

BMJ Open ‘Putting salt on the wound’: a qualitative study of the impact of FGM-safeguarding in healthcare settings on people with a British Somali heritage living in Bristol, UK

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ABSTRACT

Objectives This research documents the experiences of people with Somali heritage with female genital mutilation (FGM)-safeguarding services in healthcare and whether such services are considered appropriate by the people who encounter them.

Design Six focus groups conducted with ethnic Somalis living in Bristol, during the summer of 2018, divided by gender and whether people had experienced FGM-safeguarding as adults or children.

Setting

Participants experienced FGM-safeguarding in primary and secondary care.

Participants 30 people (21 women and 9 men), identified through local organisations or snowball sampling. All participants were of Somali heritage and aged over 18.

Results Government priorities to support those who have experienced female genital cutting/mutilation (FGC/M) are being undermined by their own approaches to protect those considered at risk. Participants argued that approaches to FGM-safeguarding were based on outdated stereotypes and inaccurate evidence which encouraged health and other service providers to see every Somali parent as a potential perpetrator of FGC/M. Female participants described providers in a range of healthcare settings, including Accident and Emergency Departments (A&E), antenatal care and general practice, as ‘fixated’ with FGC/M, who ignored both their health needs and their experience as victims. Participants felt stigmatised and traumatised by their experience. This undermined their trust in health services, producing a reticence to seek care, treatment delays and reliance on alternative sources of care. Associated recommendations include developing more accurate evidence of risk, more appropriate education for healthcare providers and more collaborative approaches to FGM-safeguarding.

Conclusion All the participants involved in this study are committed to the eradication of FGC/M. But the statutory approaches currently adopted to enable this are considered ill-conceived, unnecessarily heavy-handed and ultimately detrimental to this. Recognising these common aims can enable the development of services better able to protect and support those at risk of FGC/M in ways which are culturally competent and sensitive.

Strengths and limitations of this study

- This is the first study to explore the impact of female genital mutilation (FGM)-safeguarding in healthcare on users in the UK.
- The qualitative approaches adopted offer particular insights into these experiences.
- The study involves those who engage with FGM-safeguarding services in diverse ways.
- The research focusses on those with Somali heritage living in Bristol, UK.
- It does not explore the experiences or attitudes of healthcare providers.

INTRODUCTION

Female genital cutting/mutilation (FGC/M)¹ (see author note 1) is considered a ‘global concern’,² affecting populations from a number of African, Asian and Middle Eastern societies. Across Europe, policy responses to FGC/M have tended to criminalise those engaging in the practice.^{3 4} In the UK, it is recognised that those living with, or at risk of, FGC/M need to be provided with sensitive and compassionate care. Patient-centred healthcare responses can ‘optimise future reproductive and sexual function, psychological health and quality of life’, while also providing an ‘effective safeguarding response’ to identify and protect those at risk.⁵ Unfortunately, in spite of these positive aims, there are concerns that current approaches to FGM-safeguarding may instead work to stigmatise those it aims to support, directly weakening patients’ trust in health services.⁶ To date, no academic research conducted in the UK has effectively explored this.

UK politicians and media sources have repeatedly claimed that ‘tens of thousands of girls’ living in the UK are at risk of FGM/C,^{7–9} although the evidence available to support



these statements is problematic.¹⁰ The Serious Crime Act 2015 mandates that professionals in health, social care and education report to the police all girls aged under 18 who disclose or have physical evidence of FGC/M (see author note 2).^{11 12} Reporting was also introduced for monitoring purposes in general practice and mental health and acute trusts. This has been supported by the introduction of the FGM Enhanced Dataset, which requires National Health Service (NHS) practitioners to record detailed information about FGC/M within the patient population,^{13 14} and an information sharing system which flags the summary care records of all baby girls born to mothers who have undergone FGC/M.

While these policies appear to be well-intended, concerns have been voiced regarding the evidence underpinning the policies, as well as their effectiveness.^{6 15} For example, such policies assume a direct link between historical cases of FGC/M in the older, migrant generation and the risk to UK-born children despite their very different cultural environments.¹⁰ There is mounting evidence that the scale of risk to UK-based children is significantly lower than these approaches presume,^{16 17} with reduced levels of support for FGC/M particularly, but not only, among migrants and drastically fewer incidents of the most serious forms of the practice.^{6 18–35} As Creighton and Bewley argue, ‘gynaecologists would see more acute complications were significant numbers really happening ‘every hour of every day’ as suggested by the 2015 Home Affairs Committee (House of Commons 2016)’.³⁶

Identifying the scale of this risk is further complicated by non-response. By 2019, only 2% of general practitioner (GP) practices had submitted any information to the FGM Enhanced Dataset.¹³ The reasons for this are unclear. Official explanations suggest a potential lack of awareness of reporting requirements or practical issues affecting submissions, as well as the low levels of FGC/M in certain areas.³⁷ However, we suggest that concerns about the impact of FGM-safeguarding and monitoring in healthcare on patients may also explain this. In their 2019 *BMJ* editorial, Creighton and colleagues⁶ expressed concerns regarding the ‘emotional and financial weight’ placed on families experiencing FGM-safeguarding. These concerns are confirmed by empirical evidence of the negative consequences of FGM-safeguarding and monitoring policies in Sweden,³⁸ which ‘have ramifications that are invasive and sometimes even traumatising for the girls involved... [and] may negatively influence the sexual health and rights of [the] target group’. To date, no academic study has explored these issues in the UK. This paper responds to this gap, using evidence from focus groups with Somali people living in Bristol. International statistics, including those from the WHO and UNICEF, routinely state a 98% FGC/M prevalence rate among the Somali population, the highest in the world.^{39 40} Consequently, those with Somali heritage have received particular scrutiny in national and international debates on FGC/M and offer a valuable focus for this study.

METHODS

The study involved six focus groups which collected data on the perspectives of Somali families with experience of FGM-safeguarding in Bristol, in the summer of 2018. Our methodological approach was designed to ensure the representation of a comprehensive range of perspectives on this issue from within the Bristol Somali population. We were approached to conduct the research by people concerned by the impact of current approaches to FGM-safeguarding in the city. However, we approached a range of organisations, including those which have historically had more involvement in FGM-safeguarding policy, to ensure that we also recruited individuals who might not be so strongly motivated to report negative experiences. Participants were identified using the research team’s existing contacts with a range of organisations run by and/or representing people with Somali heritage living in Bristol and others were contacted through snowball sampling. This included those who experienced FGM-safeguarding as parents, children, significant local stakeholders, and those more active as anti-FGM campaigners and those involved in the development the ‘Bristol Model’ (see author note 3).^{41 42} This approach enabled valuable insights into the experiences of individual Somali families and also those of the Bristol Somali population more generally. While funding constraints prevented us from reaching data saturation, there is sufficient consistency in findings across the focus groups to claim with confidence that our evidence is robust.

A total of 30 participants (21 women and 9 men) were interviewed. This was the maximum number of people that could be recruited within the project constraints. All participants were aged 18 or more. Focus groups were divided by age and gender to reflect the potentially varying perspectives of those who were children at the time of safeguarding and those who were adults, and participants’ stated preferences for gender-specific groups. Focus groups 1, 2 and 3 included older women who described experiences of FGM-safeguarding as adults. Focus groups 4 and 5 included older men. Focus group 6 included younger women, who were children when their experiences of FGM-safeguarding occurred. All participants signed informed consent before taking part. Focus groups were conducted in the university and in community settings familiar to the participants and were recorded and transcribed by the research team. Translation was provided during focus groups by local Somali people when required. While not involving medical research, this project complies with the relevant requirements of the World Medical Association Helsinki Declaration.

The research aimed to explore participants’ perspectives regarding their experience of FGM-safeguarding in different domains—healthcare, education, via home visits from social services and the police, in courts and at borders—and the positive and negative implications of these. Discussions also considered the direct impact of FGM-safeguarding on service engagement, and on

relationships within families, the local Somali community and with wider British society. This paper focusses particularly on experiences in healthcare settings. Further details of the research are provided by Karlsen *et al.*⁴³ Thematic analysis⁴⁴ identified several ways in which approaches designed to support those with experience and protect those at risk of FGC/M directly undermine the provision of effective healthcare. The authors confirm that this manuscript is an honest, accurate, and transparent account of the study; that no important aspects of the study have been omitted; and that any discrepancies from the study as originally planned have been explained.

Patient and public involvement

No patients were involved in this study. Members of the public were involved at all stages of the research process. The research was motivated by a request from the public, and the project aims and methodology were developed in collaboration, building on mutual recognition of both the preferences of local partners and the requirements of ethical, independent research. People with a Somali heritage living in Bristol were instrumental in the identification of study participants and decisions regarding the conduct of the focus groups and provided practical support with the provision of childcare, translation and refreshments. All participants were invited to a presentation and discussion of findings with the research team prior to the publication of the report to confirm accuracy and support the maintenance of a sense of partners' ownership over the project. This approach was instrumental for minimising the impact of researcher characteristics.

RESULTS

FGM-safeguarding in healthcare settings was predominantly experienced by women, often in routine appointments with midwives, GPs and health visitors, although there were notable examples of FGM-safeguarding experienced in A&E. While men discussed at length issues with FGM-safeguarding (both generally, and in relation to specific contexts), there was less discussion of issues with healthcare in these focus groups. This is likely to be explained by the particular ways in which Somali women engage with healthcare, on their own behalf when pregnant and also on behalf of their children. It is not possible to assess the frequency with which these issues occurred with these data, but certain perspectives were reiterated across multiple groups. While some participants' experiences were considered less problematic, Somali women in all focus groups discussed the negative treatment which occurred repeatedly and in each of these healthcare settings. It was considered 'normal' for the midwife to talk about FGC/M 'everyday' (at every antenatal appointment). Participants in each of the women's focus groups explained that an awareness that other medical concerns, particularly those relating to a woman or girl's genital

area or stomach, were reacted to in more extreme ways by healthcare practitioners when involving Somali people.

Several themes were evident. Most simply, most participants objected to being asked about their experiences of FGC/M. This objection was aggravated by the often-repeated nature of this questioning—across multiple or within single encounters—which was seen to ignore and even exacerbate the traumatic nature of FGC/M itself. These experiences were further worsened by approaches considered culturally incompetent and insensitive to, as well as ignorant of, the facts of FGC/M. Approaches to FGM-safeguarding were felt to rely on and reinforce outdated stereotypes of the Somali community, which encouraged suspicion from health providers and directly contributed to the stigmatisation and victimisation of Somali people in healthcare and more widely. All-in-all, participants argued that the focus on getting 'results' for the NHS Enhanced Dataset meant that the health needs of the patients and their family were de-prioritised. The quality of the healthcare provided to Somali families had diminished as a result. Participants felt undermined and distrusted by professionals expected to care for their health and that of their families. Not surprisingly, this had negative consequences for their trust in and engagement with health services.

The re-traumatisation of FGC/M-affected women through invasive and insensitive questioning

Many of the women in the focus groups who had experienced FGC/M said it was something that they wished to forget. As well as the physical and psychological consequences of the experience, it had also damaged relationships within families which had taken time to repair. The majority of participants felt that being asked about their experiences of FGC/M was in itself intrusive and upsetting, with one woman stating: "This is a very private matter. You can't just ask me what it's like inside my legs". Participants objected to being asked about FGC/M when this was considered irrelevant to the health concern. But even where establishing FGC/M status might be pertinent, such as during pregnancy, participants felt that such questioning was often insensitive. That policy required these questions to be asked repeatedly aggravated women, even when they were asked sensitively. One of the issues raised most often in the focus groups was the failure of health practitioners to acknowledge that FGM-safeguarding had already been undertaken and that this information was therefore already available to them:

"When I go to the GP, they ask me again and again, did you do that [FGC/M]? I told the GP, please write down on your computer, I don't want to do that [FGC/M] and so please don't ask me any more questions. I hate to hear these kinds of questions." (Focus Group 1)

Where participants described less distressing experiences with FGM-safeguarding in health settings, encounters had been friendly and open and participants

recognised that safeguarding had been performed out of a genuine desire to protect them. This young women recounted a conversation with her GP before a holiday and described the differences between this encounter and others she had experienced:

“She wasn’t saying it in a kinda aggressive way, she was saying it as if it was a normal chat. She goes, ‘I know this is a really silly question to ask’ but she’s like, ‘I’ve gotta ask it’. She just said, ‘There isn’t any chance of you having FGM done [while you’re on holiday]?’ I goes, ‘No, there isn’t’. She goes, ‘That’s fine, then.’ If they were a bit more sensitive and they just kinda said, in a polite way, ‘I don’t mean to be rude or insensitive but is there any chance that your daughter could be at risk of FGM? No offence to you or anything’, and the parent says, ‘No’, then...there’s no need to get the police involved.” (Focus Group 6)

However, participants described numerous examples where health professionals had not achieved this:

“Did you have the FGM?” she [midwife] asked. It was like an interview. I was quite shocked... “You have to answer this question,” she told me...She was desperate to fill in this form. I was uncomfortable... It frightened me really.” (Focus Group 1)

Participants also described how these difficult conversations could occur in quite public locations, such as ‘behind curtains, other people could hear...dignity kind of went out of the window’. This reliance on an ‘interview’ style, which followed a ‘form’ or ‘script’, was explained as a consequence of a lack of understanding of FGC/M among health professionals who failed to engage with the knowledge or concerns of their patients: “They don’t know what they are talking about. It’s insulting. You feel embarrassed and attacked”. People were embarrassed by the questions, insulted by the fact that health professionals knew so little about an issue they were supposedly educating them about (and indeed, often less than the participants themselves) and attacked by the assumptions about their culture which underpinned these policies and approaches. This apparent lack of care and ‘interview’ style of questioning undermined this participant’s trust and sense of security in her relationship with her midwife, which led her to question her need for antenatal care: “I told her that I didn’t need a midwife like this”.

Approaches to FGM-safeguarding in healthcare were argued to not only ignore but actually risk exacerbating the trauma associated with the experience of FGC/M itself. Our evidence suggests that these traumatising effects are related to:

- ▶ the ways in which patients are forced to answer questions about their experiences of FGC/M, even when they explicitly express a wish not to;
- ▶ the ways in which victims of FGC/M are forced to (repeatedly) disclose details of their experience to medical staff, approaches which are generally

considered inappropriate for victims of (other forms of) child abuse; and

- ▶ the insensitive approaches which fail to acknowledge the potential psychological and physical impacts of experience of FGC/M, despite these being the premise on which these policies are deemed necessary.

Taken together, these issues were considered to risk inflicting significant damage on the welfare of individuals, particularly those with experience of FGC/M:

“The parents who had it done, they are traumatised. (...) To ask mothers who are traumatised [about FGC/M] over and over and over again. You’re putting salt on that wound, you’re making it fresh again.” (Focus Group 1)

The impact of outdated stereotypes

Participants commented that the evidence underpinning approaches to FGM-safeguarding drew on outdated assumptions about Somali culture and the positive attitudes of people with Somali heritage towards FGC/M:

“The minute you say there is a problem, because [of] who you are, the first thing the GP will look at you, if you mention anything about that [genital] area, any healthcare setting, they feel obliged to ask you [about FGC/M].” (Focus Group 2)

None of the participants in our study claimed that they supported FGC/M and they all agreed that it was a practice that children should be protected from. Participants in all groups were adamant that these attitudes to FGC/M were common among British Somalis and were frustrated that this was not acknowledged in FGM-safeguarding policy: “Young mothers, born here, do not have FGM”. It was argued that these attitudes had been encouraged by migration to Britain, to a ‘different [FGC/M] environment’. People also described the significant impact of Bristol Somali-led anti-FGC/M initiatives on awareness of the nature and problems of FGC/M in Britain. Participants reflected that attitudes to FGC/M were changing in Somalia/Somaliland, such that even these statistics were problematic: “A hundred years ago, this country had a different culture from today. Are the people still living in the same way? They modernised. So, in Somalia, we too modernised”. Participants argued that they were ‘trying to find our identity as British Somalis, and we don’t want FGM to be part of that’. But approaches to FGM-safeguarding were believed to directly undermine these aims:

“Even though, as a community, we want to move away from this practice [FGC/M], again, to be slapped across the face with it...even if communities stop practicing it, they will still be stigmatised and labelled by it, and it kind of undermines the progress that we’ve made” (Focus Group 3)

These persistent stereotypes encouraged health practitioners to treat their patients with suspicion,

misinterpreting behaviour considered normal (both for Somalis and others) as indicative of potential FGC/M risk: “[My daughter] was one of those shy kids, she wouldn’t take her clothes off in front of anybody. And the nurse kept saying to her “Do you want your mum to leave?” Approaches to FGM-safeguarding encouraged a sense of Somali parents as incompetent and prone to criminal activity: “my mum got taken for an idiot or that she was unworthy of being trusted as a parent”. Parents described how they felt forced to prove their innocence in response to the unsubstantiated negative reactions of healthcare providers. Parents were asked repeatedly about their plans to arrange FGC/M for their daughters. This was interpreted as an attempt by health practitioners to ‘catch people out’ and admit their dishonest and criminal intentions. Not surprisingly, this was considered extremely disrespectful:

“And my mum was like, “No... no-one in my family’s had it done, I don’t know where you got this information from” and she [Nurse] kept on badgering my mum, as if she was trying to get information. Like, I know when someone tries to be manipulative, as a professional, it’s very easy, she kept asking my mum... It was very patronising, and my mum was getting frustrated because... you know, when you see your child’s in pain and no-one’s helping them, so the more frustrated my mum got, the more angry and the more guilty it made her look...Everything got brushed aside. It was just fixated on making my mum look guilty.” (Focus Group 6)

A failure to acknowledge potential changes in attitudes towards FGC/M among affected groups can exaggerate a perceived risk and encourage practitioners to view their patients with suspicion, undermining the provision of sensitive and culturally competent care. This directly contributed to participants’ loss of trust in their health providers and sense of exclusion from wider society.

Loss of trust in health services

There was a strong sense from across the focus groups that the health needs of Somali families were being overlooked in efforts to collect data on FGC/M: “Before they cared about your health and how the child was feeling. Now it’s just FGM”. This sense of the de-prioritisation of a patient’s health needs was evident in a range of healthcare settings, including in general practice and midwifery care, as well as acute A&E services. Even those with potentially serious symptoms could have their health needs overlooked in efforts to conduct FGM-safeguarding:

“Instead of the nurse trying to figure out why I was in such pain – you know, the usual procedures, bloods, blood pressure, all of that – she [the A&E Nurse] skipped all those steps and directly, she was like to my mum, ‘Have you done FGM to your daughter?’... I think it’s quite dangerous when...if a nurse or a doctor hasn’t been given enough training or [has]

enough awareness on the topic to the point where they might misdiagnose the patient” (Focus Group 6)

Participants described how the Somali community—through their own educational initiatives—had become more aware of the health implications of living with FGC/M. But, even here, the focus of health providers on FGM-safeguarding and data collection meant that the health needs of women could be ignored:

“Now there is a fear [that] she [the woman with FGC/M] will lose the child, she will have health problems, complications. [Somali] People are now more aware of the [long-term] health issues [of FGC/M]. How do we get our service providers here to understand this?” (Focus Group 4)

Such evidence further highlights the limitations of assumptions regarding the educational potential of such health provider engagement.

Participants described ways in which experiences of FGM-safeguarding had directly contributed to a loss of ‘confidence in the health service’. Inappropriate or insensitive healthcare generated an on-going concern among families:

“We are just very worried now. I’ve got a daughter who is nearly 12, if anything should happen to her, to her privates, if she gets an infection, the first thing that comes in my mind is this situation [FGM-safeguarding]. [...] It’s very stressful, it keeps coming back. The first thing that comes in my mind is that the doctor will ask you this question.” (Focus Group 1)

There is a tangible fear relating to parents’ awareness of their inability to protect their children from a system perceived to be designed to harm people. This service disengagement led some participants to rely more heavily on unregulated or unorthodox medical and non-medical alternatives, while others described engaging with health services with more reluctance and at a later stage: potentially risking their health and increasing the need for more intensive medical responses. Importantly, participants reflected that the problem with FGM-safeguarding in healthcare, and more generally, was as much one of legislated policy as its implementation. Health practitioners were often argued to have no choice, that they were just ‘doing their job’: “they feel obliged to ask you [about FGC/M] because they don’t want to get in trouble”. But while this encouraged a little sympathy for health providers, it also discouraged hope for future improvement.

Policy recommendations

Participants in several focus groups recognised the positive intentions of FGM-safeguarding and all acknowledged the need to protect children at risk. However, approaches adopted to achieve this were believed to be unjustifiably aggressive and counter-productive, to the

extent that ‘Safeguarding policies [had] exacerbated and exaggerated the situation’ rather than resolving it: “I think the safeguarding policy is fantastic, [but] you have to take precautions because...the end goal is to stop this happening, but if we are to stop this happening, we need to think about the process. If we are offending people, and to a certain extent, violating people [we will be unsuccessful]” (Focus Group 6). The introduction of FGM-safeguarding was seen to have directly contributed to a loss of empathy in the provision of healthcare to not only individual Somali families, but the entire Somali population:

“People are more result-orientated than [interested in] looking at the feeling and perspective of the community and parents who are involved, or even the young child who is involved. Being result-focussed, it is more difficult to be empathetic with someone.” (Focus Group 4)

Participants argued that there were problems with the evidence underpinning these policies as well as with their implementation. People were concerned that the statistics collected as part of the FGM Enhanced Dataset, which focus on women who had experienced FGC/M as children when living outside the UK, could be ‘misuse(d)’ to inflate perceptions of the scale of the FGC/M risk posed to young girls living in the UK. Participants also considered it unhelpful that the statistics collected included those for ‘piercing’, ‘cosmetic (surgery)’ and ‘different (less invasive) categories (of FGC/M)’, which were less relevant for addressing what they considered to be the most pressing ‘FGM issue’. This amalgamation could also be used by the media and others to exaggerate the prevalence of FGC/M and further stigmatise the Somali population without justification. In order to get ‘more accurate and precise statistics... that are not so biased’, there was a need to ‘hear the views of the young people who were born in the West’.

While some participants acknowledged the contribution of Somali people to the development of FGM-safeguarding approaches in Bristol (although attitudes regarding the longer-term success of this collaboration varied), others felt that the engagement of policy-makers and practitioners with Somali people in Bristol had been less than comprehensive. Recommendations for improving services therefore emphasised the need for more inclusive approaches, involving different FGC/M-affected groups, in the development and implementation of safeguarding services, with ‘a proper consultation’ to develop ‘policies which we are part of’.

A constant theme among participants was the significant need to improve the education received by professionals involved in the provision of statutory FGM-safeguarding. Education was required to ensure that staff could identify and describe forms of FGC/M, and better support those who had experienced it. ‘FGM Standards for Training Healthcare Professionals’ were published in 2018,⁴⁵ and built on the earlier safeguarding curriculum. Training on

FGC/M type is included for some, but not all, staff. Participants also described a need for more awareness of the potentially traumatic effects of FGM-safeguarding itself:

“You gotta think about the child, as well. Imagine having to go into a hospital or doctor and get examined. Just imagine how uncomfortable you’re feeling when someone’s like searching your private parts. That’s almost like a violation to you because that’s **your** private parts... ..we have to be very considerate of the situation.” (Focus Group 6)

While current guidelines expect those conducting genital examinations of children to be considerate of appropriate approaches, it is unclear whether this will be sufficient to address this. Professionals also needed training to ensure that information gathered on people’s FGC/M experience, was gathered sensitively, to avoid it being experienced as an ‘interrogation’:

“It’s a relevant thing to ask [but] it’s a very sensitive thing to ask so the wording around it and how you actually approach a parent...it needs to be sorted out otherwise I feel like a lot of Somali parents are going to ... take it as an offence, instead of a general question. When you are questioning a mother about ‘are you going to send your child over there to get FGM done?’, it can come across as a threat against her culture, against her parenting. It’s like asking any parent, ‘Are you going to starve your child?’, [the reaction is] ‘Are you mocking my parenting? Why would I do that?’ That’s why I think a lot of people are very defensive.” (Focus Group 6)

More general training to provide sensitive care and enable health providers to ‘be sensitive to that person’s culture’ was required. More specifically, recognising ‘the historical [pre-migration FGC/M] context’ and how that might have changed over time would also enable them ‘not to automatically assume that you’re guilty of this crime’. Participants argued that not only were Somali people not supportive of FGC/M, but they now understood many of the health implications of aspects of the practice. This identified need was not recognised by health providers, and is not acknowledged in training guidelines.

Participants were particularly frustrated with the ways in which a failure to acknowledge these cultural changes encouraged mothers’ experiences of FGC/M to be used as indicators of risk for their children, which unfairly framed them as potential criminals rather than victims and drew attention away from their healthcare needs. Participants felt that acknowledging that not only Somali cultures were associated with FGC/M would help address the particular ways in which those with Somali heritage were ‘targeted’. A Public Health England FGM training video which ‘shows that it’s not just one ethnic’ group was highlighted as making a positive contribution to this realisation. Developing knowledge of these ‘facts’ was considered important for restoring a ‘belief in the system’.

A more collaborative approach in healthcare, and more generally, would enable more successful interventions within families and cultural changes that could eventually lead to the elimination of FGC/M. This improved communication should also extend to establishing more effective means of responding to negative treatment: "I think my mum did try and put in a complaint [to the NHS]) but then she left it after a while because she said, "it's not worth it if somebody's going to be uneducated. There's nothing I can do about it"". More sensitive approaches were argued to have the potential to engage families around FGC/M while minimising the harm associated with current practices, including the sense of fear, stigmatisation, criminalisation and (re)traumatisation which is evident in current approaches:

"If I was approached in a correct manner, I would obviously cooperate, but if I was approached in a manner where I felt targeted, harassed, I couldn't cooperate at all." (Focus Group 6)

DISCUSSION

Global concerns regarding FGC/M and strategies developed to safeguard potential victims are premised on the potentially traumatic emotional and physical effects of these practices.⁴⁶ But while the need to protect potential victims is of the utmost importance, evidence from this research—while limited in its scale and generalisability—suggests that current approaches to this protection risk traumatising families, and re-traumatising child victims of FGC/M in adulthood. Such experiences undermine relationships between families and their care providers and the likelihood of effective safeguarding or indeed healthcare being provided in both FGC/M-related contexts and others. This research replicates that from Sweden, which also presents the traumatising impact of policies which are 'meaning well while doing harm'.³⁸

Government guidelines suggest that 'adhering to key standards will enable professionals to hold conversations [on FGC/M] in a sensitive and appropriate way'. These include:

- ▶ making the care of women and girls affected by FGM the primary concern, treating them as individuals, listening and respecting their dignity;
- ▶ working with others to protect and promote the health and well-being of those in their care, their families and carers and the wider community; and
- ▶ being open and honest, acting with integrity and upholding the reputation of the profession.⁴⁷

The evidence from this research suggests that this is not happening universally. Our participants describe the ways in which their own needs and opinions were ignored, and their dignity and respect undermined by a service 'fixated' with gathering information on FGC/M, even at times using practices considered 'manipulative' to achieve this. Participants' experiences of FGM-safeguarding in healthcare directly disrupted their sense of what could be

expected of their healthcare providers and, as a consequence, their trust in these services. Indeed, rather than working with families and carers, professionals were identified as sometimes working to directly undermine these relationships. We have identified a number of specific opportunities to improve services, which concur with international research on this topic.^{48–50} It is imperative that policymakers and healthcare providers recognise and respond to the potentially sensitive nature of FGM-safeguarding, for those with experience of FGC/M but also more generally. There is also a need to be mindful of the changing attitudes and needs of FGC/M-affected groups, and the ways in which incorrect assumptions regarding these have encouraged policies and approaches which are counterproductive and stigmatising. There is a clear need both to protect those at risk of FGC/M and support those living with its consequences and respond to evidence from this research that a perceived risk to an (often unborn) child is overriding the care of her mother, family and wider community. Further research must be conducted to determine whether similar experiences are reported among those from other FGC/M-affected groups and Somali groups elsewhere in the UK and beyond. There is also a need to collect more accurate evidence regarding attitudes towards FGC/M among the UK-resident population and also the experiences of healthcare providers with FGM-safeguarding provision.

CONCLUSION

Criminalised approaches and intrusive FGM-safeguarding measures are actively harming vulnerable populations. The problems affecting FGM-safeguarding in healthcare are multiple and compounding, both within particular encounters with health professionals and also across them. Unnecessary, repeated and insensitive questioning, which assume levels of dishonesty, criminality and risk, foster distrust and fear in and ultimately disengagement from health services. Approaches to FGM-safeguarding and the demands of the FGM Enhanced Dataset have been found to directly undermine healthcare provision to FGM-affected women and families immediately and in the long term. These are not only issues for the individual health provider. The ways in which problematic statistics and assumptions underpin all policy in this area should be recognised and responded to.

The participants in our study are committed to the eradication of FGC/M. Many have already invested considerable time and energy in this endeavour. They have made recommendations to ensure the effective continuation of this work, and many are willing to work with health and other statutory services to see this realised. However, some participants have been seriously affected by existing approaches to FGM-safeguarding in Bristol. Our evidence suggests that stated government priorities to better support those who have experienced FGC/M are being undermined by their own approaches to protecting those considered at risk. This relates to both

a problem with policy and also with the implementation of that policy. There is considerable work to be done by local and national health providers to repair this damage and prevent the further traumatising and victimisation of both individual Somali families (and, potentially, those from other FGC/M-affected groups) and the community as a whole.

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Author note (1) While the term 'female genital mutilation' (FGM) is frequently used in policy and practice arenas, it is controversial for at least two reasons. First, it is applied to a wide range of procedures, some of which are not mutilating. Second, it typically excludes other procedures which are genital mutilating, such as forms of cosmetic surgery and male circumcision. For more detailed discussion of this, see Shahvisi and Earp (2019). The term is commonly used in relation to statutory processes relating to FGM-safeguarding. However, scholars prefer the term, female genital cutting (FGC)¹ (2) The WHO definition of FGM includes a range of procedures including: clitoridectomy - the partial removal of the clitoris or prepuce (type 1), excision - the partial removal of the clitoris and labia minora (type 2), infibulation - the narrowing of the vaginal opening (type 3) and any female genital piercing, pricking, incising, cauterising or scraping for non-medical reasons (type 4). Type 4, therefore, includes procedures which might not be associated with long-term tissue damage. FGM mandatory reporting duty in the UK includes female genital piercing, tattooing and other procedures which are medically unnecessary. WHO definitions of type 1 and 2 also mention 'total' clitoral removal, but Abdulcadir *et al* argue that this relies on anatomically incorrect understandings of the nature of the clitoris.¹¹ (3) Bristol has a long traditional of pioneering work towards the development of effective FGM-safeguarding policy. Collaboration between local policymakers, professionals from education, health, social services and the police and members of the local Somali community led to the development of the 'Bristol Model' of FGM-safeguarding, which was subsequently incorporated into approaches across the UK.^{41 42}

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