communities; hence this reflects how NASW (2001) defines culture, namely; 'the totality of ways being passed on from generation to generation' (see Harrison, Harvey and Maclean 2010, p.13). But what about cultural relativism? What does it imply?

2.8 The notion of cultural relativism

Foster (1991, p.259) believes that the works of Franz Boas (1858 – 1958) and those of his students Ruth Benedict (1887 – 1948), Melville Herskovits (1895 – 1963) and others espoused what remains to be the standard definition of cultural relativism, namely that 'cultural relativism is the view that standards of morality and normalcy are culture-bound'. If one considers Taylor's (1873) view that 'culture is that complex whole, which includes knowledge, beliefs, art, morals, laws, customs, and any other capabilities and habits acquired by an [human] as a member of society' (see Foster 1991, p.259), then it is not possible to evaluate cultures scientifically because those who do that evaluating do so in the light of standards derived from their cultural perspectives (Reteln 1988).

At the very base of the argument, relativists seek to establish that outsiders cannot and should not pass moral judgements on other peoples' values because such criticisms are unjustified, biased, misguided, or imperialistic (Sala and Manara 2001). This highlights the view that 'one culture's madman can easily be another culture's saint or prophet' (Benedict 1934) (see Anon.2 n.d., p.195).

One can thus, argue that cultural relativism is advocating for a natural cultural worldview that is free from human limitations as opposed to an essentially universal scientific moral order, or a 'pan-human-culture which does not take into consideration the plurality, uniqueness, and diversity in cultural values' (Benedict 1934) (see Anon.2 n.d., p.153). Analogically, the argument can be made that relativists would articulate the view that FGM should be allowed among members of its cultural group without the need by others or a state to impose its morality on the voluntary members of such cultural groups (Kalev 2004). This research examines FGM as a cultural practice in relation to human moral standards and aligns with universalism rather than cultural relativism. This would be made clearer in the later stages of this study.

2.9 Relating culture and cultural relativism to justifications for the practice of FGM

To understand why FGM occurs in some African communities is to understand what members of the practising communities share as the socio-cultural values of their lived world. These include values such as communal festive occasions, stages in a woman's maturity, gender positions, and institutions such as religion, and marriage. These are values that accord socio-cultural approval or disapproval (Sala and Manara 2001) to members of the practising community and ensure respect for tradition and cultural identity. This argument, therefore, helps in situating the prevalence of FGM within the theory of cultural relativism.

It can be suggested that the birth of a girl child in a family in communities where FGM is practised predisposes that child to an eventual genital mutilation procedure. The age of administration on a child differs from one community to another. In Eritrea, this could happen to baby girls as young as just seven days old, and in other practising communities, excision occurs between the ages of 4 - 10, and even later during adolescence at the time of marriage (W.H.O. 2001). In Egypt, Nigeria, Somalia, and some other countries it is done when a girl child is just three or four years old (Gruenbaum 2001). UNICEF (2016) has reported that in most countries, most of the girls are cut before age 5.

2.9.1 The cultural argument relating to the rite of passage.

One of the rationales for the prevalence of FGM is to uphold customs and traditional beliefs. Different kinds of generational, ritualistic, and customary practices form part of the socio-cultural structure of most traditional African societies. In most of the practising communities, FGM is performed as a transition rite, which Barrett *et al.* (2011) explain as an act of 'initiation to adulthood during which pain must be endured, which occurs as the girl approaches puberty and thus becomes a woman' (see Burrage 2015, p.32). Carpenter (2002) conveys the significance inherent in traditional transitional rites by stating that 'in many cultures around the world, losing one's virginity is seen as a rite of passage, a symbol of having graduated into the community of adults' (see Edley 2017, p.121).

Ahmadu (2000) for her part recreates the process of attaining adulthood through the imagery of female reproduction. For her it begins with a symbolic death which can be equated to the preparatory phase of FGM, then the young initiates enter a metaphorical womb where they are initiated. They remain in a liminal state to receive ritual instructions. They then become ritually 'reborn and figuratively removed from the 'vagina' of the sacred grove, as new persons with full social membership in the adult world' (Ahmadu 2000, p.288). In a similar vein, Hosken (1989) acknowledges that FGM is a puberty rite performed just before marriage in Mali and other countries in Francophone West Africa without which, a woman cannot get married or accepted into adult society.

Intrinsically, among the Mandinga culture of Guinea-Bissau to come across as a foolish person (*bulufu)* later in one's adulthood is according to Johnson (2000), denigrating. It is believed to result from being uninitiated/uncircumcised, hence such a person is seen as reckless, disrespectful, and unrefined. Conversely, initiation is tied to the socio-cultural construction of personhood. Among the Mandinga, undergoing clitoridectomy, for instance, brings the girl to 'know the eye', a term that

> refers to moral and educational [transition], whereby young children are taught their position in society and the correct way of acting in a variety of social situations…. To 'know the eye' also involves being socially graceful, being perceptive, and possessing the ability to anticipate the thoughts and actions of others and the knowledge to react accordingly (Johnson 2000, p.222).

This suggests that, as a cultural value for transiting into adulthood, FGM is presumed to embed lessons in propriety and decorum. It prescribes how a woman needs to conduct herself in society, hence 'it is a rite of passage to be endured on the way to [being a] woman...' (Wardere 2016, p. 167). It is, thus not uncommon that FGM is performed on females because it is a process of 'transition in age status from girlhood to [womanhood]' (Gruenbaum 2001, p.69). This fits in with the phenomenological approach which, as will be seen in the methodological interpretation of the study is all about describing the lifeworld 'as experienced by those who live it' (Psathas 1989) (see Eberle 2014, p.191).

The rite of qualification into womanhood through FGM can be said to resonate with relativists' perspective about what constitutes social reality regarding collective thinking and behaviour in a society. Benedict (1934) has argued that 'it [is] peoples' shared basic attitudes and values that [give] uniformity to behaviour' (see Anon.2, n.d. p.151). Nguema (1990) presents the use of FGM among practising communities as a demonstration of uniformity in collective cultural behaviour (see Lionnet 2005, p.105). In Nguema's (1990) argument, for a girl to achieve marriage and be considered a woman throughout traditional FGM practising cultures they will have to submit and live the experience of undergoing FGM (see Lionnet 2005, p.105). This affirms the cultural relevance of FGM as a practice which, apart from helping in transitioning girls into womanhood it connects the practising community members to their past, enhances tradition, maintains customs, and preserves cultural identity (Rahman and Toubia 2001).

With the understanding that FGM defines a part of the social lifeworld of a community, one can only postulate continuity in practising communities in the UK. Mackie (2000) affirms this view as he asserts that almost all who practise FGM say that it is required for marriage. It can be argued that marriage is a common socio-cultural practice across most societies. Parallelly, one sees why relativists perceive the prevalence of FGM on the basis that it is an integral part of a lived cultural worldview of a people. This suggests that in a cultural relativist society FGM will remain as a cultural practice without much due consideration of the safeguarding implications this may pose.

2.9.2 The argument relating to marriageability, honour, and female sexuality.

Ensuring a girl's marriageability and the control of female sexuality also accounts for the prevalence of FGM in most African FGM practising communities. Among the Rendille FGM practising community in Northern Kenya and debatably among most communities in Africa, marriage is one of the most cherished traditional institutions (Shell-Duncan, Obiero, and Muruli 2000). While marriage for men can primordially be more for honouring an ancestral socially constructed norm, for women it promotes the same traditional value but also enhances additional traditional values: for maintaining self-honour and at the pinnacle of it all marriage leads to reproduction which, provides the woman with sustainable economic security. As such 'for a mother in a society where there is little economic viability for women outside marriage, ensuring that a daughter undergoes genital mutilation as a child or teenager is a loving act to make certain of her marriageability' (W.H.O. 1998, p.47). In Sudan, for instance, as in most other practising communities in the Horn of Africa, Boddy (1982); Cloudsley (1983); Gordon (1991) argue that female circumcision is a cultural practice that is used to ensure a daughter's place in the marriage market and validates her fertility as a wife (see Balk 2000, p.55).

As part of preparing for marriage, premarital sex for a girl in some practising communities can be a very risky adventure. Knowledge of premarital sex could reduce a girl's marriageable chances by possibly zero per cent or even being divorced if found out afterwards (Gruenbaum 2001). This suggests that virginity for a girl until she is married, is extremely important. In Egypt, Somalia, and Sudan, for example, extramarital sex is completely unacceptable and female genital mutilation is used to ensure that it does not occur (W.H.O. 1998). Thus, excision of the clitoris is believed to manage sexual promiscuity among women in that,

> it will control the rampant sexual desires which adolescent girls are believed to harbour…and reduce a woman's sexual pleasures…thus reducing the likelihood that she will become sexually active with anyone other than her husband (Burrage 2015, p.33).

Burrage (2015) has further stated that it is also traditionally believed that the clitoris can develop into a penis and that a man or a baby may die if they meet it during intercourse, or during labour. Therefore, the clitoris must be excised.

Evidently, in many other cultures in the world including western cultures where premarital sex is less significant to marriage, chastity before marriage for a man or a woman would still be highly acclaimed. In Henry Fielding's (1742) novel, *Joseph Andrews,* for example, Joseph and Fanny each withstand various seductive attempts from others and they each withhold their virginity. When local curate Parson Adams eventually blesses them into marriage, they each draw the highest respect for their virtuousness in manners but especially, for protecting their chastity before marriage. For most of the African FGM practising communities, the performance of FGM on girls is believed to ensure chastity.

Embedded within marriageability and sexuality is the idea of family honour. In Islamic culture 'honor is thought of as a quality that can be lost and is very difficult to regain once lost. Honor connotes dignity and high moral status. To maintain it, one must have decency with respect to sexual behaviour' (Gruenbaum 2001, p.77). Hosken (1989) has also stated that for the sake of family honour a girl who is not operated on tends to be viewed upon as one who will run wild and disgrace her family.

From an epistemological standpoint, FGM within practising communities denotes honour, female marriageability, and control of female sexual desires. Conversely, male sexual desires would indirectly be enhanced in the process. This justifies the argument that 'in some communities, FGM is perceived as a mode of control of, or punishment for, general behaviour as well as sexual activity' (Burrage 2015, p.53).

On the flip side, these are values that for relativists encapsulate socio-cultural constructs that ensure discipline and good moral conduct among members of a community. Seeing it differently can be tantamount to disrespect of other peoples' way of life. It may be seen as reinforcing universalist, and Western values to remain influential 'on the platforms of [African] culture, nationalism, ethnicity, sexuality, [and] class….' (Ajayi-Soyinka 2005, p.51). Yet for relativists 'every moral judgement is culturally relative…. Right and wrong vary with [each] culture [and] whatever is true for one culture is false for others' (Tilley 2000, pp.507-516). By that judgement, relativists are seen as justifying the prevalence of FGM as a cultural code.

2.9.3 The argument relating to patriarchy.

Patriarchal domination and female economic insecurity are also significant cultural factors that contribute to why FGM persists. Claims have been made that FGM

> was conceived by men in some long-ago generation as a way of keeping women from having the full measure of their power and freedom and was passed down through the generation by male dominance and the ideologies of patriarchy (Gruenbaum 2001, p.40).

Equally, in her view 'one fundamental aspect of FGM is or has historically by tradition and custom been – perhaps now perpetrated without knowing the reference to origins – to perpetuate patriarchy' (Burrage 2015, p.59).

Patriarchy means 'the father and ruler of a family or tribe' (Jukes 1993, p.9). In its wider definition, patriarchy means 'the manifestation and institutionalization of male dominance over women and children in society in general' (Lerner 1986, p.239). While Morgan (1985) argues that patriarchy is still useful for the purpose behind its 'male-stream' conception (see Jukes 1993, p.9), Horsfall (1991) on the other hand argues that Morgan (1985) fails to make clear the fundamental importance of gendered power relations and its implications (see Jukes 1993, p.6).

Generally, FGM is performed by lay local practitioners or family members, who are mostly elderly women (Royal College of Nursing 2015). If patriarchy implies male influence and domination over their female counterparts yet FGM is solely carried out by women on other women, it can be reasonable to question how this constitutes patriarchal oppression of women. In response, the correlation can be made when one takes time to understand the complex socio-economic constraints that women encounter in traditional African communities.

Either as one that has grown up in Africa or, for anyone that has reasonably lived and interacted well enough in a traditional African community, it is not an understatement to assert that the most regular economic and income-generating activity among the population of most rural African communities is through peasant and pastoral farming. While the man has entitlements to land and other economic material the woman is essentially less favoured in these regards.

To buttress the point, Shell-Duncan, Obiero, and Muruli (2000) have stated that although women play an important role in economic production, they own no independent property and are thus dependent upon their husbands or, when widowed, upon their sons. Although a typical traditional African woman is very unlikely to have generated and saved up any cash funds of her own, even if she did, she would hardly have direct access to purchase land, cattle, or any other form of economic generating possessions. This is because unstated socially constructed values are patriarchy conditioned, which generally do not encourage the womenfolk to meddle in a value-based terrain such as land entitlement, considered to be customarily reserved for the menfolk.

Hence, women can only gain access to financial independence, socio-economic security and survival, and personal autonomy from their roles as wives who would have to undergo FGM. Even then 'men may [still] refuse to accept as brides, or pay a bride price for, young women whose virginity is not (supposedly) assured by FGM' (Burrage 2015, p.59). One gains further insight into the reason for the prevalence of FGM from Koso-Thomas' (1987) assertion (see Bransfiled 2004, p.9) that 'women, over time, have been successfully persuaded to attach special importance to female circumcision, motherhood, and housekeeping, to maintain male domination in patriarchal societies'.

One could assert that these patriarchal societies have over several generations succeeded to dominate and subdue their womenfolk in several ways. They have for example, successfully isolated women to a corner of ignorance such that in certain social norms such as why FGM occurs, Wardere (2016) posits that the women do not even think to question it. Arguably, in their subconsciousness, it has become a cultural value. Consequently, 'women have come to believe that mutilation of their genitals is necessary. Indeed, many women think that they are done all over the world. Thus, they are accepted as natural' (Hosken 1998, p.9). It is easy to see FGM as a gender-specific form of violence that indirectly operates at arm's length using females themselves as agents. In commendation of this view Burrage (2015, p.58) has stated that 'patriarchy is at its most powerful when it is invisible….'

Relativists would, however, argue that the practise of FGM is neither to dominate women nor the penchant to economically disempower them but rather for 'the preservation of traditional cultures – its values and beliefs' (Pollis 1996, p.322). While outsiders can interpret it as a custom that causes great pain, that economically exploits and subjugates women, relativists argue that members of practising communities have grown up into the normalcy of knowing and accepting FGM as a standard cultural norm. Even if it is acknowledged to cause pain, it is a necessary evil which, during the evolution of time until currently, has remained the way it is (Tilley 2000). For relativists, FGM is a cultural norm and enduring the pain is acceptable and 'seen as central to the transformation from childhood to womanhood…. [It] is a constitutive experience in preparing a woman for her role as wife and mother' (Shell-Duncan, Obiero, and Muruli 2000, p.117).

It can be argued that moments of pain and suffering just like moments of joy and happiness are, after all, normal aspects of life. For this reason, FGM thrives on relativist arguments such as the view held by the Mandinga community in Guinea-Bissau that:

> from the pain of childbirth to the death of a relative to the backbreaking work of clearing the fields before planting, people are said to learn to grow with each event that they are made to 'suffer'. Circumcision for boys and clitoridectomy for girls is no different – to endure the pain of the cutting is to accept one's path to self-enhancement and eventually, adulthood (Johnson 2000, p.223).

Rahman and Toubia (2001) have established that parents who procure FGM for their daughters and the practitioners who undertake the activity are not motivated by the desire to harm. The only reason behind the practice would be to conform to the values that are part of their socio-cultural identity. Erlich (1990) challenges outsiders to indigenous FGM cultures to understand that it is a practice that is 'embedded in a cultural context that encodes it as a beautifying and enriching phenomenon without which girls do not become women, and will therefore never be able to marry, have some degree of economic security, and lead full female lives' (see Lionnet 2005, p.101).

2.9.4 The argument relating to faith and traditional beliefs.

One other reason for the occurrence of FGM relates to faith and religion. Arguably, faith and religion are powerful concepts that can influence and guide thoughts,

behaviour, and the way of life for many individuals, traditional and modern societies. Burrage (2015) asserts that as a phenomenon, it is believed that FGM predates many world religions and has been known, like other harmful traditional practices from the earliest times. She argues that FGM is prevalent not only among traditional African religious adherents but also among animists and in both Muslim and Judeo-Christian countries.

One can argue that most Christians would vouch against sanctioning the procedure on their daughters as they may struggle to find biblical justification for it both in the Old and New Testaments. However, research has evidenced that the practice is prevalent among Coptic Christians although this is at insignificant scales (Gruenbaum 2001). The RCN (2006) records that the Falashe Jews of Ethiopia also practise it (see Royal College of Nursing 2015, p.6).

Some Muslim scholars and theologians have argued that female circumcision is not Islamic and should not be practised by Muslims (Kassamali 1998) (see Gruenbaum 2001, p.63). However, there is reason to link the practice to the Muslim faith because it tends to be more prevalent in communities where this religion is predominant. But above all, justification of it can also be related to the Hadith - the sayings that pertain to Prophet Mohammed. He is purported to have advised a midwife responsible for conducting circumcision in the early Islamic community saying 'Reduce, but do not destroy' (Gruenbaum 2001, p.64).

Although Muslims are of the view that 'Islam demands the practice to ensure spiritual purity' (Royal College of Nursing 2016, p.6), there are arguments which, enhance relativists claims for FGM to be seen purely as 'a cultural, not a religious, practice' (Rahman and Toubia 2000, p.6). One can posit that outsiders to this culture bring in baggage to the argument because they continue to see the practice in terms of a savage, primitive, and barbaric act. This demonstrates 'the insensitivity inherent in Western representations of other peoples' [cultural values]', (Korieh 2005, p.119). Relativists decry the double standards that are inherent in Western interpretations of FGM by 'forgetting that in the nineteenth century it was practiced on U.S. soil by U.S. doctors as a way of curing a host of ills, [yet] the West today constructs excision as the prism through which all African women are viewed, a sign of their otherness',

(Briere 2005, p.166). Amplifying this view, Bulbeck (1998) states that even in England 'female genital surgery was performed as late as 1945 as a 'cure' for masturbation, promiscuity, and nymphomania' (see Kalev 2004, p.347).

From the foregoing arguments, one can postulate that cultural relativism seeks to propagate the prevalence of FGM as a cultural right. As such, opponents to relativism need to recognise as (Zechenter 1997, p.325) has stated, that 'not only do there exist no extra cultural standards against which cultural practices may be judged as acceptable or unacceptable [but also the need to recognise that] all cultures are mutually [different and] incomprehensible'.

2.10 Health and other associated risks posed by FGM.

Regardless of any of the traditional forms of FGM administered, it is a procedure without a shortage of risks involved. The after-effects of FGM are arguably complex, including medical difficulties as well as social and legal implications. Female Genital Mutilation and its Management (see Bradley–Jones *et al.* 2022, p.2) reports that

> the physical health complications of FGM are both short and long term, ranging from haemorrhage in up to 62% of victims to implications for obstetric care and outcomes. FGM also has significant psychological sequelae including forms of anxiety such as post-traumatic stress disorder (PTSD).

The most fatal effect of FGM has resulted in death 'such as that of Mantessa Baraddji, a five-week-old baby girl [in France] who died of a slow but fatal haemorrhage on April 3, 1983, the day after she had been excised' (Lionnet 2005, p.99). Appendix 5 on page 136 summarises both the common long-term and short-term risks that are likely to be associated with FGM.

2.11 FGM as an implicit notion of child abuse and safeguarding

To determine how FGM constitutes child abuse *vis-a-vis* safeguarding and child protection it would make sense to first examine what the notion of child abuse and safeguarding means.

Waterhouse (2002) has claimed that there is no absolute definition of child abuse the reason being that one must consider whether there is definite knowledge of an intention to harm or knowingly not to prevent harm by any person having care or

custody of the child. Johnson (1990) corroborates this view with the perception that it is an impossible task to devise adequate working definitions of abuse that will cover every eventuality. This raises issues of boundaries in the true sense of what should be considered child abuse. While it can be difficult to have an absolute definition of the term, one would, however, also argue that without a working definition of the problem, professionals are arguably less likely to have a chance of identifying and tackling what can constitute acts of abuse to children.

Child abuse must, therefore, imply something, very least the maltreatment of a child. Kempe and Kempe (1978) think that although the web of cause and effect is imperfectly understood child abuse simply involves a hurt child. With relevance to the context of this research, a more befitting description suggests that:

> somebody may abuse...a child directly by inflicting harm, or indirectly by failing to prevent harm. Children may be abused in a family or in an institutional or community setting; by those known to them; or, more rarely, by a stranger. They may be abused by an adult or adults... (NSPCC 2010, p.1).

What one can draw from the extract above is the view that child abuse implies harm caused to a child either directly or indirectly.

On the other hand, what could safeguarding imply? As previously referenced in this thesis, it is common knowledge among education, health, and social workers that safeguarding is the responsibility of all those who work or are in contact, with children. The (Department of Health *et al.* 2000; HM Government 2005) have outlined as follows:

> The Children Act 1989 places a duty on local authorities to safeguard and promote the welfare of children in need in their area. Section 175 of the Education Act 2002 places a duty on local authorities and on school and college governing bodies to make arrangements to safeguard and promote the welfare of children. The Children Act 2004 places a duty on key persons and organisations to make arrangements to ensure that their functions are carried out with regard to the need to safeguard and promote the welfare of children (see Willow 2009, p.22).

Though the Children Act 1989 and subsequent Acts relating to the wellbeing of children all make references to 'safeguard and promote the welfare of children' the

notion of safeguarding seems to be only relatively newly introduced in practical terms in social care practice in the UK. The death of Victoria Climbie on 25 February 2000 after being thoroughly and brutally tortured by her great-aunt and her partner generated a huge national condemnation from the public and the media. Various regulated care agencies were criticised for their failures to protect Victoria from death.

Hence, 'as a direct response to [her] death… the new Labour government introduced policy and legislative changes which led to a shift away from the concept of child protection towards safeguarding' (Chisnell and Kelly 2016, p.10). With the introduction of programmes such as Every Child Matters (ECM) in 2003, the Common Assessment Framework (CAF), Sure Start, and the Working Together to Safeguard Children (2006), professional interventions have moved from investigation, abuse, and protection to the need for robust assessments, need, and safeguarding (Chisnell and Kelly 2016).

Given the changes implemented safeguarding has received a broader spectrum in its meaning and application. Its definition appears to be more inherently implicit in the processes social care practitioners embark upon to ensure the wellbeing of children who are at risk of harm and/or needing to be prevented from harm recurring. Lindon (2008) considers safeguarding as the process of creating a safe and protective environment for children and young people who are vulnerable or have already been harmed. The charity commission (2014) argues that safeguarding as a term is broader than child protection. However, the statutory definition states that safeguarding implies:

> the action we take to promote the welfare of children and protect them from harm...and promoting the welfare of children [means]
>
> - protecting children from maltreatment
> - preventing impairment of children's health and development
> - ensuring that children grow up in circumstances consistent with the provision of safe and effective care and
> - taking action to enable all children to have the best outcomes (HM Government 2013, p.7).

Meanwhile, The Royal College of Paediatrics and Child Health (RCPCH) defines child protection itself as 'the activity that is undertaken to protect specific children who are suffering, or likely to suffer, significant harm as a result of maltreatment or neglect' (RCPCH 2014, p.4). Safeguarding, therefore, implies processes inherent in keeping children safe. Child protection is part of that process. Otherwise stated, safeguarding can be considered as the 'how' and child protection the 'what' to do to keep children safe from abuse.

Bearing in mind the various definitions of child abuse that have been presented earlier and especially, the definition provided by the NSPCC; taking into consideration the FGM types identified earlier; mindful of the parties involved in performing the procedure; taking into consideration the reasons that explain why FGM prevails; bearing in mind the very young ages children are administered FGM; and considering the psychological, emotional and physical effects FGM can leave on the child, there, arguably is a strong case for FGM to be considered as one form of child abuse. The Royal College of Nursing (2015) has acknowledged FGM as a form of child abuse. Also, the RCM *et al.* (2013) in their intercollegiate report have clearly stated that FGM is child abuse and a severe form of violence against women and girls.

It is a criminal offence to practise FGM in the UK sanctioned by two Acts of Parliament in 1985, and 2003, respectively. Hence, in the UK 'if the offence occurs in respect of someone under 18, it, like all other harmful traditional practices (HTP), is recognised…as an illegal act of child abuse' (Burrage 2015, p.15). Because of this health care professionals, the police, education, and social work professionals, are all together tasked to consider their responsibilities in safeguarding girls and women who may be affected by, or at risk of being mutilated (The Royal College of Nursing 2015).

Having made the case for FGM as a form of child abuse suggests grounds in the context of the UK and by extension the Western context, to argue that the practice poses safeguarding implications to the girl child. The argument has also been made that the various reasons justifying why FGM prevails could be assembled into one overriding factor, namely, Culture. This view is based on the premise that FGM identifies with a practice that can be described as a way of life, and culture has been

described as 'a way of life of people including values and norms' (see Connolly, Crichton-Hill and Ward 2006, p.17).

However, to better situate the arguments within context one may need to ascertain for instance, why FGM is more blanketly seen by the communities that practise it as a cultural belief with less consideration of the risks it poses and how abusive the practice can be to the child. It has been claimed that even when the risks of the procedures could have been contemplated, some parents who decide to subject their daughters to FGM/C believe that the benefits outweigh the risks. Intriguingly, what could the notion of child abuse imply within the context of African culture in general, and specifically the African communities which practise FGM? Could it rather be that Western culture defines child abuse from no other perspective other than from a Western/Universalist perspective?

In retrospect, the main research question for this study seeks to know as follows: *How does the practise of FGM pose safeguarding concerns to BME girls in the UK, and what are the options for overcoming FGM?* Given that the practice of FGM is essentially rooted in culture, and it has been recognised as a form of child abuse in the UK, it is, therefore, in the view of The Royal College of Nursing (2015) part of the responsibilities of health and social welfare practitioners to safeguard girls and women who may be affected by, or at risk of being mutilated. One of the approaches to achieve this could entail that health and social welfare professionals demonstrate culturally congruent practice.

As much as FGM procedures can amount to the definition of culture for a given society, the need for culture to prevail should, however, not compromise the protection and safeguarding of children. Yet, this report will argue that cultural practices can impinge on the safeguarding of children where professionals within the health and social welfare institutions are not demonstrating culturally congruent practice and are not appropriately complying with professional conduct *vis-à-vis* respect of cultural values. Otherwise stated, this study argues that for safeguarding concerns linked to FGM to be effectively managed, (which could significantly contribute to the curbing of FGM in the UK), social welfare and education practitioners including practitioners across the

range of other children welfare agencies will need to demonstrate abilities in culturally congruent practice.

2.12 What is professional culturally congruent practice?

Jeffreys (2010) has argued that there is still very limited research in understanding what culturally congruent practice is all about. This is because it is still 'a developing area [in health and social welfare] with no real agreement on what is meant by various terms' (Harrison, Harvey and Maclean 2010, p.13). The shortage of literature in this field can affect how research is substantiated, but notwithstanding, this study is still keen to contribute to the subject because this study holds the view that cultural sensitivity and congruence is highly relevant to effective practice among health and social welfare professionals.

To be culturally congruent implies 'the application of evidence-based [health and social welfare practice] that is in agreement with the preferred cultural values, beliefs, worldview, and practices of the [social and] healthcare consumer and stakeholders' (Marion, *et al.* 2016, p.1).

For their part, NASW (2001) considers cultural congruence in professional practice as:

> The process by which [professionals], individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognises, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each (see Harrison, Harvey and Maclean 2010, p.8).

A rather malleable but impressionable definition upholds that culturally congruence in professional practice is 'care that is customized to fit with the client's cultural values, beliefs, traditions, practices and lifestyle' (Jeffreys 2010, p.51).

Powell (2011) contends that safeguarding children work is complex and can be challenging and emotionally demanding. Improving both professional knowledge, and value-based judgement is, thus quintessential in ensuring culturally congruent practice for the practitioner. But also, being professionally cognizant of their own culture *vis-à-vis* the best interest of the child is quite important. This is a view agreed with by Purnell (2000) who posits that 'demonstrating knowledge and understanding of the [other] person's culture' (see Harrison, Harvey and Maclean 2010, p.10) can enhance

professional cultural congruence. Furthermore, Harrison, Harvey, and Maclean (2010), have argued that culturally congruent practice entails a demonstration of a set of skills by practitioners. These include skills in communication and assessment and being sensitive to the values of care recipients.

Evidencing a range of values and attitudes can equally be considered a key model in attaining culturally congruent practice in child protection and safeguarding. However, the problem as Shardlow (1998) has argued is that there is no consensus about the meaning of values in social welfare practice. This can limit the effort to provide a working definition and a guide for professionals for a principled approach to service interventions (see Smith 2005, p.2).

In a similar light, Clark (2000) recognises the continuing difficulties experienced in the health and social care field in achieving a clear and consistent understanding of what is meant by values (see Smith 2005, p.3). This problem, Clarke (2000) further upholds, is not restricted only to those in health and social care, but also includes other fields such as philosophy, sociology, and psychology (see Smith 2005, p.3).

At the centre of the contention can be the problem of whether to look at professional values in terms of the ethical obligations and behaviour of workers towards service users or in terms of the need for workers to comply with organisational norms, policies, and expectations. As a compromise, Smith (2005, pp3-4) proposes that 'we can … therefore, [define] values as systems of principles and beliefs which are intended to govern our approach to practice … [and] guide the choices and actions of professionals in children's services'. One would think that respecting the role which culture plays, and the need for professionals to value diversity would enhance professional culturally congruent practice. Purnell (2000) also agrees with the foregoing view. He asserts that in addition to valuing and celebrating difference, professionals in health and social care should evidence a non-judgemental attitude, and be open to cultural encounters and embrace diversity (see Harrison, Harvey and Maclean 2010, p.10).

The preceding views arguably provide a suitable definition and exemplification of personal professional values. However, it is important to recognise the distinction between organisational values which, are expressed in the form of mandates or

instructions, and values which, are reflected in our own moral choices and professional judgements (Smith 2005).

While it is important to exercise personal professional principles and beliefs, Cross *et al.* (1989) argue that, if culturally congruent practice would be attained there is a need for professionals to go through organisational processes of culturally competent practice especially, valuing diversity, and being conscious about dynamics which occur when cultures interact (see Harrison, Harvey and Maclean 2010, p.10). Dilemmatic and contentious as the debate may, however, be, this study aligns with the view that for culturally congruent practice to be attained, values should entail a professional demonstration of both personal professional principles and beliefs on the one hand, as well as compliance with organisational principles on the other hand. Where there is an inability to evidence the learning and demonstration of any of these attributes culturally incongruent practice would debatably prevail.

To conclude, this literature review has attempted to draw broadly from information relevant to the subject of this research to initially address the subsidiary research questions posed in the early part of the study. A picture of the prevalence of FGM in the UK has been presented. This suggests that FGM constitutes a form of child abuse and by extension, it poses safeguarding implications for BME girls in the UK with origins from FGM practising communities in Africa. This view is, however, only anecdotal until data would be analysed and interpreted to confirm or disapprove the claim.

Additionally, knowledge has been gained which presents FGM as a traditionally entrenched phenomenon whose practice hinges on complex time-honoured social mores within its practising communities. The prevalence of FGM is conveyed through the concept of cultural relativism – a concept which claims that 'every society has its own beliefs and ways of life, and in each of them those ways are the best for that community' (Burrage 2015, p.11).

Also, with the understanding that FGM is essentially a cultural practice, the notion of professional culturally congruent practice has been explored with the view of finding out how professionals can practice competently without jeopardising both the cultural

values of service users and at the same time can ensure safeguarding for BME girls who can be at risk of abuse from a cultural practice such as FGM.

This literature review is, therefore, deemed to have addressed the subsidiary questions of the research. The interest ahead will be to find out if based on understanding what culturally congruent practice is all about, will the data that would have been collected be able to address the main research question regarding how FGM poses safeguarding concerns to BME girls in the UK? If so, what options are available for overcoming FGM?

However, going forward, the very next interest of this study is part three. It focuses on the theoretical and methodological research approaches used in the study.

3. Theoretical and methodological research approaches

3.1 Positioning the research methodology: The qualitative approach

The qualitative research design will be applied as the main methodological approach for this study. FGM is about a social phenomenon. It can be considered as an abstract concept of human belief that results in an actual practical procedure. Arguably, the most suitable approach to measure and understand the social reality implicit in the FGM procedures is to use an inductive (qualitative) rather than a deductive (quantitative) approach. Creswell (2014) has suggested that a central phenomenon is the key concept, idea, or process studied in qualitative research.

This document's central interest is to examine the safeguarding implications of FGM for BME girls, and ideas on how FGM can be minimized or eradicated in the UK. The approach is to gather lived experiences from FGM survivors both in terms of how FGM impacts survivors and how it can be eradicated. Concurrently, lived experiences from welfare professionals will also be collected and assessed in terms of how culturally congruent their practice enhances or impacts survivors of FGM and their views on how FGM can be eradicated in the UK.

Hence, a qualitative research design is deemed suitable for this purpose. It can be difficult to define qualitative research because, it is a very broad church which, includes a wide range of approaches and methods found within different research disciplines (Ormston, *et al.* 2014). The complex and interconnected concepts inherent in the term are noticed in the way one school of thought has defined it, namely, as research that involves:

> The studied use and collection of a variety of empirical materials - case study; personal experience; introspection; life story; interview; artefacts; cultural texts and productions; observational, historical, interactional, and visual texts – that describe routine and problematic moments and meanings in individuals' lives (Denzin and Lincoln 2000, p.3).

Flick (2009) for his part asserts that 'qualitative research is often described as a naturalistic, interpretive approach, concerned with exploring phenomena from the interior' (see Ormston, *et al.* 2014, p.3). The qualitative approach engages in a process which, as Creswell (2013) has highlighted begin with assumptions and the use of interpretive/theoretical frameworks that inform the study of research problems,

addressing the meaning individuals or groups ascribe to a social or human problem. One can assert that to give meaning to a concept implies first generating the concept and then giving it a context which, could either be concrete or abstract.

Arguably, where an interpretive process results in an outcome that engaged in asking 'what, why, and how questions rather than how many' (Ormston, *et al.* 2014, p.3), then the process in deriving the phenomenon can be said to be identifiable with a qualitative design approach. In this logic, 'what', 'why', and 'how' questions will tend to generate 'descriptive' processes as responses.

Punch (2016) holds the view that to describe is to draw a mental picture of what happened, or of how things are proceeding, or of what a situation or person or event is (or was like), or means, or of how things are related to each other. Hence, 'a study is classified as qualitative if the purpose of the study is primarily to describe a situation, phenomenon, problem or event … and if the analysis is done to establish the variation in the situation, phenomenon without quantifying it' (Kumar 2014, p.16). Therefore, as much as this study will be commentative and critically reflective by its qualitative nature the stylistic approach will be mostly descriptive.

This research, on the one hand, will be examining if there are safeguarding implications of FGM for BME girls from the lived experiences of survivors, and their ideas on how FGM can be overcome in the UK. On the other hand, it will also try to examine if there are safeguarding implications of FGM for BME girls resulting from the ability or inability of social welfare professionals to exercise culturally congruent practice. Additionally, ideas about how FGM could be overcome will be sought from the professionals involved in this research. To go about all this arguably requires interpretive options that are flexible. By its nature, the qualitative inquiry offers a better option for this research.

To reinforce its flexible nature, the qualitative approach accordingly,

> privileges no single methodology practice over another …. It has no theory or paradigm that is distinctly its own …. Qualitative researchers … also draw upon and utilize the approaches, methods, and techniques [among others including] ethnomethodology, phenomenology, hermeneutics, feminism …(Denzin and Lincoln 2000, p.6).

The intrinsic advantage in being flexible and accommodating crystallises well with the various aims of this document. This gives the qualitative approach an edge over its counterparts as the most suitable for this study.

Ritchie and Ormston (2014) have further argued that with subject areas in which, the phenomenon that needs to be studied is deeply rooted within the participants' personal or professional knowledge or understanding of themselves, the qualitative approach will present more favourable in this context. In document 3 for example, the prevalence of the FGM phenomenon was presented to be hinging on the belief that it is a deeply rooted cultural value. In document 4, the interest was to explore how social welfare practitioners can be culturally congruent in professional practice in a society where a deep-rooted cultural practice such as FGM prevails and yet will not jeopardise safeguarding. This document attempts to synthesise the two subject areas identified in the two preceded documents in terms of firstly, the safeguarding implications of FGM to BME girls in the UK, and secondly, the views of both participants on how FGM can be tackled. Arguably, the qualitative, more than its quantitative or mixed counterparts appear to be more favourable to provide a meaningful interpretative framework on a deep-rooted cultural subject such as FGM.

The debate over which methodological approach can be more suitable than the other could go unending among researchers. Valsiner (2000, pp.101-102) considers it an unnecessary debate and challenges social research to go beyond such rhetorical fights, recommending that 'it [should be] the phenomenon under investigation, and the general presuppositions of the research, which [should] jointly determine whether a translation of the phenomenon into data of quantitative or qualitative form makes epistemological sense or not'. As for Ackroyd and Hughes (1992), they contend that 'both qualitative and quantitative approaches have their strengths and weaknesses, advantages and disadvantages, [and] neither one is markedly superior to the other in all respects' (see Kumar 2014, p.17). What matters for Kumar (2014) should be the research problem itself which, should determine whether the study is carried out using quantitative or qualitative methodologies.

3.2 Phenomenology as the underlying qualitative research strategy

A qualitative research strategy, to go by the views of Denzin and Lincoln (2000, p.22) 'comprises of a bundle of skills, assumptions, and practices that the researcher employs as he or she moves from paradigm to the empirical world'. Although one could argue that other techniques such as symbolic interactionism, and ethnography would equally lend themselves as suitable methodological techniques for this study, phenomenology has, however, been identified as the technique that most befits the methodological approach of this research.

From Husserl's (1931) belief underlining the concept 'phenomenology deals with the way people make sense of their … world and how they construct their daily life' (see Sarantakos 2012, p.44). Husserl's concept has been expanded by other researchers hence, Schwandt (2000) advances that a phenomenological analysis is 'principally concerned with understanding how the everyday, intersubjective world the life world, or *Lebenswelt* is constructed' (see Denzin and Lincoln 2000, p.192). For his part, Denscombe (2014, p.95) highlights that 'phenomenology is concerned, first and foremost, with human experience …. [It] prefers to concentrate its efforts on getting a clear picture of the 'things in themselves' – the things as directly experienced by people'.

Informed by the theory that knowledge about a phenomenon is most realistically attained from the perspective of interpreting, describing and constructing meaning out of a prevailing life experience out there, one can concur with the Husserlian argument that 'knowing' is best attained from the subjective life experiences of people who have lived an event - for as McIntosh and Wright (2019, p.20) have questioned, 'what is any experience if it is not lived'?

Implicitly, to derive meaning out of FGM as a cultural phenomenon among a community of people will entail an understanding from members of that community what the practice means to them. Simultaneously, to make sense out of the concept of culturally congruent practice concerning safeguarding implications resulting from the prevalence of FGM it will equally require that one learns from social welfare practitioners what their understanding is, at all about a deep-rooted cultural value called FGM.

Also, learning from both groups what approaches could be used to overcome the prevalence of the practice is equally important. This by extension ascribes to the Husserlian phenomenology of 'knowing' which, Wertz and Fischer (2002, pp. 276-277) advocate, 'investigates the ways events appear when theories and constructs are for [a] … moment put aside by the researcher [to inform] … the ways a person's world is inevitably formed in part by the person who lives it'.

Approaching meaning away from the researcher's point of view relates to one aspect of Husserl's (1931) concepts referred to as '*epoche* (or bracketing), in which investigators set aside their experiences, as much as possible, to take a fresh perspective toward the phenomenon under examination' (Creswell 2013, p.80). Thus, to construct and interpret reality out of socio-cultural phenomena such as FGM, cultural congruence vis-a-vis safeguarding related to FGM, phenomenology further asserts that:

> We must lay aside our prevailing understanding of phenomena and revisit our immediate experience of them … [so that] new meanings may emerge. Current understandings have to be 'bracketed' to the best of our ability to allow phenomena to 'speak for themselves', unadulterated by our preconceptions. The result will be new meaning, fuller meaning or renewed meaning (Gray 2013, p.24).

Admittedly, the non-interference of the researcher can avoid prejudices that may bias the data and compromise the subjective experiences of participants.

Heidegger's (1889 - 1976) theory, however, challenges Husserl's claims of knowledge being seen from the subjective view of how people have experienced it. In Heidegger's view, knowledge is based on the concept of being in the world rather than knowing the world through descriptive channels other people have offered. In line with Heidegger, it has been argued that:

> From a phenomenological perspective, researchers are part and parcel of the social world they seek to investigate. Phenomenologists see the social world as existing only through the way it is experienced and interpreted by people – and this includes researchers as much as anyone else. Researchers like other people use common-sense assumptions when interpreting events, and this is where phenomenology has an important point to make for researchers (Denscombe 2014, pp.98-99).

Dahlberg, Drew and Nystrom (2008) have highlighted that 'the essence of human understanding is hermeneutic, that is, our understanding of the everyday world is derived from our interpretation of it' (see Reiners 2012, p.1). It can be a challenging endeavour, including for this study, to bracket experiences that arise while undertaking a piece of research. Gray (2013) believes that the key is gaining the subjective experiences of the subjects, sometimes by the researcher trying to put themselves in the place of the subject. This allows prospects for alternative experiences – experiences that vary from situation to situation, and from society to society.

In this study, therefore, the effort will first be made to present the lived experiences of the survivors of FGM regarding FGM as a cultural value to them. Secondly, the effort will also be made to present the lived experiences of social welfare professionals regarding culturally congruent practice towards FGM and safeguarding.

However, the researcher's interpretations of the concept would contribute to the given reality because as it has been corroborated 'people do not passively obey a set of social rules …. They, [researchers] are viewed instead as 'agents' who interpret experiences and who actively create [meaning out of observed lived experiences]' (Denscombe 2014, p.96). In line with this view, bracketing will not strictly apply to this study.

Vividly expressed, phenomenology

> carries an aura of humanism and, in its efforts to base its enquiry on the lived experiences of people in the everyday world, it represents a style of research that is far removed from any highlighted, abstract theorizing. In effect, the researcher needs to be close to the object of study (Denscombe 2014, pp. 102-103).

For this study, phenomenology presents as the most suitable methodological strategy especially, because it focuses on the realities of the life world of subjects who have directly lived the FGM phenomenon, and practitioners who provide professional social work practice to all members of the British society including members of the BME community within which, the phenomenon of FGM prevails.

3.3 The interpretive paradigm: social constructionism

In their views, Willis, Jost and Nilakanta (2007, p.8) have suggested that a paradigm in research is a 'belief system, a world view, or a framework that guides research and practice in a field'. Otherwise put, research paradigms would refer to abstract principles and beliefs which, guide researchers to give meaning to a phenomenon.

Three generically but quite interrelated principles can be identified. These are the ontological, epistemological, and methodological factors 'packaged in paradigms' (Sarantakos 2012, p.29). How interrelated these factors are, Sarantakos (2012, p.28) again posits is that 'ontology constructs the logic of epistemology, epistemology structures the nature of methodology, and methodology prescribes the appropriate types of research methods, designs and instruments'.

Deriving meaning about a phenomenon in research, it has been argued, is not just about determining the question of ontology, that is 'what is the nature of reality' (Willis, Jost and Nilakanta 2007, p.9), but it is also about the question of epistemology, that is, what Creswell (2013, p.20) states as 'what counts as knowledge'. So, to sum up, Denzin and Lincoln (2000, p.19) have stated that, 'the net that contains the researcher's epistemological, ontological, and methodological premises may be termed a *paradigm* or an interpretive framework'.

Sarantakos (2012) upholds that there are two types of ontologies namely, the realist ontology, and the constructionist ontology. The realist ontology involves an empiricist epistemology, a quantitative methodology whereby, the meaning of a phenomenon is derived from the perspective of positivist interpretation. Positivism as an empiricist epistemology explains:

> a world [view] considered to exist independently of the human mind, [whereby theoretical] propositions [are] logically deduced from theoretical statements [that] are tested … against the objectively observed, the factual nature of the real world, thus determining the truth or falsity of propositions, which in turn influence the contents of theories (Seale 1999, p.23).

Returning to the main research question can be instrumental in determining whether positivism serves as a suitable interpretive framework for this document or not.

Literarily, the main research question seeks to know if FGM poses safeguarding concerns to BME girls in the UK, and could there be options for eradicating FGM? If in realist ontology room for questioning is limited given that seeing is believing, then the answer to the question implicit in the main research question above can be a direct *Yes* – the reason being that if data is interpreted from a purely positivist/realist perspective and if more especially, such interpretations are seen through the lens of Western culture, then as a traditional rite of passage, the practices of FGM tantamount to child abuse. Hence, safeguarding implications are inherent in FGM procedures. It can be argued that arriving at such a conclusion is done based on *a priori* theory – a basis which Creswell (2013, p.24) considers to be 'reductionist, logical, empirical, [and], cause-and-effect oriented ….'

In contrast to positivist ontology, social constructionism, also often referred to as interpretivism (Creswell 2013) befits the interpretive framework of this study. It has been argued that constructionist ontology entails an interpretivist epistemology and by extension a qualitative methodology (Sarantakos 2012). For his part, Schwandt (2000) contends that social constructionism rejects the naïve realist view of representation. He justifies this with the point that 'knowing is not passive – but active; that is, [the] mind does something with these impressions, at the very least forming abstractions or concepts. In this sense, construction means that human beings do not find or discover knowledge so much as we construct or make it' (Schwandt 2000, p.197).

In this logic what we, therefore, call knowledge is just not limited to what directly 'exists out there and is waiting to be discovered' (Neuman 2003, p.72), namely, that FGM is a traditional rite of passage. To hold this view can be absolutist and reflects a realist ontological perspective. Rather, knowledge about the notion of FGM as a traditional rite of passage is obtained by not just seeing it as a cultural practice prevalent among its adherents. It is also about the researcher's interpretation of how such a practice positively or negatively impacts society.

Similarly, knowledge about how social welfare practitioners demonstrate culturally congruent practice can be determined not just by observing how compliant they are to the cultural codes of the communities they serve. It is also additionally about how

the researcher can interpret, describe and construct meaning out of these professionals' compliance to a given community's cultural values vis-à-vis their safeguarding role. Schutz (1962) explains it better by stating that 'all knowledge of the world, in common-sense as well as in scientific thinking, involves constructs, i.e., a set of abstractions, generalizations, formalizations and idealizations, specific to the relevant levels of thought organization' (see Flick 2014, p.76).

The point is not just about the 'knowing and prevalence out there' of FGM as a traditional rite of passage (realist ontology). That will limit it to just the survivors' perspective. Rather, knowledge about safeguarding implications of FGM and how it can be ended would be best determined both from the phenomenological and the interpretivist (constructionist ontology) standpoints. Similarly, finding out how social welfare practitioners exemplify safeguarding *vis-à-vis* FGM and their views about how FGM can be eliminated will be determined not just by their knowledge in safeguarding but also by an interpretation of their knowledge and skills in being culturally congruent as practitioners. This ties in with what Bradley and Schaefer (1998) describe as a 'community consensus regarding what is real, what is useful, and what has meaning especially meaning for action and further steps … [by] … groups and individuals around [social] … phenomena' (see Lincoln and Guba 2000, p.167).

With its reductionist and other associated positivist principles, it can be difficult to measure and standardise lived experiences within the context of this research in the light of positivist epistemology. Therefore, in want of an interpretive paradigm for this document, constructionist ontology offers a suitable choice for the fact that it is 'rooted in an emphatic understanding, or *Verstehen*, of the everyday, lived experience of people in specific historical settings' (Neuman 2003, p.75).

4. Research Methods

4.1 The qualitative data collection method

Punch (2013) recommends that once the researcher is satisfied with the empirical process, then the research can move from content to *method,* which is, 'the word … used to refer to a particular procedure for collecting and analysing data' (Willis, Jost and Nilakanta 2007, p.229). A qualitative approach was used for collecting data for this study. The view has been expressed that

> qualitative research explores complex phenomena encountered by clinicians, health care providers, policy makers and consumers. Poorly designed studies and inadequate reporting can lead to inappropriate application of qualitative research in decision-making, health care, healthy policy and future research (Tong, Sainsbury and Craig 2007, p.1).

With the understanding that one of the aims of qualitative research is to explore complex phenomena as stated in the extract above, it can be reasonable to suggest that to facilitate understanding for readers, policy makers, and other researchers, it will require that the qualitative research method is well-structured and clearly reported. This would arguably imply making use of internationally recognised and relevant guidelines for reporting qualitative research. This study will, therefore, apply one of the EQUATOR-Network's forms for reporting qualitative research methods – hence, the Consolidated criteria for Reporting Qualitative Research (COREQ) and its 32-items checklist. While a full discussion of the research methods will be explored next, a comprehensive presentation of this concept has also been captured in the COREQ's 32-items checklist in appendix 6 of this study.

4.2 Data gathering approaches.

4.2.1 Sampling strategy: purposeful sampling

In contrast to probability sampling which deals in numbers and statistics, purposive sampling as a variety of nonprobability sampling is appropriate for this study. This is because either as a researcher or just as an informed mind, one can 'learn about the processes of social life in a specific context [and] it selects cases with a specific purpose in mind' (Neuman 2003, pp. 211-213). This assertion applies to this study in the sense that firstly, FGM is about a socio-cultural life phenomenon. Secondly, the

insights of the phenomenon can arguably be best explored through constructing meaning from lived experiences of participants who, some on the one hand have survived the FGM experience, and on the other hand from other participants who provide professional support across the range of all members of the British society wherein, the FGM phenomenon is occurring.

Another reason for using purposeful sampling for this study aligns with what Creswell (2013, p.155) suggests, namely, that as a phenomenological study, 'it is essential that all the participants have experience of the phenomenon being studied …. [Purposeful] sampling works well when all individuals studied represent people who have experienced the phenomenon'. Creswell 's (2013) view holds for the FGM survivors who have contributed to the data in this study.

However, it can be a bit unwise to purport that all social welfare participants involved in this study would have knowledge and experience about FGM as a cultural phenomenon. Creswell (2013, p.83) has posited that 'finding individuals who have all experienced the phenomenon may be difficult given a research topic'. Arguably then, not all social welfare professionals would have life experience of dealing with cases involving FGM. However, it can be argued that as social workers, and education staff the expectation is for them as professionals to demonstrate a degree of knowledge in cultural competence due to the cultural diversity of the British society in which they practice, and among whom is an African community who profess FGM as a cultural practice.

4.2.2 Sampling size and site

There are thirteen respondents taking part in this study. Among these, seven represent the community of FGM survivors, and six respondents represent the social welfare and education professionals. Of the seven respondents representing the FGM survivors, five are women and two are men. The reason for selecting more women over men is on the basis that the procedure is performed on women. Men are, however, also required for the data because they get married to the women who have undergone FGM. It is, therefore, important to have their views and appreciations about the implications of the practice to BME girls and women in the UK and their indigenous home countries.

Most of the respondents representing the community of FGM survivors were contacted from one of the FGM hotspot cities in the UK. The city is also a host to clinics that run local FGM awareness raising both for men and women. One other female participant who is also a survivor was, however, contacted from another city. She runs a Foundation that works in conjunction with one of the women's groups in the city where most of the survivors are based.

On the other hand, the professional participants were approached from various agencies including a well-established national children's charity, the Children's Social Care service, and the Education Department of a Local Authority Council. These various agencies are, however, located in another city but still in England.

Ideally, it would be advantageous for respondents in a phenomenological study to be located at a single site given the common feature of a shared experience among them (Creswell 2013). Creswell (2013) further argues that the more diverse the research sites are, the more difficult it will be for the researcher to find common experiences, themes, and the overall essence of the experience for all participants. While this argument obtains, this did not, however, very much affect the data collection process because of the support provided by two different gatekeepers who each worked very well to facilitate access to each group of participants.

It was unclear at a given point in the study what could be the appropriate sampling size for this study. This is not an uncommon problem as 'students and new researchers often ask, how large does [a] sample have to be' (Neuman 2003, p.231). However, as the research journey progressed more insights were gained to give understanding that data for phenomenological studies can be based upon even quite small case studies especially because phenomenological studies according to Gray (2013) are less keen with generalisations to larger populations. Creswell (2014) corroborates this view stating that it is typical in qualitative research to study just a few individuals. Creswell (2014) further elaborates that the overall ability of the researcher to provide an in-depth picture diminishes with the addition of each new individual. It can also be argued that gathering qualitative data and analysing it takes considerable time, and the addition of everyone only extends the time.

Another study has stated that 'qualitative research works with fewer samples than quantitative studies do…. The appropriate sample size for many qualitative types of research is 15-20 interview subjects who are homogeneous' (Hossain, Alam and Ali 2024, p.152). In his view, Sandelowski (1995) has also stated that 'a sample size of ten may be adequate for a qualitative study in a community that is homogeneous' (see Hossain, Alam and Ali 2024, p.152).

Also, Pinnegar and Daynes (2007) have stated that 'the intent in qualitative research is not to generalize the information … but to elucidate the particular, the specific' (see Creswell 2013, p.157).

Thus, the thirteen participants selected for data collection for this study can 'purposefully inform an understanding of the research problem and central phenomenon in the study' (Creswell 2013, p.156). Having established what kind of data would be gathered, attention then switched over to what data will be gathered, and how will it be gathered.

4.2.3 Gathering verbal data

This study is attempting to respond to a central research question requiring the views of survivors of FGM and social welfare professionals on *how FGM as a practice poses safeguarding concerns to BME girls in the UK, and what options are there for curbing/eradicating FGM?* As a piece of qualitative research, the thoughts of the participants who have been earmarked for data gathering can arguably be best obtained by interacting and exchanging conversations with them. And so, the question can be asked: *what kind of data comes from conversations?* The answer to this question would arguably be *verbal data* – a description which, is 'an umbrella term covering a variety of data that have in common that they primarily consist of words' (Flick 2014, p.195).

Punch (2013) observes that obtaining empirical data for qualitative research thrives with words rather than the use of numbers. Hence, purposive data in the form of interviews would be ideal for this research and this answers the question of 'how' the data is obtained.

4.2.4 Interviewing as a qualitative data method

Many definitions can be found explaining what an interview is all about. It is, for example, 'social interaction between two strangers with the explicit purpose of one person obtaining specific information from the other. … The information is obtained in a structured conversation in which the interviewer asks prearranged questions and records answers, and the respondent answers' (Neumann 2003, p.292). However, a more befitting definition has stated that 'research interviews are a method of data collection that uses people's answers to researchers' questions as their source of data' (Denscombe 2014, p.184).

Among many types of interview methods, the one opted for in this study is the one-to-one interview, and specifically, the semi-structured interview format. It is the kind of interview that seeks to understand the lived everyday life of participants from their perspectives (Brinkmann 2015). For a study which, on the one hand, attempts to examine the views of adherents to a cultural phenomenon, and on the other hand, is seeking to obtain the lived experiences of professionals relating to how they exercise cultural congruence *vis-à-vis* safeguarding, the best approach arguably is by closely interacting with both groups as they constitute the primary participants of the experiences. The views of both groups on how to overcome the prevalence of the phenomenon will also be sought for. The semi-structured interview arguably offers a suitable format to obtain the data.

Again, as a qualitative and phenomenological study, the good thing about using semi-structured interviewing is that the 'interviewees [will] have a … stock of knowledge about the topic under study' (Flick 2014, p.217). This is certainly the case with the participants from both groups involved. So, in-depth knowledge about FGM is expected from the survivors on the one hand as well as a demonstration of a good level of awareness about child safeguarding, and cultural congruence would be expected from the professionals. However, what one does not know at this stage is if it will be evident that professionals are demonstrating culturally congruent practice in a culturally diverse Britain without jeopardising safeguarding. This can only be seen when the data would have been analysed and interpreted.

4.3 Data analysis and interpretation

It can be challenging when it comes to unravelling and making sense out of the data collected for research. Taylor and Bogdan's (1998, p.140) argument holds in support of this claim, namely that; data interpretation and analysis 'is not fundamentally a mechanical or technical process; it is a process of inductive reasoning, thinking, and theorizing'. Ritchie and Spencer (2002, p.305) have amplified the argument by suggesting that to analyse qualitative data one has to understand that it 'is essentially about detection, and the tasks of defining, categorizing, theorizing, explaining, exploring and mapping are fundamental to the analyst's role'. Drawing from these arguments, one can posit that data analysis and interpretation is at the heart of qualitative research. This is a view Willig (2014, p.136) has agreed with – stating that 'without interpretation, we cannot make sense of our data'. Ultimately, these features would be taken into consideration when the data interpretation and analyses phase of the study is engaged.

It is equally important to foreshadow here that meaning out of the data collected for this study will be interpreted by applying both the *empathic* and the *suspicious* interpretative approaches to data interpretation and analysis. The empathic interpretation approach 'requires the interpreter to enter the phenomenon, to get inside it and to try to understand it 'from within' (hence the reference to 'empathy'). The aim is to amplify meaning rather than to explain what something is really about' (Willig 2014, pp. 138-139). On the other hand, the suspicious interpretative approach

> is akin to detective work where clues are interpreted to find out what 'really happened'. Appearances are not taken at face value (hence the reference to 'suspicion') and instead are used as clues which point to a more significant, latent meaning (Willig 2014, p.138).

The suspicious approach aims at uncovering the unknown in the spoken accounts of respondents. Overall, as a phenomenological study, this study will seek to present the meaning which is contained in the lived experiences of the participants. At the same time, Willig (2014) further posits that what we usually come across provided by respondents, in other words, what appears before us, is not the whole story but just the tip of the iceberg; and that real understanding can only be gained by looking underneath to find out what is going on.

Thus, in addition to presenting the lived experiences of the participants involved, the attempt will also be made to unbracket or decode what is expressed in the spoken word to gain a better understanding of the accounts presented by the respondents. However, before getting into the data analyses and interpretation phase, the starting point is with data transcription, which Flick (2014) considers as a significant step on the way to data interpretation. Poland and Pedersen (1998) have described data transcription as 'a transformational process, taking live conversation and changing it into a textual representation of talk' (see Barbour 2014, p.253).

4.3.1 Data transcription

The data for this document was transcribed manually. This decision was made first because the size of the data was deemed relatively manageable to allow for a manual transcription approach. Secondly, the risk of exposing participants' confidentiality was taken into consideration, and it was thought this could be best minimised by manually managing data transcription. Hence, both the verbal field accounts that were jotted and the taped interviews conducted with the participants were harmonised together and transcribed into texts.

4.3.2 Coding

Coding the data was the next process. In the views of Taylor and Bogdan (1998), coding implies organising the data into typologies, classifying typologies into themes, and developing these themes into theoretical propositions. Otherwise stated 'coding implies refining and reducing the volume of data to more manageable concepts, and usually, themes' (Barbour 2014, p.261). Creswell (2013) recommends that forming codes or categories is at the heart of interpreting and analysing qualitative research. The coding approach used here is complete coding, which Braun and Clarke (2013, p.206) suggest should 'aim to identify *anything* and *everything* of interest or relevance to answering your research question, within your entire dataset'.

4.4 Structure of the data presentation and summary of the results

The presentation of the data is structured into two main sections. Section one presents data analyses and interpretations obtained from both groups of research respondents. This reports on the emerging themes that address a part of the main research question

concerning *how the practise of FGM poses safeguarding concerns to BME girls in the UK.*

The second section presents data analyses and interpretations still obtained from both groups of research respondents. However, this will be reporting on the emerging ideas/recommendations that address the other part of the main research question regarding *what options are there for overcoming FGM.*

At this early stage of talking about the structure of the data presented for this study suffice to explain that various data would be included in tables in the various sections of the table. However, in some sections, only samples and not the entirety of the data and the emerging themes will be included in a table. The rationale for this is to give a well-ordered structure to the presentation and interpretation of the data. However, the rest of the themes that emerged in each section would be fully discussed soon after the selected samples in each table would have been presented.

As indicated earlier, interviews were conducted with 13 participants involving survivors of FGM and social workers/education welfare professionals, respectively. The research project was explained to each of them, clearly highlighting the fact that it was a piece of academic research. Doubts and questions needing answers and clarifications were discussed and participants who took part each completed a Human Subjects Consent-to-Participate Form. This exercise enabled a good rapport between the researcher and respondents before each participant's agreed interview date.

For the group of FGM survivors, all the 5 females who took part in the interviews had experienced one form of FGM or the other. The 2 males were each married to a woman who had experienced FGM. All but one of the females had children. Circumcision of girls and women was acknowledged as a predominantly prevalent phenomenon in most village settings from where the participants originated.

Except for one participant, all other participants agreed that culture was the principal reason for the cutting of girls and women. One participant differed with this view notwithstanding her disapproval of FGM. She argued that African culture is beautiful and a thing to celebrate and so, cannot be seen to be harmful. In her view, the main

reasons for the prevalence of FGM are marriageability and the control of women's sexuality.

One thing that all survivor participants commonly agreed on was that FGM is a form of child abuse. However, this view has only become more prominent to them after receiving education and being exposed to a different culture outside their worldview. Each participant also stated that they will never subject their girl child(ren) through FGM. Most of them further stated that the role of African men living in the diaspora is extremely key to the eradication of FGM within indigenous African societies back in Africa, and globally.

On the other hand, throughout their professional career all the 6 professionals taking part in the interviews have each worked with at least an ethnic minority family. Five participants have each once specifically worked with an African family. Among all 6 participants in the study, only one participant had held a caseload which included two FGM cases. For the most part, the 5 others were only casually aware that FGM prevails in the UK. Even without drawing from a practical case informed experience they each could equally infer that FGM was a form of child abuse hence, it was an unacceptable practice which, poses safeguarding concerns.

One predominant feature that, however, cut across the interview analysis of the practitioners was professional cultural incongruence linked to the notion of FGM. This was reflected in their extensive lack of knowledge in FGM as a cultural practice among the ethnically diverse British society. The outcome of culturally incongruent practice among professionals would arguably suggest safeguarding implications of FGM to BME girls in the UK.

4.5 FGM poses safeguarding implications for BME girls in the UK: Evidencing with data from the survivors' group.

In the coding template, **R** stands for Researcher, and **IP** stands for Interview-Participant. Participants representing the FGM survivors are coded in alphabetic letters of **A, B, C, D,** etc. The professional participants are coded in numeric identifications of **1,2,3,4** etc.

Starting with section one, the table below presents four out of the six themes that emerged from the survivors' group. The rationale for including just four emerging themes as already explained earlier is to economise space in structuring the data presentation. The remaining two themes that emerged but which were not included in the table are fully discussed after the samples in the table.

Table 0-1 Sampling code: section 1a on FGM survivors

Researcher (R)	Interview Participants					
Data	**IP-A**	**IP-B**	**IP-C**	**Typology**	**Themes**	**Propositions**
R: I am a foreigner. I don't know much about FGM. What is FGM all about?	Right, actually, in my country, we call it *bondo*. That's the native word for it. Ok, well, back in Africa, it's sort of the norm, where we come from; so, it's like every female child should undergo it, which erm, is like, erm, cutting off a particular part of the woman's body, which our people think it's not necessary to be there at all as a woman. That is the clitoris of a woman. So, to be among women in the *bondo* society you have to do FGM	Erm, what I will say is that where I come from FGM is a traditional way of getting a girl ready for marriage. They have to cut part of the girl's female private part first. You have to be part of the *bondo* society in preparation for marriage.	You get to a certain age you have to be joined into the *bondo* society because that's how we refer it to. They then cut the girl's clitoris as a way of initiating her into the *bondo* society. So, I think *bondo* is what can be referred to as FGM	- *Bondo* is a traditional society to initiate girls into womanhood. - *Bondo* is well organised, having a cutting season, performed only by special cutters, and having special camping grounds for the ritual. - *Bondo* passes for a traditional training institution for young women to learn skills in being a woman.	*Bondo* as a traditional institution	FGM/*bondo* is seen as a well organised and exclusive female institution that manages a women's special duty of preparing them for transition and into marriage. These are two significant human and societal aspects of life that suggest that FGM will remain prevalent and present safeguarding implications to the girl child unless robust ways are sought to eradicate it.
R: As someone who has lived the experience of FGM, describe what the atmosphere and the experiences are like?	In the past, you know, when you're part of the *bondo* society, and when it was the cutting day, it was a whole big thing in the village for the women. It was a means for women actually feeling empowered between their communities as well; because they get uplifted, they get celebrated, they get given jewellery, gold and what not – something they'd never have had except, obviously when they go to *bondo* society and they get married. Those are the two times in their lives that women feel that they're really made the centre of attraction; erm, they're, they're the highlights for	I always went to visit my grandma in the village, you know, when it was the cutting season. It was an overwhelming moment in the village you know, that you are eager and wanting to belong, wanting to be part of this society; because every time I go to visit my grandma during the long vac, you know, they'd just sound the drums, probably, I'd be playing with other girls, we'd all be having fun; and then all of a sudden, they'd hit the drums, it's a message to the ones who have been part of the *bondo* society already, like a tune to call them into the shrine. And everybody	When it is the day of *bondo*, a whole village of women are standing there and they're clapping, they're singing, dancing, the drummers are drumming, and they are, *oh my goodness*. All are women, just women, no man is allowed, it's just a women's thing, and you know, it is a very interesting day in the village	- FGM/b*ondo brings* warmth and pleasantness in the community - FGM/*bondo* creates communal interaction and sharing of resources - FGM/bondo binds the society together	African atmosphere and mind	FGM/*bondo* presents a sense of an awaited eventful day in the lives of members of its practising communities. It can be difficult to easily dilute a prevalent feeling of social cordiality that has been established in the traditional fabrics of society.

	that day, you know at that moment, you know. And, and the way you get elevated in your community as a woman, as being part of the community, you're now a woman and the feeling in the village is a great one.	would leave and then you will feel this special time in the village				
R: How is FGM mainly seen and understood among a practising community like yours.	You can imagine, for example, if you live in a village where you have a thousand people, and the total population of women, for example, is 600, and then 500 of them have already gone through it, erm, you find, erm, girls feeling like, "I want to do it". Girls actually used to go to their parents and say "I want it done" because they really wanted to fit in.	I come from a Muslim home. We have tribes in our country, like the Creole who don't believe FGM and will not do FGM to their girls. But my tribe, where I come from do circumcision. So, if we're friends with some of these girls who come from some of the tribes that don't do it, and they know that we are going to do FGM, some will, at their parents' backs, come be begging us, and begging our parents to take them to do it with us. So, it was like something that all girls want to do it because it is like, you can say, copying, fashion, imitation, you know.	I was only 8 – 10 years old. Even though that was my privacy, they were invading but then willingly, I did it, to be honest with you because I was so eager, wanting to be part of this thing. All you knew was, girls went in there and when they come out, they're looking outstanding, meticulous, you know, that sort of thing, and you know, as a little girl, you admire things like that, you know. Even little girls of your age come out and they're well dressed, well looked after, you know, they put on make-up, jewellery that they never imagined putting on. You know, even at the age of 8 - 10, I could remember telling my parents so many times, "mum, why aren't you guys putting me through the *bondo* society? I want to, I want to". I cried, I threw tantrums, and all the rest of it, you know.	Girls begging to be initiated Girls want to follow the trend Girls fancy the presents of jewellery, gold, new dresses received and wearing make-ups Girls Feel meticulous and pampered Girls feel being the centre of attraction, and status elevated from girls to women	Glamourisation	FGM is seen by young women in practising communities as a cultural trend. It can be very difficult to discourage trendy lifestyles and values. Perceived in this light, the prevalence of FGM appears to be long-term and so, it remains a safeguarding concern to BME girls in the UK who hail from FGM practising societies.
R: So, if you were to sum it up overall what could be the	Culture is the main thing. Where we come from FGM	It is culture. I come from a Muslim home. FGM is	People give different reasons. But I think the main	- FGM/*bondo* is a cultural norm		Culture is the way of life of a people. It defines their way of

principal reason, among these varieties of reasons you have outlined that underpin the prevalence of FGM?	is a norm, it is a norm. So, you will find out that girls who haven't gone through that process or through that ceremony as we will call it are sort of like erm, being like outcasts.	something that is being done on all girls in many parts of my country. When I was growing up, erm where I grew up, we thought FGM was, erm like part of our family and a traditional thing that every girl should go through. And if you don't go through that, you'd not be classified in the society as a full woman, or a fully-grown girl. So, I will say it is culture	reason in my area is just a cultural thing. They think by putting the female child through female genital mutilation, that will reduce them from being promiscuous, sleeping around, and that should save them to wait till they get married	- FGM/*bondo* as a cultural value regulates moral rectitude among women in the society - FGM/*bondo* is a cultural medium to marriage for young girls	Culture	thinking, their beliefs and their aspirations. FGM/*bondo* meets all these characteristics. Members of its practising communities identify and adhere to these values. It can be difficult to take away one's culture from them. Hence, FGM would pose a real challenge to overcome.

4.6 Summary one of significant findings from data collected from FGM survivors.

The literature review for this study posited that FGM poses safeguarding implications for BME girls in the UK. While this could have been an anecdotal claim significant findings from the data collected from FGM survivors have provided emerging ideas that explain behavioural patterns that would justify the claim.

Firstly, it emerged that FGM has been traditionally institutionalised within practising communities and because of this status to opt-out of it cannot be the choice of a female child. This suggests that regardless of wherever members of practising communities find themselves in the world it is most probably that they will want to maintain the institution of FGM as an ongoing practice.

Secondly, because FGM has been institutionalised its occurrence has become a routine practice. The routine has in turn established indelible elated moments that have become the way of life within practising societies. It can be difficult to subdue such a grounded way of life. This suggests that the practice can be an ongoing phenomenon.

Furthermore, having been traditionally institutionalised and then becoming a regular social feature FGM has then become a desirous social event among young women. It emerged that FGM has also then become trendy, a fad which some young women clamour to be put through it.

Again, for being an institution that has created a routine occurrence that produces memorable and sociable times, and for becoming a practice that young women are desiring to undergo, participants confirmed that centuries of this happening have made FGM become an established cultural practice among its people. This implies that FGM is an identity of the people, and it can be difficult to take away someone's identity.

Because world populations move from one place to another, members of communities from where FGM is practised are now part of British society. It, therefore, also emerged that they have continued to uphold their cultural practice and so, FGM is practised in the UK.

All these emerging themes offer justifications that FGM poses safeguarding implications to BME girls in the UK from FGM practising backgrounds in Africa. The

picture is made clearer from the proceeding in-depth interpretations of data collected from the FGM survivors.

4.6.1 The bondo traditional institution and its implications to safeguarding.

To effectively engage in this assessment, the approach was to start by understanding from the interviewees what the whole FGM phenomenon implies to them. Two interview questions explored this.

R: I am a foreigner. I don't know much about FGM. What is FGM all about?

IP-A: Right, actually in my country, we call it *bondo*. That's the native word for it. FGM is like, erm, cutting off a particular part of the woman's body, which our people think it's not necessary to be there at all as a woman. That is the clitoris of a woman. So, they think you don't have to have it.

IP-B: Erm, what I will say is that where I come from FGM is a traditional way of getting a girl ready for marriage. They have to cut part of the girl's female private part first. You have to be part of the *bondo* society in preparation for marriage.

IP-C: You get to a certain age you have to be joined into the *bondo* society because that's how we refer it to. They then cut the girl's clitoris as a way of initiating her into the *bondo* society. So, I think *bondo* is what can be referred to as FGM

The initial theme that emerges from the data above is the reference to FGM as the *bondo* society. *Bondo* is the locally renowned name for the procedure in the community from which these participants were selected. During the interviews, most of the participants recurrently referred to the procedure as the *bondo* society. Occasionally, some would translate it as 'circumcision'. Most of them equally stated that *bondo* essentially prevails as a traditional and cultural practice. Also, most of them explained that the *bondo* procedure is performed by special traditional practitioners who are locally referred to as *cutters*. Contextually interpreted, the name 'cutters' derives from the actual activity which involves severing off part of the female genitalia. *Bondo* has a cutting season, and when it is the cutting season, the initiates are camped at a special abode where they go through various induction processes including learning skills in being a woman. At the end of the induction period, the girls are then taken into a special shrine to complete the *bondo* process, namely, initiation through severing the female genitalia:

IP-A: So, they take you into this quiet secluded place, where you get all this training how to be a mother, how to be a housewife, how to take care of your children, how to look after the home; (.) so, it sort of like replaces what is now modern education

IP-D: So, they would start off the culture by getting these girls into the *bondo* society to prepare the girls to be ready for marriage in terms of how to treat a man in bed, how to care for the man in the house, how to look after the family, the kids, those sorts of things. Years ago, it used to be something that girls get initiated and they stayed in the shrines erm for months. So, it wasn't something that actually happened like in, one week, two weeks' time, and you were out. It used to be months because they'd be there, they'd heal up, they also train them to be able to cook, to be able to look after the home, you know, demonstrating all that sort of responsibility before they get erm, erm celebrated out.

One other finding also emerged from the data above, namely that; although *bondo* essentially prevails as a traditional and cultural practice, one can equate the *bondo* society to a well-established modern institution. Broadly speaking, Hodgson (2004) considers institutions as 'durable systems of established and embedded social rules with shared conceptions that structure social interactions' (see Wang and Holton 2005, p.92).

Arguably, well established modern institutions would be purposive in ethos, would operate within established routines, and such routines may become both ritualistic and enduring in nature. Hodgson (1998), corroborates this argument with the view that 'institutions have common conceptions and routines, are sustained by shared conceptions and expectations and have relatively durable, self-reinforcing, and persistent qualities' (see Wang and Holton 2005, p.92). *Bondo* conveys across a cultural practice which, as **IP-D** states, is seen as:

> a way of life…a rite of passage.

Hence, one can argue that because *bondo,* as **IP-D** further states:

> is seen as a tradition that has been passed on, and it's been happening from generation to generation,

Bondo has, thus, become a value-laden practice. Seen in this light, *bondo,* therefore, fulfils what could be considered as one of the fundamental objectives of every established institution; namely one with a purpose to fulfil the needs of its very existence. In this case, one can argue that the purpose of *bondo* as an institution is to accomplish a traditional/cultural value. With the understanding as Burrage (2015) has postulated that members of the British communities who originate from African and other societies in which FGM is a part of culture have come along with that aspect of their culture, one can suggest that girl children in the UK from these backgrounds

are generally more likely to be subjected through abuse from this tradition. This is likely to compromise their safety, thereby, triggering safeguarding implications.

4.6.2 The African mind and atmosphere and implications to safeguarding.

The theme of culture and tradition, which crowns *bondo* as an established traditional institution, also leads to the emergence of what could be described as the concept of the African mind. The African mind, that is, the way they think, feel, and interact is usually influenced by what can be argued as a collective communal attitude - a way of life that thrives on community co-operative behaviour. Such behaviour is regulated by what can be accepted by the community as inclusive or exclusive behaviour. This is conveyed across from the following data:

IP-D: If you're all going to be initiated, and you're going to be staying in the *bondo* society for four weeks, in those four weeks they'd gonna need many bags of rice, they'd need palm oil, salt, pepper, all those ingredients that they're gonna be needing to be feeding them all, including the girls, and themselves. So, they're all in this circular, and it's not just like 10 people. When I say people, it's like a whole village of women. That is the main part of the programme, the main part of the initiation.

For this society, bringing the girls together into the *bondo* society in preparation for marriage behoves for the community to equip young girls not on an individual basis, but as a community of girls who will soon become the women of the society - running and managing marital homes. Therefore, *bondo* exemplifies the concept of the African mind where communal living is emphasised over any other form of community living.

Equally interesting is the emergence of what could be described as the concept of the African atmosphere. This would refer to what characterises the general African mood and spirit. Usually, traditional festivals and celebrations characterise the atmosphere in most African traditional communities. There is a sense of conviviality that prevails throughout the *bondo* process. Adequate food provisions to sustain both the mentors and the awaiting initiates indicates confidence and a mood of happiness in the atmosphere. But also, the atmosphere during the initiating period is highly celebrative as described by **IP-A** and **IP-C,** respectively. This was in response to the following research question:

R: As someone who has lived the experience of FGM, describe what the atmosphere and the experiences are like?

IP-A: In the past, you know, when you're part of the *bondo* society, and when it was the cutting day, it was a whole big thing in the village for the women. It was a means for women actually feeling empowered between their communities as well; because they get uplifted, they get celebrated, they get given jewellery, gold and what not – something they'd never have had except, obviously when they go to *bondo* society and they get married. Those are the two times in their lives that women feel that they're really made the centre of attraction; erm, they're, they're the highlights for that day, you know at that moment, you know. And, and the way you get elevated in your community as a woman, as being part of the community, you're now a woman and the feeling in the village is a great one.

IP-C: When it is the day of *bondo*, a whole village of women are standing there and they're clapping, they're singing, dancing, the drummers are drumming, and they are, *oh my goodness*. All are women, just women, no man is allowed, it's just a women's thing.

And so, *bondo* suggests an African society that can be said to be human-centred, that feels and thinks collectively and shares a collective mood and spirit. Such a cooperative community can only foster community cohesion amongst its people, kindness, and concern for one another. These characteristics constitute what would be described as the African mind, and the African atmosphere.

Given that FGM/*bondo* projects values that over time have become a distinguishable way of life, it can be safe to argue that the practice depicts a deep-seated form of cultural identity for the people who practise it. Some of the BME girls who are FGM survivors are UK born nationals. Others would have acquired UK nationality through a naturalisation process. The argument can be made that because some of the parents of these girls are still indigenous members of the FGM practising societies, sustaining, and cherishing their cultural values can be part of their second nature. Also, how these parents bring up their children would arguably still largely be informed by values of their ethnic origins. FGM would still be part of their cultural codes. One could, therefore, argue that it can be difficult for FGM/*bondo* to be easily overcome. As such, safeguarding implications of FGM to BME girls in the UK are still strongly imminent.

4.6.3 FGM/bondo is a fad: implications of this to safeguarding.

Glamourisation is one other very significant subject that came to light after interpreting the data. This theme emerged as participants responded to the following interview question:

R: How is FGM mainly seen and understood among a practising community like yours?

IP-A: You can imagine, for example, if you live in a village where you have a thousand people, and the total population of women, for example, is 600, and then 500 of them have already gone through it, erm, you find, erm, girls feeling like, "I want to do it". Girls actually used to go to their parents and say "I want it done" because they really wanted to fit in.

IP-B: I come from a Muslim home. We have tribes in our country, like the Creole who don't believe in FGM and will not do FGM to their girls. But my tribe, where I come from do circumcision. So, if we're friends with some of these girls who come from some of the tribes that don't do it, and they know that we are going to do FGM, some will, at their parents' backs, come begging us, and begging our parents to take them to do it with us. So, it was like something that all girls want to do it because it is like, you can say, copying, fashion, imitation, you know.

IP-C: I was only 8 – 10 years old. Even though that was my privacy, they were invading but then willingly, I did it, to be honest with you because I was so eager, wanting to be part of this thing. All you knew was, girls went in there and when they come out, they're looking outstanding, meticulous, you know, that sort of thing, and you know, as a little girl, you admire things like that, you know. Even little girls of your age come out and they're well dressed, well looked after, you know, they put on make-up, jewellery that they never imagined putting on. You know, even at the age of 8 -10, I could remember telling my parents so many times, "mum, why aren't you guys putting me through the *bondo* society? I want to, I want to". I cried, I threw tantrums, and all the rest of it, you know.

The fact that some girls are scheming, taking personal initiatives, and begging to be initiated into the *bondo* society creates a special longing to become a member of the society. *Bondo,* therefore, appears to be a glorified and glamourized institution. While uninitiated girls would fancy gifts such as jewellery, gold, new dresses, and the make-up that the initiated girls enjoy, the latter in addition also feel empowered, pampered, and enjoy the attention they get. In recounting her experiences, **IP-E** describes the glamour she fantasised about that could be associated with circumcision. This was the picture the other girls who had already been through circumcision would paint to her:

> You know, stories you'd hear from girls, big girls talking about it, you know your sisters, big girls talking about it, you know, "it's a fashionable thing", saying how proud they went through it, you know; up till date they're people I know back home, who'd be like, you know, say "am glad I went through it".

Hence, 'circumcision is a brand' (Shell-Duncan *et al.* 2000, p.118), something in vogue as a traditional beauty institution which, uninitiated girls fancy and aspire to join in otherwise they would feel left out of the trend.

Although *bondo* can be seen in the light of a traditional fashion/beauty institution for women, one can argue that patriarchal influences contribute to its glamourisation. In modern society, especially during the 1960s and 1970s, 'the beauty industry was linked to wider questions of patriarchal [influences and] oppression… [driven by] patriarchal capitalism…. This had the effect of not only drawing women into a system

of commodification and consumption but also of turning them into objects of the male gaze' (Black 2004, p.38).

While this prevails in modern society it is not unusual to find that similar patriarchal interests also abound in traditional society. As argued by one FGM practising male community member 'if a girl is not circumcised, she can stay with her family, and can have sex with her boyfriends…[but] branding makes her mine' (Shell-Duncan 2000, p.118). This argument suggests that covertly, there are subtle patriarchal influences over the glamourisation of FGM by women.

Because FGM is seen by young women in practising communities as a cultural fad, and subtly fuelled by patriarchal influences it makes it arguably difficult to discourage its trendiness. Perceived in this light, the practice of FGM appears to be a phenomenon that predictably, will be long-term for practising communities in Africa, and by extension in the UK. Hence, it remains a safeguarding concern to BME girls in the UK with parents from FGM practising backgrounds in Africa.

4.6.4 FGM is foundational to culture in practising communities.

The reasons why FGM is done can be many and intricate. It, however, emerged from the data collected that while there could be a wide range of reasons, these are all woven into the customs and culture the community upholds. Hence, FGM prevails because it is engrained within the cultural fabrics of practising communities. A research question was asked as follows:

R: So, if you were to sum it up overall what could be the principal reason, among these varieties of reasons you have outlined that underpin the prevalence of FGM?

The following responses were received:

IP-A: Culture is the main thing. Where we come from FGM is a norm, it is a norm. So, you will find out that girls who haven't gone through that process or through that ceremony as we will call it are sort of like erm, being like outcasts.

IP-B: It is culture. I come from a Muslim home. FGM is something that is being done on all girls in many parts of my country. When I was growing up, erm where I grew up, we thought FGM was, erm like part of our family and a traditional thing that every girl should go through. And if you don't go through that, you'd not be classified in the society as a full woman, or a fully-grown girl. So, I will say it is culture.

IP-C: People give different reasons. But I think the main reason in my area is just a cultural thing. They think by putting the female child through female genital mutilation, that will reduce them from being promiscuous, sleeping around, and that should save them to wait till they get married.

IP-D: Erm, it's seen as a way of life. Erm, it's erm, a rite of passage. It's also being seen as a tradition that has been passed on, and it's been happening from generation to generation.

Bondo is described as a cultural norm. Its role includes amongst others to regulate moral rectitude among women, it marks the traditional process through which a girl transits into womanhood, and it is the main process through which a woman gets married in the society. These are all socially outlined concepts that have been frequently practised over generations. Over time these have become the custom and culture of the people.

Culture can be considered as the way of life of a people. It defines their way of thinking, their beliefs, their aspirations, and their institutions. FGM/*bondo* meets all these characteristics. Members of its practising communities fully relate to these values and strongly affirm their relationship with these customs and beliefs. It can be difficult to take away one's culture from them. Due to migrations, there is hardly any country in the world with Britain included where girls would not be at the risk of FGM. And so, it is reasonable to assert that because people carry their cultures along with them as they move about, members of the UK population who have come from FGM practising countries in Africa are most likely to keep a cultural tradition of theirs like FGM. This suggests that FGM may be common in the UK, thereby, raising safeguarding concerns for BME girls with parents from FGM-practising backgrounds in Africa.

As explained earlier; to effectively manage the structure of the data presentation, not all the data could be included in Table 4-1 of section 1a. Interpretations from additional data that were obtained are presented below to continue to elucidate further emerging themes on safeguarding implications of FGM to BME girls in the UK who originate from FGM practising communities in Africa.

4.6.5 FGM is not a 'maladaptive' human behaviour among practising communities.

Suffice to quickly explain here that McElroy and Townsend (1989) have asserted that FGM is 'a maladaptive cultural pattern' (see Gruenbaum 2000, p.44). This implies practices that can be dangerous and potentially harmful to the health of individuals (Gruenbaum 2000). Yet, it can be argued that not all maladaptive practices can be seen as dangerous and harmful. It will disputably depend on the perceptions of the interpreter and the cultural context in question. One of the things that this study has

been curious about is to establish why FGM is more blanketly seen by practising communities as a cultural value and little or no interest to acknowledge that FGM is a form of child abuse. Thus, within the FGM practising cultures and even to the extended African context does *bondo* represent a maladaptive human behaviour or not? To gain knowledge about this, most of the participants responded as follows to one of the interview questions:

R: Most people in the UK and most Western cultures believe that FGM is child abuse. How is this notion perceived among an FGM practising community like yours?

IP-A: The way child abuse is seen back at home is completely different from the way it is seen in the UK; because it's the norm there, people don't see it as abuse because that is the norm. It is something everybody goes through. Physical chastisement is not really considered as child abuse, no, not unless like it causes grave harm to the child. A parent is allowed to beat their child with a cane so long as it's not causing any serious damage to them. It's like part of your role in raising the child, and you are protecting the child. It doesn't, it is not classified as child abuse.

IP-B: Erm, in my country, they don't see this as child abuse. They don't even know what child abuse is. They'd start laughing at you and will think your idea is very funny ((laughter)).

IP-D: From the context where it's being done, none of these women is doing it out of any malicious reasons. They're doing it out of love. As far as they're concerned, they're doing what they're meant to do for you in order for them to keep up to their responsibility, their roles and responsibilities as a woman in the home.

IP-E: Erm, that's an interesting question. Erm, I don't think the community will see it as a form of child abuse because if you look at it, there will never be other safeguarding issues, you know, around children who've gone through FGM. The parents are very loving. So, it's not done to punish the child. It's done because parents want their children to either fit into the community, get a husband, you know, lead a life, and then, you know, that reputation of the family. So, they wouldn't see it as a form of child abuse.

The notion of child abuse does not appear to occupy a significant value within the African context. This is reflected in the views expressed by the respondents above. Hence, it can be argued that there are no established standards to describe a practice as being abusive to a child in a traditional African context. Physical chastisement is recognised and it is acknowledged as part of parental responsibility. *Bondo* is not associated with malice. Rather, it seems to be compliant with traditional societal values.

One can, thus, posit that a Western notion that prescribes a phenomenon as an act of child abuse not only seems to be ignored but also does not seem to be a societal value within a typical traditional African mind. It does essentially appear to be an unfamiliar concept:

IP-B: Circumcision is definitely not seen as child abuse in my country. Take, for example, you know, like now, I've come to England, I've gained some knowledge. And, if I go back now to my country and tell my step-mum 'do you know what you did to us was child abuse'? She'd think that am mad, and they will probably start telling me, 'Oh, look at her, she's been to England, she's thinking like White people now. She's criticising her own culture, and her own family now'. They'd think am completely not normal. They'd ask you, 'what do you mean? We gave birth to you, we fed and clothed you, and brought you up, and now, you're turning around and telling us, we've been abusing you. How dare you'?

Someone from a Western culture could arguably feel astonished about how one could ever be challenged and possibly looked at with scorn for pointing out that a procedure as the one **IP-B** described above, she experienced was nothing else other than a classic act of child abuse. To some extent, a Westerner could even argue that not to see this as child abuse is tantamount to ignorance. However, the context matters and, in this case, the ethnic community from which **IP-B** originates does not share the same values that would constitute child upbringing in a Western context. While what **IP-B** now sees and questions with a Westerner's eye as child abuse would rather amuse members of her FGM practising communities. As she describes it:

> They don't even know what child abuse is. They'd start laughing at you and will think your idea is very funny ((laughter)).

One can only posit that the reason this sounds funny is that culturally, FGM/*bondo* to them rather embodies love for the child. While to the Westerner this can represent a maladaptive human behaviour, to the African who practises *bondo* it is an adaptive human behaviour that has the intention to protect, ensure well-being, and it guarantees the future of the girl child. In one of her responses, **IP-D** puts the argument on behalf of the practising communities as follows:

IP-D: It's like, for example, you've got your child at home, and you've got to help him through education, and you do everything in your ability to be able to get them to go to school, get them uniforms, you know, even if it's your last penny in your purse if your child comes and tells you, 'mum, I need X, Y and Z, or calculator for tomorrow', your last penny, you'd spend it to make sure your child is prepared for school for the next day, you know, that sort of thing. And that's what these women know. That's what they're working towards.

This, respectfully, represents the line of thought for this community of people.

However, to the extent that *bondo* embodies a cultural value which, understandably defines the status of a woman in each FGM practising society, it can also be argued that *bondo* represents an undynamic cultural value. Culture is dynamic and helps to regulate human behaviour (Connolly, Crichton-Hill and Ward (2006). While time has passed on, *bondo* appears to represent a generational value that seems to have

remained the same. Yet, 'cultures grow and mature…' (Freedman 1988, p.15), essentially so, because the one thing that is inevitable in human life is change. This leads to one wondering 'Why…a society [would] adopt and perpetuate a custom that is debilitating and potentially fatal [to the female members of its community]' (Shell-Duncan and Hernlund 2000, p.17).

It has been argued that a society develops when values appear, and some earlier values vanish (Eliot 1962). Similarly, Uzorka and Dekoor (2013) uphold that in every epoch, in human history change is often used as a synonym for development and progress. Taking these arguments into consideration, the prevalence of *bondo* as a generational culture disputably discredits its relevance to human and societal development as it fails to perceive the harm it causes to a girl child in communities that practise it. Hence, as Edgerton (1992) has suggested FGM is 'maladaptive and an example of the sort of problem that populations might be said to bring to themselves or by maintaining traditional beliefs and practices that are harmful to people's health and well-being' (see Shell-Duncan and Hernlund 2000, p.17).

Based on the arguments above, in a society where the notion of child abuse appears to be inexistent, and where cultural dynamism is impenetrable, there is a high likelihood that an indigenous practice such as FGM will remain prevalent. Considering that migration of world populations is an ongoing trend and that members of the FGM practising community live in the UK, the implications predictably point to inherent safeguarding concerns for BME girls in the UK with origins from FGM practising backgrounds in Africa.

4.6.6 FGM practices in the UK: Implications of this to safeguarding.

One other fundamental relevance of the data was also that it strengthened the theme of prevalence and the safeguarding implications of FGM for BME girls in the UK. This theme is quite key to the main research question, and it re-emerged as participants responded to the following interview question:

R: What is your response to claims that FGM is happening here in the UK among people who come from FGM practising communities in Africa?

The responses anticipated were for inductive interpretations to be constructed which could help to either authenticate or invalidate the relevance of the research topic. Extracts of responses from participants are captured here below:

IP-D: Erm, it is, it is true that it is prevailing, erm, because, erm of, erm, things like, erm the reporting that we do, erm of girls who've actually never, ever stepped their feet out of the UK, but when they go to have their kids, we find out that they've been mutilated. So, things like that are examples. Even a few months ago, there was a programme on, erm, am not sure if it was ITV, or BBC that there was a cutter in the country who was cutting girls in Edgware Road. But there wasn't any evidence. They didn't catch them on the practice, you know, in the scene of actually doing it.

IP-E: That's an interesting question. Erm, obviously, you know there have been challenges in terms of, erm, getting people caught. Because of the lack of prosecution and the failure of the cases that are being taken to court, it's become a huge challenge in terms of really pinning it down because, how many children will give evidence against their parents? Children will hardly give evidence against their parents. I've even heard stories sometimes of children who are being told: 'if you say anything about FGM, social services will take you away, and you will never see mum and dad, and you will never see your brothers and sisters'. So, the children wouldn't say a word.

IP-F: Erm, you'd be surprised that some communities whose people are settled here, they finance FGM back home. The only thing is that they're very secretive. Some of them say 'oh sorry my daughter is going back to Kenya or to Sierra Leone, or to Tanzania for holiday, to see their mum or grand mum'. But then they go and be cut. And when she comes back, they say 'oh sorry, don't tell anybody about it'. So, they are done back home and then they return here already cut; but these are children that are born here.

IP-G: Well, I've seen it on the news wherein my culture, my people are taking their daughters to Africa to do that. I've seen that on BBC, and it's on ITV that one woman took her daughter to have FGM, but someone reported that to Social Services and she was arrested at the airport when she came back. But I haven't physically seen that myself. But I know it is happening here.

Judging from the data presented above, it can be argued that an appropriate response to the main research question is attained. Significantly, the theme of the prevalence of FGM in the UK is re-confirmed. This is elucidated from evidence such as signs of FGM procedures found on young expecting mothers during antenatal clinical checks, yet these girls have never visited Africa. There is an account of an alleged FGM operating site that once existed in Edgware, London. There is also confirmation that the tradition is ongoing, but it is operating secretively. Parents are using trips abroad as alternative options to subject girls born in the UK to undergo FGM procedures. Furthermore, community members are aware of media reports of the prevalence of FGM in the UK; and, most significantly, children are being blackmailed by families to not make disclosures else they would be taken away from their families by social services. All these accounts reinforce the view that FGM poses safeguarding concerns for BME girls in the UK.

This subject generated the highest number of a specific speech filler from respondents, namely, the 'erm' speech filler. This appeared nine times variously from four participants. As far as qualitative data is concerned any form of the data received even if it includes ungrammatical speech, slang, misstatements, and fillers, needs paying attention to because all the data adds meaning to the phenomenon under study (Neuman 2003). Respondents appeared to be a bit cautious in the way they articulated their responses. This would most likely explain a recurrence in the use of the 'erm' speech filler in each participant's feedback. This restricted the need for follow up questions into the subject. Secondly, the feedback they provided was deemed relevant and satisfactory enough to the question asked.

What one makes out from the data in response to the relevant interview question is that FGM is undoubtedly prevalent in the UK. By implication, it is a serious safeguarding concern for BME girls in the UK. Roberts (2014) corroborates this view with the argument that FGM is not just something that is done outside of the West because in the UK for example, there have been numerous documented reports of the practice, even though it is illegal. Pointing to UK statistics Roberts (2014) further shares that while it is hard to get a handle on the true scale, figures suggest at least 4,000 women and girls have been treated for FGM in London's hospitals since 2009. The numbers have surged with a recorded 5,391 new cases of FGM recorded by The NHS in England in 2016 (BBC News 2017).

4.7 FGM poses safeguarding implications for BME girls in the UK: Evidencing with data from the social welfare and education professionals.

Just as a quick prompt, this is a continuation of section one of the data presentation dealing with how FGM poses safeguarding implications for BME girls in the UK. The table below introduces data from the professionals' group. The participants in this group were coded in numeric identifications of **1,2,3,4** etc. Unlike in the FGM survivors' group where only four out of all the six emerging themes were included, all the four themes that emerged in this section are included in the table. The reason for this is because the information provided by the professionals was slightly less in-depth compared to that provided by the FGM survivors. This is not unrealistic because the lived experiences of the professionals to the society of the African community is not

as elaborate. This arguably also means a limited amount of information they can provide. Hence, including all the information in the table will not much affect the content and structural look of the data presented.

Table 0-2 Sampling code: section 1b on social welfare and education professionals

Researcher (R)	**Interview participant (IP)**					
Data	**IP-1**	**IP-2**	**IP-3**	**Typology**	**Theme(s)**	**Proposition**
R: As a social welfare practitioner how would you grade your knowledge and understanding of the way of life of the African community which is part of today's ethnically diverse British society? Please choose from the following options and explain why. **- I have no knowledge and understanding of their way of life** **- I have very little knowledge and understanding of their way of life** **- I have a fair knowledge and understanding of their way of life** **- I have a very good knowledge and understanding of their way of life**	I think I'd like to say 3 – a fair knowledge. I work in an ethnically diverse community, including multi-faith members of the community. I have been to homes on visits and will respect values like taking off my shoes before going into the house, and maybe not shaking hands, or sometimes elsewhere, will need to shake hands. I sort of have a general understanding of the day-to-day ways of an African family; for instance, that the male oversees things, and that the women are strong and resilient. Erm, generally, I feel like I have some understanding of the culture and how, erm, maybe, erm, that they have quite a strong culture, erm, quite closed family links. I have heard that FGM is one of the cultural practices that prevail among the African communities in the UK.	I think I've got a fair knowledge, erm, I have worked with African families who have come here from Africa to live and work, or they were here as immigrants. I have a fair knowledge of, you know, the differences in culture from the mainstream British culture, differences in parenting, boundaries, you know. I've worked with two families on FGM and one where there was a cultural issue around DNA. So, I've had an experience with FGM on my caseload.	I'd say a fair knowledge due to having worked with different families before from different communities, but I'd say concerning FGM specifically, I'd say I have poor knowledge.	- Professional exposure and working with some African families - A fair knowledge and understanding of some of the African cultural codes - Superficial knowledge about FGM - Poor knowledge about FGM	Superficial lived experience for professionals	Professionals can assert a certain degree of the lived experience of the African communities in the UK. This is by having worked with some families from this background. Hence, they can claim a certain degree of knowledge and understanding of the cultural values of the African population. However, their lived experience is superficial, 'fair', hence not profound. It can, therefore, be challenging for child protection and safeguarding to be effectively implemented based on just a sketchy, 'fair' knowledge of the conditions that pose risk factors to children.
Data	**IP-3**	**IP-4**	**IP-5**	**Typology**	**Theme(s)**	**Proposition**
R: On a scale of 1 – 5 (1= not a significant limitation at all, 5= a significant limitation), please grade how the fear of	I will grade it at 4. I have heard that FGM is one of the cultural practices that prevail among the African communities in the UK. But again, erm, as I said earlier, it's not	I'd say probably a 4 to a 5. It is difficult; because I think a lot of professionals struggle with that because they don't	I think for me that will be a significant limitation because I think people might be influenced by the	- Fear of being called racist	Ineptness in transcultural self-efficacy	Professionals are not confident and lack culturally congruent skills to undertake child

cultural implications can pose limitations to professionals working with families from FGM African backgrounds	an area I have a lot of knowledge about. But also, sometimes, I feel like I have a lot of questions to ask, erm, challenging things to ask the man or the woman; but I'd hold back because am not sure, and I think I'd make things worse. I don't know, erm, again, am not confident I don't feel confident that I would know, you know. Erm, so, I think, I'd have probably to go away and maybe look at, you know look at more research, look up at things, you know	want to be called racist or not understanding cultural beliefs, so, it is a tricky subject. As a white British woman, sat with a family from Africa telling them what I think is wrong with their belief is not easy at all.	cultural thing. So, I'd grade it as a 4.	- Lacking confidence - Fear of making things worse - Not understanding cultural beliefs - Apparent insensitivity to globalization - Apparent insensitivity to acculturalization		protection work in an area that require a demonstration of understanding of the cultural codes of the service users. Culturally congruent practice is, thus unattainable. This can have implications to child safeguarding for African, and other ethnic minority groups in the UK society.
Data	**IP-1**	## ## ## ## ##	## ## ## ## ##	**Typology**	**Theme(s)**	**Proposition**
R: As a professional working with children and young people, what is the age range of the children you work with? **R: As a professional working with children, you would be aware of the following terms. Please, briefly explain to me what each of them means:** **Child Abuse** **Child Protection**	Nursery comprising children from 3 – 11 years of age. Child abuse is where children are not taken care of; erm, so where they could have been hurt, and not being looked after properly; they could have been abused, erm, sexually abused; so, it's all types of abuse against children. Child protection is where we have procedures that we have to follow, which we use to protect children.			- A qualified professional - A good professional ability to define terms that pertain to child protection and safeguarding	See projected main theme below	The data presented and interpreted here covers a series of research questions that exemplify one significant emerging theme, namely: *Compromised safeguarding practice.* Whereas professionals could confidently identify and define various terms relating to child protection and

Child safeguarding	Safeguarding is what we all have to do; it's everybody's business, and what we do is that we raise concerns to safeguard children and keep them safe.					other conventional forms of child abuse, they struggled to do the same for FGM.
Data	**IP-3**	**IP-6**	## ## ## ## ##	**Typology**	**Themes**	**Proposition**
R: Please, choose any traditional form of child abuse you prefer and explain what it is **R: What is your understanding of the phenomenon called FGM? Please, briefly explain.**	So, I'd go with maybe neglect, which is when a child is not provided with their basic needs such as warmth, shelter, affection, love, having a good attachment with somebody, living in a safe environment, and having all their basic needs met. Erm, female genital mutilation. Erm, honestly, it's not an area I have a lot of knowledge about. Erm, but my understanding is it's part of erm, a cultural practice I think in the African, mainly in the African community, erm, where they cut the female genitalia, erm, again, for purposes of whatever, I don't know.	Erm, I can go emotional, I think. With all forms of child abuse, emotional will cover and will always come in partnership with them. If they experienced physical abuse, there's always an emotional side to it. And with sexual abuse, emotional abuse is always there. Erm, yeah, so, FGM, erm, obviously, it's female genital mutilation. There are different types of FGM depending on how the children are cut; erm, and it depends on the child's culture; it's done in the UK; erm, and obviously, it's really hard to safeguard because professionals around the child will often miss it.		- A good professional ability to define terms that pertain to child abuse - A poor professional ability to define FGM as a form of child abuse - Straying away from a direct definition of the term FGM - A patchy understanding of FGM as a form of child abuse	Compromised safeguarding practice	Professionals' views about FGM are patchy and vague. This is informed by their previous expression of the inability to ascertain how effectively confident they can demonstrate culturally confident skills in a prevailing cultural practice such as FGM. Where this is the case, this research proposes that safeguarding would be compromised due to a lack of culturally congruent knowledge.

Data	IP-1	IP-2	IP-3	Typology	Themes	Proposition
R: There are two Acts of Parliament that outlaw the practice of FGM in the UK. **i. Please state the two Acts if you know them, or** **ii. Please state Not Applicable if you cannot remember or do not know them.** **R: How will you describe your knowledge level about the referral guidelines of FGM? Please tick one of the following options:** **- Very knowledgeable** **- Knowledgeable** **- Fairly knowledgeable** **- Not knowledgeable** **- Not knowledgeable at all.**	Not applicable Fairly knowledgeable	No, I don't know them. I don't know anything about official guidelines.	Not applicable I'd say Not Knowledgeable	Professional ignorance to legislation applicable to safeguarding against FGM	Obliviousness to referral procedures	Where professionals working in child protection and safeguarding demonstrate ignorance to standard child protection legal instruments, then the ability to initiate some of the protection processes such as a referral process will be limited. This study, therefore, proposes that professional obliviousness to referral procedures can have implications to child protection and safeguarding

4.8 Summary of significant findings from data collected from the professionals' group.

Arguably, exposure and understanding of the cultural values of a community can help professionals in their assessment and design of the family intervention and safeguarding plans. From an interpretation of the data, there was evidence that practitioners can demonstrate a certain degree of lived experience with the cultural values of the African communities they have worked with. However, this was essentially just sketchy and not convincing enough to inspire confident levels of professional culturally congruent practice.

On the flip side, a range of findings emerged which evidenced culturally incongruent practice among professionals. This involved a lack of self-confidence among professionals and the inability to use professional skills to work with members of the community who identify especially, with FGM as a cultural value. Such ineptness can jeopardise an effective safeguarding intervention plan.

Professionals also demonstrated a lack of insight and understanding of the concept of FGM as a form of child abuse; and finally, it also emerged that professionals lacked knowledge in legislation concerning FGM and understanding about procedures that can be used to complete FGM referrals to ensure safeguarding.

In a culturally diverse society like the UK, it can, therefore, be difficult for child protection and safeguarding to be effective if professionals are culturally incongruent in their practice towards cultural practices that can be abusive to children. An in-depth presentation of the emerging themes comes next in the discussions below.

4.8.1 Superficial lived experience for professionals

In determining how culturally congruent or incongruent professionals would respond to a cultural practice like FGM, required first to assess their lived professional perceptions and experiences about the concept. This was obtained from the following research question put to them:

R: **As a social welfare practitioner how would you grade your knowledge and understanding of the way of life of the African community which is part of today's ethnically diverse British society? Please choose from the following options and explain why**.

I have no knowledge and understanding of their way of life.

I have very little knowledge and understanding of their way of life.

I have fair knowledge and understanding of their way of life.

I have a very good knowledge and understanding of their way of life.

IP-1: I think I'd like to say 3 – a fair knowledge. I work in an ethnically diverse community, including multi-faith members of the community. I have been to homes on visits and will respect values like taking off my

shoes before going into the house, and maybe not shaking hands, or sometimes elsewhere, will need to shake hands. I sort of have a general understanding of the day-to-day ways of an African family; for instance, that the male oversees things, and that the women are strong and resilient. Erm, generally, I feel like I have some understanding of the culture and how, erm, maybe, erm, that they have quite a strong culture, erm, quite closed family links. I have heard that FGM is one of the cultural practices that prevail among the African communities in the UK.

IP-2: I think I've got a fair knowledge, erm, I have worked with African families who have come here from Africa to live and work, or they were here as immigrants. I have a fair knowledge of, you know, the differences in culture from the mainstream British culture, differences in parenting, boundaries, you know. I've worked with two families on FGM and one where there was a cultural issue around DNA. So, I've had an experience with FGM on my caseload.

IP-3: I'd say a fair knowledge due to having worked with different families before from different communities, but I'd say concerning FGM specifically, I'd say I have poor knowledge.

The data above evidence that albeit superficially, respondents were able to demonstrate a certain degree of lived experience working with African migrant populations settled in the UK. Each of the respondents stated having had *fair knowledge and understanding of the African way of life* which, translates to just average exposure to African families. This level of exposure can be considered relatively realistic given the fact that although the Black African population is the fastest-growing ethnic group in the UK today, its total population is still just about 989.628 (Sunak and Rajeswaran 2014).

By the African way of life, the reference here is to the African culture which, Ezedike (2009) defines as 'the sum total of shared attitudinal inclinations and capabilities, art, beliefs, moral codes and practices that characterize Africans. African culture, therefore, refers to a whole lot of African heritage' (see Idang 2015, p.4). Additionally, Idang (2015, p.4) compliments that the 'African culture embraces the totality of the African way of life in all its forms and ramifications'.

Hence, in their responses some professionals were aware of cultural codes such as handshakes as a way of greeting someone or engaging with them, taking off shoes before going into the house when conducting a home visit, and an understanding of the different roles and standings between males and females within the set-up of African families. Other participants have had the lived experience of knowing how parenting is conducted and the keeping of boundaries among the African family.

It would be fair to say that these accounts amount to a certain degree of a lived experience of the African communities the respondents would have worked with. As stated earlier, exposure and understanding of cultural values of a community can improve professionals' assessment and design of the family intervention and safeguarding plans. However, with just a superficial display of lived experiences, it is doubtful if any intervention plans professionals can design would ensure effective protection against a cultural practice that poses safeguarding implications to its female children.

The extent of professional culturally incongruent practice was evident in the following emerging themes.

4.8.2 Ineptness in transcultural self-efficacy (ITSE)

In an ethnically and culturally diverse British society, it is presumed that social welfare and education professionals would be culturally confident in practice based on their knowledge and understanding of merging and converging cultures (transcultural). It is also thought that by their lived experiences they would demonstrate self-belief and ability (self-efficacy) when working with members of the BME African communities. However, in interpreting the data there was evidence of a lack of self-assurance in professional performance. This emerged in response to the research question posed below:

R: On a scale of 1 – 5 (1= not a significant limitation at all, 5= a significant limitation), please grade how the fear of cultural implications can pose limitations to professionals working with families from FGM African backgrounds

The following responses were received:

> **IP-3:** I will grade it at 4. I think the fear of cultural implications will be a 4 or even a 5. I have heard that FGM is one of the cultural practices that prevail among the African communities in the UK. But again, erm, as I said earlier, it's not an area I have a lot of knowledge about. But also, sometimes, I feel like I have a lot of questions to ask, erm, challenging things to ask the man or the woman; but I'd hold back because am not sure, and I think I'd make things worse. I don't know, erm, again, am not confident I don't feel confident that I would know, you know. Erm, so, I think, I'd have probably to go away and maybe look at, you know look at more research, look up at things, you know.
>
> **IP-4:** I'd say probably a 4 to a 5. Erm, I think people do get fearful around, erm any kind of abuse that might involve cultural or religious views for fear of offending.
>
> **IP-5:** I think for me that will be a significant limitation because I think people might be influenced by the cultural thing. So, I'd grade it as a 4.
>
> **IP-6:** I'd say, and I think a lot of people are very tentative around that area, especially if it's not based on British culture; so, I'd say about a 4.

What one picks out from the data above is that even though professionals may wish to probe further into certain aspects of a family assessment which, could be useful in creating an intervention plan for an African, or even other ethnic family background, professionals lack the confidence to do so. This, accordingly, because of fear, and probably because they do not want to be seen as *making things worse*. They would not like to be seen as acting or coming across as disrespectful of the cultural values of the family. Hence, they tend to hold back, would avoid exploring further into issues, and consequently may not adequately probe into family assessments.

The point was made even clearer by **IP-4** who amplified on their response as follows:

> It is difficult; because I think a lot of professionals struggle with that because they don't want to be called racist or not understanding cultural beliefs, so, it is a tricky subject. Erm, I think people do get fearful around, erm

> any kind of abuse that might involve cultural or religious views for fear of offending. As a white British woman, sat with a family from Africa telling them what I think is wrong with their belief is not easy at all.

While one would understand the difficult position professionals can sometimes face when working within culturally sensitive settings, it can, however, be argued that the views expressed above by **IP-4** could arguably be irrational, risky to safeguarding, and incongruent to professional practice. One can also argue that it smacks political correctness. If taken as reflective of one of the beliefs that professionals hold, then it enhances, if not, could arguably justify the 'view widely held that … FGM is a cultural observance which must be left unchallenged insofar as white girls [can be] protected … whilst black girls should not be accorded that protection because their 'culture' demands it' (Burrage 2015, p.59).

Connolly, Crichton-Hill, and Ward (2006) hold the view that child protection workers need to develop relationships with diverse cultural communities so that these communities become partners and protectors in the child protection relationship. While this can be important, it, however, sounds like professionals are expected to be experts in cultural diversity. Realistically, it can be impossible for professionals to develop profound knowledge about the culture of all service users that are on their caseloads. It is recognised that 'in culturally diverse Britain, health [and social welfare] professionals can find themselves presented with clinical scenarios where issues of culture and safeguarding children collide [and] this can be a difficult balance' (Akilapa and Simkiss 2012, p.1). This notwithstanding, to avoid or hold back from engaging with community groups based on the fear of stepping on their cultural values jeopardises child safeguarding and arguably demonstrates ineptness in transcultural self-efficacy.

With the understanding that FGM is a deeply entrenched cultural phenomenon and having previously established that it is abusive to the girl child, it warrants those professionals involved in child protection services to develop essential knowledge about the cultural contexts of BME groups they work with. This study shares with the view that 'a lack [of understanding] about cultural contexts, identity and disadvantage has the potential to seriously compromise a worker's ability to understand the issues facing families who abuse and neglect children' (Connolly, Crichton-Hill and Ward 2006, p.28).

Ineptness in transcultural self-efficacy practice (ITSE), therefore, translates to culturally incongruent practice and this has implications on general safeguarding.

Jeffreys (2010) makes the case that culturally congruent health and social care is a basic human right, not just a privilege, and therefore every human is entitled to it. It is worth complimenting that

in today's essentially multicultural and ethnically diverse world, health and social care professionals working within their communities should be able to demonstrate culturally congruent practice.

Studies carried out within the nursing and social care sector variously by (Cowan and Norman 2006; Davidson et al 2003; Douglas 2003; Douglas et al 2009; Gilttenberg 2004; and Holtz 2008); all indicate that 'cultural growth, change, and the need for culturally congruent … care has been frequently reported in various countries outside the United States including Australia, Canada, … and the United Kingdom' (see Jeffreys 2010, p.4). What appears to be mostly influencing these cultural growth trends and the need for a culturally congruent practice among health and social welfare practitioners is the fact that globalization has become a worldwide phenomenon and people tend to move along with their cultural values and beliefs (CVBs).

There is, therefore, no gainsaying that acculturalisation is vital in today's ethnically diverse world, and particularly Britain, if the health and social care needs of all cross-cultural populations will be met. Hence, health and social care professionals are 'challenged to meet the needs of changing societies in new and different ways if a culturally incongruent practice were to be reversed to enhance transcultural self-efficacy (TSE). This by extension could improve on safeguarding for BME girls who could be at risk of FGM in today's culturally diverse Britain.

4.8.3 Compromised safeguarding practice (CSP)

Another unique theme that emerged from the data is what this study has described as *compromised safeguarding practice* (CSP). It was evident that respondents could easily cite and explain any other form of conventional child abuse of their choice. However, they could not do the same for FGM which, is also recognised as a form of child abuse and known to have a plethora of safeguarding implications to girl children (see appendix 5).

Respondents were for example, able to confidently define key terms that pertain to professional knowledge in practice principles such as child abuse, child protection, and safeguarding. For instance, in responding to a question that was designed to assess professional capacity **IP-1** as a sample chosen here among the others responded as follows:

> **R: As a professional working with children and young people, what is the age range of the children you work with?**
>
> **IP-1:** Nursery comprising children from 3 – 11 years of age.
>
> **R: As a professional working with children, you would be aware of the following terms. Please, briefly explain to me what each of them means:**
>
> **Child Abuse**

IP-1: Child abuse is where children are not taken care of; erm, so where they could have been hurt, and not being looked after properly; they could have been abused, erm, sexually abused; so, it's all types of abuse against children.

R: Child Protection

IP-1: Child protection is where we have procedures that we have to follow, which we use to protect children.

R: Child safeguarding

IP-1: Safeguarding is what we all have to do; it's everybody's business, and what we do is that we raise concerns to safeguard children and keep them safe.

The data above was deemed appropriate and believed to have provided befitting definitions which, would be suitable to any textbook definition of the terms. Also, any health and social welfare professional equipped with foundational knowledge about the terms like **IP-1** has provided above would arguably also be endowed with the abilities to apply this knowledge in their child protection and safeguarding work.

Meanwhile, to ascertain how well they can define and explain the various forms of conventional child abuse a follow-up question was posed as follows:

R. Please, choose any traditional form of child abuse you prefer and explain what it is.

The sample responses below amongst others were obtained:

IP-3: So, I'd go with maybe neglect, which is when a child is not provided with their basic needs such as warmth, shelter, affection, love, having a good attachment with somebody, living in a safe environment, and having all their basic needs met.

IP-6: Erm, I can go emotional, I think. With all forms of child abuse, emotional will cover and will always come in partnership with them. If they experienced physical abuse, there's always an emotional side to it. And with sexual abuse, emotional abuse is always there.

However, additional data collected in response to other questions that sought to assess knowledge and understanding of the FGM phenomenon from a professional perspective indicated a lack of knowledge among professionals to confidently explain what FGM all is about. This contrasted with their knowledge, skills, and experiences about the conventional forms of child abuse. For instance, the following question was asked, and some sample responses amongst others have been included here below:

R: What is your understanding of the phenomenon called FGM? Please, briefly explain.

IP-3: Erm, female genital mutilation. Erm, honestly, it's not an area I have a lot of knowledge about. Erm, but my understanding is it's part of erm, a cultural practice I think in the African, mainly in the African community, erm, where they cut the female genitalia, erm, again, for purposes of whatever, I don't know.

IP-6: Erm, yeah, so, FGM, erm, obviously, it's female genital mutilation. There are different types of FGM depending on how the children are cut; erm, and it depends on the child's culture; it's done in the UK; erm, and obviously, it's really hard to safeguard because professionals around the child will often miss it.

To the credit of professionals in education, social work, and healthcare there is arguably no evidence that FGM is included in their training curricula. The knowledge gap is evident when comparing the two questions above and their responses. In the former, respondents were much at ease to define and elucidate any of the conventional forms of child abuse of their choice. This was, however, not the case with the latter question. The respondents appeared to be evasive to the question and **IP-6** especially, came across as making up information along. **IP-6's** response appeared to lack coherence and not confidently articulated. This would most likely explain a recurrence in the use of the 'erm' speech filler in each participant's feedback. In all, there were ten 'erm' speech fillers between the two respondents which, could be indicative of a lack of information from both respondents about the subject being discussed.

Also, the two responses for this question showed very little or just about no sense of understanding of the definition, or what FGM is all about. The respondents were rather speculative with their responses, much of rambling around the term, and they seemed to be drawing more from wisdom rather than from a clear, or at least a comprehensible explanation that could allow one the benefit of the doubt to accept.

Still, in line with trying to probe further with professionals their knowledge about FGM as a form of child abuse, respondents were asked the following question:

> **R: How many forms/types of FGM are you aware of? Please, name them.**
>
> **IP-2**: I think there are four, but no, I wouldn't be able to name them, but *clitodectomy*, maybe is one of them…?
>
> **IP-3:** I don't know, I just know one, female genital mutilation. I know they cut different sections of the girl's vagina, but I can't remember what it's called. But the way they do it, they just cut certain parts away or cut everything away. I don't know the terms to that.
>
> **IP-4:** I understand there's three; I could be wrong. I wouldn't be able to name them. I think that the most basic one is perhaps just a prick used, am not sure where; but it's obviously around the genitalia, erm, but it involves cutting away and kind of sewing up the area. I think the two that am kind of thinking about would be similar but again, different severities, with one being more severe than the other.

Again, there is a display of ignorance or lack of education about the subject among professionals regarding the types of FGM that obtain. Compared to their knowledge of the various forms of conventional child abuse they elucidated earlier, they knew more and could explain better. None of the respondents above could name one complete type of FGM; and although one of them came close to mentioning one form, they could not say the name properly. They called it *clitodectomy*, instead of *clitoridectomy*. The fact that professionals in health and social welfare are unable to evidence some knowledge about a serious form of child abuse such as FGM suggests compromised safeguarding, likely due to insufficient education in the subject and culturally incongruent practice.

While research has established that 'FGM is recognised across much of the globe – and definitively in the UK – as an illegal act of child abuse' (Burrage 2015, p.15), there was an extensive sense of lack of understanding among respondents on how to define, identify the types of FGM, and provide basic knowledge regarding what the phenomenon is characteristically about. The importance for health and social welfare professionals to show knowledge and understanding of what constitutes FGM cannot be put aside, otherwise, this can compromise safeguarding and arguably be reflective of culturally incongruent practice.

4.8.4 Obliviousness to referral procedures (ORP)

One further learning was derived from the data which, this study has referred to as *obliviousness to referral procedures* (ORP). The information below highlights safeguarding implications resulting from the obliviousness of professionals to knowledge in legislation concerning FGM. It also evidences the lack of knowledge and understanding among professionals about the procedure and instruments that can be used to complete FGM referrals that will enhance safeguarding. This was captured from responses that participants provided as they responded to the following questions:

R: There are two Acts of Parliament that outlaw the practice of FGM in the UK.

i. Please state the two Acts if you know them, or

ii. Please state Not Applicable if you cannot remember or do not know them.

IP-1: Not applicable

IP-2: No, I don't know them.

IP-3: Not applicable

IP-4: No, I don't know.

IP-5: I'd say not applicable.

IP-6: I do not know them on top of my head.

R: How will you describe your knowledge level about the referral guidelines of FGM? Please tick one of the following options:

Very knowledgeable

Knowledgeable

Fairly knowledgeable

Not knowledgeable

Not knowledgeable at all.

IP-1: Fairly knowledgeable

IP-2: I don't know anything about official guidelines.

IP-3: I'd say Not Knowledgeable

IP-4: I'd go for not knowledgeable because I won't be able to do it off the top of my head unless I go finding out. On the contrary, I'd easily apply other legislation that I work with every day.

IP-5: I'd go for not knowledgeable at all.

IP-6: I'd go fairly knowledgeable.

In the first question above all six participants were ignorant about the legislation that is applicable to safeguard against FGM in the UK. Ultimately, owing to the significant risks that the practise of FGM poses to girl children in the UK, the act was criminalised in the entire UK by the Female Circumcision Act 1985 (Prohibition of Female Genital Act 1985). In Scotland, it is illegal under the Prohibition of Female Genital Mutilation (Scotland) Act 2005. In England, Wales and Northern Ireland, the practice is illegal under the Female Genital Mutilation Act 2003 - 5. By this Act, it is also a criminal offence for UK nationals or any permanent UK resident to take their child abroad to undergo the procedure (Burrage 2015). Accordingly, anyone found guilty of the offence faces a maximum penalty of 14 years in prison. However, none of the professionals was aware of these legislative instruments.

As for the second question about the referral guidelines, two participants indicated that they had a fair knowledge about the FGM referral procedure, while four participants stated that they did not know at all about the procedure. It can be strongly postulated that every health and social welfare practitioner in the UK would have the understanding that the Children Act 1989 is the principal legislation that provides a comprehensive framework, defining the roles of local authorities, parents, professionals, and agencies to refer to and to apply to protect, safeguard, and promote the wellbeing of children in the UK. Other legal instruments have continued to be developed over the years as required to ensure that children remain protected and safeguarded *vis-à-vis* risks associated with child abuse in the face of changing times.

One key legal instrument relevant to the protection of children (girls) against FGM is the FGM Protection Orders (FGPO). The FGPO is under the Female Genital Mutilation Act 2003. The order is intended to protect individuals at risk of FGM by prohibiting certain individuals from taking them abroad for the procedure. An FGPO can be applied by either the person who needs to be protected by the order or a third party, or any other relevant person ordered by the court can apply for it to help protect someone that has been subjected to, or at risk of FGM.

The most important legal instrument, however, that spells out the referral procedure for FGM is contained in the Serious Crime Act 2015. Since 31 October 2015, it became a mandatory duty that all regulated health and social care professionals and teachers in England and Wales must report 'known' cases of FGM in under 18s to the police (Burrage 2015). Therefore, for professionals, section 72 of the Serious Crime Act 2015 inserts section 3A into the FGM Act to create an offence for failing to protect a girl from FGM, with effect from 3 May 2015 (Burrage 2015). According to the text, the FGM mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the

Serious Crime Act 2015). If the duty applies to you and you identify a relevant case, you are legally required to make a report to the police' (Home Office 2015, p.20).

While organisations can contribute to professional staff development, it is the responsibility of every health and social care professional to also ensure regular professional and personal development through training, reading to keep up to date with key new information about child protection and safeguarding of children. However, it was evident from the data collected that the respondents were essentially oblivious to both the legal instruments and referral guidelines relevant to the safeguarding of children against FGM. No explanations were provided for these inadequacies. This can arguably be described as an expression of nominal interest from frontline professionals in child protection. This allows room for certain arguments to prevail, namely that; Western culture 'and many of those who provide services to address FGM, continue to see [an FGM victim in the West] as 'the other', as something shocking which happens, regretfully, to people not like us' (Burrage 2015, p.x).

While a lot of research has been conducted and published about child abuse, it can still be argued that a lot of child abuse out there remains under-reported. The reasons for this Gilbert *et al.* (2008) have stated may include:

- poor knowledge.
- anxiety about relationships with families.
- uncertainty about the ability of statutory agencies (i.e., social care) to respond (see Powell 2011, p.15).

The views above fit well into the arguments that have been ongoing about child abuse and safeguarding implications in general and FGM in particular. It may also not be too assuming to suggest that child protection and safeguarding face worrying times because of the obliviousness of education and welfare professionals towards practices that thrive on being defined as the way of life of a community, yet such practices can pose safeguarding risks to children. Professionals' lack of knowledge about practice guidelines such as no knowledge about the FGM referral procedures as well as being unaware of relevant legal instruments that inform how children can be protected against FGM can be considered incongruent to professional practice. This can have a significant bearing on safeguarding.

5. Perspectives for overcoming FGM in the UK

This section of the study seeks to address the second part of the main research question about ideas *on how FGM can be overcome*. Thus, the discussions here will attempt to present various recommendations for overcoming FGM interpreted from data collected from both the survivor and the professional respondents, respectively. The starting point is, however, an examination of the barriers that have made the eradication of FGM quite a challenge over time. The discussions will then progress to introducing the social convention model. This concept identifies itself with the themes that emerged from the data collected from respondents to give their recommendations on how to overcome FGM. This is followed by a discussion around universalists' advocacy for the ending of FGM. In essence, it is a response by universalists to arguments propagated by relativists about the need to respect FGM as a cultural value. The final segment of this section is the conclusions of the research.

5.1 Barriers to overcoming FGM within and beyond the UK

Several efforts have been made over the past two decades to eliminate FGM, yet these attempts have, however, encountered several barriers. Research by Brown, Beecham, and Barrett (2013); International Organization for Migration (n.d.); and Burrage (2015) have identified various reasons accounting for these barriers.

One of the barriers is the ineffectiveness of the global awareness-raising approaches. The argument is that these have been more theoretically designed and predominantly led by non-indigenous actors. Campaigns and awareness-raising about the ills FGM poses have only succeeded to generate a wider public interest but have failed to achieve large scales of abandonment of the practice.

Another reason for difficulties encountered to eliminate FGM is the arrogance with which the practice is perceived in the West and the revulsion this has created among FGM adherents. The tendency is for FGM to be still largely propagated based on Western notions and interpretations of a misfitting social concept. A case in point in the UK can be seen in the Prohibition of Female Circumcision HL Bill, (10 November 1983) in which Baroness Gaitskell stated as follows:

> We are doing very well by them in allowing them to live in this country. It is nice for them and it is nice of us to do it. But we do not have to import their kind of rules. The point is that such people are not in a position to teach us anything about sexual behaviour (see Dustin 2010, p.13).

Gunning (1992) has pointed out that 'the hallmark of the 'arrogant perception' that typifies western criticisms of other cultural practices is the difference and distance it creates between the enlightened

observer and the ignorant and backward *other*' (see Dustin 2010, p.11). While FGM devotees believe that it is their cultural value, to western beliefs, 'FGM is by any measure cruel and brutal. It is, in the view of many, therefore, barbaric' (Burrage 2015, p11). The choice of words used here to describe a cultural belief for a community of people can be considered inflated hence, unhelpful. For Jones (2000) describing FGM as 'An ancient cultural ritual [which] still blights the lives of millions of women' (see Dustin 2010, p.11), will only help in 'reinforcing this polarization between 'us' – women who make choices and are part of the modern world – and 'them' – victims of an oppressive culture' (Dustin 2010, p.11).

African feminist arguments against their Western counterparts over the issue of FGM have equally complicated efforts to eliminating the practice. FGM is considered by a predominantly critical Western conceived feminist theory as an essentially brutal, cruel, barbaric, and downright primitive cultural practice. For Burrage (2015, p.13), FGM 'is in many ways the ultimate in sickening patriarchal oppression…underpinned by a deep and often unspoken, incoherent fear of female sexuality'. Similarly, Lamb (1992) considers FGM as one of the areas that undoubtedly is a source of psychological shock and contributes to varying degrees of sexual frigidity to women. As Walker and Parmar (1993) have equally stated 'FGM endangers women and children wherever they live and impacts negatively on people's lives and health around the world' (see Bransfield 2003, p.8). These perceptions can be related to radical feminism – the type of feminism that challenges female subjugation by men because of their sex and deems the practice as barefaced violence to women and girls.

Western feminists, therefore, appear empathetic towards women in communities where FGM prevails. This arguably amounts to highlighting and strongly profiling FGM as a universally disapproved practice that impinges on the universal human rights of women in communities where the phenomenon prevails, hence, it needs urgent eradication.

While bringing the subject to the spotlight can be considered a cherished idea, the approach to its exposure has, however, generated highly controversial debates among cultural relativists, anthropologists, and most especially, African feminist scholars. African feminists have scorned how, Western feminism has generally dealt with the subject of FGM and to Toubia (1985) this is rather 'creating a backlash of over-sensitivity in the concerned communities' (see Korieh 2005, p.122). Yet such community members can be the most instrumental partners in the fight against FGM.

There is a sense among African feminists of a voyeuristic, patronising, and imperialistic attitude from Western feminists who, come across as, in Hancock's (n.d.) appellation 'Western salvationist interventionists' (see Nnaemeka 2005, p.15). Yet, these apparent Western feminist do-gooders are

considered to have very little or no insight at all about an African cultural practice they appear to castigate. Africanists claim that

> the images, the salience of the arguments, and the representations of African women in the circumcision discourse derive primarily from the ability of the West to construct a racialized 'Other' [and that] …Western interest in the discourse is a 'paternalistic' reminder of the bygone era of colonial domination (Korieh 2005, p.119).

African feminists do not endorse FGM. They disavow it. As Nnaemeka (2005, p.30) has stated,

> Female circumcision has been condemned as a 'torture' or 'degrading treatment' that lacks any 'respect for the dignity' of women and girl…. [Hence], the resistance of African women is not against the campaign to end the practice, but against [Western feminists'] dehumanization and the lack of respect and dignity shown to them in the process.

Therefore, what African feminists arguably begrudge is the sensationalisation and condescending attitude of their Western counterparts in the West's depiction of the image of the African woman *vis-à-vis* the process of FGM. Ajayi-Soyinka (2005, p.70) has acknowledged that 'bringing the mutilation of any human being whatsoever to public attention is a positive move. [But] what is objectionable is the compulsive need to denigrate in their entirety the cultural values of the people that practice it and not taking the trouble to get to know the women who have been excised and infibulated'.

Just like Ajayi-Soyinka (2005), Korieh (2005) applauds moves that advocate for the discontinuation of FGM. However, what she disapproves of is the overall tone and scope of the Western feminists' *messianic mission to save the do not know what they are doing to themselves' communities of African women.* There is a sense that Africanists not only find indisposition in Western feminists' narrative of an African cultural practice in FGM, but they also think there is hypocrisy in the West's claims of showing sympathy towards practices that depict denigration of the female body.

To Korieh (2005), and certainly to many other minds, it is hypocritical, for example, for many Western feminists and governments to have devoted themselves to criminalizing FGM yet blatantly supporting abortions and pro-choice schemes. This leads Korieh (2005, p.120) to wonder 'which procedure is more morally shocking, female circumcision or partial-birth abortion and forced sterilization practiced in many Western societies'? In a disappointing tone, Nnaemeka (2005) has, thus, implored that 'we must not be distracted by the arrogance that names one procedure breast reduction and the other as sexual mutilation, with all the attached connotations of barbarism. In both instances…some part of the body is excised' (see Korieh 2005, p.120).

Most studies on FGM in Africa Ahmadu (2000) has argued, have been composed by 'outsiders' with little or no knowledge, and with no experience about the societies they analyse. Hence, such

outsiders tend to present FGM as necessarily harmful and express an urgent need for the practice to be stopped. Speaking as an 'insider', Ahmadu (2010), debunks Western repugnance of the practice which, to her 'has more to do with deeply imbedded Western cultural assumptions regarding women's bodies and their sexuality than with disputable health effects of genital operations on African women' (Ahmadu 2000, p.284). In her critique, she profoundly disagrees with the radical Western feminist view of patriarchal subjugation of the African woman. This simply to her is an unfounded male-centred explanation and an assumption which, unwittingly creates masculinity in femininity.

The perspective of African feminism, therefore, is that to the extent that Western feminists' efforts to end FGM should be endorsed, such thoughts must be unpacked in a way that they reflect given cultural contexts elsewhere. The influential heavy voice of African feminists has only, therefore, just made an arguably smooth and successful fight against FGM less obvious.

One other significant barrier to overcoming FGM is that in most countries where legal instruments criminalizing the act have been enacted these have not been followed by any meaningful convictions and most often the approach is wrong. It could be argued for example, that efforts to reduce the prevalence of FGM in the UK are not achieving the desired outcomes because the approach is wrong, namely, a legislative punitive approach rather than a community incorporation approach. Guine and Fuentes (2007) amplify this view, stating that 'if the UK has had insufficient success in reducing the incidence of FGM/C, this may be due to the failure to pursue … [an] integrated approach' (see Dustin 2010, p.19). The legislative punitive approach arguably drives adherents to find ways to circumvent criminalization. On the contrary, an integrated approach can empower members of the communities concerned to engage in debates, change their attitudes, and create alternative ways of affirming their cultural identity (Dustin 2010).

But even the legislative punitive approach that the UK lends itself to its applicability may be seen as more of a symbolic legislative act than one with a genuine intention to apply. Research shows that FGM was outlawed in France since the mid-eighties and so far, 'some 100 parents and practitioners of FGM have been convicted…since it was banned… [as well as while in June 2013] …in Spain, two Gambian parents were sentenced to six years in prison for having clitoridectomy performed on both their daughters' (O'Casey 2013, p.2).

Yet, in the UK, although the practice has been illegal since 1985, only one conviction and one prosecution have been successfully secured, respectively. In the case of the conviction, Dearden (2019) reported that a 37-year-old mother from Uganda who subjected her three-year-old daughter

to female genital mutilation (FGM) had become the first person in the UK to be convicted for the practice. She was facing up to 14 years in prison. In the case of the first prosecution, Martin (2024) reports that a 40-year-old woman was found guilty and jailed for seven years in a legal first for handing over a three-year-old toddler and assisting a person to mutilate the girl's genitalia while outside the UK. This was contrary to the FGM 2003 Act.

It can be argued that the caginess in enforcing the legislation has not led to the attainment of its desired intention. This allows Philips (2010) to argue that the UK's (2003) Act outlawing FGM is 'simply a symbolic piece of legislation … designed to point a finger of blame at particular cultural communities than to eradicate harms to women' (see Brown, Beecham, and Barrett 2013, p.3).

The views postulated above are, therefore, just some of the arguments that have contributed to difficulties in overcoming FGM within and beyond the UK. These barriers notwithstanding, data collected from individual survivors of FGM, and professionals in social welfare was analysed and interpreted to obtain views of each participant of the two groups on how FGM can be curbed. The outcome evidenced that not the conventional campaigning model, the awareness-raising approach, or the legislative punitive approach will eliminate FGM. On the contrary, the overall emerging idea was that a behaviour change modelled through the social convention theory will be more effective in overcoming FGM.

5.2 Contemplations for a behaviour change for ending FGM: The social convention approach.

The social convention theory has been used to facilitate the understanding of harmful traditions and cultural practices such as foot-binding amongst Chinese communities and FGM (Brown, Beecham, and Barrett 2013). Accordingly,

> a social convention is a customary, arbitrary, and self-enforcing rule of behaviour that is generally followed and expected to be followed [by individuals, institutions], in a group or in a society at large. When a social convention is established, everybody behaves in a quasi-agreed-upon way, even if they did not in fact explicitly agree to do so. A social convention can thus be seen as a kind of tacit agreement that has evolved out of a history of previous interactions (Tummolini 2013, p.900).

FGM can arguably be considered as a social convention that is partly driven by severe resource inequalities in identified practising communities 'and how aspects such as gender, class, and the desire to improve one's access to social and economic resources may contribute to the establishment and continuation of the practice' (Brown, Beecham, and Barrett 2013, p.5).

Therefore, as a theory Mackie (1996) postulates that 'in the context of extreme resource inequality, FGM emerged as a means of securing a better marriage by signalling fidelity and subsequently

spread to become a requirement for marriage for all women' (see Shell-Duncan *et al.* 2011, p.1274). The social convention theory, therefore;

> delineates the means by which actions of individuals are interdependent, necessitating coordinated change among interconnected actors…. Once it becomes widely expected of potential brides, the practice is locked in place: those who fail to comply also fail to marry and reproduce (Shell-Duncan *et al.* 2011, p.1276).

To further elucidate the point, Brown, Beecham, and Barrett (2013) posit that in many FGM affected communities, women who undergo the procedure are deemed to have retained their virginity which places them in an advantageous position for marriage. Consequently, the convention of cutting females' genitals becomes accepted as a social norm as no family wants to suffer the stigma associated with having a daughter considered 'unfit' for marriage. Brown, Beecham, and Barrett (2013) further make the point that FGM is embedded and reinforced because decisions made about performing FGM are interdependent on decisions made by other intra-marrying families in the communities around them; namely, they will have their daughters cut to improve their likelihood of securing a good marriage partner.

Consequently, to avert such a social convention it has been argued that 'a convention shift, whereby a critical mass of people abandons the practice and allows their children to marry uncircumcised women, is necessary …' (Shell-Duncan *et al.* 2011, p.1276). This view has been enhanced with the argument that to end a social convention such as FGM it is critically important that a 'mass of families within a [practising] community must publicly renounce the practice; as it is only when communities desist that, individual families will believe it is acceptable and not detrimental to their status not to cut their daughters' (Brown, Beecham, and Barrett 2013, p.5).

Some of the key phrases identified which underlie the social convention theory are *a mass of people/families, interdependent/interconnected actors, intra-coordinated change.* Given that FGM is a deeply rooted cultural value, it is reasonable to argue that the practice befits its description as a social convention within practising communities. Arguably, to bring an end to the practice would most realistically come by way of a behaviour change. The social convention model can be one of the most suitable approaches to apply to influence behaviour change. Data was collected from FGM survivors requesting their perspectives on how FGM can be overcome. The interpretations and analyses provided an outcome that identified with some of the key phrases crucially influential in the social convention theory and how these can play in enhancing an end to FGM.

Also, with the understanding that social convention as a theory 'delineates the means by which actions of individuals are interdependent, necessitating coordinated change among interconnected

actors' (Shell-Duncan *et al.* 2011, p.1276), one can propose that the theory can also apply to the community of practitioners in education, health, social welfare, and other agencies working with children where interdependence in concerted actions can result in coordinated intervention processes to end FGM. Data was equally collected from individual social welfare and education professionals to get their perspectives on how FGM can be overcome. Again, their feedback could very much be related to some of the characteristics that reflect the social convention theory.

5.3 Recommendations for overcoming FGM: The perspectives of FGM survivors.

It is important to recap that this is now section two of the data interpretation. The data in this section provides interpretations that address the second part of the main research question about *ideas on how FGM can be overcome*. It begins with data that was collected from the survivors' group and presents their perspectives on how FGM could be overcome. Just like in the previous coding templates in section one **R** for this section stands for Researcher, and **IP** stands for Interview-Participant. The participants are coded in alphabetic letters of **A, B, C, D,** etc. The extract below presents the themes that emerged from the FGM survivors' group.

Table 5-1 Sampling code: section 2a on FGM survivors

Researcher (R)	Interview participant (IP)					
Data	**IP-A**	**IP-C**	**IP-E**	**Typology**	**Themes**	**Proposition**
R: If you were to recommend one important idea that can contribute to overcoming FGM in your community, what would this be?	I think men from abroad have to be involved and they have a very important contribution to make. If they can be serious and talk to their families and teach them, just educate them, because I think that is where the problem is, it is the education. If you are a male child in Africa who is educated and you have travelled and lived or are living abroad, when you go back home, people respect you highly. So, anything you say they'd listen to you. And they'd want to put it into practice just to see what our son has said to us. And this is our educated son. This is our son that lives in the Whiteman's land. So, he's come with these new ideas. So, for eradication of FGM to succeed it has to come from the men. Ok. Men in our society in Africa are highly respected. So, your decisions as a man stands. Your word as a man stands. When the man says something, it stands in the community. When the woman says something it's like 'ah, go and sit down. You're just a woman. You shouldn't be making this decision'	If the men in our communities here in the UK or anywhere else say in other countries like in the US or Europe, when they go back home, they talk to people in their families and educate their families. They can be able to raise awareness because, when you're living here in England, as a man, your family is looking up to you. As a man, they have a lot of influence in our society. Men have a lot of influence in our society than women. Men are listened more to, than females. So, our brothers here in the diaspora, if they take it seriously, they can be able to make a huge difference, they can be able to educate our people, and our people will be able to listen to them and follow their advice. Because the mentality in Africa, they think men think better than women.	Men have a huge place within the whole practice continuing and for it to stop. Part of this whole process of mutilating girls is all about men, preparing the girl for marriage, how to treat your man, how to satisfy your man in bed, how to be clean for your man, erm, you know all those sorts of things are all revolving round men, men, men, men, men; what is it about men (slight cynical laughter), you know, erm; and therefore, if especially, the many enlightened African men living abroad come into this fight to actually eradicate FGM, the challenges that we're having, I won't say it would be completely stopped, but then, men have a strong power within the family, within the community, more than women. And if they say, no to it, I tell you what: it will not happen.	- African men are more respected especially the educated and diaspora-based ones - African men are more listened to 'talk', 'serious', 'educate their families', and 'listened to'	- The role of men backed under selective patriarchal conformism (SPAC) - Education drive by diaspora menfolk (EDDiM) - African men for uncut women (AFMUWO)	If African men both in the diaspora and back home would champion the campaign against FGM then the practice can be curbed/eradicated back in Africa and by extension, in the UK.

5.4 Summary two of significant findings from data collected from FGM survivors.

With the sole aim of this section of the study to seek mainly *ideas on how FGM can be overcome* only two interview questions were arguably considered adequate to obtain the information. In the first question various insightful recommendations were suggested as summarised below:

R: What ideas can you suggest about overcoming the prevalence of FGM not just in the UK but in your homeland in Africa?

IP-B for example mentioned that alternative traditional rites have been used in a neighbouring country to her own country to mark the passage rite into womanhood. It was her view that this can be introduced to replace *bondo* in her own home country.

For her part, **IP-D** suggested that training girls in health matters especially, about the female anatomy can result in girls becoming more aware of the effects of FGM on their physical wellbeing. This could lead girls to resent FGM.

IP-G for his part suggested a whole community approach that should involve international and government stakeholders to raise awareness to the community on health and human rights implications related to FGM.

While separate ideas were floated by each participant as contained above, other ideas were recurrently reiterated across by most respondents to the second question. They mostly suggested that men will need to take lead in the eradication process such as in using their domineering role in the society to influence change; that the African diaspora menfolk wield a lot of influence back home and so can easily bring about change; and that the men especially, young men should review their interest in marrying women who are cut. These ideas stood out as the main recommendations and so these have been analysed below as the principal recommendations from the FGM survivor group.

5.4.1 Selective patriarchal conformism

One of the themes that came out of the data analysis is what this study has described as *selective patriarchal conformism (SPAC)*. This implies the purposeful compromise by the female gender over some societal value-laden aspects that could be beneficial

to the community if considered best influenced by the male gender. The following question was posed to respondents:

R: If you were to recommend one most important idea that can contribute to overcoming FGM in your community, what would this be?

The following responses were received:

IP-A: So, for eradication of FGM to succeed it has to come from the men. Men in our society in Africa are highly respected. So, your decisions as a man stand. Your word as a man stands. When the man says something, it stands in the community. When the woman says something it's like 'ah, go and sit down. You're just a woman. You shouldn't be making this decision'.

IP-C: Men have a lot of influence in our society than women. Men are listened more to, than females…. The mentality in Africa, they think men think better than women.

IP-E Men have a huge place within the whole practice continuing and for it to stop. Men have a strong power within the family, within the community, more than women. And if they say, no to it, I tell you what: it will not happen.

The views expressed above suggest undertones of undue subservience, and possibly, subjugation of the womenfolk by the menfolk. However, elsewhere in the data **IP-D** asserts that for the campaign to eradicate FGM to succeed 'it has to come from the men'. This sounds like tipping the power balance to the advantage of the male gender and, coming from a woman her view may be deemed as unfavourable to the African woman who is already seen as '… just a woman [and] shouldn't be making any decision' as stated above by **IP-A**.

As domineering, although, debatably, as men in the African society already appear to be, **IP-D** has further re-empowered them to take lead in effectuating change over the prevalence of FGM in the society. In so doing she could be misconstrued as conforming to patriarchism. On the contrary, it could be argued that **IP-D**'s recommendation sounds like the voice of an enlightened and visionary African woman. As gratuitous as she may seem to be conforming to patriarchism, yet, if this would result in the elimination of a deeply rooted and unhealthy practice, then that might be the one necessary trade-off to gender equality.

Although FGM is perpetrated by women on other women it is, however, ultimately to the overall interest of the man. **IP-C** backs this up by stating in one part of her response as follows:

> Part of this whole process of mutilating girls is all about men, preparing the girl for marriage, how to treat your man, how to satisfy your man in bed, how to be clean for your man, erm, you know all those sorts of things are all revolving around men, men, men, men, men; what is it about men (slight cynical laughter).

On the basis that FGM is all about indirectly satisfying the interest of men, they can influence its direction in any way they want, including influencing an end to it. **IP-E** is very clear about this and stated thus:

> Part of this whole process of mutilating girls is all about men… if especially, the many enlightened African men living abroad come into this fight to actually eradicate FGM, the challenges that we're having, I won't say it would be completely stopped, but then, men have a strong power within the family, within the community, more than women. And if they say, no to it, I tell you what: it will not happen.

Hence, *selective patriarchal conformism* emerged as one of the recommendations that can bring about an end to the prevalence of FGM from Africa to the UK, and beyond.

5.4.2 Education drive-by diaspora menfolk (EDDiM)

Another key recommendation that was recurrently reiterated by respondents was the need to educate the community. It is interesting that the respondents who proposed this idea not only each identified the African diaspora menfolk but also justified why they each identified the African men living abroad as the most suitable for the job. The reason for this group they explained is because of the status that diaspora men enjoy back in Africa. It can be difficult to find and quantify the percentage of more educated African men in the diaspora over the less educated ones. However, even if the figures for the less educated ones are more than those of the educated, the educated ones are presumed to be still more influential in their communities back home by their educational statuses. Secondly, it is believed that they are more sophisticated in their worldview beyond the exposure and experiences of the local population back home. **IP-A** succinctly captures it as follows:

> If you are a male child in Africa who is educated and you have travelled and lived or are living abroad, when you go back home, people respect you highly. So, anything you say they'd listen to you.

Respondents used words and phrases like 'talk', 'serious', 'educate their families', and 'listened to", to position the responsibility African men living in the diaspora should take in driving the campaign to overcome FGM in their communities.

IP-A: If they can be serious and talk to their families and teach them, just educate them, because I think that is where the problem is, it is the education. If you are a male child in Africa who is educated and you have travelled and lived or are living abroad, when you go back home… anything you say they'd listen to you. And they'd want to put it into practice just to see what our son has said to us. And this is our educated son. This is our son that lives in the Whiteman's land. So, he's come with these new ideas. So, maybe, what we're doing is not right.

IP-C: They can be able to talk to people in their families and educate their families. They can be able to raise awareness because, when you're living here in England, as a man, your family is looking up to you. As a man, they have a lot of influence in our society. Men have a lot of influence in our society than women. Men are listened more to, than females.

Research has shown that Somali men in Oslo acknowledged that men in Somalia disliked the practice and fathers in Egypt acknowledged the wish to abandon FGM and a longing for change (Varol *et al.* 2015). Judging from the views obtained from some of the respondents it can be more effective if these Somalian diaspora menfolk can practically translate this disapproval back, for instance in Somalia by taking up the responsibility to educate the local community. In recognising the educational role African men living abroad can play which, could significantly bring about a change in attitude **IP-C** stated as follows:

> So, our brothers here in the diaspora, if they are serious, they can be able to make a huge difference, they can be able to educate our people, and our people will be able to listen to them and follow their advice. Because the mentality in Africa, they think men think better than women.

A change in attitude that is achieved through EDDiM, and which results in FGM being curbed back at the base would translate to FGM being curbed in the UK. Therefore, a leadership responsibility by African diaspora menfolk in partnership with local agency programmes to educate the local community emerged as one of the key points which can potentially bring about an end to FGM.

5.4.3 Men for uncut women (MUWO)

This was another emerging theme that could contribute to curbing the prevalence of FGM in society.

FGM can become less prevalent if men who are the ultimate targeted beneficiaries started preferring uncut women. Varol *et al.* (2015, p.5) have shared that 'Somali men in Norway no longer felt social pressure to perform FGM. In fact, they maintained that it was prestigious for a woman not to have been cut'. In responding to the question about one important idea that can contribute to curbing/overcoming FGM in their community, **IP-D** in one part of her response gave the following compelling account:

> Just yesterday, we had a lady from Sudan who came to speak to us, erm just wanting to know about the work we do on FGM; and to share ideas basically, on what they're doing, you know, and one of the booming things right now is actually working with men. And they themselves are working with men, in Sudan, you know. And the power they're having there, it's the men now of this generation who are now saying to their families, and these rituals, and to these cutters, 'if you cut the girls, we're not marrying them, because we don't want girls that have been cut. What sort of barbaric behaviour is this'?

Whilst it can be argued that men indirectly influence the prevalence of FGM, yet in her view, **IP-D** suggested that FGM will come to a stop if men declared little or no interest in circumcised girls. She went further to subtly suggest a campaign message that men can use to quickly get the attention of cutters. For her men should advocate for an end to FGM with the following message:

> if you cut the girls, we're not marrying them, because we don't want girls that have been cut…. If you cut them, we don't want them.

IP-D sees an end nearing FGM and the apparent futility of the practice. To her, men would soon be the ones to reject circumcised women. She puts her message across as follows:

> I can now see the end of it. Honestly, the men are turning themselves against it now. You know, years ago they used to say, 'for the men, for the men, for the men'. Well, the men are now saying, 'well, it's not for us. If you cut them, we don't want them'.

IP-D can be seen as the go-between who conveys the message from the men to the cutters who are themselves, women. She can be heard re-iterating a message from the men to the cutters when she states as follows:

> 'We're not gonna marry them. So, who exactly are you cutting these girls for? Is it for us the men'?

One thing that has been interestingly elusive about FGM is the very limited research on views of men about how the procedure despite it being undertaken on women

impacts men. Knowledge about this can validate or invalidate the claim that men can successfully call for an effective stop to the phenomenon.

A study carried out about the effects of FGM on men reveals that:

> FGM affects men as well as women and… it can no longer be considered an issue pertaining only to women's health. Men married to women with FGM have health complications as well and feel they, too, are victims of this practice. Indeed, the adverse effects of FGM on men have been well documented in a Sudanese study of married men, most of whom expressed difficulty with vaginal penetration, wounds or infections on the penis and psychosexual problems. Most notable was the finding that men perceived their wives' suffering as their own problem. Most of the young men stated they would have preferred to be married to uncut women (Varol *et al.* 2015, p.5).

If men are experiencing such physical and psychosexual effects because of FGM procedures on their partners, then it can validate the claim that they are most likely to be keen to take up the crucial role of influencing an end to the practice.

It can, however, be argued that with the understanding that FGM is a deeply rooted cultural value, the views of members from practising communities based abroad are not likely to evolve just for the sake that they live in the diaspora. Hence, it would need a dedicated diaspora group. Research has shown that the African diaspora can be very instrumental in the struggle against detrimental socio-cultural codes. Accordingly, 'without losing their own cultural heritage and identity, diaspora members and returnees can challenge traditional power hierarchies between men and women and promote better recognition of women's…rights' (International Organization for Migration – IOM, n.d. p.5).

In their views, as is the case with most of the participants **IP-A**, and **IP-C** not only identified diaspora men as actors to bring about change, but they each used the adjective *serious* to describe the calibre of diaspora men to be relied upon. The social convention theory suggests for a mass of people acting as interdependent and interconnected actors, in coordinated ways to bring about change for a social conventional practice such as FGM. It can be considered that by using the adjective *serious*, **IP-A**, and **IP-C** are referring to that relevant group of diaspora men among the entire diaspora men that can take up the mantle to initiate change and the rest would follow. Meanwhile, **IP-D** states as follows:

> …it's the men now of this generation who are now saying to their families and these rituals, and to these cutters, 'if you cut the girls, we're not marrying them, because we don't want girls that have been cut. What sort of barbaric behaviour is this'?

Although this move does not specifically pertain to diaspora men, it nonetheless, points to the concerted power men can wield which, as prescribed by the social convention theory it influences a behaviour change. There is no gainsaying, therefore, that the efforts of African men in general, can significantly influence a behaviour shift to the abandonment of FGM back within indigenous practising communities in Africa and by extension, the UK.

5.5 Recommendations for overcoming FGM: The perspectives of social welfare and education professionals.

This is section 2b of the data interpretation. It presents outcomes from data collected from the professionals' group. It is expected that the recommendations obtained thereof would address the second part of the main research question about *how FGM can be overcome*. Again, just like in the previous coding templates **R** for this section stands for Researcher, and **IP** stands for Interview-Participant. The participants here are coded in numeric codes of **1, 2, 3, 4,** etc. The extract below presents the theme that emerged from the professionals' group.

Table 5-2 Sampling code: section 2b on social welfare and education professionals

Researcher (R)	Interview participant (IP)					
Data	**IP-3**	**IP-4**	**IP-6**	**Typology**	**Themes**	**Proposition**
R. What ideas can you suggest about tackling FGM in the UK?	Erm, well, maybe making it a bit more obvious, I mean I work in child protection, but I don't know those two laws outlawing FGM you mentioned, you know, yet I know most of the other laws in child protection; so, making it more obvious as in, making it maybe, a compulsory part of, erm, social work training, or you know, your yearly Annual Performance Review training, will give professionals a better understanding of FGM.	I think FGM actually needs to be a taught piece of course in Uni for social workers; you know, we talk about child sexual abuse, domestic violence, why is FGM not, erm, you know, part of that in specific, rather than, this is just a little side branch of another form of abuse? I think it should be within the course modules in social work training at the Uni, erm, and I think it should be, especially in a social work office, I think there should be an FGM specialist like we have CSE specialist, why is there not an FGM specialist?	I think as much as everyone will want to and will have the same goals in mind to safeguard children, I don't think it will ever be possible to eradicate any form of abuse, including FGM, just because you won't be able to monitor it all the time. We're not Big Brother. We don't have cameras planted everywhere. So, I think, there will always be children, unfortunately, who will slip through the net, and we can't do anything about it. However, we could limit it and I'd say that all professionals need to be trained to understand the signs and symptoms of FGM just like we are aware of the signs and symptoms of other forms of child abuse. As social workers, we really need to be aware of FGM including schools, health professionals, and anyone that has contact with children needs to be aware of signs of FGM. I think it's really important for frontline workers to be aware of FGM, so, training will give confidence to professionals to help them become part of tackling it in society.	- FGM not given serious attention to by professionals -FGM is a form of child abuse - Professionals not aware of the signs and symptoms of FGM compared to other forms of child abuse - FGM needs to be part of the training curriculum in social work training	Professional training and University Colleges to educate and train professionals	If training in FGM became integrated as a course module in education, health, and social work training at the University, professionals working with children would acquire knowledge and confidence in supporting children who can be vulnerable to the risks of abuse to FGM.

5.6 Summary two of significant findings from data collected from the professionals.

Like a variety of ideas survivors of FGM shared, the professionals also suggested various views on some approaches they believed could help in overcoming FGM. Again, the main aim of this section of the study is to seek mainly *ideas on how FGM can be overcome*. Only one main question was arguably considered to be adequate to obtain the required opinions of the professionals. Generally, they each suggested some real perceptive recommendations which have been summarised below.

R: What ideas can you suggest about tackling FGM in the UK?

IP-1 for example suggested that more prosecutions resulting in convictions must be done against perpetrators of FGM be they parents who perform FGM on their daughters or professionals who complacently create loopholes for FGM to prevail. She regretted any missed opportunities to thoroughly investigate and convict perpetrators and accomplices stating as follows: 'two have been dismissed'. This is about the first prosecutions for FGM in the UK which took place in 2015 against a doctor for performing FGM and another man for aiding and abetting. Both were found not guilty. **IP-1** was, however, impressed with the fact that 'we just had one recently in February 2019' referring to the first successfully secured conviction in February 2019 in the UK of a mother for performing FGM on her 3 years old daughter. More of this to **IP-1** can go a long way to stifling FGM in the UK.

For her part, **IP-2** suggested that FGM should be taught in schools so that both teachers and pupils are aware of its effects. She stated as follows:

> Hmm, I suppose, erm, you know, making sure that school staff are aware of it; you know, for children to have more knowledge about it as well. I don't know how much of it is taught in schools, but everybody should know about it.

IP-7 suggested a whole community approach which, should involve FGM survivors, and community leaders to raise awareness. She stated as follows:

> I suppose it could be about using victims of FGM, you know if they're able to speak in their communities about the impacts; obviously, probably talking to mums of childbearing age; but also, it's about the elders in the communities, isn't it and getting past them.

While these separate opinions were recommended one domineering idea, however, recurrently reverberated among responses from most of the professionals, namely, education and training.

5.6.1 FGM in course modules for universities' professional training schools

This idea was suggested as the most important that can help professionals working with children acquire the knowledge and confidence skills required in designing intervention plans to support families that have experienced abuse from FGM. It would also apply to children who can be vulnerable to the risks of being subjected to FGM. The question was asked as follows:

R. What ideas can you suggest about tackling FGM in the UK?

The following responses were obtained:

IP-3: I work in child protection, but I don't know those two laws outlawing FGM you mentioned, you know, yet I know most of the other laws in child protection…; so, making it more obvious as in, making it maybe, a compulsory part of, erm, social work training, or you know…will give professionals a better understanding of FGM.

IP-4: I think FGM needs to be an actual taught piece of course in Uni for social workers; you know, we talk about child sexual abuse, domestic violence, why is FGM not, erm, you know, part of that in specific, rather than, this is just a little side branch of another form of abuse? I think it should be within the course modules in social work training at the Uni….

IP-6: I think as much as everyone will want to and will have the same goals in mind to safeguard children, I don't think it will ever be possible to eradicate any form of abuse, including FGM, just because you won't be able to monitor it all the time. We're not Big Brother. We don't have cameras planted everywhere. So, I think, there will always be children, unfortunately, who will slip through the net, and we can't do anything about it. However, we could limit it and I'd say that all professionals need to be trained to understand the signs and symptoms of FGM just like we are aware of the signs and symptoms of other forms of child abuse. As social workers, we really need to be aware of FGM including schools, health professionals, and anyone that has contact with children needs to be aware of signs of FGM. I think it's really important for frontline workers to be aware of FGM, so, training will give confidence to professionals to help them become part of tackling it in society.

It would be recalled that section 4.8 of this study presented a critical appraisal of findings from the data collected from professionals which evidenced incongruent practice among professionals to the FGM phenomenon. The suggestion was that there are safeguarding implications of FGM to BME girls in the UK because of professionally incongruent practice. It is, therefore, not unexpected for education and training to have emerged as the means to help professionals acquire the knowledge and develop the skills required for ongoing support to families of children faced with the risks of undergoing FGM.

While a course content for education and training in FGM was not suggested, the participants who repeatedly recommended this idea were, however, each categoric that this must be a mandatory taught course for social work training at the University. To emphasise this **IP-3** stated that:

> … so, making it more obvious as in, making it maybe, a compulsory part of, erm, social work training, or you know…will give professionals a better understanding of FGM.

The same view was stated by **IP-4,** and **IP-6,** respectively as follows:

IP-4: I think FGM needs to be an actual top priority taught piece of course in Uni for social workers.

IP-6: **…** training will give confidence to professionals to help them become part of tackling…[FGM] in society.

It can be reasonable to think that a course that would help professionals understand the safeguarding implications of FGM to children would most likely be appreciated. The objectives of such a course module may include amongst others:

- Understanding what FGM is about and the various types.
- Understanding why FGM prevails
- Understanding the signs for FGM about to take place or, signs that FGM has taken place.
- Understanding what intervention plans can be suitable.
- Understanding what the law states about FGM and the mandatory reporting duty and process in the UK.

The role of social welfare and education professionals debatably entails a few things. Firstly, to advocate, secondly to educate and thirdly to work towards protecting and improving human wellbeing especially, people who can be vulnerable, oppressed and living in poverty in the society. Every given society one will argue has its social conventions which define how people interact and intra-act accordingly. At any given point, social conventions may come into being either arbitrarily, customarily, or by self-enforcement. How people respond to their social conventions could impact either positively or negatively on society. Positive outcomes will suggest that the convention needs encouraging while negative outcomes would suggest a curtailment of the

convention. To influence a shift in any direction requires agents be they individuals, groups, or institutions.

Bearing the above argument in mind the community of professionals involved in this study see educational institutions as agents who can significantly contribute in efforts to overcoming FGM. Otherwise stated, Universities' professional training schools or colleges can influence an end to a harmful social convention as FGM with an inclusion of a module in FGM in their training curricula. This way education and social welfare professionals will be well equipped to advocate, educate and work to bring about change without which girls and women in FGM prevalent communities will remain vulnerable to the social convention.

Levy *et al.* (2021) have shared that training and clinical exposure to FGM-affected patients can be very important in enhancing the knowledge levels for health and social care professionals (see Sheerin, Jefferson and Chang 2023, p.104).

A research study has suggested some key recommendations that can benefit health care professionals in the UK and other none FGM practising societies especially, in high-income countries in their support for FGM survivors and, therefore, contribute towards the overcoming of FGM:

- Inclusion of continuous further mandatory training on FGM for all health professionals in high-income countries with specific focus on nurses.
- Teaching on FGM to be mandatory as part of child protection for health professionals at all three levels.
- Including health professionals' cultural sensitivity, emotional response, and potential biases and the impact this can have on patient care in training programmes (Sheerin, Jefferson and Chang 2023, p.105).

Also, the research works of Turkmani *et al.* (2018), and Lane *et al.* (2019), respectively, identified that 'Health professionals were found to desire more training, specifically on FGM management, legislation, culture, and practice knowledge' (see Sheerin, Jefferson and Chang 2023, p.104).

Thus, based on the knowledge gap in FGM that came across among professionals in section 4.8 and the implications to safeguarding, it is understandable that they have identified the need for mandatory training in FGM. This can allow professionals to contribute to the curbing of FGM in practising communities in Africa and by extension, the UK, and as Jacoby and Smith (2013) have postulated 'training can increase health professionals' confidence and overall knowledge. This in turn aids health professionals' ability to provide care, educate patients and their families, and assist in the overall eradication of FGM' (see Sheerin, Jefferson and Chang 2023, p.104).

5.7 Advocacy for the ending of FGM: the universalist perspective

The physical and psychological short- and long-term effects of FGM on survivors can be overwhelming. Over the years, different organs of the United Nations and several other children and women welfare agencies around the globe have engaged in raising awareness and campaigning for an end to the practice of FGM. Various strategies have been used some of which 'have encompassed advocacy and education interventions aimed at communities and leaders, legislative interventions, capacity-building interventions, health care interventions, media interventions, and community dialogue' (William-Breault 2018, p.11).

Advocacy for the ending of FGM has mostly been espoused by universalist ideology. Universalism is based on the argument that 'there is an underlying human unity which entitles all individuals, regardless of their culture or regional antecedents, to certain basic minimal rights, known as human rights' (Zechenter 1997, p.319). James (1994) posits that universalism is a theory based on the thinking that human rights are natural, and universal simply derived from a basic human nature we all share.

The preamble of the 1948 United Nations Universal Declaration of Human Rights (UNUDHR) reaffirms a 'faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women' (United Nations 1948, p.1). The UNUDHR's treaties which have been ratified by all nations and enshrined in most other contemporary international and national human rights frameworks form the basis of the notions of universalism. Therefore, universalism propagates the natural and rational law theories, which in combination both reflect the ideas that:

> human rights are held by each human being, in an individual capacity, due to the universal capacity of all humans to think [naturally and] rationally...[and] that universal human rights exist independent of culture, ideology, or value systems. In this view, universal human rights are a class of rights each individual possesses by virtue of being a human (Zechenter 1997, p.321).

While cultural relativism situates the prevalence of FGM as an aspect of a lived cultural reality for a community of people, universalism argues that the prevalence of FGM jeopardises the physical health, psychological and emotional wellbeing of millions of girls and women around the world, and particularly in Africa. International human rights law clearly states that:

> Subjecting girls and women to FGM violates a number of rights protected in international and regional instruments. These rights include the right to be free from gender discrimination, the rights to life and physical integrity, the rights to health, and children's right to special protection (Centre of Reproductive Rights 2006, p.13).

FGM occurs without seeking the consent of the girls and women who are subjected to the procedure. Most girls are coerced by adults into submission without understanding or having access to information about the consequences and potential implications of the FGM procedure (Rahman and Toubia 2001). Although relativism would argue that culturally complying interests surpass questions of consent, there is arguably a false morality in claiming, for example, to control premarital sex when the natural bodily integrity and right of a child or a woman is affected. Tilley (2000, p.518) has argued in support of this view, stating that 'any thesis that purports to be about morality…must address needs of [inhuman treatment]. Otherwise, it …[is] a contrived understanding of morality'.

Universalism advocates for an end to FGM because it mistrusts the justification for its prevalence as a culturally transitional rite into womanhood. Article 5 of the United Nations Universal Declaration of Human Rights (UNUDHR) clearly states that 'No one shall be subjected to torture, or to cruel, inhuman, or degrading treatment or punishment throughout the world' (United Nations 1948, p.5). Survivors of FGM arguably go through a process of severe pain during the procedure. Inherently, the procedure can be said to portray disrespect to a woman's privacy, especially as the

argument in favour of its prevalence seems to be premised on the notion that women's bodies are flawed and require correction (Rahman and Toubia 2001). This sounds like giving a new definition to a woman, namely, one with binary sexuality, hence an unnatural and flawed body, which as Lionnet (2005, p.105) has described 'is considered 'too masculine' and socially unacceptable when not marked by excision'. Thus, in FGM practising cultures sexuality is defined by the cultural practice of circumcision. In the eyes of universalists, sexuality should be defined by a natural biological orientation of male/female.

The physical, psychological, and emotional effects of FGM have been summarised as follows:

> This practice represents severe pain and harm to these girls. The harm is permanent, if indeed it does not cause death. Shock, infertility, infections, incontinence, painful menstruation, painful intercourse, maternal-foetal complications and protracted labour, are the normal consequences, all of which represent an assault on dignity that is not limited to physical damage but must also extend to psychological and moral offence. We can say that female genital mutilation associates female sexuality with pain, not with enhancing female self-respect, respect for women in general, or responsible adulthood (Sala and Manara 2001, p.249).

Given the element of harm and pain entailed in FGM, it can hardly be ground-breaking to push forward the argument that cultures are unique, different from each other, and no one can impose their culture on the other. To the extent that such an argument can be true, one can also argue that some moral standards universally apply across all cultures. It can, for instance, be unconvincing to sanction the practice of FGM which inflicts harm and pain on children and women barely on the grounds of it being a cultural practice more especially when there is no proven medical benefit for the procedure.

As an act of culture, it can arguably be seen as disparaging to the dignity of young girls and women. Otherwise stated 'causing pointless suffering is universally wrong' (Tilley 2000, p.534). FGM can be a cultural value of one community, but it does not necessarily make it acceptable neither to all members of that community if they have a choice, nor does it make it a universally accepted value.

Furthermore, to use FGM as a medium of marriage and female economic empowerment suggests limited or no options at all for girls who aspire to make families through marriage or become economically self-sustaining. Feminist theory advocates for women to have 'the ability to make choices and resist oppression' (Creswell 2013, p.30). If to attain marriage and/or economic self-sustainability obliges those girls to go through FGM then this implies discrimination, subjugation, and domination of women by societal power-wielding agents.

Although it has not been veritably established that men directly influence FGM operations, there is a sense that their unverbalised opinions are immensely powerful. Burrage (2013, p.100) elucidates the point by stating that 'in every instance, whether the act is perpetrated directly by men or indirectly for men, the result is the intimidation and subjugation of women to serve the interests of dominant males'.

Again, to imply that FGM constitutes an unquestionable cultural value suggests cultural dogmatism. It can be argued that cultural values and practices differ from one context to the other. As Gruenbaum (2000) posits, it is neither preventable nor harmful to see cultural differences naively from one's cultural perspective. FGM is one of those cultural practices that will be different from the cultural perceptions of other societies. Therefore, a universalist perspective that roundly latches out and labels FGM practices as 'barbaric', 'crude', 'unsophisticated', and 'primitive' (Burrage 2015) would sound harsh especially, when its adherents deeply believe in it because for them it 'is requested in order to guarantee the future 'membership' of girls in the community… [and to enhance] respect for tradition and cultural identity' (Sala and Manara 2001, p.249). From this perspective, it can be stated that cultural relativism acknowledges such a cultural practice based on collective community rights rather than intrinsic individual rights.

Salient and as strongly articulated as the case for cultural relativism can, however, be, such arguments may not be far-reaching. Essentially, one can posit that culture is dynamic, and its essence should be to serve the changing needs of its people. In their view Kroeber and Kluckhohn (1952) uphold that 'culture includes *both* modalities of actual behaviour *and* a group's conscious, partly conscious, and unconscious designs for living...' (see Gastil 1961, p. 1282). This implies that culture is not only about the

'conscious', that is, the insightful representation of human behaviour, but it is also about the 'partly conscious', and the 'unconscious'. In Williams' (1951) opinion, this implies 'the learned and adaptive human behaviour' (see Gastil 1961, p.1281).

Based on the preceded arguments one can see why universalists strongly advocate for an end to FGM. Hopes in FGM coming to an end are high as:

> action taken at international, regional and national levels over the past decade or more has begun to bear fruit. Increasing numbers of women and men from practising groups have declared support for discontinuing the practice, and in some areas, the prevalence of female genital mutilation has decreased (World Health Organization 2008, p.13).

The United Nations has remained committed to the mission of eliminating FGM. Under its auspices in 2012, its General Assembly 'adopted a milestone resolution calling on the international community to intensify efforts to end the practice' (UNICEF 2016, p.1). Also, in a joint effort, both the United Nations and the European Union have

> recently started a global multiyear initiative focused on eliminating all forms of violence against women and girls. This effort, titled 'The Spotlight Initiative,' brings attention to violence against women and girls in order to achieve gender equality and women's empowerment and is in line with the 2030 Agenda for Sustainable Development (William-Breault 2018, p.1).

Mention can be made of Egypt, Ethiopia, Northern Sudan, Kenya, and Senegal where, FGM has always been practised by most of the population. National rates of prevalence have been known to be high in each of these countries. However, during the past decade, concerted efforts have been made to end the practice in these five countries. General attitudes have, thus, changed, and there has been organized collective abandonment of FGM and other harmful practices in some local communities (UNICEF 2010). The United Nations and its affiliated organs have engaged in four methods aimed at ending FGM. These have included 'bodily and sexual integrity; human rights; legislative; and the health approach. [However], thirty years on since the WHO called for the ending of FGM, there is conflicting evidence as to whether these approaches have led to a reduction in the practice' (Brown, Beecham, and Barrett 2013, p.2). FGM arguably remains prevalent around the globe with an extensive prevalence in many

African countries where millions of girls and women are understood to remain at risk of being subjected to the procedure.

6. Conclusion

The conclusions for this study seek to verify if the research questions have addressed the aims and objectives set out for the research. Other elements of the conclusion will include stating the contributions to knowledge, implications for professional practice, how knowledge from the research will be disseminated, and a list of further recommendations for tackling FGM.

6.1 Restating the aim and the main research question and findings that emerged

This research has principally aimed at examining the safeguarding implications of FGM for BME girls, and ideas on how FGM can be tackled in the UK. To attain these aims required responding to the following research question, namely: *How does the practise of FGM pose safeguarding concerns to BME girls in the UK, and what are the options for overcoming FGM?*

Several findings emerged from the study to address both the first segments of the research aims and the main research question. One of the main findings was that the prevalence of FGM in the UK is no longer conjecture. Rather, its prevalence is real. In expressing their lived experiences, the participants who represented the group of FGM survivors attested to the actual prevalence of FGM in the UK.

One other key finding that emerged still from the group of FGM survivors is that in recounting their lived experiences, FGM is presented as a normalised cultural tradition – the *bondo* society. This is a well-established and powerful traditional institution which, can wield much influence over the developmental stages of a girlchild in the community. Participants articulated this argument as the principal reason for the sustainability of FGM.

Concurrently, lived experiences from welfare professionals were also collected and assessed in terms of how culturally congruent their practice would enhance or impact survivors of FGM. Four main findings emerged from the data interpretation. One of the themes evidenced a minimal degree of lived experiences by the professionals to the ways of life of the African migrant population in the UK they have worked with. With regards to the first parts of the research aim and main research question, three

themes emerged to evidence that professionals displayed ineptness transcultural self-efficacy (ITSE), that they were oblivious to referral procedures (ORP), and they demonstrated compromised safeguarding practice (CSP).

On the premise of these findings, and by extension based on an interpretive analysis of the lived experiences shared by the two groups of participants a further finding has been constructed, namely that: *the prevalence of FGM in the UK poses safeguarding implications for BME girls in the UK with links to African backgrounds.* With this outcome established, a significant part of the study was then directed towards addressing the second part of both the research aim and main research question. This involved seeking recommendations from both participant groups on how to minimise or eradicate the prevalence of FGM with the view of improving on safeguarding.

The findings included several illuminating ideas from both groups. For the FGM survivors' group, various roles were identified for the African diaspora menfolk to undertake which can influence the eradication of FGM among practising communities. Meanwhile, the main finding that emerged from the professional group was the need for universities' professional training schools to include an FGM mandatory module in the training courses for trainees looking to work with children.

In presenting the emerging findings that substantiate the safeguarding implications of FGM to BME girls in the UK, and how the prevalence of the practice can be curbed, it can, therefore, be safely suggested that these findings have succeeded in addressing both the aims and objectives of the research on the one hand and the main and subsidiary research questions on the other hand.

6.2 Contributions of the research to knowledge

Being a social worker undertaking a professional doctorate course should allow anyone who identifies in both capacities to speak knowledgeably and confidently about their subject of research. Hence, a process to share findings from this research with the view of informing, educating, and filling in knowledge gaps for the community of FGM survivors, and contributing to professional practice has been ongoing.

Overall, three public presentations have already been delivered. One was to a men's group in Reading on the 11th of January 2019 on the subject *Men talking FGM*. Two

workshops have also been delivered on the subject *FGM and Safeguarding: Practice Implications for Professionals.* The first presentation was at the Hilton Hotel in Reading. This took place on the 8th of February 2019 commemorating the United Nations Zero Tolerance Day every 6th of February. The UN's mission is to target the eradication of FGM by 2030. The second presentation was delivered on the Development Day for NSPCC staff in Nottingham on the 27th of March 2019.

By sharing the findings with the community of men, the presentation sought to raise awareness that although men are not at the forefront of perpetrating FGM, their silent but influential and powerful voices underlie why FGM prevails. This was an eye-opener to the men to realise that they could also use their influential role to end FGM in their communities.

For the professionals, the presentations not only brought awareness to most of the knowledge about what FGM is all about but also exposed the debilitating effects the practice bears on children and women. It generated debates among professionals and they wondered how social workers and professionals working with children can be so oblivious to a practice that appears very abusive to children. It also resulted in professionals learning more about the mandatory duty for professionals to report as a key part in stifling the prevalence of FGM.

As the idiom 'knowledge is power' goes, knowledge empowers. Most significantly, therefore, undertaking this research and obtaining expert knowledge in this subject matter has not only contributed to self-empowerment but has also provided a complete sense of self-fulfilment. Thus, the completion of this research implies an enhancement in personal development and career prospects. An extended presentation of personal knowledge gained in undertaking this research is covered ahead in the reflective/reflexive report of the study.

6.3 Implications for professional practice

Research has evidenced that effective service delivery by social workers and other professionals to African families in the UK encounters various challenges (Bernard and Gupta 2008). One of the key challenges relates to the cultural differences between African migrant culture and the indigenous British culture. As Brophy *et al.* (2003) and

Laming (2003) have highlighted 'some of the challenges for social workers [in] assessing and making decisions for African children and families [lies in the African culture which] …differs from the majority [of the] white population in Britain' (see Bernard and Gupta, 2008, p.485).

This study has established from the information provided by the FGM survivors' group that culture is the main reason for the prevalence of FGM. While social welfare and education professionals working with children and families would be aware that Britain is an ethnically and culturally diverse society, the study, however, highlighted inattention among professionals to the safeguarding needs of African children. One of the reasons and a key limitation stated by the professionals who were spoken to was the fear of being labelled racist. And beneath this fear is the difference in cultural beliefs between the practitioners who are of the majority culture and the BME African population.

Arguably, one of the implications for practice is that where the expectation is for professionals to take action to protect and safeguard children, but they fail to do so for fear of being labelled racist, children would become more vulnerable and would be subjected to greater risks of harm from cultural practices that can be abusive. This debatably would be disappointing for professionals whose duty is to ensure the safety and wellbeing of children. Bernard and Gupta (2008, p.486) have corroborated this view by stating that 'the fear of being seen as racist, combined with cultural stereotypes, can lead to a failure to make judgements and intervene appropriately regarding practices that are clearly harmful'. Also, taking the option to be aloof so as not to come across as being racist can be interpreted as professionals prioritising political correctness over child protection and safeguarding.

Understandably, while the complex cultural differences would pose a challenge both for the African families and more especially to the professionals, the Framework for the Assessment of Children in Need and Families (Department of Health 2000) maintains that there is always a partnership between the State through regulated children's agencies and families in bringing up children. This partnership lies at the heart of childcare legislation.

Thus, to enhance professional practice this study is proposing that for effective child protection and safeguarding to be attained, practitioners would have to remain highly conscious about the need to prioritise the promotion of human rights and social justice for all children in the society. This needs to take precedence over a gratuitous valuing of community cultural codes. The Department of Health (1989) clearly states that 'differences in bringing up children due to … culture and ethnic origins should be respected' (see Department of Health 2000, p.12). This implies that understanding and respecting cultural codes are important and can be vital in how social welfare and education professionals provide services to communities. However, for service provision to the BME population in the UK in general and black families, in particular, to be fair and effective, professionals will need to understand the 'dynamics of working with difference in relation to race, ethnicity and culture' (Maitra 1995, Dutt and Phillips 2000, and O'Neale 2000) (see Bernard and Gupta 2008, p.487). This thus, highlights the importance of culturally congruent practice for professionals working to protect and safeguard children in a culturally diverse society like the UK.

Another key finding that emerged from the data collected from the professionals was the obliviousness of professionals to the use of legal instruments to protect and/or support BME girls who are at risk or have suffered abuse from FGM. There are certainly implications to professional practice when professionals are not drawing from theory, research findings, legislation, and guidance to inform their knowledge of the professional practice. Yet, social work practice is arguably grounded in evidence that is 'based on policies laid down in legislation and government guidance' (Department of Health 2000, p.16).

This research, therefore, further proposes that to enhance professional practice, it is quintessential that practitioners are well informed with knowledge about FGM. Also, practitioners will need to be grounded with knowledge in legislation, national policies and practice guidance for child protection and safeguarding. With regards to FGM this study led to the researcher's understanding of various key legal instruments relevant to the protection of children (girls) against FGM. In the UK, several Acts of Parliament prohibit FGM. Since 31 October 2015, regulated health and social care professionals and teachers in England and Wales must report known cases of FGM in under-18s to

the police. Knowledge of these instruments is fundamental in improving professional practice for all practitioners.

While culture emerged as the fundamental reason for the prevalence of FGM, one other significant learning derived from the data provided by the FGM survivors was that the notion of child abuse is inexistent within the African context. That explains why for African families performing FGM on the child this is seen as an act of love rather than an act of abuse. The implication of this to a practitioner with an allocated African family is the likelihood for the practitioner to make assessment and intervention plans through the lens of western values.

Making decisions that filter through the lens of ethnocentrism can skew practitioners' assessment outcomes. Dominelli (1997) and Chand (2000) have cautioned that in providing support to black families 'on the one hand a pathologizing approach…may lead to unnecessarily coercive intervention and, on the other hand, a cultural relativist approach may lead to non-intervention when services are required' (see Bernard and Gupta 2008, p.487).

Therefore, practitioners working in a cross-cultural society like the UK would expect to come across cultural practices which embody empowerment, a positive identity, and a sense of belonging to members of the practising culture. Yet, where the cultural practices are interpreted as being harmful and violating the human rights of children, practitioners must challenge such practices. To sum this up, it has been argued that;

> if professionals are to achieve better outcomes for African children... a balance must be struck between sensitively challenging claims that certain types of behaviours are the norm in African families whilst at the same time not losing sight of children's welfare needs. Inherent in child protection work is the balance between protecting children at risk of significant harm, whilst at the same time ensuring minimal unnecessary intervention into the lives of children and families (Bernard and Gupta 2008, p.488).

6.4 Dissemination of research knowledge

The most ultimate vision of this study is to contribute knowledge in health and social care and to social science in general, as well as join other voices that promote efforts to bring an end to FGM. Thus, disseminating findings from this research constituted a significant part of the process. The idea was to assess the value and acknowledgement

of the work both as a piece of academic research and as an informative/educational resource for academics and professionals. This was envisaged to be achieved firstly through presentations at workshops, conferences and providing training to practitioners especially, in the health and social care sector, education departments, and the police force. The second medium of dissemination envisaged is a serial publication of various sections of the research in social research journals.

The series of 2019 presentations already validated that the research was a worthy source of knowledge both to members of the local community and to professionals. Other workshops for 2019 - 2020 were already pre-booked with Derby City Council's Children Social Care, and networking was ongoing for further workshop bookings with the *MOJATU* Foundation in Nottingham, the *Utulivu* Women's Group in Reading, and the Cameroon Doctors in the UK (CamDoc UK). Unfortunately, the 2019 Covid pandemic led to cancellation of all the arrangements. There is confidence for an uptake for several workshops and conferences to share knowledge once society eventually re-opens fully. However, one draft is now ready for submission to kick start a series of journal publications as part of the dissemination process.

6.5 Final word and recommendations

This project has been informed by literary material from across the range of social science disciplines such as cultural and social anthropology, sociological research, references from history, and information from political science. The ensemble of these resources has been well harnessed and succeeded in evidencing that FGM is a form of child abuse and that it poses debilitating safeguarding implications to young girls and women of the BME communities in the UK.

In terms of broad recommendations, it is the view of this study that to overcome FGM a big behaviour change needs to take place. This would directly involve members of the affected communities. This view is supported with the assertion that 'many scholars correctly argue that the issue of determining the future of female genital cutting is best resolved by members of the communities in which the practice is found…' (Shell-Duncan & Hernlund 2000, p.38). A behaviour change might, however, not be completely successful if solely left in the hands of members of the communities engaged in the practice. Public organisations, charity and all other stakeholders that

advocate for the protection of children and the vulnerable in society need to also engage in institutional behaviour change. It took a concerted behaviour change both for mothers and campaigners to work and successfully eliminate foot-binding in China in a single generation, although it was practised on women for 1,000 years. Likewise, behaviour change can also bring an end to FGM.

In the hope that this research has added value to social research and social life, the following recommendations can further contribute to efforts towards bringing an end to FGM:

- Using the medium of indigenous cultural association groups both in the diaspora and in Africa to encourage young and adolescent African men to adopt the concept of seeking to marry only women who have not gone through FGM.
- Using influential traditional institutions in local communities in Africa such as the *MASAI* in Kenya, and similar strong traditional institutions in other local African communities to come on board the campaign.
- Using more of a community integration than a criminal punitive approach to engage with FGM practising communities in the UK.
- Engaging Faith Leaders and local community leaders both in the diaspora and back on the ground in local African communities to be part of the campaign.
- For agencies working with children and families to include a demonstration of knowledge and understanding in FGM in Annual Performance Reviews (APR) and Development Plans for professionals.
- For professionals working with children and families to not only acquire knowledge in cultural congruence but additionally in cultural competence and cultural humility.
- Working with indigenous FGM practising communities and encouraging them to use alternative passage rites for girls.

7. References

Ahmadu, F., 2000. Rites and Wrongs: An Insider/Outsider Reflects on Power and Excision. In: Shell-Duncan, B. and Hernlund, Y., eds. *Female "Circumcision" in Africa: Culture, Controversy, and Change.* Boulder: Lynne Rienner Publishers, pp.283-312.

Ajayi-Soyinka, O., 2005. Transcending the Boundaries of Power and Imperialism: Writing Gender, Constructing Knowledge. In: Nnaemeka, O., ed. *Female Circumcision and the Politics of Knowledge: African Women in Imperialist Discourses*. Westport: Praeger, pp.47-77.

Akilapa, R. and Simkiss, D., 2012. Cultural influences and safeguarding children. *Paediatrics and Child Health* [online]. 22(11) (November 2012), pp.490-495. Available at: http://www.paediatricsandchildhealthjournal.co.uk/article/S1751-7222(12)00118-7/abstract [Accessed 24 January 2017].

Ali *et al.*, 2020. Exploring young people's interpretations of female genital mutilation in the UK using a community-based participatory research approach. *BMC Public Health* [online]. 20(1132), pp.2 – 15. Available at: Exploring young people's interpretations of female genital mutilation in the UK using a community-based participatory research approach | BMC Public Health (springer.com) [Accessed 20 May 2024].

Anon.1, [n.d.] *Historical background of FGM*. [online] Available at: Historical Background (globalnet.co.uk) [Accessed 11 December 2016].

Anon.2, [n.d.] *Ruth Benedict: Configurationalism and the Patterns of Culture* [online]. Available at: http://public.gettysburg.edu/~dperry/Class%20Readings%20Scanned%20Documents/Theory%20Scans/Exegeses/Benedict%20exegesis.pdf [Accessed 07 September 2017].

Balk, D., 2000. To Marry and Bear Children? The Demographic Consequences of infibulation in Sudan. In: Shell-Duncan, B. and Hernlund, Y., eds. *Female "Circumcision" in Africa: Culture, Controversy, and Change.* Boulder: Lynne Rienner Publishers, pp.55-71.

Barbour, R.S., 2014. *Introducing Qualitative Research: A Student's Guide.* 2nd ed. London: SAGE.

BBC News, 2017. *FGM: More than 5,000 newly-recorded cases in England* [online]. BBC News. Available at: FGM: More than 5,000 newly-recorded cases in England - BBC News [Accessed 10 February 2019].

BBC News, 2019. *Mother guilty of genital mutilation of daughter* [online]. BBC News online. Available at: https://www.bbc.co.uk/news/uk-england-47094707 [Accessed 10 February 2019].

Bernard, C., and Gupta, A., 2008.BVlack African Children and the Child Protection System. *Journal of British Social Work* [online]. (38), pp.476-492. Available at: BCL38(3).book(bcl370.fm) (silverchair.com) [Accessed 24 August 2021].

Biere, E.A., 2005. Confronting the Western Gaze. In: Nnaemeka, O., ed. *Female Circumcision and the Politics of Knowledge: African Women in Imperialist Discourses*. Westport: Praeger, pp.165 - 180.

Black, P., 2004. *The Beauty Industry: Gender, Culture, Pleasure.* Oxon: Routledge.

BMA, 2011. *Female Genital Mutilation: Caring for patients and safeguarding children* [online]. Available at: https://www.bma.org.uk/-/media/Files/PDFs/.../Ethics/femalegenitalmutilation.pdf [Accessed on 27 July 2017].

Bradbury-Jones, C. *et al*., 2022. FGM Medical Education at a United Kingdom Medical School: students' perspectives (FGMed Study). *Research Square* [online]. DOI: https://doi.org/10.21203/rs.3.rs-2058291/v1 [Accessed 23 May 2024].

Bransfield, E., 2004. *Female Genital Mutilation* [online]. An MA Thesis in Gender, Anthropology and Religion. Available at: http://www.users.globalnet.co.uk/~lavie/fgm/dissertation.html [Accessed 04 September 2017].

Braun, V. and Clarke, V., 2013. *Successful Qualitative Research: A practical guide for beginners.* London: Sage.

Brinkmann, S., 2015. *Interviews: Learning the Craft of Qualitative Research Interviewing.* 3rd ed. London: SAGE.

Brown, K., Beecham, D., and Barrett, H., 2013. The Applicability of Behaviour Change in Intervention Programmes Targeted at Ending Female Genital Mutilation in the EU: Integrating Social Cognitive and Community Level Approaches. *Obstetrics and Gynecology International* [online]. 2013, pp.1-12. Available at: The Applicability of Behaviour Change in Intervention Programmes Targeted at Ending Female Genital Mutilation in the EU: Integrating Social Cognitive and Community Level Approaches (hindawi.com) [Accessed on 13 May 2021]

Burrage, H., 2015. *Eradicating FGM: A UK Perspective.* Surrey: Ashgate Publishing Limited.

Carpenter, L., 2016. *The Development of Cultural Competence in Social Work Practice and Education* [online]. Available at: The Development of Cultural Competence in Social Work Practice and Education (stkate.edu) [Accessed on 1 March 2017].

Centre for Reproductive Rights, 2006. *Female Genital Mutilation: A Matter of Human Rights*. Second edition [online]. New York: Centre for Reproductive Rights. Available at: file:///C:/Users/User/Documents/KEY%20ARTICLE%203/FGM%20An%20Advocates%20Notes.pdf [Accessed 12 September 2017].

Chisnell, C., and Kelly, C., 2016. *Safeguarding in Social Work Practice: A Lifespan Approach.* London: SAGE.

Connolly, M., Crichton-Hill, Y. and Ward, T., 2006. *Culture and Child Protection: Reflexive Responses.* London: Jessica Kingsley Publishers.

Costello, S., Quinn, M., Tatchell, A., Jordan, L., and Neophytou. K., 2015. In the Best Interests of the Child: Preventing Female Genital Cutting (FGC). *British Journal of Social Work* [online]. (45), pp.1259-1276. Available at: untitled (silverchair.com) [Accessed 21 August 2021].

Creswell, J.W., 2013. *Qualitative Inquiry & Research Design: Choosing Among Five Approaches.* Los Angeles: SAGE Publications.

Creswell, J.W., 2014. *Educational Research: Planning, Conducting and Evaluating Quantitative and Qualitative Research*. 4th ed. Essex: Pearson Education Limited.

Dearden, L., 2019. FGM conviction: Mother of 3, girl, becomes first person found guilty of female genital mutilation in UK. *The Independent* [online]. 01 February 2019. Available at: FGM conviction: Mother of girl, 3, becomes first person found guilty of female genital mutilation in UK | The Independent | The Independent [Accessed 15 March 2021].

Denscombe, M., 2014. *The Good Research Guide: For small-scale social research projects.* 5th ed. Maidenhead: Open University Press - McGraw-Hill Education.

Denzin, N.K. and Lincoln, Y.S., 2000. Introduction: The Discipline and Practice of Qualitative Research. In: *Denzin, N. K. and Lincoln, Y. S., eds. Handbook of Qualitative Research. 2nd ed.* London: Sage.

Dustin, M., 2010. Female Genital Mutilation/Cutting in the UK: Challenging the Inconsistencies. *European Journal of Women's Studies* [online]. 17(1), pp.7-23. Available at: Female Genital Mutilation/Cutting in the UK (sagepub.com) [Accessed 10 May 2021].

Eberle, T.S., 2014. Phenomenology as a Research Method. In: Flick, W., ed. *The Sage Handbook of Qualitative Data Analysis.* Los Angeles: SAGE, 2014, pp.184 – 203.

Edley, N., 2017. *Men and Masculinity: The Basics.* London: Routledge.

Eliot, T.S., 1962. *Notes Towards the Definition of Culture.* London: Faber and Faber.

FGM National Clinical Group, 2015. *FGM Information: Historical & Cultural* [online] Available at: http://www.fgmnationalgroup.org/historical_and_cultural.htm [Accessed: 8 April 2016].

Fieldings, H., 1742. *Joseph Andrews.* London: J.M. Dent & Sons Ltd.

Flick, U., 2014. *An Introduction to Qualitative Research.* 5th ed. London: SAGE.

Flicklearning, 2016. *FGM - Where is it happening and who is most at risk?* [online] Available at: https://www.flicklearning.com/blog/fgm-where-is-it-happening-and-who-is-most-at-risk [Accessed 16 May 2016].

FORWARD, 2007. *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales: Summary Report* [online]. Available at: PREVALENCE-STUDY_FINAL.pdf (city.ac.uk) [Accessed 8 November 2015].

Foster, G.P., 1991. Cultural Relativism and the Theory of Value: The Educational Implications. *The American Journal of Economics and Sociology* [online]. 50(3) (July). Available at: Cultural Relativism and the Theory of Value: The Educational Implications - Foster - 1991 - American Journal of Economics and Sociology - Wiley Online Library [Accessed 15 January 2017].

Freedman, R., 1988. *Beauty Bound: Why women strive for physical perfection.* London: Columbus Books.

Gastil, R.D., 1961. The Determinants of Human Behaviour. *American Anthropologist* [online]. 63(6), (December 1961), pp.1281-1291. Available at: The Determinants of Human Behavior on JSTOR [Accessed 18 January 2017].

Gray, D.E., 2013. *Doing Research in the Real World.* London: Sage.

Great Britain. HM Government, 2018. *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* [online]. Available at: Working Together to Safeguard Children 2018 (publishing.service.gov.uk) [Accessed 21 January 2017].

Great Britain. Charity Commission, 2014. *Safeguarding children and young people* [online]. Available at: safeguarding-children-and-young-people-2014.pdf (zakon.co.uk) [Accessed 21 January 2017].

Great Britain. Department of Health, 2000. *Framework for the Assessment of Children in Need and their Families*. London: TSO.

Great Britain. Department of Health, 2015. *Commissioning services to support women and girls with female genital mutilation* [online]. London: Department of Health. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418549/2903842_DH_FGM_Commissioning_Accessible.pdf [Accessed 25 November 2016].

Great Britain. HMIC, 2015. *The depths of dishonour: Hidden voices and shameful crimes. An Inspection of the police response to honour-based violence, forced marriage and female genital mutilation* [online]. Available at: the-depths-of-dishonour.pdf (justiceinspectorates.gov.uk) [Accessed 2 May 2016].

Great Britain. Home Office, 2015. *Mandatory reporting female genital mutilation: procedural information* [online]. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/573782/FGM_Mandatory_Reporting_-_procedural_information_nov16_FINAL.pdf [Accessed 10 August 2017].

Gruenbaum, E., 2001. *The Female Circumcision Controversy: An Anthropological Perspective.* Philadelphia: University of Pennsylvania Press.

Gruenbaum, E., 2000. Is Female "Circumcision" a Maladaptive Cultural Pattern? In: Shell-Duncan, B. and Hernlund, Y., eds. *Female "Circumcision" in Africa: Culture, Controversy, and Change.* Boulder: Lynne Rienner Publishers, p.41.

Harrison, R., Harvey, R. and Maclean, S., 2010. *Developing Cultural Competence in Social and Health Care.* Rugeley: Kirwin Maclen Associates.

Hossain, S., Alam, K., and Ali, S., 2024. Phenomenological Approach in the Qualitative Study: Data Collection and Saturation. *ICRRD* [online], 5(2), pp.147-172. Available at: 09062024071340-Phenomenological-Approach.pdf (icrrd.com) [Accessed 26 September 2024].

Hosken, F.P., 1989. Female genital mutilation: strategies for eradication. *Women's Health Newsl.* [online], 26(2), pp.4-5. Available at: SafetyLit: Female genital mutilation: strategies for eradication [Accessed 20 March 2020].

Idang, E.O., 2015. African Culture and Values. *Phronimon* [online]. 16(2), pp.97-111. Available at: (PDF) African culture and values (researchgate.net) [Accessed 20 October 2019].

International Organization for Migration (IOM). [n.d.] Supporting the Abandonment of Female Genital Mutilation in the Context of Migration. *IOM International Organization for Migration* [online] Available at: Supporting the Abandonment of Female Genital Mutilation in the Context of Migration (iom.int). [Accessed 10 May 2021].

James, S.A., 1994. Reconciling International Human Rights and Cultural Relativism: The Case of Female Circumcision *Bioethics* [online]. 8(1), pp.1-26. Available at: https://repository.library.georgetown.edu/handle/10822/742016 [Accessed 10 September 2017].

Jariya, A.M.I., 2012. Western Cultural Values and its Implications on Management Practices. *South East Asian Journal of Contemporary Business, Economics and Law* [online]. 1 (2289-1560). Available at: file:///C:/Users/User/Documents/FEMINIST%20THEORIES/JARIYA%20WESTERN%20CUL%20VALUES.pdf [Accessed 10 September 2017].

Jeffreys, M.R., 2010. *Teaching Cultural Competence in Nursing and Health Care.* 2nd ed. New York: Springer Publishing Company.

Johnson, M.C., 2000. Becoming a Muslim, Becoming a Person: Female "Circumcision," Religious Identity, and Personhood in Guinea-Bissau. In: Shell-Duncan, B. and Hernlund, Y., eds. *Female "Circumcision" in Africa: Culture, Controversy, and Change.* Boulder: Lynne Rienner Publishers, pp.215-233.

Jukes, A., 1993. *Why Men Hate Women.* London: Free Association Books.

Kalev, H.D., 2004. Cultural Rights or Human Rights: The Case of Female Genital Mutilation *Sex Roles* [online]. 51(5-6) (September), 2004, pp.339-348. Available at: Cultural Rights or Human Rights: The Case of Female Genital Mutilation - ProQuest (oclc.org) [Accessed 05 September 2017].

Kempe, R.S. and Kempe, C.H., 1978. *Child Abuse: The Developing Child.* Glasgow: Fontana Press.

Korbin, J.E., 2007. Cultural Competence. In: Wilson, K., and James, A., eds. *The Child Protection Handbook: The practitioner's guide to safeguarding children.* 3rd ed. Edinburgh: Elsevier.

Korieh, C., 2005. **"Other" Bodies**: Western Feminism, Race, and Representation in Female Circumcision Discourse. In: Nnaemeka, O., ed. *Female Circumcision and the Politics of Knowledge: African Women in Imperialist Discourses*. Westport: Praeger, pp.111-132.

Kumar, R., 2014. *Research Methodology: a step-by-step guide for beginners.* 4th ed. Los Angeles: SAGE.

Lamb, C., 1992. Female Excision: The Feminist Conundrum. *Ufahamu: A Journal of African Studies* [online]. 20(3), pp.13-28. Available at: http://www.escholarship.org/uc/item/2s98b7c8 [Accessed 21 August 2017].

Lerner, G., 1986. *The Creation of Patriarchy*. New York: Oxford University Press.

Lionnet, F., 2005. Women's Rights, Bodies, and Identities: The Limits of Universalism and the Legal Debate around Excision in France. In: Nnaemeka, O., ed. *Female Circumcision and the Politics of Knowledge: African Women in Imperialist Discourses*. Westport: Praeger, pp.97-110.

Lorenzi, R., 2012. How Did Female Genital Mutilation Begin? *Women Network News* [online]. Available at: https://womennewsnetwork.net/2012/12/14/how-did-female-genital-mutilation-begin/ [Accessed 12 December 2016].

Macfarlane, A. and Dorkenoo, E., 2015. *Prevalence of Female Genital Mutilation in England and Wales: National and local estimates* [online]. London: City University London. Available at: http://www.city.ac.uk/__data/assets/pdf_file/0004/282388/FGM-statistics-final-report-21-07-15-released-text.pdf [Accessed 2 January 2017].

Mackie, G., 2000. Female Genital Cutting: The Beginning of the end. In: Shell-Duncan, B., and Hernlund, Y., eds. *Female" circumcision" in Africa: culture, controversy, and change.* Colorado: Lynne Rienner Publishers, pp.253-281.

Marion, L., *et al.*, 2016. Implementing the new ANA standard 8: Culturally Congruent Practice. *Online Journal of Issues in Nursing* [online]. 22(1). Available at: Implementing the New ANA Standard 8: Culturally Congruent Practice (nursingworld.org) [Accessed 24 June 2019].

Martin, A-C., 2024. Woman jailed for seven years for handing over girl, 3, for female genital mutilation. *The Independent* [online]. 16 February 2024. Available at: Woman jailed for seven years for handing over girl, 3, for female genital mutilation | The Independent [Accessed 29 August 2024].

McFalls, J.A., Jr., and McFalls, M.H., 1984. *Disease and Fertility* [online]. Orlando, Florida: ACADEMIC PRESS, INC. Available at: https://books.google.co.uk/books?uid=111828512846067121000&as_coll=2&source=gbs_lp_bookshelf_list [Accessed 16 December 2016].

McIntosh, I. and Wright, S., 2019. Exploring what the Notion of 'Lived Experience' Offers for Social Policy Analysis *Journal of Social Policy* [online]. 48(3), pp.449-467. Available at: McIntoshandWrightJSPprepublicationsversionLivedExperience.pdf (stir.ac.uk) [Accessed 10 February 2019].

National FGM Centre (2015) *Female Genital Mutilation (FGM) Protection Orders*. [online] Available at: https://barnardosfgm.custhelp.com/app/answers/detail/a_id/23/related/1 [Accessed 10th April 2016].

Neuman, W.L.; 2003. *Social Research Methods: Qualitative and Quantitative Approaches*. Boston: Allyn and Bacon.

NHS Digital, 2017. *Female Genital Mutilation (FGM) Enhanced Dataset: January 2017 to March 2017, England, experimental statistics* [online]. Available at: Female Genital Mutilation (FGM) - January 2017 to March 2017, Experimental Statistics Report - NHS Digital [Accessed 14 September 2017].

NHS Digital, 2020. *Female Genital Mutilation (FGM) Annual Report – April 2019 to March 2020 (Experimental Statistics Report)* [online]. Available at: Female Genital Mutilation (FGM) Annual Report - April 2019 to March 2020 (Experimental Statistics Report) - NHS Digital [Accessed 10 September 2020].

Nnaemeka, O., 2005. African Women, Colonial Discourses, and Imperialistic Interventions: Female Circumcision as Impetus. In: Nnaemeka, O., ed. *Female Circumcision and the Politics of Knowledge: African Women in Imperialist Discourses*. Westport: Praeger, pp.27-45.

Nour, N.M., 2008. Female Genital Cutting: A Persistent Practice. *Obstet Gynecol* [online]. 1(3), 135 – 139. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2582648/ (Accessed 8 December 2016).

NSPCC inform, 2010. *Child protection fact sheet: The Definitions and signs of child abuse* [online]. Available at: The definitions and signs of child abuse (NSPCC child protection fact sheet) (psnc.org.uk) [Accessed 12 March 2018].

Obiora, M and Nkosi, M., 2020. Experiences of young women who underwent female genital mutilation/cutting. *Journal of Clinical Nursing* [online]. 29 (July), pp.4104-4115. Available at: Experiences of young women who underwent female genital mutilation/cutting (wiley.com) [Accessed 12 November 2020].

O'Casey, E., 2013. *The "cutting season" and FGM in the UK: A national disgrace, a national shame.* [online]. National secular society. Available at: The "cutting season" and FGM in the UK: A national disgrace, a national shame - National Secular Society (secularism.org.uk) [Accessed 10 May 2021].

Ormston, R., *et al*., 2014. The Foundations of Qualitative Research. In*: Ritchie, J. et al., eds. Qualitative Research Practice: A Guide for Social Science Students & Researchers.* Second ed. London: Sage.

Pollis, A., 1996. Cultural Relativism Revisited: Through a State Prism. *Human Rights Quarterly* [online]. 18 (316-344). Available at: https://www.researchgate.net/publication/322641157_Cultural_Relativism_Revisited_Through_a_State_Prism_Adamantia_Pollis_bio [Accessed 10 September 2017].

Powell, C., 2011. *Safeguarding And Child Protection For Nurses, Midwives And Health Visitors: A Practical Guide.* McGraw-Hill Education.

Punch, K.F., 2013. *Introduction to Social Research: Quantitative and Qualitative Approaches.* London: Sage.

Punch, K.F., 2016. *Developing Effective Research Proposals.* 3rd ed. London: SAGE Publications.

Prohibition of Female Circumcision Act 1985 (c. 38)

Rahman, A. and Toubia, N., 2000. *Female genital mutilation—a guide to laws and policies worldwide.* London: Zed.

RCM *et al*., 2013. *Tackling FGM in the UK: Intercollegiate Recommendations for identifying, recording, and reporting* [online]. London: Royal College of Midwives. Available at: https://www.rcn.org.uk/professional-development/publications/pub-004531 [Accessed 19 January 2017].

RCPHC, 2014. *Safeguarding children and young people: roles and competences for healthcare staff* [online]. London: RCPHC. Available at: Safeguarding children and young people - roles and competencies | RCPCH [Accessed 20 January 2017].

Reiners, G.M., 2012. Understanding the Differences between Husserl's (descriptive) and Heidegger's (interpretive) Phenomenological Research [online]. *Journal of Nursing Care,* 1(5), 1-3. Available at: https://www.hilarispublisher.com/open-access/understanding-the-differences-husserls-descriptive-and-heideggers-interpretive-phenomenological-research-2167-1168.1000119.pdf [Accessed 01 February 2020].

Ritchie, J. and Spencer, L., 2002. Qualitative Data Analysis for Applied Policy Research. In*:* Huberman, M.A., and Miles, M.B., *The Qualitative Researcher's Companion.* Thousand Oaks, California: Sage Publications.

Roberts, M., 2014. *Anatomy of female genital mutilation* [online]. BBC News. Available at: https://www.bbc.co.uk/news/health-27188190 [Accessed 10 February 2019].

Ruiz, I.J. *et al.*, 2014. Men facing the ablation/female genital mutilation (A/FGM): cultural factors that support this tradition. *Procedia-Social and Behavioral Sciences* [online]. 132, pp.631-638. Available at: Men Facing the Ablation/Female Genital Mutilation (A/FGM): Cultural Factors that Support this Tradition (core.ac.uk) [Accessed 10 April 2018].

Sala, R. and Manara, D., 2001. Nurses and Requests for Female Genital Mutilation: Cultural Rights versus Human Rights. *Nursing Ethics* [online]. 8(3), pp.247-258. Available at: Nurses and Requests for Female Genital Mutilation: cultural rights versus human rights (sagepub.com) [Accessed 20 May 2017]

Sarantakos, S., 2012. *Social Research.* 4th ed. Basingstoke: Palgrave Macmillan.

Schwandt, T.A., 2000. Three Epistemological Stances for Qualitative Inquiry: Interpretivism, Hermeneutics and Social Constructivism. In*:* Denzin, N.K., and Lincoln, Y.S., eds. *Handbook of Qualitative Research. 2nd ed.* London: Sage*.*

Seale, C., 1999. *The Quality of Qualitative Research.* London: Sage.

Serious Crime Act 2015 (c. 9)

Sheerin, B., Jefferson, E. and Chang, Y.S., 2023. Female genital mutilation in high-income countries: knowledge and experience among health professionals. *British Journal of Nursing* [online]. 32(3), pp.100-106. Doi.org/10.12968/bjon.2023.32.3.100 [Accessed 12 July 2024].

Shell-Duncan, B., and Hernlund. Y., 2000. Female "Circumcision" in Africa: Dimensions of the Practice and Debates. In: Shell-Duncan, B. and Hernlund, Y., eds. *Female "Circumcision" in Africa: Culture, Controversy, and Change.* Boulder: Lynne Rienner Publishers, pp.1-40.

Shell-Duncan, B., *et al.*, 2011. Dynamics of change in the practice of female genital cutting in Senegambia: Testing predictions of social convention theory. *Social Science & Medicine* [online]. 73(2011), pp.1275-1283. Available at: Dynamics of change in the practice of female genital cutting in Senegambia: Testing predictions of social convention theory - ScienceDirect. [Accessed 14 May 2021].

Shell-Duncan, B., Obiero, W.O., and Muruli L.A., 2000. Women Without Choices: The Debate Over Medicalization of Female Genital Cutting and its Impact on a Northern Kenyan Community. In: Shell-Duncan, B. and Hernlund, Y., eds*. Female "Circumcision" in Africa: Culture, Controversy, and Change.* Boulder: Lynne Rienner Publishers, pp.109-128.

Slack, A.T., 1988. Female Circumcision: A Critical Appraisal. *Human Rights Quarterly* [online]. 10, pp.437 – 486. Available at: Redirecting... (heinonline.org) [Accessed 23 August 2021].

Smith, C. M., 2005. Origin and Uses of Primum Non Nocere - Above All, Do No Harm! *The Journal of Clinical Pharmacology* [online]. 45(4), pp.371-377. Available at: Origin and Uses of Primum Non Nocere—Above All, Do No Harm! (wiley.com) [Accessed 10 February 2018].

Smith, R., 2005. *Values and Practice in Children's Services.* Basingstoke: Palgrave Macmillan.

Sunak, R. and Rajeswaran, S., 2014. *A Portrait of Modern Britain.* London: Policy Exchange.

Tylor, E.B., 1920. *Primitive Culture: Researches into the Development of Mythology, Philosophy, Religion, Language, Art and Custom* [online]. London: Murray. Available at: Primitive culture: researches into the development of mythology, philosophy, religion, language, art, and custom: Tylor, Edward Burnett, Sir, 1832-1917: Free Download, Borrow, and Streaming: Internet Archive [Accessed 23 April 2016].

Taylor, S.J. and Bogdan, R., 1998. *Introduction to Qualitative Research Methods: A Guidebook and Resource.* 3rd ed. New York: John Wiley & Sons, Inc.

Tilley, J.J., 2000. Cultural Relativism. Human Rights Quarterly [online]. 22(501) Available at: file:///C:/Users/User/Documents/FEMINIST%20THEORIES/JOHN%20J%20T%20RE%20CUL%20RELESM.pdf [Accessed 10 September 2017].

Tummolini, L.; 2013. Social Conventions. *Researchgate* [online]. Pp.900-902 (January 2013). Available at: (PDF) Social Conventions (researchgate.net). [Accessed 17 May 2021].

United Nations, 1948. *Universal Declaration of Human Rights: Preamble* [online]. Available at: udhr.pdf (un.org) [Accessed 15 January 2017].

United Nations Children's Fund, 2013. *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change* [online]. New York: UNICEF. Available at: Female Genital Mutilation/Cutting: a statistical overview and exploration of the dynamics of change on JSTOR [Accessed 10 July 2020].

United Nations Children's Fund, 2016. *Female Genital Mutilation/Cutting: A Global Concern* [online]. New York: UNICEF. Available at: FGMC-2016-brochure_250.pdf [Accessed 27 December 2016].

Varol *et al.*, 2015. The role of men in abandonment of female genital mutilation: a systematic review. *BMC Public Health* [online]. 15(1034), pp.1 – 7. Available at: The role of men in abandonment of female genital mutilation: a systematic review | BMC Public Health | Full Text (biomedcentral.com) [Accessed 07 May 2021].

Valsiner, J., 2000. Data as representations: Contextualizing Qualitative and Quantitative Research Strategies. *Social Science Information* [online]. 39(1), pp.99-113. Available at: Data as representations: contextualizing qualitative and quantitative research strategies (sagepub.com) [Accessed 12 June 2019].

Wang, G.G. and Holton, E.F., 2005. Neoclassical and Institutional Economics as Foundations for Human Resource Development Theory. *Human Resource Development Review,* [online] 4(1), pp.86-108. Available at: Neoclassical and Institutional Economics as Foundations for Human Resource Development Theory (sagepub.com) [Accessed 10 October 2019].

Wardere, H., 2016. *Cut: One woman's fight against FGM in Britain today*. London: SIMON & SCHUSTER.

Waterhouse, L., 2002. Child Abuse. In: Davies, M., ed. *The Blackwell Companion to Social Work*. 2nd ed. Oxford: Blackwell Publishing.

Williams-Breault, B.D., 2018. Eradicating Female Genital Mutilation/Cutting: Human Rights-Based Approaches of Legislation, Education, and Community Empowerment. *Health and Human Rights Journal* [online]. 20(2), pp.223-233. Available at: Eradicating Female Genital Mutilation/Cutting (nih.gov). [Accessed 20 March 2021].

Willig, C., 2014. Interpretation and Analysis. In: Flick, U., ed. *The SAGE Handbook of Qualitative Data Analysis.* London: SAGE, pp.136-149.

Willis, J.W., Jost, M. and Nilakanta, R., 2007. *Foundations of Qualitative Research: Interpretive and Critical Approaches.* Thousand Oaks: Sage.

Willow, C., 2009. Putting Children and Their Rights at the Heart of Safeguarding Process. In: Cleaver, H., Cawson, P., Gorin, S., and Walker, S., eds. *Safeguarding Children: A Shared Responsibility.* Chichester: John Whiley & Sons Ltd.

Worsley, A., 1938. Infibulation and Female Circumcision: A study of a Little-Known Custom. *BJOG: An International Journal of Obstetrics and Gynaecology* [online]. 45(4) (August), pp.686-691. Available at: Infibulation and Female Circumcision A Study of a Little-known Custom - Worsley - 1938 - BJOG: An International Journal of Obstetrics & Gynaecology - Wiley Online Library [Accessed 11 December 2016].

World Health Organization, 1998. *Female Genital Mutilation: An Overview* [online]. Geneva: W.H.O. Press. Available at: file:///C:/Users/User/Documents/KEY%20ARTICLE%203/FGM%20AN%20OVERVIEW%20WHO%201998.pdf [Accessed 1 September 2017].

World Health Organization, 2024. *Female genital mutilation* [online]. Available at: Female genital mutilation (who.int) [Accessed 25 July 2024].

World Health Organization, 2001. *Integrating the Prevention and the Management of the health complications into the curricula of nursing and midwifery: A Teacher's Guide* [online]. Geneva: W.H.O. Available at: WHO_FCH_GWH_01.3_eng.pdf [Accessed 27 December 2016].

World Health Organization, 2008. *Elimination Female genital mutilation: An interagency statement OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, W.H.O.* [online]. Geneva: WHO Press. Available at: 9789241596442_eng.pdf (who.int) [Accessed 27 December 2016].

Zechenter, E.M., 1997. In the Name of Culture: Cultural Relativism and the Abuse of the Individual. *The Journal of Anthropological Research* [online]. 53(3) (Autumn), pp.319-347. Available at: In the Name of Culture: Cultural Relativism and the Abuse of the Individual on JSTOR [Accessed on 13 January 2017].

8. Appendix

Appendix: COREQ checklist

The Consolidated Criteria for Reporting Qualitative Studies (COREQ): 32-item checklist

Topic	Item No.	Guide questions/descriptions	Notes	Reported on page no.
Domain 1: Research team and reflexivity				
The research team Gate keepers: JK, VN Principal researcher: WT				
Topic	**Item No.**	**Guide questions/descriptions**	**Notes**	**Reported on page no.**
Personal characteristics				
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	WT conducted all semi structured interviews. WT was simply abbreviated as R standing for Researcher. JK and VN were the moderators during the administration of the consent to participate form	pp.54-56, pp. 70-73 p.91, and p.98 of the thesis titled Document 5. pp.20-22 of the thesis titled Document 6.
Credentials	2	What were the researcher's credentials? - MA, Educ - MA, Dev't Management - MA, Social Work	JK: BA Midwifery VN: MBA Leadership and Management	
Occupation	3	What was their occupation at the time of the study?	JK: Midwife and Campaigner against FGM VN: CEO of Mojatu Foundation and FGM Consultant	p.22 of the thesis titled Document 6.
Gender	4	Was the researcher male or female?	Both semi-structured interview facilitators	

			(JK and VK), were females	
Experience and training	5	What experience or training did the researcher(s) have?	JK and VN both had experience with qualitative research methods including facilitating and conducting semi-structured interviews	
Topic	**Item No.**	**Guide questions/descriptions**	**Notes**	**Reported on page no.**
Relationship with participants				
Relationship established	6	Was a relationship established prior to study commencement?	The research team had contact with some of the participants prior to the informed consent being obtained. This was specifically with the FGM survivors' group. This was because some of the participants were members of an FGM survivors' group in which members of the research team also belonged. Meanwhile, the researcher had no professional or ongoing relationship with neither participant groups.	
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Participants were made aware by the researcher that this was a research project to explore the implications of FGM among BME girls in the UK. The research team acted as gatekeepers for accessing the FGM survivors' group. The professionals' group was approached by the researcher. The researcher explained	p.20 of the thesis titled Document 6.

			that the main goal of the study was to explore ideas which can contribute to the curbing and possibly overcoming the practice of FGM and improve lives in the UK and ostensibly beyond where FGM can be occurring.	
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Due to their deep insight and involvement in campaigning against FGM, the research team had an interest in understanding what ideas could emerge from the research that would contribute towards curbing and/or eradicating FGM in the UK.	
Domain 2: Study design				
Topic	**Item No.**	**Guide questions/descriptions**	**Notes**	**Reported on page no.**
Theoretical framework				
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	The methodological framework for the research is the qualitative approach. This approach was considered most suitable for a social phenomenon subject such as FGFM. Phenomenology was also considered as the most suitable strategy to get the realities of the life world of subjects who directly lived the FGM phenomenon, and practitioners who	p.35 p.41

			provided professional social work practice to all members of the British society including members of the BME community within which, the phenomenon of FGM is being practised. Furthermore, qualitative research methods were used. Hence, the data was collected using purposive interviewing in the form of verbal data/semi-structured interviewing. The data was also analysed in an inductive manner (implying that it was analysed without preconceived ideas).	p.45 pp. 48-49 pp.50-51
Topic	**Item No.**	**Guide questions/descriptions**	**Notes**	**Reported on page no.**
Participant selection				
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	The researcher mainly used purposive sampling. The researcher attempted to vary the FGM community participants to include female and male participants. A variation of the professional participants was also applied – hence, these included professionals from the local authority, education, and two charitable organisations – all	

			locally based in a city in England.	
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	All participants were recruited through gatekeepers JK, and VN, respectively. Both gatekeepers used face-to-face contacts.	
Sample size	12	How many participants were in the study?	13 respondents in all took part in the study. Among these, 7 were from the community of FGM survivors, and 6 respondents represented the social welfare and education professionals. Of the 7 respondents representing the FGM survivors, 5 were women and 2 were men.	p.46
Non-participation	13	How many people refused to participate or dropped out? Reasons?	A total of 20 participants were initially earmarked for the study - 10 participants from the FGM community and 10 from the professionals' group. However, 2 female FGM survivors, and 1 male participant from the FGM community dropped out. The male participant travelled abroad, and the 2 female survivors did not give reasons for their non-attendance. 4 from the professionals' group did not participate and each apologised their inability to attend due to a busy diary. Hence, a combined total of 7 participants	

			did not attend the interviews.	
Topic	**Item No.**	**Guide questions/descriptions**	**Notes**	**Reported on page no.**
Setting				
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	A community event was organised at a local community centre where the FGM participants amongst others were all invited to attend. Whilst attending the event, we then also used the opportunity to invite each at a time in a separate room for the interview. Meanwhile, each of the professionals was met at their workplace where they each arranged an office room for the interview to be conducted face-to-face.	
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	There were no people present during the data collection besides participants and researchers.	
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	The average age of the FGM participants was 38, while for the professionals was 32. Of the participants in the FGM group all were born outside the UK. For the professionals, all were born in the UK.	

Topic	Item No.	Guide questions/descriptions	Notes	Reported on page no.
Data collection				
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Questions were presented to each participant group only on the interview date. Participants were given simple guidance on how the interview would be conducted and how long it could take. Participants also occasionally benefitted from prompts during the interview.	
Repeat interviews	18	Were repeat interviews carried out? If yes, how many? There were no repeat interviews with the same participants.	There were no repeat interviews with the participants.	
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	All interviews were audio recorded with permission of participants.	
Field notes	20	Were field notes made during and/or after the interview?	Researcher made field notes during the interviews.	
Duration	21	What was the duration of the interviews?	The interviews with the FGM participants had an average duration of 45 minutes while for the professionals the interviews had an average duration of 35 minutes.	
Data saturation	22	Was data saturation discussed?	Data saturation was reached on all the topics.	
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction?	Transcripts were not returned to participants for comment and/or correction.	

Topic	Item No.	Guide questions/descriptions	Notes	Reported on page no.
Domain 3: analysis and findings				
Number of data coders	24	How many data coders coded the data?	The interviews were all coded by the researcher.	
Description of the coding tree	25	Did authors provide a description of the coding tree?	There is no description of the coding tree. However, coding was structured under headings of typologies, themes, and propositions. They typologies suggested ideas, from which themes were derived, and the themes suggested various propositions from which meaning and conclusions could be made or drawn.	
Derivation of themes	26	Were themes identified in advance or derived from the data?	Themes were derived from the data in an inductive manner. This was helped by coding	
Software	27	What software, if applicable, was used to manage the data?	No software was used. The gathering of the data, organization, structuring, coding, analysis, and interpretation were all done through the natural human efforts of the researcher.	
Participant checking	28	Did participants provide feedback on the findings?	There was no member check performed by the research team.	

Topic	Item No.	Guide questions/descriptions	Notes	Reported on page no.
Reporting				
Quotations presented	29	Were participant quotations presented to illustrate the themes/ findings? Was each quotation identified? E.g. participant number.	Key findings of the study were supported with selected quotes in text.	
Data and findings consistent	30	Was there consistency between the data presented and the findings?	All findings were derived from the data and all themes are supported by illustrative quotes.	
Clarity of major themes	31	Were major themes clearly presented in the findings?	Major themes were derived from the data and are clearly defined by a subheading/paragraph title.	
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	All the themes identified in the study are major findings.	

PROFESSIONAL DOCTORATE IN SOCIAL PRACTICE

DOCUMENT 6: REFLECTIVE/REFLEXIVE REPORT

BY: WALTERS TANIFUM

Research Topic:

Examining safeguarding implications and perspectives for overcoming Female Genital Mutilation among Black Ethnic Minority Communities in the UK.

Supervisors: Dr Adam Barnard and Dr Linda Gibson

Document 6 submitted in part-fulfilment of the requirements for the degree of Professional Doctorate in Social Practice (D Soc Prac) of the Nottingham Trent University.

Date: 30th September 2021

Total Word Count = 5,727 words

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List of abbreviations

BME	Black and Ethnic Minority
FGM	Female Genital Mutilation
NHS	National Health Service
SWRB	Social Work Reform Board
PCF	Professional Capabilities Framework
UK	United Kingdom

1. Completing the Doctorate in Professional Practice and how it impacted me.

This final document offers me the occasion to be generally self-referent. It allows me the opportunity to express my inner thoughts on how completing the professional doctorate in social practice has strengthened my self-awareness as a more reflective practitioner. As part of being effectively reflexive 'qualitative researchers need to 'position' themselves in their writings…' (Creswell 2013, p.216). Reflexivity 'involves turning back on oneself …' (May and Perry 2014, p.109). Thus, this document is a reflexive and reflective undertaking that, on the one hand, allows me the chance to express my beliefs *vis-à-vis* FGM and safeguarding, and on the other hand, my reflections on the learning experiences I have acquired upon completing this research. In so doing, I will also express how the study impacted my life and the resilience I developed to overcome the challenges encountered.

2. Positioning my personal and professional reflections to universalism

I am an African by origin from the former British Southern Cameroons. Apart from having developed a good understanding of African cultural values from specialising and researching in African literature both at the undergraduate and postgraduate *Maitrise* University studies, I also have an insider's perspective because I am an African. These are avenues that give me a considerable level of confidence and the unique lens through which to appreciate various aspects of African cultural values.

Several reasons motivated me to research this topic. However, of all the reasons, two were the most significant. Firstly, the honour of earning a professional doctorate in social practice. The knowledge acquired would make me more curious and reflective in practice which in turn enables professional development. Secondly, undertaking the research would equip me with the academic abilities to apply and contribute to the fight against FGM among BME young girls and women within and beyond the UK.

Whilst in the first quarter of my master's in development management course in 2001, I tried to write a research article about the need to eradicate puberty initiation rites (genital mutilation, especially in the woman) among most African communities. I expressed the view that the practice is abusive to a woman's bodily integrity and did not promote local community development. The draft article underscored the view that performing female circumcision inevitably pitted itself against goal 3 of the UN's Millennium Development Goals (United Nations, 2015). The Millennium Development Goals require that all member states encourage gender equality and empower women. My message has never been

disseminated to a wider audience because my paper remains unpublished to date; however, my stance against the FGM practice has never wavered. Completing this research has given me a new impetus and I believe the more that FGM is an unhealthy cultural practice. Hence, regularly researching and publishing literature on FGM would be one of my key interests after this study.

Maybe my attitude towards the girl child would have formed the basis on which my values essentially differ from the values towards the gender of a child in most of the communities of my ethnic origin. I cherish and value the girl child as naturally equal to a boy child. In my worldview, a child is just a child regardless of their gender.

Arguably, in most traditional, and even including a good number of modern African societies male dominance is correlative to patriarchy – a concept which 'denotes a social structure where the actions and ideas of men are dominant over those of women' (Soman 2009, p.253). In most patriarchal societies the father or the eldest male is considered the patriarch or head of the household (Soman 2009). Quite often gender inequalities tend to prevail in patriarchal societies.

In most African societies, for instance, son preference over daughters is still very much a popular family cultural value. In these communities, the tradition is always for the man to be assumed as the head of the family. After his death, his successor is traditionally one of his sons and never one of his daughters. That arguably explains why in most African societies a woman would be subjected to give birth several times if she has not yet had a boy child. The view is that the continuation of a family lineage is traditionally apportioned to the man, hence, when a boy inherits their father, he maintains both the lineage as well as his father's assets within the nuclear family. Family assets and the wealth of the family are usually ascribed to have been essentially acquired by the man.

In contrast, a girl child is always seen as only temporarily living in the family home waiting for when she grows up to maturity at which point, she would get married and leave the family home to start her own family. It is held against her that were she to be their father's next-of-kin the family assets she stands to inherit risk being lost because she could either deliberately or be coerced by her husband to transfer the assets over to her own nuclear family.

I find it difficult to endorse such values because in my view these arguments seem to be founded on patriarchal sentiments. To me, values are part of someone or a society's beliefs. And so, when I came of age and continued to mature into adulthood most friends from my ethnic background both, male

and female would blush at hearing me express the wish to have daughters and in particular the wish for my first child to be a girl. This had nothing to do with me having less regard for a son. Today I feel blessed to have two daughters and a son. It would be preposterous to claim to be the best father or to claim to have the best achieving or best-behaved children; however, I can describe the relationship between my children and me as a precious one.

I lost my father as a very young child. The impact of the absence of a father figure in my childhood made me be determined to not allow my children to experience the same difficult times I encountered growing up. On reflection, this belief would have remotely formed the foundation on which I would subsequently become a social worker. Having thus, become a children's social worker, I align with the core principles underpinning all work to safeguard and promote the wellbeing of children, as outlined in Working Together to Safeguard Children (2013), namely:

- protecting children from maltreatment
- preventing impairment of children's health and development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care and
- taking action to enable all children to have the best outcomes (See HM Government: The charity commission 2014, p.7).

3. Reflecting on learnings from undertaking this research

In Gray's (2013) explanation of epistemological reflexivity, he upholds that reflexivity involves the realization that the researcher is not a neutral observer and is implicated in the construction of knowledge. Arguably, knowledge derived from a research work results from the ability of the researcher to have engaged in a critically reflective process in the research phenomenon they undertook. Mezirow and Associates (1990) have argued that 'we make sense of a situation by interpreting it and that interpretation is based on prior experiences, beliefs, assumptions and what we expect to happen' (see Hughes 1990, p37). Reflection, thus 'involves challenging your own values, beliefs and behaviour…' (Hughes 2012, p.37).

Reflecting and making sense out of an experience to inform a professional action is also what Schon recommended from his research in the 1980s. He describes this concept as 'reflection-in-action (Schon 2008, p.62) which, he believes is valuable for the social, health, and education practitioners to apply to make more sense out of a phenomenon. Accordingly, 'when a practitioner reflects in and on his

practice, the possible objects of his practice are as varied, as the kind of phenomena before him and the systems of knowing-in-practice which he brings to them' (Schon 2008, p.77). Reflection in action contrasts with the technical rationality approach which to Schon (2008) is rather too scientific, inclined to positivist epistemology and unsuitable for reflection to professions such as social work, education, the Police service, divinity, etc.

The Social Work Reform Board (SWRB) England, which was created in 2010, undertook the responsibility to propose a report which would move the National Occupational Standards for Social Work to a Professional Capabilities Framework (PCF). Undertaking this research has led to an increased emphasis, in my practice to be critically reflective per components of the PCF. This is because the framework encourages social workers 'to apply the principles of critical thinking and reasoned discernment…augmented by creativity and curiosity' (SWRB 2010, p.11). This informs and provides a rationale for professional decision-making.

One of the key components of the PCF that the SWRB (2010) includes is 'an ethical component that integrates knowledge of culture, values and social awareness into professional practice' (see Hughes 2012, p.34).

Based on the logic of all the arguments presented above, I can say that completing this research subjected me to an important experience of testing both my personal and professional values. I came to the realization firstly, that my values and beliefs *vis-à-vis* the values of my ethnic background have improved. Unlike before when I tended to be more subjective and defensive of the cultural practices of my ethnic background, I have, for instance, become more objective and reflective and now tend to question the validity of some of the cultural practices of my ethnic community. The more I reflect the more I feel that some of the cultural beliefs can be detrimental to human development.

Secondly, I have remained assiduous to my professional values as a social worker. While I still relate with the ethnic-cultural codes of my ethnic background, however, after undertaking this research and gaining profound knowledge about FGM, I realized that my parental values essentially take precedence over certain cultural practices that form part of my ethnic identity. My duties and responsibilities towards my daughters and any other girl child from my ethnic background are to protect and ensure that they are provided with a nurturing and protective environment in which to thrive and aspire. These

personal beliefs do not, therefore, allow me to condone any cultural values that can be dangerous, harmful, and counterproductive.

In congruence to my professional practice, the standards, and values of a social worker in England require me to

> respect and promote the human rights and …feelings of the people I work with, balancing rights and risks…, respect and promote people's dignity and privacy…, recognise the risk indicators of different forms of abuse… and their impact on people…, assess the influence of cultural and social factors over people and the effect of loss, change and uncertainty in the development of resilience (Social Work England n.d., pp1-8).

Mindful of the professional standards and values of a social worker in England I differ with an argument that can justify the performance of FGM on a child under the guise of a cultural value. It can be argued that the practice of FGM is far from reflecting universal moral mores, hence, the justification for its prevalence based on it being a cultural value is debatably not a compelling argument.

The significant features of values are that they characterise morally desirable ways of acting in the social world (Smith, 2005). Clark (see Smith 2005, p.3) has also stated that 'to speak of values is thus a shorthand reference for beliefs and dispositions about what is morally or otherwise good'. Understandably, as a social worker, I am expected to respect 'diversity and different cultures and values' (TOPSS UK Partnership 2002, p.9). However, cultural practices and values that can jeopardise the wellbeing of people can by extension negatively impact the development of a society. Undertaking this research has, therefore, been an enlightening experience for me. I have become more critically reflective and can now question the morality of some of the cultural mores that are practised within some communities of my ethnic background. These thought-provoking and critical reflections have improved my values and will not only enhance but will also guide me to be more critical and curious in my professional practice.

From a purely professional and a balanced perspective, completing this research has opened my mind to be more reflective about how the interpretation or misinterpretation of some African cultural values among social welfare practitioners can result in assessment outcomes that may not reflect the real context in which safeguarding implications and child protection plans for BME children in the UK can be initiated. This came across in the main research's findings when data collected from social welfare and education professionals were analysed and interpreted.

In my view, there is a need for social care professionals and possibly the wider UK population to give due regard to some aspects of the African culture such as their way of life, use of expressions and practices. It could be as in understanding for example, that when an African parent tells the child that 'I'd beat you', they are not implying that they would physically chastise the child, though it comes across as they are sounding verbally intimidating to the child. While verbal intimidation can be emotionally abusive to a child the expression 'I'd beat you' is intended to caution the child to simply behave themself because they run the risk of being disciplined. It is equal to a British parent warning their child to behave else, they risk being sent to the 'naughty corner'. Now, would there be a need for creating a general legal framework that could delineate how parents, including African parents, can discipline a child in the UK? It can be an interesting debate, but I will struggle to ascribe to such a legislative framework.

Child protection legislation in the UK 'considers all forms of physical punishment beyond a 'minor smack'…illegal' (Tansley 2004, p.1). Therefore, for a health visitor or a social worker who does not understand the cultural code, it is easy for such a visiting practitioner to the home of an African parent to misinterpret the saying 'I'd beat you' and assess that the parent is being emotionally or physically abusive to the child. Arguably, misinterpretation of cultural codes can jeopardise safeguarding for Black and Ethnic Minority (BME) children with origins from Africa. Research has supported this thesis. In a study exploring ethnicity and cultural perspectives in child maltreatment Polnay *et al.* (2007), for example, have posited that 'ethnic minority families are more likely to suffer from socio-economic deprivation as well as being marginalized within society (they describe as a 'double jeopardy')' (see Powell 2011, p.60). It, thus, makes good practice, in other words, 'within the scope of professional practice, [that] nurses and other [welfare] professionals… to actively seek out ways to promote culturally congruent care as an essential part of professional practice' (Jeffreys 2010, p.10).

As an African, I would advocate for African culture to be promoted to the apex. But, at the same time, I am a social work professional. Hence, upholding cultural values does not imply condoning values which, can be abusive to a child and which can jeopardise the wellbeing of children. I am of the view that no culture should permit or facilitate the abuse of children. Additionally, I disapprove of failing to protect children from abuse based on fear. And so, for professionals to be culturally congruent in practice and to ensure safeguarding, they must overcome the fear of being labelled racists or being

described as culturally insensitive. Professionals working with children and families must make it a priority to remain focused on the safety and wellbeing of the child.

From a professional standpoint, FGM needs to be viewed as a very concerning child protection matter because it involves emotional and especially, physical harmful implications to a girl child/young woman. Not coming forthright as a professional to state the debilitating impact of the practice is compromising both the short- and long-term future of a girl child in communities that engage in the practice. Therefore, it is highly relevant to conscientize and raise awareness among professionals and members of communities directly related to this practice in the UK. In this way, many people can become educated about the broad issues of child abuse implicit in FGM.

In terms of content and process, one key learning that I have gained is the realization that when the researcher unbrackets themself to the research they feel a sense of freedom. By extension, this translates into a feeling of identity and belonging with the researched community for the researcher. Unbracketing oneself as a researcher could no doubt risk compromising ethical research procedures. However, I did not encounter such an experience. On the contrary, at the moments that I unbracketed myself during the data collection times, I benefitted and learned more about the inner reflections of members of each participating group. This would have been at times when my interactions and engagement with participants would either be like an African or a professional rather than as an academic researcher.

In a wider perspective, unbracketing can allow the researcher the opportunity to gain a good understanding of the knowledge gaps that exist in the worldview of the researched community. This applied to this study where knowledge gaps for both participant groups were captured. By unbracketing and reading both the expressed and unexpressed reactions of participants from the FGM group, I learned that the FGM survivors' group remain uncertain, anxious, and still do not understand the law and criminalisation around FGM. There is thus, the need for these fears and uncertainties to be alleviated among members of these communities. As for the professional group working with children, they knew very little about FGM in general, and the process of mandatory reporting. From both positions as a researcher and a professional and learning about these information gaps, I have now carved out the actions I will engage in post qualification to address these needs. This will be discussed under the 'what next' heading a bit further ahead.

Completing this course has brought me to one of the most challenging dilemmas, namely, the direct conflict between aligning with my cultural beliefs and values or with my professional social work values. Siding with universalism in the process of undertaking this research sometimes made me feel like an irrelevant cultural renegade and I sometimes questioned myself if I were not becoming a victim of cultural assimilation. However, the knowledge gained about FGM provided a means from which I could reflect. I realised that changes in someone's circumstances can also change their core values. At the time that I was not yet a parent, as well as when I would not have trained as a social worker my beliefs and values would have most resonated with my traditional cultural beliefs. Becoming both a parent and a social worker influenced a shift in my perception of things but above all completing this course has led me to be more open-minded and more receptive to cultural dynamism. My social work values have made me question the benefits of some of my cultural values, beliefs and practices and the *raison d'etre* on which some of the practices are still occurring.

Another learning experience was the realisation that as a social worker undertaking a professional doctorate course, other agency teams working for children and families rightfully or wrongfully already tend to see both the professional and the expert in you. Being perceived this way can be pressuring. However, if taken positively the outcome is a sense of self-fulfilment, self-esteem, and self-confidence to advocate for the vulnerable in society and enhance opportunities for others to improve.

Also, I have developed abilities to be more academically and professionally critical and reflective through undertaking this research. I view my role and duty to advocate for the vulnerable in society with more intensity compared to before when I did not undertake this research. My thinking horizons to reflect academically have broadened and the knowledge gained has empowered me to be more professionally curious about child protection and safeguarding issues.

I have now also additionally developed self-confidence that has led to self-belief and self-growth. I do not currently have any experience in publication. I have friends who have completed PhD programmes before. Some have shared that before completing their PhD courses they already published one or two articles. To enhance the profile of the research at the viva phase I need to have published, they have advised.

I duly respect the recommendation above from my caring friends and believe it is vital. But I would like to believe that publishing an extract from the research is not much to enhance the standing of my

research at the viva than to disseminate the research to a wider audience. I embarked on this doctoral course, first, to improve on my practice through further knowledge acquisition, secondly to share the knowledge acquired to improve on professional practice for practitioners working with children and families, and then thirdly to share new knowledge in social research. Several routes would be used to achieve these aims. On reflection, I am confident that I am attaining all these aims so far. Although I have not published yet, I have, however, presented extracts of my research at workshops and conferences which, have received positive feedback and, but for the pandemic in 2019, I would have already honoured more requests to present at other public events. With the support of my supervisors, I have been fully focused on completing the research. I already have a few draft articles extracted from the research and I believe that wider dissemination through publications especially, contributions with the British Journal of Social Work and other different channels will see the light soon.

Overall, the learning gained from undertaking this research has been beyond expectations to me.

4. Challenges encountered in completing this research.

Completing this research has not been an easy endeavour. There have been several moments of self-doubt, insecurity, and a time I nearly gave up on pursuing it further.

The very first difficult situation was the loss of my mother, and then next, my direct junior brother back in Cameroon in 2017, just less than a year after I started the course. These two bereavements hit hard on me. Emotionally, I was very closed and attached to both but unfortunately due to distance, I had not seen either of them for a considerable time before they each passed on. I have always wanted to share my attainment of a doctorate with my mother and my junior brother. Their passing on successively, thus, left a huge emotional gap and impacted my motivation to remain on the course.

One other very challenging experience in terms of the core stages of the research relates to a field issue that then extended to ethical research implications. The original interest was to recruit midwives, health visitors, and school nurses for the professional respondent group. However, I encountered very challenging circumstances regarding complying with NHS ethical procedures. Initially, it did not seem like it could be an insurmountable problem because at the time what seemed to be presenting more as a challenge was sourcing out the professionals that would contribute to providing the data. It was only at a certain stage after I had succeeded to source my Midwife and Health Visitor respondents that I became aware of the very complex stages that take to carry research involving professionals working

with the NHS. By this time, I had already wasted so much time which ended in a frustrating unsuccessful effort.

Major difficulties were also encountered sourcing out participants from the FGM practising community. Although a gatekeeper had been sourced who was keen to rally together some women and men, she could not, however, guarantee the commitment of the potential participants to participate. I was made aware that most of them were still seeking gainful employment avenues and most of them also encountering difficult personal circumstances associated with establishing themselves anew in their current communities. Hence, their focus was more on having a breakthrough and trying to integrate into a relatively new social-cultural environment with demanding economic expectations to meet. Thus, if they had to prioritise anything, participating in an interview activity for a research project was not going to be top of their wish list. They could easily view a request to participate in a research interview as a distraction. For future research in a similar or closely related subject, it might be more effective to travel to Africa especially, if it is funded.

Also, the intimate nature of the FGM procedure can be a deterrent to open discussions with some of the participants. Unspoken cultural codes which define the cultural backgrounds of these women render women to be very guarded with how they engage in certain subjects, and what they say. Openly engaging in some subjects such as intimate sexual discussions can be perceived within their cultural milieu as a lack of moral rectitude. Associated with this is the likelihood of some of the women being coy talking about intimate and personal experiences to a man. Even though by coincidence I shared the same cultural and ethnic background as them, still I am both a male figure and a stranger. Hence, some of the women would have been less expressive and would not be freely forthcoming in sharing their personal experiences.

Furthermore, fear of likely self-incrimination that could result from inadvertently disclosing that FGM has been performed on their daughter(s) appeared to restrain open discussions. Also linked to this for me was the challenge over managing confidentiality that could arise from disclosures. All these actual and envisioned difficulties were overbearing and presented emotionally traumatizing moments during the research journey.

One additional difficult experience I have had to live during this period of the research is my parenting *vis-à-vis* other responsibilities. I have three children who are currently, 11 years old, 16 years, and 19

years old chronologically. Five years so far into the doctorate studies mean that they were 6 years old, 11 years, and 14 years old, respectively. I am also a full-time social worker. While, I have made good efforts to remain actively committed in the lives of my children with the time that I can afford, yet, combining the doctorate studies, full-time work, and other extra-curricular activities would imply that I have definitely missed out on a good chunk of time and would not have been fully emotionally and practically available to them. Thus, I would not have instilled in them as much as I would have desired the family values I cherish; I would not have contributed very much to their learning through support with their school homework, and I would not have maximally listened to them share their aspirations so that I could guide them. On reflection, I wonder if I would not have made it that these demanding experiences fitted around my parenting responsibilities? I have an inkling that my family deserved to have had an edge over the rest of my other life activities during this period of the research, yet that does not seem to have been the case.

One more exceedingly difficult experience was that I contracted the coronavirus from being exposed to a service user at the early stages of its prevalence. The ailment is one that no one will wish for their worst enemy. It sapped a lot of energy and created so much psychological despair in me.

When I mustered some courage afterwards and tried to carry on, the University's IT system could no longer recognise my student status, and I was considered to have graduated. This was during the peak of the pandemic-stricken period and although it appeared like the University would have taken measures to keep things running as normally as possible the practical reality was not yet as effective. For example, it was a challenge trying to sometimes get people on the phone to resolve technical matters like the system no longer recognising me as an enrolled student. After I finished chasing this up and somehow this was resolved, I was then unable to borrow books from the library as it was closed and accessing online borrowing was affected by a depleted Staff due to the pandemic. As I managed to somehow succeed to secure some books, the next difficulty I encountered was that my RefWorks crashed and despite all attempts to engage the University's IT department to resolve this, they could not and kept referring me to and forth RefWorks itself. Although I had gone too far into the studies, these incessant frustrations coupled with all other previously stated challenges made me come very close to not just deferring the course but seriously contemplated quitting it completely. However, for every journey, tenacity, perseverance, and application are necessary parts of journeying. These were the philosophical reflections that remained ringing through my mind and kept me trudging on.

5. Overcoming the tough times

Every research arguably comes across challenges at one stage or the other through the research process, and so, this one was no different.

I realised that I came round to find a way to carry on and would overcome one challenge each time one presented itself. For example, to overcome the challenge in recruiting clinical health personnel from the NHS, the next very best alternative was to resort to another core group of the health and social welfare sector. Hence, social work professionals were recruited from a reputable and well-established national children's charity. Other social workers, and education welfare and safeguarding staff were also recruited from the children's social care service and the education service, respectively from a Local Government Authority in England.

Distributing any benefits of this research could be through publications, presentations at professional conferences, or any other public medium. Therefore, compromising the well-being of participants who have taken part in this study could be tantamount to undermining ethical research principles. The point has been made that 'researchers must be very careful [not to] place research participants in physical danger or embarrassing-inducing situations. They must painstakingly monitor events and control what occurs' (Neuman 2003, p.258). Flick (2014, p.57) shares the same view and emphasises 'avoiding to harm participants in [the process of] collecting data'.

From an ethical standpoint, I ensured that no harm was caused to the participants during the data collection process. Ethical issues were not only robustly managed during the data collection phase, but transparency was maintained throughout the research project.

In respect of the assertions above, ethical clearance was sought for and approved by the ethical governance of Nottingham Trent University (NTU) for the Professional Doctorate in Social Practice (D Social Practice) research (see appendix 1 on p.18). This study, therefore adhered to and was conducted within the ethical ambit of respect, honesty, and openness to participants, as defined by the NTU Professional Doctorates Research Ethics Committee (PDREC).

Before the interviews were conducted and as part of further ensuring that ethical requirements were appropriately complied with, all potential participants each completed a *Human Subjects' Consent to Participate Form* (see appendix 2 on p.20).

In my view, a learner is arguably as good as their mentor can be. I received incisive, respectful critical perspectives, but above all understanding and immense support from my supervisors. They each took a keen interest in my research and individually as well as collectively provided the much-required guidance which, significantly diluted some of the challenges I encountered.

On reflection, I have recognised that the most important factor that has contributed to my ability to overcome all the challenges that presented was the ever-burning zeal to obtain the doctorate. It has been my life-long desire to earn a doctorate, and proof is in that despite becoming over 50 years old, I have not lost this desire. Each time during the project when I have been overwhelmed by a difficult encounter, I have heard myself repeating a familiar adage, namely that; 'if others can do it, I can do it too'. Hence, on reflection, overcoming the hurdles encountered has made me realise how self-determination can trigger incredible levels of resilience in someone.

In hindsight, the doctoral process as previously stated has not been an easy endeavour, but overall, it has been an exceedingly positive and enriching experience. Just for the fact that challenges to overcome the project presented themselves yet, I succeeded to get to the final line gives me a sense of total fulfilment. This is part of self-discovery which indicates that one can always offset any challenges if one has self-determination, self-belief and above all, resilience. I will be able to draw from my experiences and share to my children, and why not to my grandchildren that if their father and grandfather could overcome various difficult encounters and obtain a doctorate when he was over the age of 50 years old, then they should always believe in themselves and always set their sights to attain higher goals.

6. What next?

Whilst the completion of this research sounds like the end of a project, it is just the beginning of another page in my life storybook. As previously stated elsewhere, I would want to disseminate this research in several ways, through publications for the social research community but especially, through workshops, training and consultancies to professionals working with children and families.

I will also continue to assess my practice and continue to explore areas of similar research that will contribute to academic knowledge. One area of research that comes to mind and which was explored and considered relevant for this study was the debate between cultural competence and cultural humility among clinical and social welfare professionals and its relevance to safeguarding.

Unfortunately, for want of space, this could not be included in this study. However, I envisage approaching peer-review journals and proposing the research for publication.

Finally, this study has broadened my researching horizons, increased my knowledge base, inspired me to be more confident and above all given me the feeling of a new person, namely, the identity of a professional doctor in social practice. I, therefore, have the conviction that undertaking this research has generated knowledge that can inform social work practice regarding indigenous cultural practices and safeguarding implications within multi-cultural contexts like the UK. I have enjoyed the experience.

7. References

Creswell, J.W., 2013. *Qualitative Inquiry and Research Design: Choosing Among Five Approaches.* 3rd ed. Los Angeles, CA: Sage publications.

Flick, U., 2014. *An Introduction to Qualitative Research.* 5th ed. London: SAGE.

Gray, D.E., 2013. *Doing Research in the Real World.* London: Sage

Great Britain. Charity Commission, 2014. *Safeguarding children and young people* [online]. Available at: safeguarding-children-and-young-people-2014.pdf (zakon.co.uk) [Accessed 13 July 2021].

Hughes, M., 2012. *Is social work education life changing? A unitary appreciative inquiry into the impact of social work education on a person's beliefs, values and behaviour* [online]. Ph.D. thesis, Bournemouth University. Available at: [PDF] Is social work education life changing? : a unitary appreciative inquiry into the impact of social work education on a person's beliefs, values and behaviour | Semantic Scholar [Accessed 21 July 2021].

Jeffreys, M.R., 2010. *Teaching Cultural Competence in Nursing and Health Care.* 2nd ed. New York: Springer Publishing Company.

May, T. and Perry, B., 2014. *Reflexivity and the Practice of Qualitative Research.* Los Angeles: Sage.

Neuman, W.L., 2003. *Social Research Methods: Qualitative and Quantitative Approaches.* 5th ed. Boston: Allyn and Bacon.

Powell, C., 2011. *Safeguarding And Child Protection for Nurses, Midwives and Health Visitors: A Practical Guide.* McGraw-Hill Education.

Schon, D.A, 2008. *The Reflective Practitioner: How Professionals Think In Action* [eBook]. New York: Basic Books. Available via: ProQuest Ebook Central. [Accessed 14 July 2021].

Smith, R., 2005. *Values and Practice in Children's Services.* Basingstoke: Palgrave.

Social Work England, n.d. *Professional Standards* [online]. Available at: 1227_socialworkengland_standards_prof_standards_final-aw.pdf [Accessed 14 July 2021].

Soman, U., 2009. Patriarchy: Theoretical Postulates and Empirical Findings. *Sociological Bulletin* [online]. 58 (2), pp. 253–272. Available at: Patriarchy: Theoretical Postulates and Empirical Findings on JSTOR [Accessed 29 September 2021].

Tansley, J., 2004. *Why we must ban smacking* [online]. Available at: Why we must ban smacking - Liverpool Echo [Accessed 8 August 2021].

TOPSS UK Partnership, 2002. *The National Occupational Standards for Social Work [online]. Leeds: Topps England.* Available at: The National Occupational Standards. Social Work. Topss UK Partnership - PDF Free Download (docplayer.net) [Accessed 15 July 2021].

United Nations, 2015. *The Millennium Development Goal Report* [online]. New York: United Nations Available at: MDG 2015 rev (July 1).pdf (un.org) [Accessed 18 June 2021].

8. Appendices

8.1 Appendix 1: Ethical Declaration Form

Professional Doctorates Research Ethics Committee (PDREC)

Ethical Approval Checklist for Ed D/D Soc Prac/D Legal Prac/D Fashion/ADBE professional doctorate group of courses.

This form must be signed off by the research student, one member of the supervisory team, and a course leader, to signify that the proposed research conforms with good ethical principles and standards, before commencing any research in preparation for **Documents 3, 4 or 5** in any of the Ed D/D Soc Prac/D Legal Prac/D Fashion/ADBE professional doctorate group of courses.

Assurance that all research will conform with good ethical standards is provided by the student when signing this form. Please complete this document following the Ed D/D Soc Prac/D Legal Prac/D Fashion/ADBE professional doctorate group of courses ethical approval guidelines.

Award title **Delete as appropriate*	*Doctor of Social Practice
Cohort	9
Research Student's Name	**Walters Tanifum**
Project title and short description of project	**Examining safeguarding implications and perspectives for overcoming Female Genital Mutilation among Black Ethnic Minority Communities in the UK.** The research is principally concerned with examining the safeguarding implications of FGM for BME girls in the UK. The view in the study is that there is lack of sufficient understanding of FGM, especially around the notion of cultural sensitivity among professionals in education, health and social care; hence this limits their ability to identify and ensure the protection of girls from ethnic minority communities in the UK wherein FGM is considered a practice. The qualitative research approach is used to examine the practice of FGM as an aspect of the socio-cultural worldview among its adherents. Literary

	descriptive data of lived experiences of FGM practising cultures as well as views of respondents are reviewed and analysed to determine the viability of FGM as a safeguarding concern among BME girls in the UK. This research will involve face-to-face interaction with human participants, so throughout the research lifecycle it will be conducted with full compliance of ethical research principles of NTU's Professional Doctorate Research Ethics Committee (PDREC) for D Soc Prac, and more particularly the guidelines established in the Economic and Social Research Council (ESRC's) ESRC framework for research ethics 2015.
Supervisors: (List lead supervisor first)	1. Adam Barnard 2. Linda Gibson
Date	21.10.2017
Identify any questions in the completed form which indicate that approval by PDREC or its successor is required.	

Compliance with Ethical Principles

Please sign the declaration below, to confirm that this form has been completed to the best of your knowledge and after discussing the answers provided with your supervisor(s). If at any stage you have been asked to submit an application for ethical approval to the PDREC or its successor, please also complete and submit the appropriate form (which appears on the following page).

Signature of Research Student: Walters A. Tanifum…. Date: 21.10.2017……

Signature of Lead Supervisor ……. Date ……

(note that this signature confirms that you have seen and approved any participant information sheet/consent form and research instruments such as questionnaires)

Signature of Course Leader/nominee ……. Date ……

8.2 Appendix 2: Consent to participate form

Professional Doctorate in Social Practice

Nottingham Trent University

Research Topic:

Examining safeguarding implications and perspectives for overcoming Female Genital Mutilation among Black Ethnic Minority Communities in the UK

BY: WALTERS TANIFUM

Human Subjects' Consent to Participate Form

Dear Participant,

The following information is provided for you to decide whether you wish to be interviewed in the present study or not. Ethical procedures for academic research undertaken from UK institutions require that interviewees explicitly agree to be interviewed and how the information contained in their interview will be used. This consent form is, therefore, necessary for this study to ensure that you understand the purpose of your involvement and that you agree to the conditions of your participation.

The purpose of the study is to examine the safeguarding implications of Female Genital Mutilation (FGM) for BME girls in the UK, and ideas on how FGM could be curbed or eradicated in the UK, and possibly beyond the UK.

Data will be collected in the form of face-to-face interviews involving the use of semi-structured interviews. The interview sessions are anticipated to last for about an hour.

Overall, the views of FGM practising community members, as well as the views of professionals, will all be gathered. The interviews may be recorded and transcribed. The views will be presented and analysed by the researcher to determine if FGM poses a safeguarding concern among BME girls in the UK. The data will be securely protected and stored on the computer and other securely protected electronic devices. The data shall not be kept for longer than it is necessary. Hence, it shall be destroyed within six years of the completion of the study.

You should be aware that you are free to decide not to participate or to withdraw at any time without affecting your relationship with this researcher, your community group organiser or your organisation. If you chose to withdraw you can request that your data is removed from the study and your request will be acted upon immediately. Professional participants MUST NOT disclose the details of their employment agencies. This is to protect against deductive disclosures.

The main individual involved in the data collection will be the researcher. Do not hesitate to ask any questions about the research either before participating or during the time that you are participating. Anonymity and confidentiality will be rigorously protected, hence neither your name nor the agency you work for will be asked or associated with the research findings in any way. Each participant will be assigned a unique identification code for this research. I will be happy to share my findings with you after my research is completed.

There may be some low-level emotional discomfort with a local community group participant who may recollect a previous negative FGM experience. If at any point a participant became significantly distressed, they could be immediately attended to by an experienced local community FGM Counsellor/therapist who will be contactable. They could also be referred to the NSPCC FGM Helpline Service for further counselling. On the other hand, professional participants may be worried about their professional knowledge being subjected to questioning should their response to a question suggest a lack of professional curiosity to FGM safeguarding implications. Should such fears arise during the interview they could be advised to contact their local GP's for referral to free NHS counselling services. They could also be advised to access other free online counselling services such as Stress Group or MindWell.

The expected benefit associated with your participation as a local community member is that you will be more enlightened about the criminal implications FGM perpetrators in the UK are exposed to. Meanwhile, the benefits of participating as a professional include the fact that you will learn more about FGM as a form of child abuse, professional implications of lack of knowledge to complete FGM referral forms, and how to overcome safeguarding barriers.

Please sign your consent with full knowledge of the nature and purpose of the procedures. A copy of this consent form will be given to you to keep.

By signing this form, I agree that:

i. I am voluntarily taking part in this project. I understand that I don't have to take part, and I can withdraw at any time and can also request that my data is withdrawn from the study.
ii. I understand that the interviews may be recorded and transcribed.
iii. I don't expect to receive any benefit or payment for my participation.
iv. I have been able to ask any questions I might have, and I understand that I am free to contact the researcher with any questions I may have in the future.

Date:……

Signature of Participant:……

Walters Tanifum; Researcher.

Facilitators:
Jammie Koroma – Midwife and Campaigner against FGM
Valentine Nkoyo - CEO of Mojatu Foundation and FGM Consultant