How can approaches aimed at preventing female genital mutilation be improved and developed using participatory methods with second-generation young people in the UK?

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Dedication

This thesis is dedicated to my late father. May his soul continuously rest in

eternal peace – Ameen.

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This research would have been impossible to complete without the help and generosity of many individuals. Although I may not be able to mention every one of them, I am extremely grateful to them all.

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Abstract

Background: There is considerable interest in Female Genital Mutilation (FGM) at global level, and within the United Nations Development Programme Sustainable Development Goals (SDGs), goal 5.3 aims to eliminate all harmful practices, including reducing the global prevalence of FGM by half by 2030. The UK has played an active role in engaging with FGM-practising communities as well as in developing legislation that aims to protect women and girls at risk, which are both said to have contributed to the reduction of the prevalence of the practice.

Aims: To examine how young people directly or indirectly affected by FGM interpret and understand the practice and to explore their views on current approaches aimed at preventing the practice in the UK.

Methods: A community-based participatory methodology was developed, involving two phases. Phase One involved recruiting 9 young people aged 15-18 years living in Bristol and training them as co-researchers. This training required them to participate in ten 2½ hour workshops over five months that utilised a variety of participatory methods, including drawing, singing and role play. A training manual was developed with the co-researchers. The data collected from the training formed the initial phase of data collection and helped to develop the second stage of the research. Phase Two involved recruiting 20 participants aged 13-15 years from Bristol, Cardiff and Milton Keynes, who participated in focus groups and one-to-one semi-structured interviews led by the co-researchers and the lead researcher.

Results: The young people involved in this study – whether as co-researchers or as phase 2 research participants – showed a general lack of knowledge about the practice of FGM. They tended to assume it to be a historical issue that was of little or no relevance to them in a UK context. Moreover, it would seem that the meaning of FGM to young people has evolved from what was formerly considered a cultural issue to a complex, multifaceted phenomenon that is concerned with identity, body image and self-esteem. The research findings reveal that young people directly or indirectly affected by FGM

identify as "bicultural"; on the one hand, they attempt to construct a social position, identity and sense of belonging rooted in the dominant Western UK culture, whilst also identifying – to greater or lesser degrees – with the imported non-Western culture of their parents. This is challenging for young people who have to negotiate their status and identity where culture and religion intersect. This suggests that future strategies to tackle and prevent FGM – and to bring about cultural change – should embrace a positive holistic, intersectional approach, which is relevant to young people and guided by their values, beliefs and views. This implies moving beyond the preoccupation with a harm reduction approach towards one that engages with communities in positive and productive ways.

Glossary

Co-researcher: Individuals aged 16-18 years, who will assist in conducting the research.

De-infibulation: Refers to the practice of cutting open a woman who has been infibulated to allow intercourse or to facilitate childbirth.

FGM: Female Genital Mutilation.

FGC: Female genital cutting.

FGM affected community: Women and girls affected or at risk of FGM, as well as other people within their social sphere, such as children, young people, and spouses.

FORWARD: Foundation for Women's Health Research and Development.

High-Income countries: High-income countries are defined as those with a gross national income per capita of $12,736 or more (World Bank, 2016).

NGO: Non-government Organisation.

NHS: National Health Service exists throughout the United Kingdom.

Pharaonic: Type III FGM.

Reinfibulation: Refers to the practice of sewing back the external labia following childbirth, after deinfibulation.

Sunna: Arabic word meaning 'tradition' or 'way'. Within the context of FGM, Sunna is often used to describe Type I FGM.

UN: United Nations.

UNICEF: United Nations International Children's Emergency Fund.

UNFPA: United Nations Fund for Population Activities.

Young participant: Aged 13-15 years, they will be involved as participants in interviews and focus groups.

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Chapter 1 Introduction

This chapter provides a definition, background and brief historical context of the practice of female genital mutilation (FGM). These issues will be explored in depth later in subsequent chapters. The chapter also explains the background to this research, including several approaches already taken to prevent the practice in the UK. This leads to the definition of the problem statement that concisely outlines the issues to be addressed in this research. After the problem has been clearly articulated, the research question, aims and objectives ensue.

1.1   Background

Female genital mutilation, also known as female genital cutting (FGC), is an overarching term used to define cultural practices that result in the modification of female genitals for non-medical reasons (UNICEF and WHO, 1997; UNFPA, 2014). Although the history of FGM is not well known, the practice is believed to have originated in Ancient Egypt as a sign of distinction among the aristocracy and spread to East Africa from Egypt over 2,000 years ago, (Althaus, 1997; Elchalal et al., 1997; Porterfield, 2006; Toubia, 1995; Leonard, 1996). Furthermore, it is suggested that practising communities invented the practice to protect young girls herding animals from being raped (Brotmarcher, 1955; Huelsman, 1976). It was also used as a birth control method to maintain the population size in relation to the availability of resources (Brotmarcher, 1955; Hayes, 1975; Lightfoot-Klein, 1989).

Immigration has made the issue topical in Western countries although, to date, the exact number of women and girls living in Europe who have undergone the procedure is not known (Leye et al., 2014). An estimated 103,000 women aged 15-25 years and 10,000 aged 0-14 years who have undergone FGM are believed to be living in England and Wales today (Macfarlane and Dorkenoo, 2015). Despite the decline in the incidence of FGM over the last three decades in Europe, UNICEF (2016) states that, due to population growth, the total number of girls and women affected by FGM globally will rise significantly in the next 15 years, if the necessary actions are not taken to prevent the practice.

FGM is often performed on young girls aged between four and twelve years, at the later ages to signify their transition to womanhood (Toubia, 1995). Although it is important to note that the age when FGM is performed varies according to country, tribe and circumstances, it can range from a few days old to adolescence, adulthood, before marriage, or even after pregnancy (Momoh, 2004; Johnsdotter et al., 2016). Explicitly referring to the United Kingdom (UK), Dorkenoo (1994) stated that girls are most likely to be subjected to the practice between the ages of five and ten years, a claim supported by NHS Digital (2017), although these findings must be viewed with caution due to the changing nature of the practice, FGM being performed at increasingly younger ages (Summer and Ratcliffe, 2019). The rise in campaigns and legislation prohibiting FGM in the UK may have contributed towards a shift in practice, with it now reported to be undertaken in hospital settings in countries of origin as well as on the black market in the UK (Dorkenoo, 1995). One example of this was the recent case of a three-year-old in London, whose mother has been sent to prison for 11 years (Summers and Ratcliffe, 2019), which is discussed in depth in Chapter 2.

FGM has been illegal in the UK for 35 years under the Female Circumcision Act 1985, which was amended to the Female Genital Mutilation Act in 2003. The legal framework has been subject to scrutiny due to its inconsistency and discriminatory language, leading to several revisions. As a result, the Serious Crime Act (Home Office, 2015), was amended to protect domicile and non-domicile girls and women resident in the UK. This amendment also included the mandatory duty to report any known cases of FGM on females under 18 years and was primarily aimed at all regulated professionals. Although these efforts were aimed at reducing and preventing FGM, many commentators have argued that this was not sufficient, as it risked driving the practice underground (Berer, 2015; Plugge et al., 2018).

In addition, there are various health promotion approaches undertaken with the intention of reducing the practice, at both the national and international level. These interventions have targeted communities at the individual, interpersonal, community and national levels, mostly focused on first-generation immigrants (see Brown et al. 2011; Muteshi and Sass, 2005). Such strategies to tackle FGM need further empirical research to ascertain their effectiveness at changing behaviours and customs at community level. Moreover, Gruenbaum (2005) argues that FGM interventions targeted

at migrant communities require an informed understanding of the social and cultural dynamics within those communities that may contribute to its perpetuation (See also Berg and Denison, 2013).

To gather evidence on preventative strategies, research has focused on both women's and men's perceptions of the practice (Gele et al., 2015; McGown, 1999; Fabos, 2001; Kissamali, 1998; Morrison et al., 2008). These scholars have argued that migration can lead to a situation where individuals gradually leave behind old cultural customs such as FGM, as they assimilate with the host community. However, Reitz and Somerville (2004) have argued that the integration experiences of second-generation youth are different to those of first-generation migrants, simply because the initial settlement barriers, such as language, have been removed. A key question, then, is how the attitudes, values and beliefs of second-generation young people in the UK differ from those of their first-generation parents and relatives.

Due to the age at which FGM generally occurs, young people are best placed to provide information as well as guidance on how these efforts can be improved to enable effective services and prevention strategies. Willow (1997) argues that neglecting to involve young people in research fails to consider their views as future citizens, rendering them voiceless. I would, therefore, argue that approaches aimed at tackling and preventing FGM should be consistent with young people's values, beliefs and experiences, and are relevant to their circumstances, which means listening to and consulting with young people to determine how to begin addressing the issue.

Therefore, the contribution to knowledge in this research is twofold. On a theoretical level, it aims to identify a preliminary set of learner factors that arise out of young people's views on how the approaches used to prevent the practice in the UK should be framed. On a practical level, although creative approaches have been applied in a wide range of disciplines, for example, in healthcare (see McGarry and Bowden, 2017), the engagement of second-generation young people as partners in FGM research and evaluation is unique to this project. The collaboration between myself (the researcher) and the participants provides novel insight into young people's views, and a valuable contribution towards the literature on FGM, with a specific focus on young second-generation immigrants in the UK, from FGM practising countries.

The research question, aim and objectives are outlined below:

1.1.1 Research question

How can approaches aimed at preventing FGM be improved and developed using participatory methods with second-generation young people in the UK?

Aim:

To examine how young people directly or indirectly affected by FGM interpret and understand the practice and to explore their views on current approaches aimed at preventing the practice in the UK.

Objectives:

1. To review the research literature on how young people from communities affected by FGM, living in high-income countries, perceive, interpret and understand FGM.

2. To review the research literature on interventions and policies targeted at young people from FGM-affected communities in high-income countries, to prevent the further practice of, and support for, FGM.

3. To use a community-based participatory research (CBPR) approach to explore young people's perceptions, attitudes, and beliefs around FGM.

4. To use a CBPR approach to explore with young people the acceptability and value of current FGM prevention approaches and to gather their ideas and suggestions for improving and developing these.

Chapter 2 Understanding the practice of FGM

2.1   Introduction

This chapter situates the study within current academic literature, theory and debates, in order to fulfil objective 1 and 2 of this thesis. The literature search strategy utilised in this study will be described. This will be followed by the historical context of the practice, in Africa and the West, articulating the complexities surrounding the origins of the practice of FGM in comparison to female cosmetic surgery. Definitions of FGM using the classifications of the World Health Organisation ensue, Table 2.2, followed by the sequelae of FGM, as well as its prevalence. I then explore the highly politicised nature of the practice of FGM by engaging in a critical debate surrounding the use of terminology, from the human rights frameworks to feminists' perspectives. The section ends by providing the reasons behind the practice from social norms perspective, in which issues of gender, power and religion are explored.

2.2   Search strategy

The literature review identified both published and grey literature. The search commenced in January 2016 and was subsequently repeated every six months to ensure the inclusion of all relevant literature. A three-step search strategy was conducted in this review: a preliminary search of MEDLINE and CINAHL was completed, followed by an analysis of the text words in the title and abstract, as well as the index terms used to describe an article. A second search using all identified keywords and index terms was undertaken across all databases. Thirdly, the reference list of all identified reports and articles were searched for additional studies. Studies published in English only were considered in this review, with no limitation on the country of publication.

The databases used were Web of Science, EBSCO, ETHOS, and ProQuest Sociology. The search for grey literature was undertaken through general websites such as Ovid, WHO, UNICEF, UNFPA, FORWARD, Department of Health, National FGM Centre, BMJ, NICE and Google Scholar. The search used relevant Medical Subject Headings (Mesh) terms,

including all subheadings combined with separate keyword searches. A PEO format was used for searches where participant (P) terms were combined with exposure (E) terms and outcomes (O) (see Table 2.1) and search filters were added where appropriate. For an example of the search results, see Appendix A.

Participant	Exposure	Outcomes
Young people from FGM practicing communities	Any approaches designed to prevent FGM; including but not limited to: Behaviour change, legislation, formal education, mass media messages, positive deviance, alternative rites and community empowerment.	Acceptability, sustainability, changes in beliefs, perceptions and attitudes.

Table 2.1: The PEO format used in the literature review.

Following the search strategy described above, it became clear that additional literature and contextual information was needed about key topics on gendered power relationships and cultural assimilation. An additional search was then undertaken in 2017. The keywords utilised in this search were: culture OR custom OR tradition OR belonging AND migration OR immigration OR asylum AND female genital mutilation OR female circumcision OR female genital cutting. The databases used for the searches were PubMed, Social Policy and Practice, Web of Science, Medline, EBSCO and grey literature. No restrictions on country or year of publication were applied. See appendix A for an example of a search strategy.

Limitations of literature

There is scant empirical research on FGM in high-income countries. Where empirical research is available, scholars focused on first-generation immigrants, with the majority of the studies based in Africa, with some in Sweden and Norway, resulting in a dearth of literature that explores the views and beliefs of second-generation young people, and no research undertaken with young people in the UK. This chapter, therefore, provides a broader narrative on beliefs, perceptions and attitudes of the practice, as well as approaches being implemented both nationally and internationally.

2.3 Historical context

2.3.1 Africa

The exact history of FGM is not well known. First narrative reports trace its origin to Ancient Egypt in the second century B.C., where it was rooted in the Pharaonic beliefs on the bisexuality of gods (Boyle, 2005; Gruenbaum, 2001). According to these beliefs, every individual possessed a female and male soul, and *'circumcision'* was required to create identifiable male or female traits. In Ancient Egypt, circumcision was a sign of distinction among the aristocracy. Boys were circumcised to remove their female organ, believed to be the foreskin. Conversely, girls needed to have their male organs removed, which were believed to be the clitoris and labia (Boyle, 2005; Gruenbaum, 2001).

It is hypothesised that FGM was also used by the Romans to represent higher status (Lightfoot-Klein, 1989). In situations where the emperor required a fidelity control practice, FGM was a condition of marriage (Mackie and LeJeune, 2009). Consequently, Ortner (1996), Betzig (1982) and Dickemann (1979) claim the practice was then adopted by families who wished to increase the status of their daughters, however, it was not enough to satisfy an absolute social standard and, as a result, these women had to be more chaste and faithful to distinguish themselves from the rest. Once the practice had achieved a high concentration within the community, the more impoverished families began competing by also subscribing to the practice to guarantee marriage, even within their stratum. Subsequently, according to Mackie (1996), over the centuries, FGM became a universal prerequisite for marriage.

The premise is that the practice of FGM migrated to East Africa from Egypt in the fifteenth and sixteenth centuries through slave traders, who thought that it prevented female slaves from conceiving (Althaus, 1997; Boyle, 2002; Elchalal et al., 1997; Johnsdotter, 2012). This migration of the practice means that attitudes towards the relationship between FGM and chastity and fidelity vary across practising communities. While some groups have concerns to do with unmarried girls remaining chaste and avoiding pregnancy, others are concerned with control over women, and as a rite of

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passage that enables girls to form peer groups (Hunt and Quataert, 1997; Hayes, 1975; Mackie, 1996).

2.3.2 Western genital cutting practices

While it is often assumed that medical female genital procedures are purely an African phenomenon, there is also a long history of the practice in the West, although it is not termed FGM. According to Johnsdotter (2012), historically, the practice was incorporated into the medical model of disease and cure, thus legitimised and performed with no consequence. In the United States, Germany, France and United Kingdom (Johnsdotter, 2012), 'clitoridectomies' were performed in the 1940s as a cure for masturbation and hysteria, and as a treatment for lesbian inclinations (Horowitz and Jackson, 1997). In England and Germany in the eighteenth century, Dr Isaac Brown treated hysteria by performing a clitoridectomy on his patients, who were women aged 16-55 (Johnsdotter, 2012). This is illustrated by a quote from a medical report from the British Medical Journal cited in Finzsch and Hulverscheidt (2018):

> "On the last of these occasions, her mother, who accompanied her, explained that her daughter was given to habits of masturbation… various procedures, moral and remedial, were tried without effect, with the sanction of her mother, I removed her clitoris…" (Brown, 1868; cited in Finzsch and Hulverscheidt, 2018).

When Dr Brown was publicly questioned as to whether this procedure was proven scientifically to cure such ailments, he had to admit that he had never cured insane women, but instead referred them to an asylum. Following the decline of the practice after Brown's questioning, it re-emerged in the twentieth century, but within a different context. It is suggested that some medical authors advocated for female cosmetic surgery (FCS) by comparing the practice to male circumcision: 'if the male needs circumcision for cleanliness and hygiene, why not the female?' (McDonald, 1958).

In the United States, physicians began undertaking an incision of the clitoral prepuce to treat women inability to orgasm during sexual intercourse (Horowitz and Jackson, 1997), as well as for aesthetic reasons such as vaginal labiaplasties (reducing the size of the clitoris and labia) (Hodgkinson, 1984). This practise continues today in the US, and some other countries conveniently termed 'female cosmetic surgery'. There have been several

arguments contrasting the case made for the continuation of clitoridectomy in the West and the demonisation of FGM in non-Western countries (Moruzzi, 2005).

2.3.3 Framing of procedures

The practices in the West and those arising in Africa are generally framed differently in public discourse, one being a benign medical procedure, and the other a value-laden form of violence against women, linked to patriarchy and control (Gordon, 1997; Njambi, 2004; Kennedy, 2009). Others have argued that the choice to undergo clitoridectomy itself is a social construct, linked to patriarchy and control, rather than one of individual choice, as often portrayed in Western literature and laws (Finzsch and Hulverscheidt, 2018; Njambi, 2004). For example, Braun and Kitzinger (2001), claim that the social-cultural accounts about what constitutes a desirable vagina in the West, include, 'a tight but not too tight' is desirable and a 'loose vagina' is undesirable (Braun and Kitzinger, 2001. p.263). This discourse was also evident in their research amongst undergraduates, where women with loose vaginas are positioned as promiscuous.

Johnsdotter (2012) adds that the history of the practice is rather one-sided, in that the texts originate from Western writers rather than from regions traditionally associated with the practice; resulting in an interpretation of the practice from the Western gaze, thus carrying a biased perspective. Due to the practices that were apparent in the West during those historical times, the clitoris became a highly politized part of the body, seen as a symbol of sexual independence (Ahmadu, 2000, p.304), therefore, within a Western feminist context, all African practices that involved women's genitalia were viewed as patriarchal attacks of women.

The critical exception, one might argue, is the age of which FGM is practised when comparing the two practices. In most cases, FGM is practised in children. For FGC, the argument is that the age of consent is over 18 years. However, evidence suggests that cosmetic genital surgery in children and adolescents is on the increase in the UK (Wood, 2018). The BBC (Mackenzie, 2017), with data sourced from the National Health Service, claim that, in 2015-2016, more than 200 girls under the age of 18 in England had undergone labiaplasty, amongst these, 150 of the girls were under 15 years. In fact, the article presents an interview from a 14-year-old, who considered undergoing

labiaplasty; she was quoted explaining her reasons: "I just picked up from somewhere that it wasn't neat enough or tidy enough and I think I wanted it smaller" (Mackenzie, 2017). Furthermore, in her research on why women considered labial reduction, Zwier (2014), found that emotional discomfort regarding body image, sexual and social relationships to be prominent motives. Though due to the scarcity of research in this area, it is difficult to ascertain the validity of these claims and understand the drivers behind these practices from a young person's perspective.

2.4   Classification of FGM

Although there are several variations in the practice of FGM (Prazak and Coffman, 2007; Njambi, 2004; Onsongo, 2017), it is commonly classified by the WHO (1997) using four types, according to the anatomical extent of the procedure, ranging from 'mild' (Type I) to 'severe' (Type III), Type IV, includes all other harmful procedures done for none medical reasons, as shown in Table 2.2. These ubiquitous four-category typologies shown here, show what is meant to be the reality of all the practices of FGM.

Type I	Partial or total removal of the clitoris and the prepuce – also known as clitoridectomy.
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora – also known as excision.
Type III	Narrowing of the vaginal orifice with the creation of a covering seal, by cutting and a positioning the labia minora and/or the labia majora, with or without excision of the clitoris – also known as infibulation.
Type IV	All other harmful procedures to the female genitalia for non-medical reasons, including pricking, piercing, incising, scraping and cauterisation.

Table 2.2: WHO classification of FGM (1997).

2.4.1   Sequela of the practice of FGM

The WHO (1997) has concluded that FGM has no known health benefits and is harmful to girls and women due to the removal of healthy genital tissue, which interferes with the natural functioning of the body (Khaja et al., 2010; WHO, 2008). The severity of health complications is also determined by underlying factors such as surgical and clinical hygiene, the girl's physical health and the type of FGM (Khaja et al., 2010), and may be varied. FGM has been associated with both long and short-term physical and

psychological implications (UNICEF, 2013; WHO, 2008; Varol, 2014; Biglu et al., 2016; Ibrahim et al., 2013; Khaja et al., 2010; Behrendt and Moritz, 2005).

According to the WHO (2008), during and immediately after the procedure, a woman is at significant risk of death due to haemorrhaging. Other risks associated with the procedure include infection (both short and long-term), and urine retention, due to pain and damage to other adjacent organs leading to the inability to void the bladder (Balfour et al., 2016).

Long-term side effects include incomplete healing, dyspareunia; menstrual difficulties; increased risk of caesarean sections; and post-partum haemorrhaging in women with who have undergone Type I, II and III FGM (WHO, 2008). The practice has also been linked to negative impacts on mental health, such as post-traumatic stress disorder (Mulongo and Martin, 2014; Moritz, 2005; Vloeberg et al., 2012). Other long term complications often associated with the removal of the clitoris, lead to sexual complications that may disenable women from pleasure and orgasm during sex (Rymar, 2003).

Due to the variations of the practice, within a medical context, Ahmadu (2001) argues that the most extreme cases receive unequal attention and that the health effects of FGM are overstated and lack empirical evidence. To add, in their systematic review, Obermeyer and Reynolds (1999) note the lack of evidence supporting the claims that FGM causes health complications. The authors concluded that the notion of the clitoris being key to sexual responses is a Western construction, further arguing that orgasm is not the only measure of healthy sexuality. Although there remains a lack of evidence regarding the health implications, a recent systematic review by Berg et al. (2013) support the discontinuation of the practice and towards supporting survivors of the practice.

2.4.2   Prevalence of FGM

There are challenges in identifying the prevalence of FGM worldwide and within Europe. A recent analysis of the shift of prevalence in Africa and the Middle East illustrated a decline of prevalence amongst 0-14-year olds, with the highest percentage fall in East

Africa followed by North and West Africa (Kandala et al., 2018). However, UNICEF (2016) claims that, due to population growth, the total number of girls and women affected by FGM globally will rise significantly in the next 15 years.

Research in the UK has highlighted that, generally, affected populations reside within large urban metropolitan areas (Macfarlane and Dorkenoo, 2015). Greater London has the largest estimated proportion of people from FGM-practicing countries (21.0 per 1,000 population), with estimates for Bristol 12-15 people per 1,000 and 7 per 1,000 from Milton Keynes and Cardiff (Home Affairs Committee, 2014; Dorkenoo and Macfarlane, 2015).

While it is certain that there are many women living in diasporic communities who are survivors of FGM or who are at risk from FGM, the lack of available accurate national data on FGM means that the exact number of women and girls living with FGM in Europe is unknown (European Commission, 2013). The European Parliament estimated that, in 2009, up to half a million women residing in Europe were FGM survivors, with an additional 180,000 at risk every year. There are obvious limitations in the accuracy of these numbers: they did not include asylum seekers or undocumented immigrants, and the data did not distinguish between generations, therefore, making it difficult to estimate the number of second-generation immigrants who might be at risk. Furthermore, the figures provided do not appear to differentiate between types of FGM. Therefore, they might include those which are said to be 'less severe' types, such as genital piercings.

These data limitations have led to the introduction of legislation that requires regulated professionals to report known cases of FGM in the UK. In 2015, the 2003 FGM Act was extended by the Serious Crime Act (Home Office, 2015). This extension included the introduction of a mandatory duty required of all regulated health professionals in England and Wales to report cases of FGM, whether there is a first-hand disclosure or where FGM is found upon examination (Home Office, 2015). Nonetheless, limitations in the accuracy of the data remain apparent. Gerry et al. (2016) criticised the mandatory reporting duty, raising concerns about the failure to evaluate the data collected. Dixon et al. (2018) add that most of the cases highlighted through the mandatory duty have

been 'historical', also emphasising the 'lack of data' that considers how able women and girls feel to seek help within schools and healthcare settings.

In addition to the mandatory duty to report (Home Office, 2015), NHS Digital introduced an FGM-enhanced dataset in 2015, which has made it compulsory for all General Practitioners, Acute Trusts, and Mental Health Trusts in England to submit data detailing FGM-related cases to the NHS Digital enhanced dataset (NHS Digital, 2015). This data collection is aimed to support the Department of Health's NHS FGM Prevention Programme by providing national statistics of FGM in England (NHS Digital, 2017). The data show that 86 per cent of women and girls were born and had FGM in an African country, while 88 per cent of cases undertaken in the UK are said to be piercings, suggesting that the remaining 12 per cent may be piercings, but there is a lack of clarity on what the 12 per cent comprise. Although the data collection aims to calculate the prevalence of FGM in England, which will enable the provision of services around the practice, the Department of Health's NHS FGM Prevention Programme has been criticised due to data protection issues. Dixon et al. (2018) claim that the Home Office can access identifiable information and use this to locate and deport undocumented immigrants.

Adding to this, criminal prosecutions involving FGM, particularly in France and Sweden and recently the UK, indicate that the practice of FGM may still be being carried out within the EU (Terry and Harris, 2013; Leye, 2008; Norman et al., 2009; UNICEF, 2008; Summers and Ratcliffe, 2019) though the data presented in the NHS digital does not support these claims.

2.4.3 Terminology

It has been argued that in this field, attention to language and historical background is essential and allows for a deeper awareness of the political and ideological debates surrounding the use of the term 'FGM' (Abusharaf, 2013). There have been competing perspectives surrounding the practice, which stem from several theoretical disciplines such as post-colonialism (i.e. Ahmadu, 2007; Cowan et al., 2001; Njambi, 2004), cultural essentialists (Hosken, 1979; Daly, 1978), and human rights (WHO, 2005; United Nations General Assembly, 2012). To enable a deeper understanding of the use of these terms, it is essential to understand the context in which they were created.

The phrase 'female circumcision' (FC) was used in the international literature until the 1980s (Wade, 2011; Gruenbaum, 2001). However, with the growth of Western feminist movements (Spivak, 1996) and public concerns from international health organisations, that term was rejected. It was argued that when the term 'female circumcision' is used to describe FGM, it suggests that it equates to male circumcision (Earp, 2014). This de-emphasises the severity of the practice by comparing it to male circumcision, i.e., 'the removal of the foreskin' (Shell-Duncan and Hernlund, 2000), a relatively minor procedure.

Following the third African Committee on Traditional Practices Affecting the Health of Women and Children in Addis Ababa, Ethiopia in 1990, the UNICEF, WHO and UNFPA together defined and adopted the term 'female genital mutilation', though it is claimed that the term had originated from a Western feminist Hosken in 1976 (Boyle, 2005; Gruenbaum, 2001). Consequently, in 1991, the WHO recommended that the United Nations adopt the term. This was followed by a joint statement issued in 1997 by WHO, UNICEF and UNFPA, who defined FGM (UNICEF et al., 1997), and adopted FGM as a definitive term, stating that this would assist in the abandonment of the practice as well as enforce its gravity. The term has subsequently been widely applied in several UN conference documents and literature to date (Izett and Toubia, 1999; Dorkenoo, 1994).

However, although the term 'FGM' has been accepted and used by scholars and organisations alike, it has been contested within the affected communities and by postcolonial feminists such as Mohanty (2003) and Njambi (2004), who argue that the phrase is offensive to those who do not regard themselves as mutilated. It has also been considered to hinder the process of social change by creating a barrier, as opposed to aiding its abandonment (UNICEF et al., 1997; Rahman and Toubia, 2000) as Western feminists often portray FGM as a simplified case of abuse (by women) against women (Lane and Rubinstein, 1996; Parker, 1995). Moreover, postcolonial feminists (Njambi, 2004; Shweder, 2002) argue that this further silence and alienates women of colour, defining them as victims rather than agents in a struggle that often seems to oppose (Western) feminism and their interpretation of 'authentic' cultural identity. According to Moruzzi (2005), this situation presents a dichotomy, in that, if activists become involved in campaigns that are shaped by language and attitudes which demonise the

practices and practitioners, the result may be defensiveness, which consequently leads to less effective initiatives.

To this end, the term 'FC' continues to be used by some researchers as a sign of respect for women's understanding of the practice and to avoid offending their culture and beliefs (Leye et al., 2007). Though Gunning (1991) proposed the use of 'genital surgery' as a more neutral term, others feel that this term suggests FGM is practised as a medical necessity (Shell-Duncan and Hernlund, 2000). Some NGOs have adopted the term 'female genital cutting', which they consider is less intrusive and more sensitive to the values and beliefs of FGM-practicing communities (Abusharaf, 2013). Moruzzi (2005) called for a re-writing of the discourse around FGM, arguing the term itself is determinative since the terminology used to define the types is indicative of attitudes shaping the Western discourse. As an alternative between barbarity and cultural imperialism, a reduction to the continuum of alienation and rescue, Moruzzi (2005), advises the use of 'female circumcision', contextualising it as a culturally constructed phenomenon.

While acknowledging these pertinent discourses, I have chosen to adopt the official term 'female genital mutilation (FGM)' in this thesis, thus situating this study within current political and public health discourse. However, during my work with young people, I was mindful of the sensitivities around the use of language, and during fieldwork, the terms FGM and FC were employed interchangeably. The reasons for this were twofold: firstly, as aforementioned, it was considered essential to avoid alienating individuals who did not perceive the practice as 'mutilation'. I argue that the practice is a socially constructed phenomenon that holds valid meaning in specific contexts, both historical and contemporary. Therefore, like Moruzzi (2005), I will avoid generalising the practice simply as 'mutilation', as this would inevitably provide a one-sided argument which postcolonial feminists would argue against (Prazak and Coffman, 2007; Njambi, 2004; Moruzi,2005). Secondly, I thought that some young people might not be familiar with the term FGM, and would, therefore, have difficulty understanding or following discussions within focus groups.

2.4.4 Cultural relativism and feminist universalism

There have been several debates amongst scholars, activists and organisations, surrounding the practice of FGM and approaches towards its elimination, including questions of cultural relativism, universal human rights, cultural autonomy, individual agency and risks and harm, not to mention fetishisation of the black female body (Njambi, 2004; Spiegel and Walker, 1996; Braun, 2009). As a researcher, I occupy an uncertain position in relation to these. I argue that our cultural practices are often normalised in that they are seldom subject to the same public scrutiny as of 'others' (see also Darby and Svoboda, 2008). Therefore, turning a critical lens and challenging what is seen as the norm (i.e. female cosmetic surgery) in comparison to other practices, publicly framed as 'cultural practices' (female genital mutilation) can offer a compelling insight into Western practices, and the unquestioned presumptions which they both rely on and reproduce, which could, in turn, contribute to how young people interpret the practices.

This is summarised by the quotation below:

> "The difference between Muslim excision and Western genital and cosmetic surgery are complex, but the tendency of some westerners to dismiss FC as an incomprehensibly alien custom is somewhat at odds with their own history and present practice" (Adams, 1997, p.67).

The term 'cultural relativism' claims that there is infinite diversity of beliefs and that every culture is equally valid (Herskovits, 1972; Gruenbaum, 2006), which therefore suggests that the principles used to judge FGM are relative to the culture in which they are familiar. In contrast, Universalists form a one-dimensional frame, arguing that FGM is a universal form of patriarchal control (Daly, 1978; Hosken, 1981; Walker, 1996). While Hosken (1981) and Walker (1996) frame FGM as the suffering of girls and women, who are viewed as helpless victims of a patriarchal practice; Finzsch and Hulverscheidt (2018), stress that this kind of equalisation of highly complex societal instruments and the simplification of patriarchy disregards the social, cultural, political and economic conditions surrounding FGM, and contributes to ethnocentric 'othering' of women who are, in this view, the 'other' denied a voice, interest, and perspective.

This notion introduces the patterns of imperialism, neo-colonialism and racism, which are often claimed to be concealed within the arguments of feminism (Spivak, 2016; Nnaemeka, 2005; Njambi, 2004; Moruzzi, 2010). It sometimes leads to the practising communities rebelling against external influences; for example, the Kikuyu of Kenya resisting Christian missionaries' 'End FGM' movement as a way of fighting against colonialism (Winterbottom et al., 2009). In contrast, Western women having their labia trimmed is not seen as an illegal act, even though close inspection would suggest these procedures fit within a strict anatomical 'cultural' interpretation of the law (Braun, 2009). This double standard of morality (Essen and Johnsdotter, 2004, p.613) illustrates that citizens of different countries, cultural contexts, skin colours and traditions, residing in the West are effectively subject to different laws within the state (Braun, 2009). A cultural pluralist such as Kallen (1924) implies that migrants should be allowed to practice their own culture without prejudice and discrimination.

Feminist cultural relativists Kurtis and Adams (2015) have critiqued the health consequence arguments surrounding FGM outlined by the likes of Hosken (1981), claiming excessive exaggeration of the health risks. Others have argued that FGM is comparable to Western cosmetic and plastic surgery (Sheldon and Wilkinson, 1998; Morgan, 2009; Korieh, 2005); however, this does depend on the type of FGM. Shweder (2002) argued for the values of pluralism and tolerance to be upheld to FGM, instead of the Universalist approach to beauty, commanding the non-judgement of others based on subjective normative assumptions.

This discussion of feminist universalism versus feminist cultural relativist approaches illustrates that while both provide a partial analysis of FGM, reproducing notions of the body as an object, they fail to acknowledge the body as lived in the complexity of power relations, and the role of gender and social norms in decision making. Also, such a one-sided approach fails to acknowledge the coming of age and gender identity rituals involving 'FGM' embedded in the lives of many women from practising communities (Shweder, 2002). The practising communities often refer to FGM as female circumcision, which is typically regarded as a cause for celebration and a rite of passage intended to honour the girls and welcome them into adulthood (Kopelman, 1997). It is, however, essential to note that, although contradictory, the approaches have a common ground,

that of 'free will' on continuing FGM in non-Western communities and the continuation of genital surgeries in the West.

Having reviewed this literature, I feel that a focus on the concept of 'free will' has the tendency to focus on norms to the exclusion of other factors that influence people's behaviour and may position interventions for failure, ultimately discrediting strategies, simply because, in isolation, they are inadequate to improve health. The socialisation and internalisation that may explain its perpetuation are essential aspects of context that are often absent from feminists' Universalist arguments. On page 35, I discuss how FGM is viewed as a violation of human rights, specifically, as a violation of the rights of the child.

2.5   Reasons for the practice: a social norms perspective

This section will explore a variety of different reasons that are put forward to explain and justify the practice of FGM including; social norms, religion, gender and power relations.

2.5.1   Social norms

Having defined FGM and ascertained the health complications associated with it, it is important to discuss the motivations behind the practice, which are often complex and woven into beliefs and values of the practising communities. Behaviour choices cluster within social networks, which are people's systems of personal relationships and social interactions (Smith and Christakis, 2008). One significant process through which the environment affects behaviours is social norms. Social norms are typically regarded in the social sciences as customary rules that sustain behaviour by causing conformity (Bicchieri and Mercier, 2014; Cialdini and Trost, 1998; Sherif, 1936). The explanations behind the practice vary and thus pose a significant challenge, due to the differences in how FGM is carried out in different social contexts, where the age of the girls, the rituals accompanying the practice and sexual meanings of the practice differ. Generally, though, the reasons include control of women's sexuality, custom and tradition, social pressure and religion (Shell-Duncan et al., 2018; UNFPA, 2009).

Social norms theory provides a conceptual framework for understanding health behaviours including FGM (UNICEF, 2016) in a particular context (Shell-Duncan, 2018), situating human relationships within communities at their centre (Shweder, 2000). The theory contends that the perpetuation of harmful practices, and the creation of new ones, maybe due to social motivations which often involve a whole community's beliefs and actions rather than merely individuals and their families. Beliefs about what other people do (typical behaviour) and what others think people should do (appropriate behaviour), in a particular social context and for a given population, often guides an individual's actions (Shell-Duncan, 2018; Mackie et al., 2015; Cislaghi and Heise, 2018).

In a community where FGM is practised, people may share or subscribe to the view that FGM is acceptable. Parents may condone the practice because it is culturally acceptable and, therefore, becomes normalised. For example, parents may believe that if their daughter is not cut, her clitoris will become toxic and, if it touches her baby's head during childbirth, the baby will die (Nour, 2008). The view that it is harmful or wrong may be rejected, given the need to conform to what has become socially accepted. This is known as cognitive dissonance, where parents are aware of the complications associated with FGM and may even have experienced the problematic effects of it, but still support the practice, acting in a way that contradicts their personal beliefs to avoid the social embarrassment of transgressive norms (McKimmie, 2015). Therefore, adhering to the community's social norm is perceived as an essential aspect of behaviour, not only to maintain an individual's acceptance and social standing in the community but also to preserve the status of her family and the social order. However, Shell-Duncan et al. (2018) suggest that the beliefs that uphold the practice of FGM have the potential to change over time.

Social norms can be independent, dependent or interdependent; when FGM is practised because everyone else does it, this is an interdependent norm (Mackie, 2015). In addition to this, the role of culture and beliefs explain why a practice such as FGM is hard to eradicate (Baillot et al., 2018; Berg and Denison, 2013). Those shared values that are regarded as constructive of social structure and cohesion, known as the 'normative system', also enforce the practice (Tones and Tilfold, 2013; see also Kaplan et al., 2011), so the social and cultural roots of the practice condition its perpetuation.

Cialdini (1991) introduced the concepts of descriptive norms/empirical expectations and injunctive norms/normative expectations, the former forms what others do and the latter is what others think should be done (See also Bicchieri and Chavez, 2010). While Cialdini (1991) believes that descriptive and injunctive norms are two different types of social norms, Bicchieri and Chavez (2010) argue that a belief only becomes a norm when people hold both empirical and normative expectations around it. The practice of FGM in Somalia began during civil war and was believed to protect young girls from rape when herding animals (Hayes, 1975; Lightfoot-Klein, 1989; UNHCR, 1994), and the practice continues as a norm today in some communities due to the belief that the practice is required, either as a prerequisite of marriage or to protect young girls. I use the term 'protect' loosely here, because it may be difficult for parents to see the practice as 'control' of the young girls' sexuality.

Several theorists explore compliance with social norms. Young (2015) identified three primary mechanisms that may sustain social norms; the first is '*the desire to coordinate'*, which relates to when people want to achieve a specific goal that requires coordinated action among a social group, they follow what they believe to be standard rules for that action. According to Momoh (2004), some of the reasons given for performing FGM in Somalia vary across urban and rural areas, as well as by age and gender, with the 'standard rule of action' being tradition and religion.

Secondly, is '*the fear of being sanctioned'*, when people fear being stigmatised due to the noncompliance with FGM. According to the WHO (2008), FGM is a social convention governed by rewards and punishments, which are powerful forces for the continuation of the practice, despite understanding that it is harmful to the girls who are subjected to it, illustrating why it is often difficult for families to abandon the practice without the support of the broader community (UNICEF, 2005). For example, amongst some communities in Kenya, the practice enables the rite of passage for young women, while in others, it is considered a critical symbol of ethnic identity as well as a religious requirement. In their study in Senegambia (The Gambia), Shell-Duncan et al. (2018) found that 'pressure to conform' (p.8) was exerted through negative sanctions towards parents and young girls, and the study reports that, when an uncut girl is married into a community that practices FGM, she may experience abuse and violence, as well as exclusion.

This leads to the third mechanism, *'the maintenance of membership within a group'*, such as the continuation of FGM in a Western context enabling a sense of identity towards their cultural values (Morris, 2015, Kaplan et al., 2011; Gage and Rossem, 2006). In Nigeria, the Gambia and the Maasai tribe in Kenya, the practice is continued to mark the rite of passage. The act symbolises the transition from a girl to a woman, which is often seen as an achievement itself and relates to the female's increased social status within the community (Gruenbaum, 2001). Similar reasons for FGM exist within the Kikuyu tribe in Kenya, where FGM is an essential step to becoming a mature human being, allowing the woman to be seen as a full member of the society who can fully participate in political, economic (Harari, 2014). The very reasons that emphasise the continuation of the practice, such as norms linked to historical and structural factors, have been associated with religion, in other words, how individuals interpret religious texts for their benefit.

2.5.2   Religion

In addition to the perpetuation of FGM due to beliefs and culture, some communities often practice it because they believe that it is required by their respective religions (Khaja et al., 2009; Gruenbaum, 2001; Shell-Duncan and Hernlund, 2010; Herieka and Dhar, 2003). The practice is evident in Islamic, Christianity and Jewish culture.

There are two contradictory, yet coexisting conceptions of female sexuality based on a critical reading of the Quran: the explicit (passive) and implicit (active) theories (Mernissi, 1991). The passive sexuality theory views women as having passive, submissive roles towards men. According to this view, men are the sexual aggressors and women are passive recipients of their attentions; the key to women's femininity is the experience of pleasure through suffering and oppression. In relation to FGM, therefore, the passive sexuality theory allows the removal of the clitoris as the locus of sexual pleasure, rendering the female as a passive being and the man as the sexual aggressor in intercourse.

On the other hand, the implicit theory sees women as naturally possessing significant power through their appetite for sex and attractiveness to men. So that men can fulfil

their religious obligations without distraction, this viewpoint argues that women, therefore, need to be controlled and their sexuality restrained for the good of society. Here, the removal of the anatomical source of pleasure enables men to continue with their daily routine without the temptations or constant demands from highly sexual women.

Interpretations of religious texts are also often used to justify the practice of FGM. For example, in their community-based action research, in Italy, Portugal and Spain. Reisel et al. (2016) found that the most commonly-mentioned theme that supports the practice was the requirement for women to cleanse themselves through undergoing FGM so that they can adequately undertake Islamic rituals. According to this, if a woman is not cut, she is deemed impure and unfit to perform Muslim prayers and fasting. Additionally, undergoing the practice was perceived to strengthen a woman's faith and reinforce her relationship with God. In contrast, others have argued that there is no specific support of FGM in the Quran and that the practice predates all currently practised religions (Winkel, 1995; Rouzi, 2013). Other authors emphasise that neither the Quran nor the Bible advocates the practice of FGM (Shell-Duncan and Hernlund, 2000).

Rouzi (2013) claims that the main reason why Muslim countries associate FGM with religion is through the Hadith (the recorded practices and sayings of the Prophet Mohammed), in which Prophet Mohammed gave precise instructions related to a procedure that was practised before Islam, with one specific passage stating that: '*If you cut, do not overdo it.*' The Hadith also adds the belief that this practice brings radiance to a woman's face and is more pleasing for the husband (Rouzi, 2013). However, the authenticity and validity of these remarks are questionable.

However, the importance of religion in driving FGM is undermined by a study conducted by Grisaru et al. (1997) who identified 113 Ethiopian Jewish immigrant women in Israel, of whom 27 per cent had partial or total clitoridectomy. The women did not link the practice to religion, though they claim the intention of creating adhesions was to prevent pre-marital intercourse and some for aesthetic reasons. Therefore, it is interesting to ascertain the position of young people in this debate, which will enable us

to understand whether they perceive that their religion remains a contributing factor to the continuation of FGM.

2.5.3 Gender and power relations

Gender is a principal cause of division within social groups, especially where patriarchal structures are oppressive towards women and girls (Alhassan et al., 2016; Lynete-Monagan, 2010). This section builds on the social norm approach and aims to critically discuss whether the inequality linked to men's patriarchal control and dominance over women contributes to the continuing practice of FGM. To enable this critical discussion, we must first define what is meant by gender in the context of this research.

The terms 'gender' and 'sex' are often used interchangeably, though they do not hold the same meaning. By definition, sex is assigned at birth and denotes to one's biological status of being either male or female, associated mainly by physical characteristics such as chromosomes, hormones and anatomy (Stroller, 1968). According to the reproductive theory, biological status marks the distinction between each sex's reproductive roles. In other words, females' reproductive role is to gestate offspring and males' is to impregnate. This conceptual basis of sex roles is binary and stable and allows us to distinguish between males and females on the grounds of their reproductive systems, which differs from merely the behaviours exhibited by males and females. According to Connell (2014), 'gender' refers to the socially constructed roles, behaviours and attitudes that a given society considers fitting for boys and girls (see also Stroller, 1968; West and Zimmerman, 1987), which influence how people interact. In her performativity theory, Butler (2004) affirms that gender is a constructed status radically independent from biology or bodily traits, with the consequence that a man can signify a female body and the opposite for a woman.

Whereas biological sex is similar across different cultures, gender is context-specific. Thus, the cultural definitions of femininity and masculinity differ (Baber, 1994). From this perspective, gender is a result of 'nurture', and therefore social and fluid, while sex is the result of 'nature', given merely by biology. Butler (2004) claims that the making of a man or woman begins before birth, from the moment one wonders if the child is a boy

or a girl. This continues into the ritual announcement at the birth of transforming 'it' into a boy or a girl. The skills and positioning that children develop are rooted in the specific historical and cultural activities of the community in which they interact with (Rogoff, 1995). Therefore, sex determination sets the stage for a lifelong process of gendering, as a child becomes, and learns how to 'perform' as, a male or a female. However, these performances require support from one's surroundings from an early age, reaffirming the roles of social structures and (macro) determinants in defining gender.

Gender norms are embedded in institutions and nested in people's minds, playing a role in shaping women's and men's access to resources, thus affecting women's and men's voices, agency and power (Foucault, 1997). Patriarchy is both a structural institution and an intentional act and is often used to explain FGM. This claim characterises FGM as an intentional patriarchal action whose goal is the oppression of women (Dagne, 2006; cited in Lejuenne and Mackie, 2008), one that is motivated by male domination and held in place by inequalities between men and women. However, to say that patriarchy is the only cause of FGM is insufficient, because not all communities who practice FGM are patriarchal. As Amaduime (1997) argues, patriarchy was not the primary political or social organisation within an African context before colonisation (see also Oyewumi, 1997). There had been several matriarchal societies where women held significant roles and constituted the balance of society, such as those of Yoruba in Nigeria. Therefore, Diop (1989) asserts that the hegemony of patriarchy stems from Indo-European nomadic culture. Similarly, Amaduime (1997) claims that, in pre-colonial Africa, there was no transition between matriarchy and patriarchy, the social structure was essentially matriarchal, females ruled, and men were utilised in marriage or for sexual union.

The rationale of the practice also reflects social and cultural principles that correspond to the role that women play in guarding and perpetuating the FGM practice in each of these ethnic groups. Hegemonic femininity, developed from Connell's mode of multiple masculinities (Connell, 1995), is conceptualised as covering characteristics defined as womanly which legitimate a hierarchical and complementary relationship to hegemonic masculinity and that, by doing so, warrant the central positions of men and the subordination of women (Schippers, 2007. p.94). Therefore, hegemonic femininity

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supports the overall existence of hegemonic masculinity by accepting and serving the interests of men. Connell claims that the majority of men benefit from hegemonic masculinity through its overall subordination of women and other men.

Adding to this, the term 'hegemonic' derives from Gramsci's (1971) concept of hegemony, denoting the preservation of the status quo through consent rather than coercion. It is related to power whereby everybody in a given social context complies in one way or another to a dominant person or group. For example, in Sierra Leone, Liberia and Guinea, the force behind the practice is linked to a secret society, such as the Bondo society in Sierra Leone. This society is controlled by senior women, who work in conjunction with powerful male members. Their role is to dictate a range of activities and behaviours of its members, and one such activity is FGM.

Hegemonic masculinity is, thus, a form of masculinity that is culturally exalted (Connell, 1995, p.77). Dialogue plays an essential role in maintaining hegemonic masculinity because it informs and regulates its articulation and legitimation (Schppers, 2007, p.94; Connell, 1995; Connell and Messerschmidt, 2005). The more powerless people are not aware of their status in the hierarchy, or even that a hierarchy exists, while the more dominant ones enjoy the status quo. The less powerful may choose to allow others to wield power over them because they do not recognise power effects or since there are some benefits (such as being awarded power over others). Therefore, hegemonic power is maintained not through coercion but ideology (Fairclough, 2001), understood as common sense values that apply to everybody in a community.

In a hegemonic situation, a culture of consensus develops whereby the people who have less power help to maintain the status quo because they identify with the values of the powerful, transformed into norms. Therefore, while colonial missionaries attribute female compliance of FGM to the inherent conservatism linked to the oppression of women, Boddy (1989) argued that such adherence to the practice is linked to women's efforts to preserve 'bargaining tools' with which to negotiate their subaltern status and enforce their complementarity with men. Kandiyoti's (1988) concept of a 'patriarchal bargain' is useful here, which argues that women utilise bargaining tools to safeguard their security and well-being in a given society.

In almost all ethnic groups, women take responsibility for guaranteeing that the procedures of the practice are followed through. For instance, women oversee the FGM process, which may include, ensuring the strict absence of men during the procedure (Boyle 2002; Shell-Duncan et al., 2000). In some groups, this restriction extends to all uncircumcised people in general. For example, in the Rendille tribe in Kenya, uncircumcised males and girls are forbidden from entering the hut where the circumcision is performed (Shell-Duncan et al., 2000).

This aspect of the practice, which requires the women to be in charge, adds to the hierarchical dynamic amongst women and girls. In her study on the Meru tribe in Kenya, Thomas (2000) observed that the women involved in the process of initiation teachings, ceremonies and celebrations, possessed absolute authority over other individuals. The social standing of the mothers and grandmothers of girls going through the initiation process also improved (Thomas, 2000). The study also found that women tend to defend the practice of FGM more than men, as shown by the term 'Ngaitana' (I will circumcise myself), used by girls in Meru when British missionaries banned the practice in the 1920s.

The gender theory approach emphasises how people are socialised into upholding cultural values about gender and how these gender norms reinforce existing inequalities of power and access to resources. In FGM-practising communities, individuals may have a vested interest in upholding discriminatory gender norms. For example, for economic capital, in the form of the dowry (bride price) parents receive for a girl who has had FGM, and also the fee paid to the cutters for performing the practice. Mackie and LeJeune (2009) claim that men support the perpetuation of the practice because of their need to maintain patriarchal institutions. These patriarchal institutions include the social-economic dependency women experience, relying solely on marriage for asset control and, therefore, being unable to choose not to have FGM.

However, framing women as powerless subjects who have been forced to 'butcher each other' has become a contested terrain (Thiam, 1986, p.75; see also Johnsdotter, 2012) and an apparent weakness of this model. It fails to acknowledge the non-universality of FGM by framing the practice under universal patriarchy (Mackie, 1996). Indeed, as Johnsdotter (2012) articulates, there has been a lack of arguments that this practice

originates from matriarchal structures and, in dismissing the female point of view, the model reflects an attitude that is patronising and certainly 'othering' (Ahmadu, 2000; Obiora, 1997). In conclusion, merely associating FGM with patriarchal power and the role of Westerners saving Africans from this 'barbaric' practice, contributes to neo-colonialist values (Boddy, 2007; Njambi, 2004).

2.5.4 Cultural assimilation

The concepts of acculturation and assimilation are used to conceptualise the immigration process (Stuart et al., 2010). Acculturation is said to be the first stage of assimilation. Berry et al. (2005), defined acculturation is the study of immigrants, refugees, asylum seekers and sojourners (i.e., International students) who have settled in host communities. Licciardello and Damigella (2014) added that acculturation is the process by which two different ethno cultural groups come into contact for an extended period of time, leading to cultural changes within the two groups.

According to Berry (1997), the process of individuals acquiring the beliefs, values and practices of host countries does not necessarily imply that an immigrant will discard the beliefs, values and perceptions of their own country. He developed a model of acculturation in which receiving culture acquisition and heritage culture retentions are independent dimensions. Within this model, the two dimensions meet to create four acculturation categories, namely: assimilation (identifying mostly with the receiving culture), integration (high identification with both cultures), and separation (identifying primarily with the culture of origin) marginalisation (low identification with both cultures).

Assimilation is a complicated process of gradually adapting to the culture of the dominant group in a given society, which depends on the circumstances of a particular social group. Gordon (1964) has explained the four significant sub-processes and three ideologies of assimilation; the 'popular view' assumes that immigrants will become assimilated within three generations. This presumes that the first generation often faces difficulties in assimilating due to the language barrier. The second-generation find the process more accessible due to fluency in the language, enabling them to gain better jobs in host countries. The third generation, the first generation's grandchildren, tend to be completely assimilated. However, this theory may be problematic to some groups,

like Somalis, since they are so dissimilar to the dominant group, therefore choosing to sustain their cultural practices across the generations (Waite and Cook, 2011).

Acculturation and assimilation both express the idea that an immigrant will eventually adopt the dominant ethnic group's sentiments, attitudes and relational patterns (Brubaker, 2003; Stuart et al., 2010). However, neither term encapsulates the change adequately or acknowledges that this kind of change is a slow and gradual process, thus making the assimilation complex. Merely bringing different groups together will not necessarily ensure that a fusion of their cultures will occur – in fact, it often results in conflict rather than convergence. Sometimes immigrants find themselves in a new environment that does not embrace certain aspects of their culture, such as the practice of FGM. Assimilation into Western culture is often a slow or non-existent process, due to all these factors (Kalev, 2004; Padilla and Perez, 2003) and can often result to separation, where immigrants reject the receiving culture and retain their heritage (Berry, 1997).

Gruenbaum (2006) and Lightfoot-Klein (1989) made the compelling argument that it is essential to understand the details of a particular culture, which are all too often assumed to be homogeneous and unchanging. However, cultural views differ among various social groups comprising a culture, such as males, females, minorities, religious leaders, and educated, illiterate, older and younger people. Different generations will encounter social changes due to several factors, which may lead to changes in culture itself, where new ideas are adopted, and the old ones no longer perceived as useful (Shell-Duncan and Hernlund, 2000; Toubia, 1985). Meaningful insights are gained by listening to the points of views of different people. This is particularly relevant in the context of second-generation immigrants, and it is important to understand what 'culture' means to the second-generation of young people and whether those views inform their perceptions of FGM.

Therefore, a critical issue is the extent to which acculturation and assimilation may impact on the attitudes to, and the practice of, FGM. This was explored in a qualitative study of Somali men and women conducted in Sweden by Johnsdotter (2016), which claims that migration gives rise to cultural reflection. The study suggests that Somali immigrants are allowed to challenge the status quo of traditional practices, through the

ability to assert that FGM is not linked to religion, which could convince Somali immigrant men to consider marrying women who have not undergone FGM. On the other hand, a recent study carried out in Italy, Portugal and Spain by Reisel et al. (2016) found that 14 per cent of interviewed Gambian and Senegalese women said they were afraid of being accused of discarding their culture if they choose to abandon the practice of FGM in the West. Although both Padilla and Perez (2003) and Johnsdotter (2016) argue that immigrants go through a process of assimilation, Reisel et al. (2016) provide evidence that some remain close to their cultural beliefs out of fear. This, therefore, raises the possibility that, although immigrants may claim to have stopped the practice, it may be practised secretly.

Key cultural variables, including ethnicity and religion, are important in the perpetuation of FGM, but although the prevalence of FGM varies between ethnicities, ethnic variation is not a substantial motivating factor in more than a few isolated contexts (Mackie and LeJeune, 2008). Instead, FGM is likely to be practised to maintain membership within a group (Young, 2015; Mackie and LeJeune, 2008) – in other words, as a means of belonging, rather than of differentiation. Migration, due to ethnic pride in new and sometimes difficult circumstances, might, therefore, lead to exaggerated traditions such as FGM. Mackie and LeJeune (2009) provide the example of foot binding lasting longer in America than it did in China, raising the question of whether the practice of FGM can be eradicated in the West rather than driven underground.

It is essential to consider the process of assimilation in the context of both the continuation and abandonment of FGM. If a community desires to assimilate, it is likely to adopt the norms prevalent in the host society. On the other hand, a commitment to ancestral heritage might be the reason for preserving and continuing the practice. Research examining migrant responses to stereotypes in the West have argued that migrants may reify their traditional practices that symbolise the culture lost behind (Cohen, 1999; Golomb, 1978). Immigrant groups are often subject to discrimination, and alienation from mainstream society, prompting the retention of their values and cultural practices to be used as a form of defence against social oppression (Jonas et al., 2015; Wright, 1990).

Nonetheless, it must be acknowledged that change is not static and can be subject to modification at any given time (Berry, 1980; Padilla and Perez, 2003). This view is supported by Berry's (1980) model of acculturation, which claims that individuals can also revert to their former cultural heritage. Berry (1980) brings forth the notion of power, stating that if an immigrant group lives in a community where they are the minority, it is more likely that they will hold onto their practices as a sign of their cultural identity and power within the community. For instance, in their explorative study in Sweden, Isman et al. (2013) found that women were unsure about the practice, though some were opposed to its continuation, others acknowledged the positive connotations associated with the practice, providing reasons such as ensuring virginity and protecting family honour.

Although individuals retain compound identities, nationality can become a basis of mutual obligations, and social solidarity, Smith and Jarkko (1998) use the term 'social glue' to express this sense of a shared identity that holds a nation together. One example of a nationality-based intervention, the UK government's policy on community integration (Cortes et al., 2015), targeted Somalis living in the UK, amongst other communities, to highlight the importance of community-based English language learning and supporting participation. This is an essential step towards cultural integration, although not all communities are aware of these resources, so such schemes do not reach everyone they are intended to. On the other hand, failure to learn the common language places many immigrants in a vulnerable position, often unable to find work or socialise. Because of this non-integration, immigrants tend to seek refuge in places they perceive as welcoming and familiar, often settling in neighbourhoods and communities where they are in the majority (Kalev, 2004; Padilla and Perez, 2003).

Reisel et al. (2016) note that, within the Gambian and Senegalese community in Spain, uncircumcised girls are called *Solima*, a term meaning 'rude' or 'ignorant'. Among the Guinea Bissau community residing in Spain, such girls are perceived as immature and promiscuous, showing that the stigma associated with not having FGM can remain a problem even in host countries. Reisel et al. (2016) add that, although these labels are not widely used amongst migrant communities, mothers remain conscious of them so continue the harmful practice to prevent their daughters from being affected. Therefore, individuals do not always give up one culture and take up another, due to the

continuing pressures faced in both the host countries and from their home countries (Berry, 1980).

In addition to this, Gruenbaum (2013) asserts that social norms embedded in cultures may be subject to global and religious influences, immigration and other trends, and tend to change regularly, as stated previously. Cultures are subject to core dynamics of change as the needs and ideas of different groups interact. These cultural dynamics influence people's behavioural habits and help to provide the context for new norms to take root and for the old ones to dissipate. In their study amongst the Somali community in Norway, Gele et al. (2015) explored how attitudes can evolve, arguing that the way to change attitudes towards FGM is dialogue at a community level on the meaning surrounding the practice. Their study shows that, amongst the second generation of Somalis either born or brought up in exile, the meaning of FGM has evolved from being a rite of passage to a violation of human rights.

Similarly, Schwartz et al. (2009) suggest that acculturation is achieved through interpretations and conversations with the external world. Although Gele et al. (2015) shed light on how attitudes are changing, their study was limited to the views of Somali women aged 16-22. Therefore, this explanation overlooks other vital components that may contribute to the continuation of the practice, such as the lack of financial support from Western countries, often forcing families to rely on ties to their communities back home and consequently having to comply with the practices prevalent in their home countries.

McGrown's (1999) study in London and Toronto shows growing opposition to FGM amongst migrant communities. A similar process of change and abandoning the practice on migration was observed amongst Sudanese people moving to Cairo (Fabos, 2001), amongst Sudanese and Egyptians migrating to the Gulf States (Kassamali, 1998), and immigrant Somalis in London (Elmi et al., 2004). Morrison et al. (2014) in a mixed-methods study amongst young and older Somalis in London, claim that immigration at a younger age reduces support for the practice, though both 18% women and 43% men still supported the continuation of the practice. The study showed that older generations and those who showed few signs of assimilation were less likely to abandon the practice.

One critical issue is that communities' perceptions of, and reasons for, abandoning FGM are not homogenous, as cultural assimilation may occur in some areas but not others. Overall, there seems to be some evidence indicating that cultural assimilation can contribute to critical attitudes and views of FGM, although it can also contribute to its perpetuation (Alhassan et al., 2016; Gele et al., 2015; Johnsdotter, 2009).

2.5.4.1 Caught between two cultures

Academic literature on FGM to date has mainly focused on the first generation, who are immigrant parents, although their children, by default, become second-generation immigrants and are often 'between two cultures' (Watson, 1977). The underlying assumptions are that parents predominantly strive to maintain their background cultures in the new country by trying to cling on to identities, images, and practices from their home culture, such as FGM. It is assumed that these cultural identities are then passed on to their children, who inevitably become assimilated within the values and norms of mainstream society, thus generating tension within their families. As a consequence, young people find themselves caught between representing their parents' cultures and wanting a sense of freedom to form their own identities, thus rejecting parental cultures, values, and aspirations (Watters et al., 2009).

A qualitative study conducted in Italy amongst Italian-born young people with parents of immigrant decent by Arevalo et al. (2015) illustrated such tensions. In Italy, immigrants often find themselves stuck with minimal or limited opportunities as a result of racial tensions. As such, those who belong in the second generation of immigrants find themselves in a contradictory situation, forced to share their parents' lack of social belonging, due to being perceived as foreigners in their own country and labelled as illegal children (Sayad, 2006 Cited in Arevalo et al., 2016). In addition to this, research conducted on the second generation suggests the importance of understanding the second generation's experiences and tensions about acculturation, concluding that, if this fails, there is an added risk of third generations failing to acculturate (Kasinitz et al., 2008), thus potentially continuing with practices such as FGM.

In an attempt to offer a resolution to this conundrum, James et al. (2009) explain that young people should be regarded as independent individuals with an ability to choose, not reliant on family networks. In issues of identities, however, there is a differentiation

between processes occurring in adults and in young people, where James et al. (2009) explain that children learn who they are through interaction with adults (p.203). However, if seen as outsiders in Western communities, teachers may have a lack of understanding of young people's needs, or not discuss cultural issues such as FGM, due to not wanting to be seen as 'racist'. In their study conducted in Italy, Arevalo et al. (2015) explore this concept of 'lost identity':

> "I can only say that I was born here in Italy. I am used to an Italian environment… however, my origins are different. I know my parents' culture well, and I also know what my own culture is" (Dusi et al., 2016, p.564).

This illustrates the tensions and difficulties faced by second-generation young people, which might play a role in wanting to hold onto the traditions and beliefs of their parents, partly to please their parents, but also because doing so might offer a sense of belonging which their *'home'* (emphasis added) may not.

2.5.5   A human rights approach to FGM

The main principle of the international human rights law is that every nation respects the rights of its citizens, and the international community has the responsibility to speak out against the violation of these rights. Underpinning this is the belief that there are universal human rights. There has been an international shift over time from thinking of FGM as primarily a health issue, to considering it as an issue of women's health and human rights. The 1994 Declaration and Programme of Action of the International Conference on Population and Development (ICPD) specially mentioned FGM and called for its prohibition (WHO, 2001). It urged governments to actively support efforts among non-governmental and community organisations and religious institutions to eliminate the practice of FGM. The Declaration and Platform for Action of the Fourth World Conference on Women held in 1995 (WHO, 1995), in Beijing, listed FGM as one of the various aspects of sexual and economic exploitation of girls and calls for an end to the practice. Despite being defined as a human rights issue, the practice persists. It is therefore essential to examine the attempts taken by the international community to prevent the practice of FGM.

The UN's involvement in eradicating FGM began in 1958. The UN Economic and Social Council, in association with WHO, examined the practice and its plans to eliminate it.

However, this was disregarded by the WHO in 1959 and 1961 due to the practice being conceptualised as a cultural issue (Brennan, 1988; Lionnet, 2005). Eventually, a conference organised by the World Health Organisation in 1980 led to UNICEF establishing the Inter-African Committee on Traditional Practices (Gunning, 1998). In 1980, members of the practising communities eventually worked out an agreement calling non-Africans to refrain from criticism, while assisting with technical and financial assistance (Brennan, 1988).

This agreement came about because any intervention in FGM from non-African countries was viewed as a contributing factor to African women resisting the efforts of international organisations. The Association of African Women for Research and Development (AAWORD, 1993) emphasised this issue; although conceding the need for action, the organisation maintained the requirement that feminists from developed countries must accept that FGM is a problem for African women. Therefore, change is only possible with the involvement of African women as active participants rather than viewed as victims. In the mid-1990s, the Inter-African Committee successfully lobbied for the inclusion of a ban on FGM in the draft protocol to the African Charter on the Rights and Welfare of the Child (Wheeler, 2003).

While a continuation of the practice is often associated with social and religious reasons from a human rights angle, the practice reflects the inequality between the sexes and is arguably creating a form of discrimination against women. FGM has been a longstanding issue to the United Nations, within the Universal Declaration of Human Rights (UN, 1948) and two general covenants adopted in 1996 – the International Covenant on Civil and Political Rights (ICCPR,1966) and the International Covenant on Economic, Social and Cultural Rights (ICESCR,1996). These both prohibit sex discrimination and emphasise respect for the rights of individuals and the promotion and security of health.

The Convention on the Elimination of All Forms of Discrimination against Women (UN, 1979) and the Convention against Torture and other Cruel, Inhumane and Degrading Treatment or Punishment both prohibit the infliction of physical or mental pain or suffering on women (WHO,2001). The Convention on the Rights of the Child (UNICEF, 1989) obliges member states to protect their nationals from harmful practices such as

FGM, thus placing the responsibility on governments to address FGM within their jurisdictions. Article 2 states:

> "States' Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment by the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members" (UNCRC, 1989, p.48).

As FGM is nearly always carried out on children and young people, from birth to 13 years, it can be seen as violating the rights of the child (UNCRC, 1989). This Convention on the Rights of Children (UNICEF, 1989) was signed in 1990 by several countries, including but not limited to, the UK, Kenya, Somalia, Ethiopia, South Sudan, India, Pakistan, and Sudan. By ratifying this Convention, these countries agreed to consider the best interests of the child when doing anything that affects children. Performing FGM is thus a clear violation of this right to children. Furthermore, the practice violates girls' and womens' right to health, life and physical integrity, the right to be free from torture and cruel treatment, due to the risks associated with FGM (Joan, 2009; United States Department of State, 2001; Xiorong 2001).

Nonetheless, the human rights approach has some limitations. While the violations of human rights are monitored and evidenced, international enforcement is limited to applying political pressure on abusing actors (Boulware-Miller, 1985). On the other hand, local punitive and preventative legislation is enforced by governmental institutions and therefore is, in theory, more efficient at tackling immediate FGM-related concerns. However, it is important to note that international human rights declarations often serve as guidelines for the formulation of local policies and legislation. Therefore, although FGM is globally known as a human rights issue, it may not have been adopted as such locally. Also, legislation and sanctions vary in practising countries.

There is, however, some debate as to whether it is appropriate to classify FGM as a human rights issue since this appears to be grounded in a Western conception of health. That is to say, human rights assume the universality of a particular concept of health, although it is well known that ideas of health vary across different contexts (Baker, 1998; DeLaet, 2009; Dustin, 2010). It can be argued that communities who practice FGM may be doing so for what they perceive as beneficial health reasons, not seeing it as an act

of violence or abuse of human rights (Varol et al., 2017). As a researcher in public health, I understand FGM from a human rights framework. However, I also acknowledge that various contexts by which the community would argue against this; therefore, I operate between the two.

In conclusion, the reasons behind the practice are as varied as the communities that practice it. As noted in this chapter, they range from cultural to social and religious reasons including societal pressures, the rite of passage as well as claims on religious mandates. While these justifications may not be scientifically substantiated, they illustrate the complexity and diversity of the reasons behind the practice of FGM. As such, the development of preventative strategies requires that the complex nature of the practice is taken into account, acknowledging a one size fits all is insufficient. In the following chapter, I critically examine the current approaches that are utilised to prevent the practice of FGM globally.

Chapter 3 Approaches to the prevention of FGM

3.1 Introduction

Over the years, FGM has received much attention from governments, non-governmental organisations and international communities, leading to the implementation of various interventions aimed at preventing FGM at local, regional, national and international levels. These have encompassed interventions at a local level that have focused on educating communities about the harmful effects of the practice, while at a national level, anti-FGM legislation may act as a legal deterrent against performing the practice (WHO, 1999). In this thesis, these interventions are considered to be health promotion approaches. This chapter provides some background on health promotion and then discusses FGM prevention strategies within this context.

3.2 Definition of health promotion

In 1986 the WHO defined health promotion as the process of enabling people to increase control over and improve their health (WHO, 1986). Nutbeam (1988) described health promotion as the process of empowering people to have ownership over the determinants of their health, thus improving their health. In 1997, Jones defined the term as actions and interventions to support and enhance people's health. These definitions present a broader concept of health, illustrating that people's health is not just influenced by human biology but also by lifestyle, environment and health services (Lalonde, 1974).

Health promotion began to gain acceptance globally following the launch of the Ottawa Charter for Health Promotion conference held in Canada 1986 (WHO, 1986, cited in Labonte and Laverack, 2008). The charter introduced a focus on health and its determinants into a debate that was until then dominated by the biomedical approach to health. This led to the Ottawa Charter for Action to Achieve Health for All by the year 2000 and beyond (Labonte and Laverack, 2008). Health promotion was defined as the

process of enabling people to take control over and improve their health and identified five key action areas: build healthy public policy; create supportive environments; strengthen community action; develop personal skills; and reorientate health services (WHO, 1986). Subsequently, political, economic and social changes were recognised as tools to achieve health for all. Health promotion was highlighted as a positive model, although the charter was criticised for manufacturing a catch-all agenda for health promotion with vague priorities (Jones, 1997).

What followed was a more concrete proposal set by the International Conference on Health Promotion held in Adelaide (WHO, 1988). Although it continued along the direction set by the Ottawa Charter, its four key proposals were: public health policy, improving women's health, food and nutrition, tobacco and alcohol (WHO, 1998) within an overarching aim of creating supportive environments to enable health promotion efforts.

During the 1980s, poverty, low levels of education, poor leadership and man-made as well as natural disasters were recognised as factors affecting health development in Africa; while 'ignorance' was seen as the main barrier for health development (Nyamwaya, 2003). This was part of the public health model of health development in the regions. Also, poverty among women, their weak economic capacity and social and gender-based violence, including FGM, remained significant issues within the African regions (WHO, 1991).

3.2.1 Definition of health

According to Tones and Tilfold (2001), the term 'health' is vague and multi-dimensional, open to multiple interpretations. The Ottawa Charter (WHO, 1986) claimed that health is created in the context of everyday life and environment, where people live, love, work, and play. As a result, historically, there have been several interpretations of what 'health' constitutes. One contested definition is that health is defined as *"state of complete physical, mental and social well-being and not merely the absence of disease"* (WHO, 1946).

This definition, while affirming that health is not merely a physical or biological phenomenon, made health an impossible goal (Baylies, 1986), not least by its inevitable relativity. It became a phenomenon that is extremely difficult to assess, being subject to varied interpretations, especially in an African context. While the Western health definition and components of healthcare are accepted in most African countries, they also rely on various cultural traditions, such as traditional healers, religion and natural medicine (Asare and Danquah, 2017). Arguably, such definitions are problematic, as they appear to be grounded in a Western conception of health. That is to say, they assume the universality of a particular concept of health, although it is well known that ideas of health vary across different contexts (DeLaet, 2009; Dustin, 2010, Johnson, 2010). This results in not acknowledging that communities who practice FGM may be doing so for what they believe are beneficial health reasons, thereby conceptualising it in a limited way as an act of violence or abuse of human rights (Varol, 2014).

Modern definitions of health consider health as more than the 'absence' of disease, but also a capacity for individuals to reach self-actualisation and self-fulfilment, such that health is a socially and culturally constructed reality (Foster et al., 1978; Hahn and Inhorn, 2009; Hyder and Morrow, 2005). People hold health beliefs and behaviours that stem from their culture; these are a set of practices and behaviours defined by customs, habits, language, and geography of the group in question (Napier et al., 2014). Similarly, Tylor (1971), cited in Hyder and Morrow (2005), defined culture as a complex whole which includes knowledge, belief, morals, law, custom and any other skills acquired by a member of a given society. Therefore, some have argued that while the WHO for example, recognises the existence of alternative medicines and, by implication, local therapeutic knowledge systems, it privileges the hegemony of the Western biomedical health model over local health concepts, and this is seen in its language as well as policy recommendations. This implies the rejection of other health practices and the communities that practice them, justifying the prohibition of such practices for 'cultural reasons' (Gunning, 1991; Oba, 2008, p.14; Mohanty, 1984, p.336).

3.3 Typology of health promotion interventions

Beattie's model (1991) is used as an analytical framework and enables a comprehensive overview of the empirical research on interventions linked to FGM, as a way of bridging the gap between theory and practice. This section is not intended to analyse the effectiveness of interventions (for that, see Berg and Denison, 2012; Lee-rife et al., 2012), but rather to provide a synthesis of approaches aimed at preventing FGM, their uses and contexts.

Beattie's model (1991) is used here to distinguish between the mode of approach (authoritative/negotiated) and the focus of the intervention (individual/collective), in relation to FGM. The model consists of four quadrants, which represent the different approaches towards health promotion: health persuasion, legislative action, personal counselling and community development techniques, as shown in Figure 3.1.
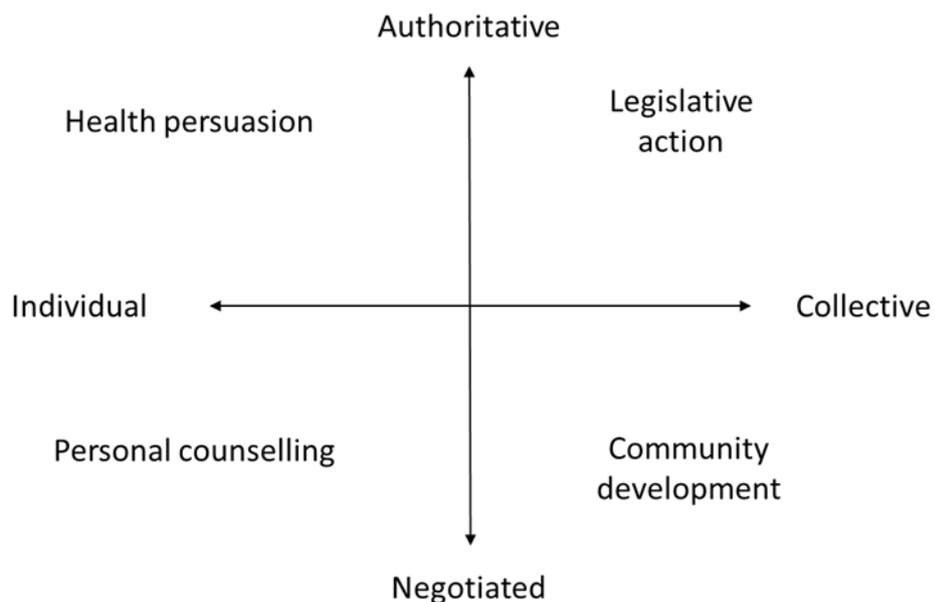
Figure 3:1: Adapted from Beatie's model of health promotion (1991).

All four types of approaches have been utilised in the prevention of FGM, such as the development of legal frameworks, education in schools, media programmes and community development. The next section explores how the different components of Beattie's model (1991) have been used to prevent FGM. The top-down level

(authoritative and legislative action) will form the first part of this section; the bottom-up level will ensue, consisting of personal counselling and the community development framework. The community development framework is where this research is situated.

3.3.1 **Authoritative**

3.3.1.1 Health Persuasion

The extensive usage of models targeted at the individual level, such as the health belief model in behaviour change (Becker, 1974), have been used to communicate the risks of FGM and have resulted in a number of communities understanding the negative health impacts of FGM (Connelly et al., 2018). The model constructs are perceived susceptibility, perceived severity, perceived benefits and barriers, cues to action and self-efficacy (Becker, 1974; Champion and Skinner, 2008).

The perceived susceptibility construct refers to an individual's subjective belief about reaching a harmful state as a result of engaging in a particular behaviour (e.g. I will not have any health problems if I practice FGM). This construct assumes that the more susceptible a person feels about a given act, the higher the likelihood of that person not practising it. The perceived severity construct refers to a person's subjective belief in the extent of harm that can result from an action (consequences of FGM). The perceived benefits construct represents beliefs in the advantages associated with not practising FGM. Perceived barriers are the beliefs concerning the actual, imagined cost of following the new behaviour. If individuals believe the stigmatisation (barrier) of not continuing FGM outweighs the benefits, they will not be motivated to stop. Cues to action are the triggering factors that make an individual feel the need to take action; if their susceptibility is low, then intense cues of action are required to encourage them to pursue a new behaviour. Finally, the construct of self-efficacy stems from social cognitive theory (Bandura, 1977) and is the confidence a person has in their ability to pursue a given behaviour.

This theory possesses some positive aspects, as research conducted in Senegal and Egypt has shown that young men began to question the practice after learning about the health risks associated with FGM (Diop and Askew, 2009). Furthermore, they feared that it would also reduce sexual pleasure upon learning how FGM adversely affected

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women (Diop and Askew, 2009). Therefore, although the education of individuals has not resulted in complete abandonment of the practice, it has raised awareness, which is indeed an initial valuable output.

An apparent weakness of this theory, however, is the assumption of a direct link between an individual's intention and behaviour. These interventions failed to take into account the complex interactions of decision-makers and the contexts in which decisions are made (Davies, 1992; Parker, 2004; Shell-Duncan and Hernlund, 2006; Yoder, 1997-2001). An illustration of this was a study conducted in Ethiopia amongst women by Boyden et al. (2012) where, although educated about the harmful effects of FGM, the women still believed that practising FGM carried positive health benefits, stating that "The bleeding cleanses the girl; 'cut' girls are more hygienic".

Moreover, this provision of information on health risks could lead to changes other than abandonment, such as the increase in the medicalisation of FGM observed in some communities such as Egypt, where increased education has led to medicalisation rather than abandonment (Johansen, 2010; Royal College of Obstetricians and Gynaecologists, 2015; WHO, 2011). This approach also creates opportunities for a shift from Type III (infibulation) to Type I FGM (partial/total removal or pricking of the clitoris), also known as Sunna (Berg et al., 2013). A recent qualitative study conducted in Somaliland amongst the districts of Borama and Hargeisa, participants ranged from married to unmarried women, men, and health workers between the ages of 20-49; Powell and Yusuf (2018) found that respondents reported a shift away from infibulation to Sunna (Type 1) FGM. Furthermore, participants encouraged the medicalisation of the practice, further illustrating the limitations of education of health risks.

Furthermore, health risks strategies have also been utilised in the UK. Leyla Hussein, a Somali psychotherapist and social activist, featured in a Channel 4 documentary, 'The Cruel Cut', which depicted FGM in the UK. This was followed by a global media campaign to end FGM by *The Guardian* newspaper, from May 2014 to September 2015. The campaign focused on accelerating the end of FGM in the UK and later expanded to focus on other countries. *The Evening Standard* also launched anti-FGM media campaigns in 2014 to raise public awareness of the practice, and other media mentions have been included in TV drama *'Call the Midwife'* in 2016 and TV documentary series *'Extreme*

Wives' in 2017. Connelly et al. (2014) note, however, that, although media allusions to FGM have increased, the focus has been on child protection, and criminalisation of the practice, as in the documentary termed 'FGM detectives', which followed a lead detective as part of a larger criminal case in Bristol, 2018. This was a one-dimensional account, dismissing the community engagement processes, which has also led to research on the effectiveness of the safeguarding policies in Bristol (see Karlsen et al., 2019).

Other tools utilised to educating the public about the practice of FGM include storytelling, dramas, and poetry. However, these tools have not yet been seen in mainstream media in the UK, and data exploring their effectiveness remains scarce. Arguably the stories currently used in the media give a one-dimensional account, rather than allowing the full use of creative work (Khalifa, 2016). A more balanced approach is required, as these could be seen as negative and stereotypical by practising communities.

3.3.1.2   Legislative action

Every society enacts rules and sanctions that control the behaviour of its citizens. Ideally, these rules are designed to promote the welfare and freedom of its population by eliminating harmful practices, such as FGM. The purpose of legislative action is arguably twofold: to protect and prohibit. These purposes are related, in that prohibiting FGM leads to the protection of innocent females from harm. The problem is that the legislative action is vague and has led to several differing interpretations. In this section, I discuss both international and national legislative action aimed at preventing the practice.

The Prohibition of Female Circumcision Act was introduced in the UK in 1985 and was subsequently updated and is now known as the Female Genital Mutilation Act 2003. The 2003 Act asserts that a person is guilty of an offence if they *'excise, infibulate or otherwise mutilate the whole or any part of the girl or woman's labia majora, labia minora or clitoris'* (Section 1, FGM Act, 2003). There are exceptions to the offence when it is a necessary operation performed by a registered medical practitioner for 'physical

or mental health' grounds, as well as when performed to facilitate labour or birth; but these exceptions do not include beliefs, customs or rituals.

It has been argued that the 1985 and 2003 Acts contribute to a legal double standard that has been the subject of extensive scholarly debate (Avalos, 2015; Dustin, 2010; Gunning, 1991; Sheldon and Wilkinson, 1998). The wording of the 1985 Act raised concerns that it would criminalise cases where girls had anxieties about the shape or size of their normal genitalia and their distress could only be eased by surgery (Dustin and Philip, 2008). Medical professionals mobilised to block legislation that would criminalise these procedures. Consequently, the government introduced an amendment to allow for genital surgery on the grounds of mental or physical health, declining to include any accounts based on belief (Dustin and Philip, 2008).

Therefore, the law arguably allows for a girl or woman to choose surgery to follow Western norms of how one's genitalia should look, but at the same time prevents conformity to traditional minority values (Berer, 2015; Dustin and Phillips, 2008). A study conducted in Australia (Allotey et al., 2001) identified migrant women who had been refused the right to re-infibulation after childbirth to restore their genitals to what was *'normal'* (my italics) to them. They viewed the denial as institutional racism, arguing that the country tolerated clitoral piercing for Australian women but not re-infibulation for them. Although the adverse health implications of FGM are clear, one could also question the legitimacy of female cosmetic surgery. The Acts of 1985 and 2003 criminalise FGM when performed on women and girls without distinction of age or consent but do not criminalise female cosmetic surgery, even in younger people. There is an apparent inconsistency which distinguishes between cosmetic surgery based on 'choice' defined by sexual freedom outside of the culture, while FGM reflects cultural coercion and is therefore illegal, in the context of consenting adults (see also Rogers, 2013).

In practice, the law has been seldom used in the UK. 2015 saw the first criminal prosecution of a medical professional for undertaking FGM, and this case collapsed during accusations towards the Crown Prosecution Service for staging what was called a 'show trial' in response to political pressure to prosecute (Gill, 2016, p.27). The accused, an obstetrics and gynaecology registrar called Dr Dhanuson Dharmasena, was

found not guilty of performing FGM on a patient in Whittington Hospital in North London. He was alleged to have performed re-infibulation on a woman post-partum but stated that he had never treated someone with FGM before and had not been given the necessary training to do so. Against this backdrop, there were two other cases in 2018, which also collapsed due to lack of evidence. However, as aforementioned, a woman was found guilty of FGM in March 2019 and was convicted to 13 years in prison (Summers and Ratcliffe, 2019) for undertaking FGM on her three-year-old daughter in London.

Having discussed the top-down aspects of Beattie's health promotion model – authoritative and legislation action – I will now consider the bottom-up levels – personal counselling and the community development framework.

3.3.2 Negotiated

3.3.2.1 Personal counselling

Personal counselling and educational approaches are often favoured over other approaches discussed previously, as they are viewed as being less authoritarian (Waigwa et al., 2018). For many years, anti-FGM advocates have been campaigning for full and relevant sex and health education, in both general and affected communities, that includes information about FGM. This could potentially reduce the negative consequences affecting young people's sexual health and knowledge. It is believed that beginning conversations at Year 5 and 6 (age 9-11) would ensure that young people gain a robust understanding of the practice.

In the UK, The Children and Social Work Bill (Department for Education, Dfe, 2017) requires that all secondary schools in England teach Personal Social and Health Education (PSHE), although parents retain their right to withdraw their children from such activities (Section 405, Education Act, 1996). There is also statutory guidance, Keeping Children Safe in Schools (Dfe, 2019), that asserts the importance of incorporating safeguarding into the school curriculum, including FGM in secondary schools. Furthermore, the government amended the Children and Social Work Act in March 2017, stating that, from 2019, all primary schools in England must teach

relationships in education and secondary schools must teach relationships and sex education (PSHE Association, 2017; DfE, 2019).

Schools are often able to tailor their provision to meet the local population's needs; this is often accomplished by engaging parents, community leaders and pupils in a consultation. In addition, the new guidance from the Department for Education (DfE, 2019, p.12), notes that there is no requirement for primary schools to teach sex and relationship education, though they encourage schools to include age-appropriate education.

However, the standard of delivery of education in practice is variable, with a 2000 report finding that young people who have participated in sex education in schools often complain that it is too focused on the physical aspects of reproduction and that there are no meaningful discussions about feelings, relationships, and values (Blake, 2000). This report also highlighted the specific components included in sex and relationship education, such as puberty, menstruation, contraception, abortion and safer sex. The report did not mention the practice of FGM. The topics related to the report above are also included in the NSPCC PANTS campaign (Bird, 2018) and Speak Out and Stay Safe tools (NSPCC, 2013), which are often used in primary schools to facilitate discussions.

A study conducted in the UK with 11 primary school teachers from the North West of England showed that, although teachers were willing to talk about the subject (PHSE), their lack of confidence and perception that they required authorisation to intervene, prevented them from doing so (Hirst et al., 2017). Furthermore, the Office for Standards and Education (Ofsted, 2013) completed a report on PSHE education, 'Not yet good enough', which highlighted the need for significant improvements. Similar to Wood et al.'s (2017) study, Ofsted found that teachers lacked the confidence to teach PSHE. However, most PSHE will not routinely include information about FGM, and according to Landry et al., (2003), in America, discussion of the issues associated with FGM remains controversial.

Though some schools provide anti-FGM awareness sessions, this is generally through external organisations such as Integrate UK and FORWARD (Home Affairs Committee, 2014-2015). However, there remains a lack of research about the views of young people from affected communities in high-income countries, linked to their own experiences of

FGM education in schools. Therefore, it is difficult to assess the effectiveness of these activities. This research attempts to bridge that gap.

3.3.2.2   Community development

Within Beattie's model, community development encompasses both empowerment and community-based action research. According to the WHO (2014), community empowerment is the process that allows communities to increase control over their lives. In relation to this thesis, communities are defined as young people from FGM-affected communities. Empowerment refers to the process by which people gain control over the factors and decisions that shape their lives, enabling them to increase their assets and attributes and build capacity to gain access, partners, networks, and voice (Labonte and Laverack, 2008). Arguably, people cannot be empowered by others but rather empower themselves by acquiring power and knowledge that may lead to social change (Labonte and Laverack, 2008; Rowlands, 1997). In the context of community-based action research, therefore, the role of an agent (researcher) is to facilitate the community in acquiring power, thus gaining the capacity to make a change (Wallerstein and Duran,2006).

The Jakarta Declaration (WHO, 1997) reaffirmed the importance of participation and community involvement as a necessity of health promotion, further noting that participation is essential to sustain efforts and, thus, people have to be at the centre of health promotion action and decision-making processes for them to be effective.

The Rio Political Declaration on Social Determinants of Health established public participation as one of the five areas of global health action (WHO, 2013). Within this paradigm, community engagement is used as an inclusive term covering the breadth and complexity of participatory approaches, from minimal involvement to an approach where communities take full control.

3.3.2.2.1   *Critical consciousness, collective action and community empowerment*

According to Vestergren et al. (2019), collective action for change is a process that does not happen quickly; it requires an awareness of a social health problem and recognition

of the need to come together and instigate change. Freire (1970) developed what is now known as the critical consciousness model, which enables an understanding of collective action and how this can be achieved. Freire describes the notion of didactic and top-down teaching as an informative approach of teaching which assumes that learners are passive beings in need of controlled knowledge, which fails to foster critical thinking and serves the purpose of keeping the rich and the elite in power, further oppressing the poor and powerless.

Therefore, Freire (1970) introduced an alternative approach to teaching, one where learners engage in dialogue that is equal, making the learners central to the learning process as opposed to them being objects, therefore introducing participatory education. Freire (2000) notes that education is about creating safe spaces for discussion, thus allowing people to share their life experiences and develop ideas collectively, forming new understandings towards community empowerment.

To Freire, community empowerment begins when people listen to each other, engage in participatory dialogue, identify a common problem and construct strategies towards change. He argues that critical thinking evolves over a series of stages, starting with intransitive thought. At this first stage, people do not see it as within their power or control to instigate change and improve their life situation. Therefore, in a community where FGM is driven by patriarchal power, women would not recognise their power to instigate change, but would instead be agents advocating for FGM. Freire's second stage is semi-transitive thought. Here, people begin to see the connections between their actions and a change to their lived realities and therefore experiment with various actions to instigate change. In relation to FGM, this could be the call for a shift from Type III (infibulation) to Type I, a less severe form of FGM. However, at this stage, there is a struggle to connect their problems with the broader social structures and determinants that impact their lives; in other words, practising communities may not associate the social determinants of health and inequality as impacting on their decisions to continue with the practice. Lastly comes the critical transitivity stage, where people experience an awakening of their 'critical consciousness', enabling a critical engagement with their life situation and making a connection between their social problem and the oppression that keeps them in that condition, thus generating interest in instigating change.

What Freire (2000) proposes is the creation of social spaces for reflection and critical dialogue as a vehicle towards a more critical consciousness, where people become aware of and empowered in their social situation, increasing the likelihood to translate this awareness into collective action. An advantage of this theoretical exposition is that it highlights the importance of seeing development as a process which involves a partnership between those with more power and those with less power.

However, one fundamental limitation of this model is the failure to recognise the importance of awakened people in building relationships with resourceful external actors. Therefore, people might be aware that the practice of FGM causes problems, but lack the resources to instigate change. On the other hand, if the process of change is successful, sustaining a long-term commitment to the empowerment process is complicated, due to setbacks and the inability to guarantee immediate results (Cornwall, 2000). Therefore, in communities where FGM is endemic, the lack of resources, such as money, contributes to the continuation of the practice; for the family in the form of a bride price, for the community leaders who are paid per girl who undergoes FGM, and for the cutters who charge for their service.

In addition, it may be challenging to guarantee sustainability when health promotors and NGOs have exhausted their resources and exited a community; at that point, many people will return to their original ways of living. However, if it is done correctly, the process of community empowerment should result in a paradigm shift, from affected communities being recipients of services to having self-determination (Afshar, 1998). It should build a social movement where communities collectively exercise their rights and are recognised as an authority, being equal partners in planning, implementation, and monitoring (WHO, 2012).

3.3.2.3 Examples of approaches to FGM using community-based models

In an attempt to change behaviour at a community level, Mackie (1996-2000) introduced the Social Convention Theory in Senegambia. This model highlights the importance of a reference group in decision making; these can be social groups. This means that an individual's actions are interdependent, thus necessitating coordinated change among interconnected actors. According to Gruenbaum (2005), the decision to continue the practice of FGM is associated with a complex decision-making process

within a culture. She emphasises that when the social pressure is illuminated, and the social context is changed, communities chose not to continue with the practice. The social convention theory explains how certain harmful social practices are self-enforcing social conventions, why they are universal within communities, and why they are so resistant to change. Mackie and LeJeune (1998) argue that the ability to change a convention depends on organising the rapid mass abandonment of a convention.

Conversely, Mackie (1998) argues that the social convention theory is a study of interdependent decision making so that the choice one person makes depends upon another person's choice. Moreover, this means that, in an interdependent group, each member's decision depends on the choice of all the members. Arguing that, the decision to stop the practice of FGM cannot be independent, as it requires a whole group to change. For example, if FGM is conceptualised as a convention maintained by marriage: once it becomes expected by a potential husband and his family, the practice becomes a social norm; therefore, those who fail to comply will suffer social sanctions, such as stigmatisation and inability for their daughters to marry.

Therefore, if one entire group pledges to refrain from FGM but other intermarrying groups do not, it will not end. Thus, in Mackie's (1998) opinion, group consensus is the only way to end the practice. This commences when a small group known as the 'critical mass' decide to abandon FGM. If they decided to recruit remaining members of the community to join in the effort conditionally, this would continue until a large enough number, the 'tipping point', is reached, who are prepared to continue the steady abandonment of the practice. At this point, per the social convention theory (Schelling, 1960), a consensus is reached to discard the practice (Mackie, 1998; Powell and Yusuf, 2018).

Mackie (1998) notes that the commitment to change must be in the form of a public commitment or announcement, so that the community can see that most of its members are abandoning the practice, enabling a shift in status quo equilibrium. However, an inappropriately imposed convention shift can cause a backlash and ruin the credibility of this pledge approach completely. The process of information sharing, persuasion and mutual deliberation about the advantages and disadvantages of abandonment spreads through social networks within what Mackie (1998) calls

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'intermarrying groups'. This process is known as 'organising diffusion'. The diffusion must spread outside the community so that to continue the 'shift'.

A project that utilised Mackie's (1998) social convention theory was the Senegalese Tostan project [Tostan, 2012]. The project claimed to organise public declarations to abandon harmful traditional practices, including FGM. They worked with villages and community leaders through discourse and dialogue, exploring the harmful effects of FGM in each context, leading to self-declarations against the practice. The Tostan project supports the effectiveness of the social convention theory (Mackie, 2000; Tostan, 1999; Easton et al., 2003). Although Diop and Askew (2006) argued that, instead of the practice continuing openly, it had merely been driven underground, away from public eyes, as a consequence of this project, instead of being eradiated. Furthermore, Diop and Askew (2006) explain that villagers saw the Tostan actions as incentives, money offered in exchange for their pledge to abandon the practice. Similarly, Adinew (2017) argues the stated decline was not always an accurate interpretation of reality, in that people had not changed their attitudes and practices around FGM, but began underreporting it due to feared legal sanctions.

Furthermore, very few studies have explored the theoretical dimensions of behaviour change (UNICEF, 2005, 2010; Hayford, 1998). One exception is a demographic and health survey conducted in Kenya, testing whether group norms associated with marriage influenced parents' decision to circumcise their daughters. Here, Hayford (1998) found links between women's decisions to circumcise their daughters and group norms, as predicted by the social convention theory.

In contrast, a study on the dynamics of behaviour change linked to the social convention theory in Senegal and the Gambia by Shell-Duncan et al. (2010) investigated the dynamics of decision making relating to FGM, setting out to assess whether these link to theories of behaviour change. She proposed five stages of change applicable to decision making around FGM: non-contemplation, contemplation, reluctant practitioner, willing abandoner of FGC, and reluctant abandoner of FGC. However, they found no direct link between marriageability and FGM. In fact, women continued the practice to increase their power in the community, as having FGM meant gaining a guaranteed level of social capital as well as the ability to participate in the hierarchy of

power. The study highlighted some limitations; interestingly, that the decision for or against FGM may be revisited several times across changing environments, such as after marriage or even after childbirth. Another limitation of this proposed theory is its inability to conceptualise the negotiation of decision making and differentials in power between decision-makers, as well as how power dynamics change over time.

Mackie (2000) argues that change must be coordinated by a social network to avert sanctions within. However, opposing the marriage convention, Shell-Duncan et al. (2010) propose peer convention as a means of directing efforts across generations, also noting that conventions and norms change over time and vary, depending on contexts. They argue that it is therefore crucial for programmes to be locally attuned and address shifting contexts of the practice. This notion is especially true in the Western community because, as the reasons for the practice vary across different communities, interventions must also address these reasons. As a result, it is difficult to build a 'one size fits all' programme.

Another behavioural change theory applied to FGM is the diffusion theory (Rogers, 2002), which analyses how the process of innovation is connected through networks over time between community participants. This theory examines people's capacity to adopt a novel or innovative behaviour. However, making a decision about innovation is not a sudden one; it is an ongoing process. Rogers lists five stages that enable the decision-making process: firstly, knowledge, which occurs when an individual or community becomes aware of the existence of the innovative behaviour and gains some understanding of how it functions. The next stage is persuasion, when leaders form a view of the new behaviour. The third stage is decision; this transpires when individuals or leaders unite and decide whether to adopt or reject the development. Fourth, implementation, involves acting on the innovation and, lastly, confirmation occurs when decision-makers seek support for an innovative decision or reject the approach if exposed to conflicting messages or experiencing negative outcomes from the innovation.

To some practising communities, abandoning FGM has some disadvantages, such as its incompatibility with current behaviour, its complexity, the potential for adverse impacts on social relations, economic devastation, as well as uncertainty for marriage.

Therefore, given this likely perception, the idea of not practicing FGM is challenging to diffuse (Bartholomew, 2011), especially in countries where the practice is endemic. Wejnert (2002) also draws attention to environmental factors that affect diffusion. These include the political context and wealth for the actors. In relation to Mackie and LeJeune's (2009) model, the influence of patriarchy, religion and culture, as well as social capital in terms of the monetary value of the practice, demonstrate that no single factor is likely to be the direct reason for the perpetuation, eradication or innovation of FGM. However, these are all influential and vital factors in planning and organising change.

Slater et al.'s (2000) community readiness model is another one linked to FGM prevention. This model proposes nine stages of community readiness: (i) no awareness, (ii) denial, (iii) vague awareness, (iv) preplanning, (v) Preparation vi) initiation, (vii) stabilisation, (viii) confirmation, and (ix) professionalisation. To apply these stages to an identified community, Slater et al. (2000) suggest methods for assisting in the classification of a community. These include using key informants who are non-specialist community members aware of the issue. The approach includes teaching the theory to community members, enabling them to devise appropriate strategies and policies to move the community through the stages of readiness. It is argued that these 'influential' members of the community may well have the characteristics and motivation to become 'innovators'. Using this community readiness development, strategies have been introduced that enable the movement of communities from one stage to the next, and these approaches have been shared as suggestions with communities who have then developed and adapted them within their context (Edwards et al., 2000).

A similar approach to Edwards et al.'s (2000) model is the REPLACE cyclic framework for social norm transformation (Barrett et al., 2012), which aimed to examine and replace the dominant methods used to tackle FGM in the EU among the Somali and Sudanese community. A study using REPLACE was conducted in the UK, Netherlands, Spain, Portugal, and Italy, using community-based participatory action research (CBPAR) combined with behavioural change theories. This toolkit aimed to empower communities by working with influential people, such as community leaders and peer groups, to question the social norms supporting FGM. The toolkit proposes a process of behaviour change, where the community moves through five cycles, namely:

community engagement, understanding the social norms perpetuating FGM, community readiness to end FGM, intervention development, and evaluation.

The first element of this cycle, community engagement, involves engaging FGM-affected communities to gain their trust in the project, particularly influential people, peer groups and community leaders. These individuals are then motivated to begin challenging the social norms supporting FGM in their communities. Community-based researchers are appointed and trained at this stage (Barrett et al., 2012).

Following this element is the understanding of social norms perpetuating FGM, here the CBPR approach is used to identify belief systems and other mechanisms that preserve FGM in a community and to identify barriers to behaviour change about FGM. The third aspect involves understanding the community's level of readiness to end FGM. Fourth is the intervention development stage, where community-based researchers and community peer group champions suggest appropriate target interventions, the peer groups are then trained and supported to implement the target interventions. Lastly is the evaluation stage, where qualitative and quantitative methods are used pre-and post-intervention implementation, in order to monitor attitude and behaviour change and progress towards social norm transformation.

A qualitative study conducted in Scotland interviewing policymakers, service providers and community representatives (Connelly et al., 2017) state that the REPLACE project was innovative due to its use of measurable behavioural change methods. The Tackling FGM Initiative established in the UK in 2010 used similar approaches and followed a six-year approach to strengthen CBPR. This programme enabled the training of community champions to become paid community facilitators, who then worked with healthcare professionals to run anti-FGM advocacy sessions (Brown, 2013-2016).

A similar initiative was sister circles from the Africa Advocacy Foundation, relying on social networks in creating a sustained dialogue between women in South East London (Khalifa and Brown, 2016). In a study by Connally et al. (2017) participants highlighted the importance of including young people in preventative work. The studies cited above were not clear about the age of their participants. It is therefore essential to understand the impact that culture has on prevention, especially for young people.

The success of any behavioural change interventions is based on context, and the risk factors associated with FGM are not generic. The importance of context is highlighted by work with boys and men, where dominant social contractions of male sexual privilege and masculinity which perpetuate FGM may not be identical, or universally shared within communities, let alone across societies and beyond.

While several of the aforementioned behavioural change approaches have been utilised in the UK, analysing their effectiveness is extremely difficult. Few studies have compared the effectiveness of these community-based approaches against other methods of health promotion linked to FGM. The Replace study aforementioned found that behavioural change approaches should focus on the context of which the practice occurs. Specifically, in the EU, the study highlights the need for holistic approaches that incorporate the intrapersonal and interpersonal aspects located at the individual level (Brown et al., 2013. P.2).

Powell and Yusuf (2018) list the potential reasons for the relative ineffectiveness of interventions to prevent FGM or increase the rate of abandonment as inadequate enforcement of preventative legislative measures, unsatisfactory monitoring and sub-optimal advocacy in communities and perhaps, the most relevant, the lack of theoretical FGM intervention models that consider the collective social norms supporting the practice. Also, these community programmes have not involved second-generation young people who, in my opinion, are key actors towards abandoning the practice.

3.4   Conclusion

This review has provided a critical discussion around the practice of FGM, showing that the phenomenon has attracted more attention in recent years and has been subjected to a political discussion as well as policy-making that bans the practice. Because of immigration, the practice is believed to be present in certain communities in the West. The increased attention on condemning the practice and incorporating legal action against migrant communities has led to the first conviction for FGM in the UK this year.

However, the introduction of and amendments to anti-FGM policy in the West have not been informed by the views of second-generation young people. In this review, I have

argued that an ethnocentric approach has only exacerbated the discrimination and racialisation of the practice in the name of gender equality– indeed, as Karlsen et al. (2019) illustrated in their research, the women as seen as 'suspects'.

The review has found (consistent with Leye (2005) that there is limited evidence of the effectiveness of behavioural change techniques in the prevention of FGM in Africa and Europe and an absence of consensus as to which approach is most relevant (see also Berg and Denison, 2012). Similar findings were evident in a scoping review in Europe conducted by Ballot et al. (2018), highlighting gaps in professional knowledge and community participation as well as any evaluation of interventions. Several pieces of the literature reviewed stress the need for interventions to be targeted at young people (Salam et al., 2016; Ballot et al., 2018; UNICEF, WHO, 2008).

In conclusion, this thesis will address evidence gaps identified in the literature above. Firstly, it explores the perspectives of second-generation young people. Secondly, it addresses the paucity of studies targeted at young people to the best of my knowledge, none of which have worked with young people aged 13-15 years. Lastly, by using a community-based participatory methodology, this study provides a unique opportunity for young people to share their knowledge and views on approaches to prevention and be part of the research process.

The following chapter explores this process fully in respect to my methods and methodological considerations.

Chapter 4 Research Design & Methodology: the CBPR Approach

4.1 Introduction

This chapter introduces, explains and discusses the rationale for the Community Based Participatory Research (CBPR) design and methods used in this study. Firstly, the ontological and epistemological stance of the research are explored and how these informed decisions about methodology and research design. An in-depth discussion and analysis of the CBPR approach are then presented, including an explanation of how this was used within this research. The remainder of the chapter provides a detailed discussion of the research process, beginning with issues of access, research governance and ethics, then recruitment and sampling, data collection, data analysis and issues of quality, rigour and reflexivity.

4.2 Ontology and epistemology

The aim of this research was to examine how young people who live in communities in the UK directly or indirectly affected by FGM, interpret and understand FGM and view approaches aimed at eliminating and preventing its practice. A participatory qualitative methodology was considered to be appropriate as a means to enable the young people who would participate in the research to become actively engaged and sufficiently confident to be able to participate in the research process and voice their views.

Research approaches – or 'paradigms' – are governed by philosophical beliefs and traditions that influence how researchers select their research questions and methods and make ontological, epistemological and methodological decisions about how to execute their research (Morgan 2007; Dures et al. 2011; Denzin and Lincoln 2011). Ontologically, this means determining the nature of the 'reality' or experience one is interested in, and epistemologically this means deciding what form of knowledge should be sought to ascertain this (Lincoln and Guba, 1985). Methodologically, one then determines the approach that will be used to access knowledge about the phenomenon

or experience. Being clear about my ontological and epistemological assumptions was, therefore, crucial in making methodological choices for this research. In this regard, a social constructivist, intepretivist stance was taken, which assumes that access to people's realities, experiences or 'lifeworlds' may be achieved through direct social involvement and communication on the part of the researcher, to create active, reciprocal engagement and to develop shared meanings and interpretations (Myers, 2008). Lincoln and Guba (1994) explain this in terms of the research becoming socially situated within the research setting and able to engage and adapt appropriately to the research environment. The premise is that participants and researchers alike bring their individual unique perspectives and values to the research and operate as social beings (Gadamer, 1975, p.537). In this sense, there is no singular reality or the experience; rather, a range of perspectives and interpretations – of FGM – that may manifest.

This attention to shared experiences as a way of understanding reality was significant in acknowledging the idea that social, cultural and political practices play a role in young people's understanding of the practice of FGM. Young people's subjective and social explanations and interpretations of FGM are shaped by their personal beliefs and experiences, which are formed and influenced by the social context in which they live. As a result, FGM for them is culturally situated and ascribed meaning through people engaging with one another. "FGM" is therefore externalised, objectified and internalised in the social setting (Berger and Luckmann, 1984) through social relationships. FGM is not only defined and internalised socially but also through external 'structural' norms, for example, the law, politics, history and the media. As a result, there is the local, familial and peer socialisation of knowledge, beliefs and values but also the more external knowledge that affects young people's perspectives on FGM.

The issue of 'insider versus outsider' thus became an essential epistemological matter in this project, because the position one holds as a researcher in relation to their participants, impacts directly on the knowledge that is co-created between them (Hayfield and Huxley, 2015; Grbich, 2012). According to Kanuha (2000), insider (emic) research is when researchers conduct research with populations of which they are also members. Therefore, the researcher shares an identity, language and experiential base, with the study participants. Moreover, Manderson et al. (2006) suggest that social

factors such as gender, age, socioeconomic status and ethnicity, need be acknowledged as factors that may influence the data collection, analysis, and findings.

As Manderson et al. articulate, it is important to acknowledge these factors. As a second-generation, 32-year old female, whose parents are both from FGM-practicing communities, I found myself having much in common with the co-researchers and participants. According to Wallerstein et al. (2011), though, the researcher is also an outsider due to several factors such as educational attainment. In relation to this research, I was an outsider due to the age difference and my education attainment, which could convey certain privileges and challenges in terms of power relations.

In an attempt to acknowledge these social factors, I found several advantages of being an insider researcher, such as holding a privileged position when conducting qualitative research; this is particularly evident when the researcher discloses this sameness to participants (Perry et al., 2004). For example, in this research, it was apparent that my disclosure of being 'Somali' was beneficial in gaining access, primarily through gatekeepers, I discuss this on p. 95 of this thesis. This membership role gives researchers a certain amount of legitimacy (Adler and Adler, 1987). The insider role status often enables researchers to gain more rapid and more complete acceptance by their participants. As a result, participants are usually more open with the researchers, so there may be a greater depth to the data gathered. Furthermore, my experiences and knowledge of FGM situated me in a strong position to conduct ethical research, keeping participants and co-researchers at the top of my research agenda (Bridges 2001; Dwyer and Buckle, 2009; Gair, 2012). For instance, this meant working 'with' the co-researchers to design interview schedules, to access and recruit participants, as well as during data collection and analysis.

However, there are also disadvantages and challenges to being an insider, as Watson (1999) and Armstrong (2001) describe. In her research, Watson articulates her inability to recruit people because of her insider status, while Armstrong (2001) raises the critical point that access to the individuals she studied would have probably been problematic, if not impossible if she was not an insider of the group she was researching herself. As I acknowledge these researchers' perspectives, I reflect on my own research experience, concluding that this research would not have been successful if I had not previously built

trust with the community over the years, especially within the three years of the PhD. Thus, 'trust and time', as well as a shared culture (Winters and Patel, 2003) are indeed critical components in gaining accessibility and credibility (Emmel et al., 2007).

As I continued to explore the issue of 'insiderness' in this research, I became aware that, although this status conveyed many benefits, it also held some potential costs, such as the risk of failing to notice the familiar or unique, as well as feeling responsible to one's community (Labaree, 2002), especially to young people. As Asselin (2003) explains, the researcher must be able to research with 'open eyes', assuming that they know nothing about the phenomenon under study because, although the researcher might be part of the culture, he or she might not understand the subculture. However, as an insider, I brought my own history, values, assumptions and perspectives into the research. In fact, according to Braun and Clarke (2013), in qualitative research, our subjectivity can be used as a tool.

Heron and Reason (1997) add that engagement with people through direct social interaction serves to strengthen one's interpretations. In other words, greater credibility is achieved through building strong research relationships, as opposed to operating from a more detached, objective stance. Crotty (1996) argues that 'objectivity' is impossible in qualitative research, and that attempting to achieve impartiality is likely to prevent empathetic relationships forming. Therefore, subjectivity awareness is more beneficial. As such, reflexivity was crucial throughout this research process and required me to consider my position in relation to the research.

Reflexivity in a research context refers to the process of critical reflection on the knowledge we produce, and our roles in producing that knowledge. Wilkinson (1988, cited in Braun and Clarke, 2013) distinguish between two forms of reflexivity: functional and personal. Functional reflexivity refers to the critical attention to how the researcher choice of research tools may have influenced the research. For example, the stories young people told about FGM may have been influenced by a selection of participatory tools used.

Personal reflexivity refers to the process by which the researcher acknowledges who they are as researchers in other words, how their background and assumptions can shape the knowledge being produced. In Chapter 7, I explore this further by reflecting

on my cultural history, thoughts, actions and emotions and how these factors influenced the research process and findings.

4.3   Historical and philosophical underpinnings

There are several interpretations of the origins and history of collaborative, participatory research approaches (Brydon-Miller et al., 2003; Bradbury, 2015; Fals-Borda, 2006; Hall, 2005; McTaggart et al., 1998; Park, 2006; Kemmis et al., 2013; Kindon et al., 2007; Israel et al., 2005; Wallerstein and Duran, 2008).

CBPR, as an interpretavist participatory methodology, also seeks to give voice and power to research participants. Young people are therefore situated within a broader theoretical remit of emancipatory knowledge. Epistemological contributions by theorists, such as Habermas's (1984) theory of communicative action and Freire's (1996) concept of critical consciousness have significantly influenced my philosophical position. This view acknowledges that learning is constructed by cultural differences and by the context in which it takes place (Freire, 1996).

Wallerstain and Duran (2008) have located the historical and theoretical roots of action and participatory approaches to research in two distinct traditions that occupy opposite ends of a theoretical and political continuum. The 'northern tradition' describes a pragmatic, problem-solving, utilitarian approach, exemplified by the Action Research of Kurt Lewin (1946). Lewin asserted that action research provided a means to overcome social inequalities. He argued that, for evidence to be relevant, researchers must engage in the process of active and participatory data collection about problems and interventions (Minkler, 2000; Wallerstain and Duran, 2008; Lewin, 1946). Lewin (1946) rejected the notion that, for researchers to be objective, they needed to move out of the community of interest and instead seek to involve community members in the research process (Wallerstein and Duran, 2006), thus repositioning them as 'participants' rather than subjects or objects under investigation. He envisaged the action research process as a methodology that primarily sought to engage participants (or the 'community') via a spiral or circular process of planning, action and achieving results (Lewin, 1946, pp.34-35; Wallerstein and Duran, 2008). Bray et al. (2000) criticised Lewin's model of action research, stating that, although a change might be identified by

a collaborative process of reflection and action to solve an identified problem, in practice the process can be manipulated by those in power, who dominate the decision making. This means that researchers may not engage in the power-sharing process but, instead, dominate the project.

In contrast, Wallerstain and Duran (2008) describe the 'southern tradition' as a more explicitly emancipatory approach that emerged as a challenge to traditional 'top-down' neo-colonialist approaches that were seen as taking power from or exploiting communities. It arose in the 1970s in Latin America, Asia and Africa, mainly in response to the work of Paulo Freire (1970) and Fals Borda (2006). Freire was a critic of authoritarian paradigms in which education was unidirectional, objective and decontextualised, creating a 'culture of silence' in which those without power lost the means to critically respond to the dominant culture that was 'forced' upon them (Wallerstein and Duran, 2008).

Freire's influential method of popular – or critical – education (Freire, 1996; Fals-Borda, 1991) centred on the analysis of personal lives concerning the structures that might control them. His goal was not only to produce knowledge but also to engage in the process of liberation that would result in a critical consciousness – that is, the capacity to perceive social, political and economic oppression and take action against it. This would lead to oppressed people gaining power and awareness and thus being able to transform their environment by their own praxis (Freire, 1996; Ferreira and Gendron, 2011; Fals-Borda and Rahman, 1991).

Both the northern (Lewin, 1946) and southern traditions (Freire, 1996; Fals Borda, 1991) challenged the concept of the objectivity of science. Each approach used its particular lens to explore ways in which power differences may influence the research process. These methods called for research that is collective, contextualised and humanly compelling, by the involvement and collaboration between community members and researchers in the exploration of issues affecting the community (Kemmis and Smith, 2008).

While Freire (1970) worked with marginalised groups and communities using methods such as participatory education, art and consciousness building, his goal was for action and social transformation that was rooted in practical responses to real-life problems.

He argued that dialogue and discussion were vital in attempting to develop this critical consciousness. Lewin (1946) attempted to understand the role of attitudes and stereotypes, as well as the influences that social class, politics, and economics had on behaviour, asserting that, this would result in changing social behaviour in industry and resolving workplace issues.

When considering how to employ CBPR in this research, I engaged with the debates outlined above. I was predominantly interested in the distinctions between collaborative knowledge generation and taking action to bring about social change, so the following exert from Freire (1970) appears fitting in this thesis:

> "The starting point… must be the present, existential, concrete situation, reflecting the aspirations of the people…[we] Must post this… to the people as a problem which challenges them and requires a response, not just at an intellectual level, but at a level of action" (Freire, 1970, p.75).

Therefore, any research topic should be culturally informed and appropriate to the target population; in this way, the research process aims to promote communities' respect for the research and, thus, increases their likelihood of engagement and participation.

These commentators' endorsement of equitable and emancipatory approaches to knowledge creation informed my view that research should engage in both theory and action and that those whose life experiences are the focus of the study are, indeed, the experts on the subject under scrutiny.

4.4 Community-Based Participatory Research (CBPR)

Based on the philosophy of participatory research discussed above, a range of methodological approaches have emerged, receiving much recognition for their ability to support more equitable and emancipatory engagements between academics and communities (Borg et al., 2012). For example, Kemmis and McTaggart (2013) identified the use of 'classroom action and critical action research in education', while Israel et al. (1998) and Parker (2008) have used the terms 'community-based participation', 'community involvement', 'community collaboration' and 'community-centred

research', to describe public health research. In this thesis, the term 'participatory research', using lower case letters, indicates an overarching term to discuss the range of methodologies of which community-based participatory research (CBPR) is one.

According to Israel et al. (1998), CBPR is a collaborative approach to research that seeks to involve and engage participants and stakeholders in all aspects of the research process; thus all partners contribute their expertise and share responsibility for, and ownership of, the research. The goal is to enhance the knowledge of a given issue by collaborating with those affected by it and integrating the knowledge gained from them with action to improve the health of community members (Israel et al., 1998; Minkler and Wallerstein, 2003).

There are, however, noteworthy differences in the scope and level of engagement utilised in research implementing a collaborative approach. The variance is evident across the disciplines; ranging from tokenistic engagements with research participants to emancipatory forms of collaboration. Israel et al. (2013. Pg. 6) adds that, despite the different terms applied to participatory research, each one with its specific emphasis, the principal aim of them all is a commitment to carrying out research that involves and shares, to *some degree* (emphasis added) power with stakeholders and participants. I highlight the use of 'some degree', as it highlights the idea that participatory research may vary from minimal engagement through to co-constructed research design, data gathering, analysis and reporting. Therefore, I argue that the weaknesses associated with a participatory methodology can be in its implementation, rather than the theory that underpins it. The inherent lack of a universal or generic formula for undertaking collaborative research leaves it open to subjective interpretation and even manipulation. As a result, engaging with and contributing to the methodological debate around its application with young people, specifically on the concept of participation, is an integral part of my research process.

4.4.1 The case for participation

As I familiarised myself with both the theoretical literature and implementation of collaborative approaches in research studies, it became apparent that, while distinctions

between different methods seemed clear in theory, in practice the boundaries appeared much less defined. This being said, there is a clear division between prioritising collaborative research to flatten out power relations, and research which supports knowledge generation where 'participation' is an essential element. Cornwall and Jewkes (1995) suggest two different levels of participation: 'shallow participation', where researchers control the entire process, and 'deep participation', where there is a movement towards relinquishing the control and developing ownership of the process to those it concerns.

Therefore, why is this concept of participation assumed to be universal, despite its multiple implications? Every project with a participatory element has its own unique dynamic, which is contingent on contextual factors such as the social, political, economic and cultural climate in which it operates (Hickey and Mohan, 2004). Though the term 'participation' is used in CBPR, the meaning given to the word can differ significantly in how researchers interpret and use it within their projects. As such, Birch and Miller (2002) claim that participation embodies specific principles of co-production between the researchers and the researched, that should be applied to form a 'good,' 'honest' and reciprocal relationship. Therefore, they recommend that researchers must question where the power lies, whether all research involves participation, and what constitutes participatory research within their projects (see also Bopp, 1994; Gaventa and Cornwall, 2008; Cornwall and Jewkes, 1995). Yet, dealing with the specifics of 'how', 'what' and 'for whom' remains an ongoing challenge which is inherent to working out participation in practical terms.

The use of CBPR in this study aimed to facilitate a collaborative inquiry, handing over a significant level of leadership to the co-researchers, although this was not always possible, these practicalities are discussed in depth in Chapter 5. The iterative emergent process of inquiry was intended to facilitate the creation of knowledge, as well as build the capacity of the co-researchers through a collaborative, democratic process that was designed to enable young people to become co-researchers (Chapter 5). Additionally, the research design intended to enable young people to empower themselves through the knowledge they created, such an approach implies that power of the researcher is challenged, and the young people begin to develop their new awareness of their reality and to act for themselves (Selener, 1997 cited in Gaventa and Cornwall, 2006).

Additionally, Boyden and Ennew (1997; see also Hart, 1997) add that the participatory nature of CBPR creates a potential source of empowerment for young people, by enabling fuller participation in decision making on matters which affect them.

To this end, CBPR relies heavily on openness and transparency that might not be required in traditional approaches. These conditions are made possible by developing a closeness between researcher and co-researchers that is built on mutual trust and respect. Bergold and Thomas (2012) assert the need for researchers to ascertain which activities co-researchers should or can participate in and whether different groups should have different levels of participation. Although I agree with Bergold and Thomas (2012), I stress the need for dialogue with co-researchers to ascertain 'their' ideal level of involvement. Accordingly, various typologies of participation have been developed that offer a range of stages and criteria with which to assess the extent of the participation, which I will discuss now.

Arnstein's ladder of participation (1969) is discussed first. The model has 8 rungs, which range from the manipulation of a community by a researcher or agency to the point of citizen control, whereby the community takes full control and ownership of local resources. Cornwall (2008) points out that this view assumes that full ownership is the most successful form of participatory work, not acknowledging that co-ownership might work as well. White (1996) argues that participation as a process, where the interests and expectations of all participants are identified, and participation holds different forms enacted to varying extents throughout the research period. Cornwall (2008) argues that there is a need to think about how different acts of participation are potentially of equal value. This moves the participation debate away from a discourse based on 'more is better' to a more fluid approach, where participation is context-specific.

Therefore, rather than the idea that full ownership is best and that any knowledge produced without it will be of 'lower quality' or irrelevant, it is important to acknowledge the context of the research (Bergold and Thomas, 2012). For example, the constraints of using CBPR within a PhD, such as time restrictions due to deadlines, may reduce the significance of participant agency in shaping and the research agenda and how sense-making process is defined. Wallerstein et al. (2011) explore this well,

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asserting that, for a researcher's collaboration with communities to bring about change, there is a need to acknowledge that the process is fluid, dynamic and at times slow-paced and, therefore, it requires a long-term commitment. They argue that merely 'planning and then executing the plan' is too simplistic, that researchers must be open to change, improvement and alterations due to unexpected obstacles, for example, delays in recruitment. A discussion exploring this idea with reference to working with young people, which argues that the concept of participation is context-specific and should have a level of flexibility; and not rely on the 'one typology fits all' approach, is provided in the 'research process' section of this chapter – see section 4.5.

4.4.2   Emancipation and voice

'*Participation*' (emphasis added), is one of the guiding principles of the United Nations Convention on the Rights of the Child (UN General Assembly, 1989, p.7). Article 12 of the Convention states that children have the right to participate in decision-making processes that may be relevant to their lives and to influence decisions taken in their regard, including decisions made within the private and public spheres. Furthermore, the UN's Sustainable Development Goals, specifically, Goal 17: Target 5.2 and 5.2.2, aim to eliminate forms of violence against women and girls and to reduce the proportion of girls under 15 subjected to sexual abuse (UNHCR, 2017). Additionally, the guiding principles of the Universal Declaration of Human Rights (UN General Assembly, 1948) highlight the need to empower vulnerable members of communities.

These declarations and conventions, therefore, acknowledge that young people are social players (James and Prout, 1997) who have the right to hold opinions and to assume responsibility for their actions (Kirk, 2007). However, the Convention on the Rights of the Child (UN General Assembly, 1989) does not define competence in line with age-related skills of development. Instead, it accords the same rights to all children and young people and emphasises the obligations of adults to create contexts in which these rights can be enacted. Such a view recognises that competencies evolve and may differ according to the context in which the rights are adopted, further acknowledging that participation is, indeed, context-specific.

Young people are becoming increasingly involved in participatory research, mainly research geared towards those viewed as vulnerable or marginalised (Lundy et al., 2011; Berge et al., 2009; Jull et al., 2017; Kirk, 2007). This includes research that has sought to 'empower' young people, not only by including their 'voices' as experts on their own lives (see Alderson, 1995) but by involving them in the research process itself. For example, a participatory approach may be used in study design, in data collection, such as peer interviewing (Young and Barrett 2001; Kirby et al., 2003; Percy-Smith and Thomas, 2010), or dissemination of findings (Hart, 1992; Blerk and Ansell, 2007). Despite the widespread usage of the term participation though, there remains a considerable lack of clarity about what is meant by participation in the context of young people, specifically those who are marginalised. Jacquez et al. (2012) reaffirm the need to involve young people in research, claiming that research conducted with young people is more likely to be disseminated and accepted by young people.

The knowledge gained from CBPR research is, therefore culturally relevant and connected to young people lived experiences. Consequently, it is more likely to be translated into action than knowledge generated purely from academic theory or outsider perspectives. Davis (2007) lists the perceived benefits of participative projects as: helping young people develop self-worth, feelings of empowerment and a sense of social justice, and also having a protective factor, arguing that, when children are given a voice, they are less likely to experience abuse, as their involvement contributes to improving services (Cossar et al., 2011). However, how best to involve young people practically in research is often contested (Lansdown, 2006; Shaw et al., 2011).

With this in mind, Kirby and Woodhead (2003, p.236) have argued that, for children to experience empowerment through research, they must be considered active participants. In their view, this is:

> "About children's activity and agency being recognised; about children being treated with dignity and respect; about them being entitled to express their feelings, beliefs, and ideas; about being listened to and about their voices being heard. It is about children being consulted on matters that affect them and being given adequate information to be able to form an opinion. It is also about children making choices and influencing decisions, contributing to the understanding and solutions of social issues."

Although the number of CBPR studies with young people has increased, it can be challenging to determine the point to which studies described as 'participatory' actually fully involve young people as research partners (Malone and Hartung, 2010). There are several 'how-to' guides and toolkits on participatory research, and a wide range of models that suggest how to effectively involve young people in research (UNICEF, 2017; Save the Children, 2004; Shaw et al., 2011; INVOLVE, 2016; Kirby, 2003). Nevertheless, these remain fewer and less well developed than those designed for use with adults (Hawke et al., 2018). Consequently, most approaches used to inform participatory research with young people have emerged out of participatory research undertaken with adults. For example, Hart's ladder of participation (1992) has been adapted from Arnstein's ladder of citizen participation (1969). This lack of clear guidance for carrying out participatory research with young people presents challenges when undertaking research on sensitive topics or with particularly vulnerable young people (Wong and Zimmerman, 2010; Mason and Hood, 2011; Shamrova and Cummings, 2017).

4.4.3 Models of participation

According to Wong and Zimmerman (2010), participatory approaches must build on young people's strengths and should aim to engage young people in issues that they have identified. While it may indeed be appropriate for the level and nature of participation to be determined by the circumstances of the young people involved, many professionals, who have a commitment to engaging with young people, often find it challenging to translate this into practice (Calder, 1995), particularly when it means relinquishing power and status.

Consequently, initiatives put in place to involve young people as decision-makers, such as youth forums and school councils, have so far provided opportunities for children to practice good citizenship, rather than facilitating active collaboration (Crowley, 2015; Jacquez et al., 2012). For example, agreeing how the shared goal of young participation can be achieved, is often overlooked, as many adults see young people's contribution as a minor one rather than as a deeper pool of resource.

Furthermore, Cairns (2006) suggests that these initiatives all fall within the model of representative democracy (working with small groups of children to represent the broader population), rather than participative democracy (creating opportunities for young people to be participants on their behalf). While such initiatives can be useful for young people to influence decision making, they are mostly about adult-led and context-specific participation, rather than supporting young people's individual and collective self-empowerment in ways which would challenge adult-child power relations (Davis 2009; Mason and Hood, 2011).

To this end, young people's participation can be attached to different agendas and in diverse ways. White (2002) explores three models that explain these power relations. The first views the child as pre-social, one that requires strict discipline; here, power rests with an adult and is best understood as control. The second appreciates the child as innocent and pure; therefore, one that requires protection from the external world, again power lies with an adult, but perhaps a gentler assertion of protection and nurturing. The third, essentially neo-liberal, view emphasises adult training that will enable the child to develop their natural abilities, encouraging voice, choice and participation as a framework.

Nevertheless, while power inequalities in adult-child relationships may always be present in some way, actively involving young people in the research process as participants or co-researchers offers a way of shifting power. Pascal and Bertram (2009) advise caution on the challenges of creating symmetrical dialogues, such as avoiding adults taking 'control' of what is being voiced, documenting what is being said accurately, as well as challenges in interpreting another's voice. I argue that a more effective participatory way is to view the young person as a subculture, one with distinctive meanings, which require comprehension in their own terms. By subculture here, I mean social words that are created and experienced by young people.

Drawing on Arnstein's model of citizen participation (1979), Hart's ladder of participation (1992) is regarded as the most influential framework for assessing how genuinely young people are involved in projects (Malone and Hartung, 2010). Arnstein's model positioned citizen participation in relation to power, arguing that engagement cannot be had without the re-distribution of power. Hart (1992) adopted the continued

'8-rung' metaphor of the ladder, with the 8 rungs depicting differing degrees of participation: from manipulation, decoration, and tokenism to youth informed, assigned but informed, consulted and informed, genuine partnership, child-initiated and directed and child-initiated, shared decisions with adults (Hart, 1992. p.9-14).

Although this model provides the foundations for participation, highlighting the need for the researcher to consider power relations, it has been criticised for being too linear, with an emphasis placed on the single dimension of power rather than acknowledging the complexity of participation, such as the challenges discussed previously in this section (Treseader, 1997; Willow, 1997; Tritter and McCallum, 2006). It is also important to ascertain that the very notion of 'participation' may be interpreted differently by participants and, where this is the case, this needs to be worked into the research design. Several studies have also shown that young people recognise the limits of their autonomy and accept their need for guidance and support from researchers (Morrow, 1999).

4.4.4 Participatory methods in FGM research

Models of participation are useful as they assist researchers in aligning themselves and their research with a participatory agenda, and they aid in locating research at some point of the continuum. However, Porter et al. (2010) allude to the novelty of youth involvement and how researchers may interpret participation in a way that is exploitative rather than collaborative. Furthermore, researchers are often not transparent about the whole research process. One such example is Participatory Ethnography Evaluation Research (PEER) developed by O'Brien et al. (2016), which utilised participatory approaches in a project with FGM-affected communities in Scotland. The project aimed to facilitate engagement with women, men and young people, as well as religious figures, to enable their voices to be heard. Although claiming to have involved participants, their research lacked transparency regarding the level of participation, so, the claim of enabling 'voices to be heard' is debatable, without any clear and transparent discussion of the process. Aldridge (2016) states that projects claiming to have used participatory approaches must locate themselves at a point somewhere on the participatory ladder or within a recognised framework or model.

Gallagher and Gallagher (2008) note that participatory research with children is often labelled as empowering, while managed by scholars, involving children, therefore risking being highly passive rather than an active, engaging process. An example of this is a study conducted with the Bondo community in Sierra Leone by FORWARD (2016), which involved young women in designing and carrying out interviews with their peers and claimed to be participatory. The project recruited three peer supervisors aged between 18 and 21 from three girls' clubs in Waterloo, Brookfield and Grey Bush, Freetown. The supervisors then recruited a further nine girls aged 15-18, who were members of the Girl2Girl (G2G) club as peer researchers. Like O'Brien's PEER project (2016), this project claimed to have trained the peer researchers to conduct in-depth interviews with different members of their social groups. However, the process and length of the training were not transparent. Wattar et al. (2012) observe that detailing the duration of training and involvement in a participatory project is essential and thus distinguishes studies from being either tokenistic or fully participatory, further exemplifying the challenges often faced by researchers in providing accounts of the process of participation.

Additionally, Cornwall (2006) argues that, although dialogue through invitation is a necessary step towards participation, it is not sufficient to ensure participation. Much depends on how people take up and make use of what is on offer, as well as on the supportive processes that can help build capacity, cultivate voices and enable people to empower themselves. An example of this is illustrated by a study by Johnson et al. (2009) with Somali migrant women of their experiences of the United States healthcare system. They asserted that the Somali women involved in the research were 'empowered and found a voice'. Arguably, however, empowerment is an ongoing process that requires an evaluation from the perspectives of participants and co-researchers, as well as the researchers, and it is unclear if this was attempted in the study.

4.4.5   Limits to participation

While the nature of participatory research encourages the researcher to carry out a collaborative project, it is crucial to recognise the risks and limitations associated with this approach. Spyrou (2001, p.155) argued, in reflecting on his participatory research on Greek-Cypriot children's construction of national identities, that voices of young

people are context-specific. For example, children in schools are often encouraged to provide the 'correct answers', whereas this may differ if research is conducted in a child-controlled neighbourhood playground. Research conducted in external settings provides flexibility for young people to draw upon alternative discourses, which may be undermined if conducted exclusively within a school setting. Furthermore, it can become exploitative if researchers are solely concerned with extracting academic knowledge from participants, rather than prioritising participants' involvement, engagement and full agency within the research process.

By working in collaboration with the co-researchers and engaging in the constant reflexive practice, my research aimed to reduce the risk of becoming preoccupied with academic deliverables. Engaging co-researchers in the research process encouraged me to continually return to question how this research was contributing to existing knowledge on FGM concerning young people in the UK. I also felt that it was important to disseminate the findings on platforms advocated by the co-researchers and to use language that would be accessible to young people.

This critical exploration of participatory typologies in adults and children shows that there is a need to focus on practical issues that are often entangled within the term participation, in other words, the 'messiness' of co-production. These practical issues are often not clearly articulated in 'how-to' guides, such as the lack of adequate resources and its potential impact upon the level of participation. While they play a significant role in participation, resources such as time, finance and those of a physical nature such as equipment or meeting spaces are not considered in the typologies. Therefore, it is vital to examine how 'meaningful participation' can be achieved with different participants and in different contexts, so this needs to be worked into research design, providing a level of flexibility to researchers.

This leads me to mention two significant points of omission within the context of health promotion participatory initiatives. First, if participation is important in all aspects of the research process, then the guidelines should (but do not currently) include contextual factors that influence partnerships, for instance, economic, social and cultural determinants. Second, the need to be flexible and responsive to changes in circumstances as the research evolves is perhaps implicit but needs to be made overt,

in other words specifying how the researcher should respond to challenges in practice. These are two crucial aspects that I believe require acknowledging in 'how-to guides', especially for researchers working in sensitive areas who are seeking to reach the 'gold standard' of participation, otherwise the sense of activity and dynamism of the term 'participatory' might be lost.

Nonetheless, some consideration of models of participation is essential, as it highlights the need to examine the nature of involvement within a research project, as well as providing the foundation for evaluating aspects of participation in the study. Adding to this, clarifying the level of participation within a research project also lends greater clarity and rigour in participatory projects (Aldridge, 2016). York (2005) notes that, generally, the level of participation varies depending on the decisions involved and the capacity, as well as choices, of the young person. Thus, should be viewed as a process rather than an isolated activity.

Therefore, it is important to recognise the complexity of collaborating with young people and to accept that it is a slow process due to several factors, for this study, mainly the nature of the research topic. Engaging young people in discussions about female genital mutilation is often challenging and slow but significant. Hawke et al. (2018) agree, asserting that some researchers might struggle to engage youth in a meaningful way; however, by providing genuine opportunities for them to express their views, this process can be made more accessible. I considered CBPR appropriate for the aims of this study because the methodology is often used to give voice to marginalised and oppressed groups, to empower them to solve their problems and to develop themselves and their communities (Cornwall and Jewkes, 1995; Freire, 1970).

To add, according to Israel et al. (2008), there is no single principle that applies to all participatory researchers. Having engaged with a range of research philosophies, I identified four main principles that underpin my research position:

- Research should be mutually beneficial to young people and academic researchers.

- Knowledge should be co-constructed by the researcher and those with lived experiences of the phenomenon under study (young people).

- The phenomenon under study is influenced by a broader historical, social, cultural and political context and cannot be separated from this.

- The project should provide young people with genuine opportunities to participate, linked to a clear purpose for both the co-researchers and researcher.

These principles significantly influenced the decisions I made in constructing and developing this study, informing how the empirical work was carried out and ensuring that research progression aligned with the underlying principles and philosophical position. In addition to guiding the research, these principles helped me to identify how I wanted to develop my research capacities and what underlying values informed these choices. One example involved improving my facilitation skills (I completed a group facilitation course), which played a vital role in increasing my awareness and enabling me to create space for meaningful participation during this research.   Therefore, I concluded that I wished to take a CBPR approach and that any research topic should be culturally informed and appropriate to the target population; in this way, the research process aims to promote communities' respect for the research and, thus, increases their likelihood of engagement and participation.

The next section of this chapter describes the methods used, the research settings, and research process, and includes, access, sampling approach, issues on quality and rigour, methods and practices of data collection used, and reflects on my experiences of undertaking this research with young people.

4.5   Research process

The main question I reflected on here was, how can I effectively engage young people in this research process? Following a review of the literature on participation, I found there was a lack of clarity between the different participatory approaches and how they should be employed. This section provides a detailed account of the research methods beginning with a discussion of initial access to the 'field' via gatekeepers, stakeholders and ethical and governance protocols, then discussing participant access, recruitment

and sampling, data collection, data management and analysis and techniques of quality and rigour. Chapter 5 presents the co-researcher learning process, along with the analysis of the training. Chapter 6 outlines the findings of the two phases of the research – the training phase and the research phase.
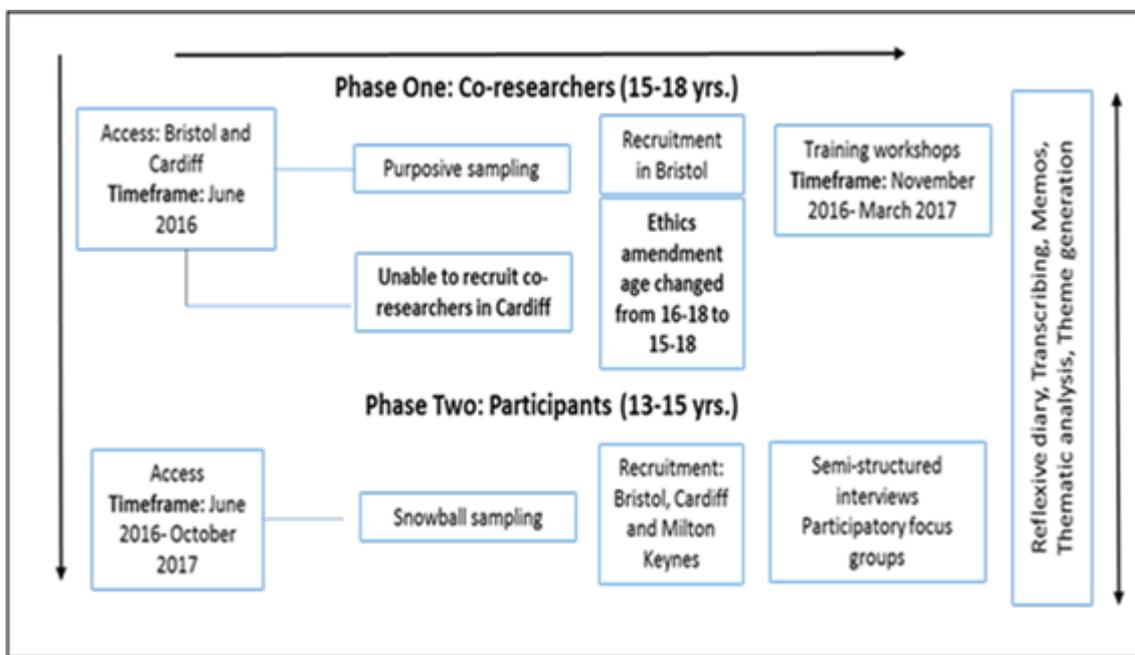
Figure 4:1: The research process.

Phase One involved recruiting, gaining consent, and training the co-researchers, as well as developing the CBPR methods. Initially, I had aimed to recruit and train ten co-researchers in Bristol, who would then train ten of their peers in Cardiff to become co-researchers. However, due to restrictions with gatekeepers in Cardiff and the timeframe, this was not possible. Therefore, Phase One recruited and trained nine co-researchers in Bristol. The co-researchers had also consented as participants, taking on a dual role as both co-researchers and research subjects, in effect researching themselves and their peers.

Initially, Phase Two was planned to comprise identifying and recruiting ten participants in Bristol and ten in Cardiff, using snowball sampling. However, due to limitations in Cardiff, a decision was made to add a third place, Milton Keynes. As a result, eleven were recruited in Bristol, five in Cardiff and three in Milton Keynes. Following this successful

recruitment, interviews and focus groups were facilitated by the co-researchers and myself in Bristol and Milton Keynes. Due to restrictions discussed later in this section, I completed the focus groups and interviews in Cardiff. Thus, this thesis provides an empirical study of 20 semi-structured interviews in Cardiff, Bristol and Milton Keynes, two focus groups, in Cardiff and Bristol, and ten workshops in Bristol. Figure 4.1 illustrates the research phases.

4.5.1 Research settings

This section provides a brief contextual backdrop around the three research sites, estimates of the extent of FGM practice, as well as current structures and activities of groups campaigning against FGM. This provides the rationale for my choice of the three locations included in this research. While I acknowledge that all cities and settlements are different, as a product of their unique environmental, social, cultural, political and economic factors, this section intends to outline the general situation in the three places studied: Bristol, Cardiff and Milton Keynes.

Bristol is located in the southwest and is the sixth-largest city in England, with a population of 454,200 people. According to the Local Authority's equality data, Bristol's community is diverse, with over 45 religions and at least 187 countries of birth represented, and more than 91 main languages spoken by its residents (Bristol City Council, 2018). The Bristol City Council population census conducted in 2011 shows that the Somali community is the second-largest immigrant population in Bristol. Four thousand nine hundred forty-seven residents were born in Somalia, making it the fourth-largest Somali-born community in all local authorities, after Birmingham (7,765), Brent (6,855) and Ealing (6,468). The census also shows that 55% to 80% of the Black Asian and Minority Ethnic (BAME) population in Bristol reside in Lawrence Hill and St Pauls.

During 2017-18, there were 200 newly-recorded cases of FGM in Bristol (Bristol City Council, 2018). The data presents the prevalence of FGM amongst girls and women, who may have undergone the practice at some point in their lives. Organisations tackling the practice of FGM include Refugee Women of Bristol (RWOB), who mainly work within a community engagement agenda, and Integrate Bristol, which aims to empower young people to participate equally on the FGM agenda (Integrate UK, 2019).In addition to this, Bristol is known as a success story, with the involvement of several agencies working together to tackle FGM, including health, police, education and community organisations. The Bristol model includes establishing an FGM safeguarding and delivery group, which works to coordinate and support community engagement.

Cardiff is the tenth-largest city in the UK, whose population has increased by 8,800 in the past five years. Historically, port workers from the then British colony of Somaliland first settled in Cardiff and Bristol a century ago, which explains why Cardiff has the most inhabitants of Somali-lineage in the UK. According to the 2011 census, Whites are the dominant ethnic group in Cardiff with 84.7 per cent of the population. Other groups include Blacks (2.4 per cent), Asians (8 per cent), Arabs (0.6 per cent), and Mixed (2.9 per cent). According to Macfarlane (2015), Cardiff has one of the highest number of people from FGM-affected communities in the UK, specifically those of Somali heritage. In 2017, 600 women were said to have been survivors of FGM in Wales and, between 2017 and 2018, there were 271 newly-reported cases of FGM in Cardiff (Public Health Wales, 2018), this data presents reports of existing cases. The Black Association of Women Step out (BAWSO), and Hayaat are the key organisations in Cardiff working within communities to address the issue of FGM. BAWSO focuses on areas such as positive parenting and challenging traditional paradigms within the communities.

Milton Keynes formally recognised as a town in 1967 and now has a population of about 230,000, of which ethnic minorities constitute around 6%. Data from Milton Keynes Council (2015) states that 13,100 residents classified themselves as Black Africans. Additionally, a school census (Milton Keynes Council, 2015), identified 342 Black Somali girls and 1,158 girls from Ghana, Congo, and Nigeria. Milton Keynes' children's safeguarding board added FGM to their agenda in 2015, where it has remained. It has since published information aimed at young people, which attempts to change attitudes and perceptions in the immigrant communities that may lead to reporting perpetrators. It has also formulated a joint strategy between Milton Keynes Council and Thames Valley Police, which has piloted a community-led project, 'Be Bold' that promotes a zero-tolerance policy towards FGM in immigrant communities.

The rationale for the choice of cites is twofold. Firstly, according to Macfarlane and Dorkenoo (2015), London holds the highest prevalence of women from FGM practicing communities, though the rates of the individual local authorities vary, with Cardiff, Bristol and Milton Keynes cited as cities with high prevalence. Secondly, having formed relationships with organisations in Bristol that worked with women from FGM-practicing communities and acknowledging the secretive nature of the practice, a

decision was made to utilise the links I had already formed in Bristol to recruit young people. This pragmatic approach was necessary due to the time constraints of conducting a PhD. Cardiff was chosen due to the presence of large communities from FGM affected communities, as well its proximity in relation to Bristol. Milton Keynes was added after difficulties in recruiting that arose in Cardiff. I had already formed relationships in Milton Keynes, which enabled me to recruit without further delay.

However, having recruited from communities that had prior knowledge or were activist against the practice, the data produced would have been homogenous. It was therefore essential that the research elicit multiple perspectives (i.e. men and women as well as different social roles). Therefore, to seek and document multiple viewpoints, this research recruited young girls and boys from three different locations, with the view of triangulating the data collected, to enhance rigour. Though it is acknowledged that the sample selected may not have represented every voice or social group within the communities. For example, it is recognised that parents may have consented to their child participating due to their roles as community advocates against the practice and therefore a lesser chance for their child to have been subjected to FGM. Though not all young people recruited had been exposed to these narratives, as their parents were not involved in campaigning. Furthermore, I was known as an FGM campaigner, and my insider status may have had an impact on whom I recruited.

The next section describes both of the stages in this research design in a sequential timeframe, thereby highlighting a step-by-step procedure that aimed to ensure reliability, replicability and trustworthiness. The first part discusses Phase One, covering accessing and recruiting co-researchers in Bristol and Cardiff, followed by Phase Two. A description of the sampling methods utilised in this research ensues.

4.6   Ethical and governance protocols

This section examines the ethical challenges that occurred in this research, acknowledging the particular challenges that are inherent in a participatory research approach. To begin with, I should acknowledge that this research was given full ethical approval by the University of the West of England, following Faculty Research Ethics Sub-

Committee (FRESC) procedures before I began my fieldwork (reference: HAS.16.07.176. Appendix B). I have also abided by the Economic and Social Research Council procedures (ESRC, 2015).

Along with these general ethical procedures, Morrow (2009) notes that researchers should consider other provisions that may affect the child-adult researcher. Firstly, a young person's perceptions and frameworks of reference may differ to the adult researcher's due to a range of social differences, including but not limited to gender, race, age, culture and personal characteristics (Morrow, 2009, p.52). Secondly, children are vulnerable and may be at risk of exploitation when interacting with adult researchers, and third, the apparent child-adult power relationship at the point of interaction, as well as during the presentation of findings needs to be considered. I acknowledge the complexities of researching with vulnerable populations, similar to other researchers (Bonevski, 2014; Emmel et al., 2007). I reflect on my position as a woman from an ethnic minority carrying out the research within my own community, the challenges I encountered, and how they were handled.

The sensitive nature of my research topic, coupled with the involvement of young people in the research process, did indeed generate specific ethical challenges. Therefore, as a researcher, it was important that I engaged in an ongoing reflective process with the co-researchers. This included discussions around: confidentiality, power imbalances, safeguarding which links to the obligation of 'do no harm', while respecting young people's rights (see also Gillemim and Gillam (2004). The Ethical Research Involving Children guidance (ERIC, Graham et al., 2013), states that:

> "Researchers are required to take contexts of children's lives, their experiences and competencies into account in ensuring that children are afforded opportunities for decision making and respect in the exercise of their rights while being protected in accordance with their age and still evolving capabilities" (p.7).

Due to these ongoing processes, researchers should not only consider these when beginning to engage with the research process but at specific points before, during and after the research (Bell, 2008). I adhered to such an ongoing process driving ethical engagement by collaborating with the young people in my study at all stages of the research process.

A risk assessment of the location, times and access, as well as threats that might be posed to co-researchers and myself as the researcher was conducted prior to commencing the fieldwork. In addition to this, along with the supervisory team, I developed 'actions on', various possible scenarios, which allowed me to respond quickly and safely to potential risks (Kindon et al., 2007). Safety issues were also reviewed regularly throughout the project. This is important in CBPR research because new questions, themes, tools and approaches arise during the research which may not have been accounted for in the initial risk assessment.

4.6.1 Confidentiality

The issue of confidentiality was, and remains, an important one in this research. The participants, having dual roles as community members and co-researchers, may have come across information not generally accessible to the public during this study, specifically through focus groups and interviews. This issue was addressed by discussing the principles of confidentiality with all participants and co-researchers, as well as what this meant within the context of the research.

Also, to ensure privacy, all co-researchers and participants were encouraged to choose a pseudonym, which was used in all cases referring to the research. It was also made clear to all participants from the outset that there were limitations in being able to guarantee full confidentiality; for instance, if a safeguarding concern arose, I would have to follow safeguarding procedures. Still, the participants were informed that their responses would be confidential and that the results would be presented in such a way that they would not identify them (see also Flicker and Guta, 2008).

Ethical matters were discussed initially informally, and later on, more formally with the co-researchers and participants in this project. This covered issues of anonymity and confidentiality as well as mutual expectations of what participation in the research would entail (see Chapter 5). This period was crucial and aided in the development of trust and shaping research relationships with young people. For example, when discussing the research with parents, it was essential to take into consideration culturally-specific ethical practices that they may have expected or assumed (McEwan, 2005).

Parents were provided with information sheets (Appendix C) and, after a 'cooling-off' period of two weeks, I followed up with to gain consent and assent from the young people who had expressed an interest in taking part. This was a more formal process where I discussed the research process again, reviewed the main ethical concepts and distributed the ethical documents (consent forms, see Appendix C). All participants and co-researchers were provided with leaflets and contact details for organisations that provide support around FGM and were encouraged to discuss any concerns with the Bristol children safeguarding lead, who was aware of the research.

4.6.2 Consent: engaging young people in research ethics

Due to the nature of the subject, it was important to seek parental consent as well as participant assent. Consent is a legal expression of the moral principle of autonomy and must be obtained prior to any research involving children and young people (Morrow and Richards, 1996). As a critical ethical consideration in the negotiation of ongoing consent, the participants were aware of their right to withdraw from the research without obligation (General Data Protection Regulation (GDPR), 2018). The information sheets explained the procedure to withdraw from the study to young people, which involved informing me, although none withdrew.

The United Nations Convention on Children's Rights (UNCRC, 1989) defines a 'child' as any person under the age of 18; however, by the convention of the British courts, all persons under 18 are minors, those under 16 are children, and 16-17-year olds are young people. The fundamental principle is that children grow and develop in maturity. Therefore, adults must respect and promote their views and wishes. Additionally, Kennedy and Grubb (1998) state that, in the process of becoming full autonomous adults, children pass three developmental stages: the child years, where responsibility lies with the parent or guardian, the Gillick competent years, applied in the UK to under-16s, then young people aged 16-17, who are capable of consenting as full adults. As it relates to giving consent for medical treatment, there have been debates as to whether the Gillick competency can be applied to research (Hunter and Pierscionek, 2007). This would require considering whether the child is capable of understanding the nature of the research, their rights concerning the research, and the risks and benefits of participating in the research. In my study, although the young people were seen to have

the capacity to consent, I also thought it was important to seek parental consent, due to the sensitive nature of the research topic. The co-researchers consented for both, as participants and co-researchers in this project.

4.6.3   Power relationships

For a young person's voice to be captured within the research process, it is crucial to limit the adverse effect of adult-child power relationships and enable children to become active co-creators throughout the research process. Therefore, researchers need to consider the unequal power relationships between child and adult, and the impact this could have upon the young person's responses within the research environment (Mayall, 2008; Kirby, 1999). Collaborative approaches aim to redress these power imbalances, in line with Alderson's (2000) assertion that participatory research can aid in addressing intergenerational power imbalances.

Discussions of power in relation to young people often draw on Foucault's (1983) notion of 'power as a diverse' uncertain web of relations, rather than a unidirectional force of domination. Gallagher (2008) emphasises the dynamic, shifting and multiple layers in which power is evident in interactions between young people and adults. As a result, 'power' is conceived as a form of action, exercised in multiple ways, by all participants. This can include resistance, disobedience, and subversion, as well as compliance. While Smith et al. (2015) highlight how resistance can sometimes signify a positive exercise of power, as a means of liberation, it can also marginalise others. Viewed in this way, Foucault (1983) argues that power can be regarded as both productive and regressive, offering opportunities for action, but also constraining possible actions. Therefore, power is dynamic, relational and often complicated.

The factor that sustains unequal power relations in participatory studies is the relation between the young person and the researcher, especially the belief that adults are superior and knowledgeable to young people. According to Kellett and Robinson (2004), how adults share or hold back control is crucial; therefore, adult researchers should be prepared to relinquish certain elements of control. This process allows young people to

develop skills and capacities and a willingness to express their ideas and opinions in research. According to Morrow (2009), the extent to which researchers share their power with others can be linked to how they view children.

Young people as co-researchers may see adults as having authority in the research setting, which would affect their ability to contribute. They may feel unable to express areas of disagreement or opinions that they fear adults would not understand or view as acceptable. By training young people to become interviewers in this study, my aim was to support young people to express their actual views openly to their peer group. This technique is promoted as a method that allows for a less hierarchical relationship between the researcher and the researched (Alderson, 2000; Kirby, 1999), suggesting that young people discuss topics more openly amongst their peers than they would with adult researchers (Kellet et al., 2005; Lansdown, 2006). Overcoming this problem might result in a deeper understanding of young people's lives. Therefore, this choice of method can generate a unique contribution to knowledge that can 'only be made' by young people themselves (Kellet et al., 2005).

4.6.4 Safeguarding

Research in this sensitive area required consideration of safeguarding issues. The term 'safeguarding' extends beyond the definition of child protection, to include the notion of prevention. This is the need to avert any harmful practices from happening, which may be relevant to researchers hearing any disclosures of FGM risk. Therefore, Braun and Clarke (2006) suggest that vulnerable people should only be interviewed if the researcher has professional experience within the participant group, due to the additional skills required to handle any such disclosures.

In general, then, the primary purpose of safeguarding is to ensure that young people are kept safe and grow up in the circumstances most likely to promote their safety. The document Working Together to Safeguard Children (Department for Education, 2018) defines safeguarding as:

> "Protecting children from maltreatment, preventing impairment of children's health or development, ensuring that children grow up in the circumstances consistent with the provision of safe and effective care and undertaking the role to enable those children to have the best outcomes" (p.5).

The participants of this research were classed as vulnerable people when they took part in the research, due to both their ages (13-15 and 15-18) respectively, and the sensitivity of the topic. This meant there was a risk that, during the data collection process, participants would disclose sensitive information and I needed to ensure that, if this did happen, there were procedures in place to protect them from harm, and that participants were treated with dignity and respect. For example, one particular concern was that issues might arise regarding maintaining a participant's anonymity and confidentiality where information was disclosed in an interview or focus group. Due to the nature of the subject and the involvement of young people, it meant that some of the young people might have undergone FGM already or indicate potential harm of undergoing it in future. The guidance for dealing with such issues is vague, specifically that provided by universities.

Furthermore, the relevant legislation and statutory guidance revealed a similar lack of clarity regarding the researcher's responsibilities to refer child protection concerns to statutory agencies (Children Act, 1989; Education Act Section 175, 2002; Every Child Matters, 2003; Children Act, 2004). These documents do not provide a single legal directive for researchers working with young people. However, they do impose a clear professional duty to report concerns and to be able to alert indicators of abuse and neglect. Additionally, the Female Genital Mutilation Safeguarding and Risk Assessment guidance (Department of Health and Social Care, 2015), states the need to discuss with local safeguarding leads if a child or adult gives details of a family member which indicates they may be at risk of FGM, but do not have information to suggest the risk is imminent or would not describe it as severe.

Due to the dearth of CBPR research in the area of FGM and young people, I was faced with a dilemma on safeguarding procedures that would effectively guide my research process. However, due to the collective knowledge from my supervisors and my experience working in this area, as well as the contacts I had formed within the community and professionals, I was confident that my research had an adequate safeguarding procedure in place.

I completed Level 3 Safeguarding training and held prior experience of working with this specific group of people and, although I did not conduct all the interviews personally, I

was present throughout. Additionally, a safeguarding pathway adapted from the Department of Health (DoH)'s FGM safeguarding pathway (2015), was completed for the use of this research. This pathway was helpful when a young person had disclosed their cousin had FGM in this country (Fig 4.2).
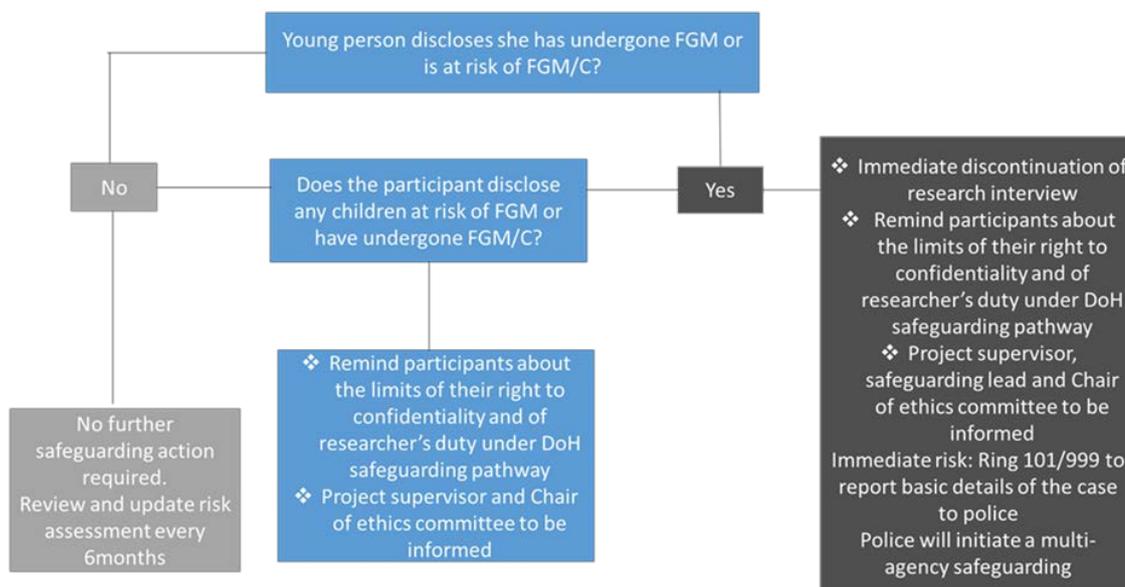
Figure 4:2: Research safeguarding protocol, adapted from the DoH's safeguarding protocol (2015).

4.7 Phase One: Accessing and recruiting co-researchers

The inclusion criteria for co-researchers was that they had to be:

- 15-18 years old.
- Have parents from FGM-affected communities.
- Born or have lived in high-income countries.
- Now live in Bristol, Milton Keynes and Cardiff.
- Male and Female.

4.7.1 Bristol

Certain social groups are often excluded from social research, due to the difficulty in accessing and recruiting them; these include young people, women and minorities

(Ellard-Gray and Jeffrey, 2015). Coupled with the sensitivity of the topic, gaining access using traditional sampling methods is often ineffective, inappropriate and time-consuming. The recruitment of co-researchers echoed this notion; it was not an easy process as the detailed description of both phases below makes clear.

Following an in-depth literature review, consultations with the supervision team and a key community organisation in Bristol (Refugee Women of Bristol, RWoB), it was felt that young people age 16-18 years would be able to consent but also parents were more likely to allow co-researchers to be involved in evening training sessions. Therefore, a pragmatic decision was made to recruit young people of this age range. The recruitment of co-researchers commenced by approaching secondary schools in areas with a high proportion of second-generation immigrants in Bristol, in June 2016. The process of identifying potential co-researchers was aided by the schools as gatekeepers. At the time, I was co-chair of the Bristol FGM Safeguarding Partnership group and, due to the relationship I had formed with the board members, I was able to contact the FGM lead for schools in Bristol and request the details of relevant school headteachers. I then sent an email to these headteachers and those at other schools I know, an approach advocated by Rice et al. (2007). The email contained details about the proposed study, including aims and a timeline. The headteachers were asked to contact me if they could nominate young people that fitted the selection criteria. My selection of the particular schools was based on two factors: first, the positive working relationship I had with the schools, due to other ongoing work I was doing at the time; second, the location of the schools and the high proportion of young people from FGM-affected communities. Unfortunately, none of the eight schools initially contacted replied.

Consequently, between June and July 2016, I identified key contacts within community organisations in Bristol and Cardiff. Having also been a trustee and having formed relationships with workers as well as service users within the organisation in Bristol, this made it easier to approach the manager. After a discussion with the manager, where I explained my research aims, she provided a platform for me to meet the trustees and workers. That meeting enabled me to discuss the scope of the research, ethical issues, project timescale and confidentiality. At first, the women I spoke to were willing to help with recruitment, even identifying parents with children that met the selection criteria. However, when the time came to contact the parents, some of the women decided not

to help anymore. There could be several reasons for this shift, such as the sensitive nature of the topic, which deterred them from communicating with their friends. A parent expressed the difficulty she faced when attempting to engage her son with the project, stating the son was unaware of the practice. She was, therefore, unwilling to engage, fearing her children were too young.

A period of uncertainty followed when I speculated on how I could bring together a group of young people to form a research group. In hindsight, I had experienced a shift, from that of being immersed as a community activist, to becoming a full-time researcher. Therefore, although I had well-established networks and contacts in the community, the challenge to recruit young people remained. This is an important point to reflect on. I had assumed that parents would consider it a positive opportunity for young people to join this project, due to the skills they could gain, but I had not realised that there were several other issues that may hinder this process, one of which was that some parents had not spoken about FGM to their children. In fact, one of the parents I approached expressed this, when she handed the information sheet to her son who was 13 at the time, and he promptly asked his mother what FGM/C is.

Wallerstein et al. (2008) emphasise the importance of trust and confidence in the researcher's capability, as well as their overall motive and commitment to the research being undertaken. At the time, I did not see this as a barrier, because I had worked with most of the parents in my previous roles and had assumed, due to their own awareness of the practice, they would have spoken to their children about it, but this turned out not to be true in most cases. This was indeed an important conversation to be had but, due to time constraints, I sought to recruit more young people, rather than pursuing opportunities to discuss the research in-depth with parents who were unsure. Although this process did not aid in recruiting more young people, it instead highlighted the importance of time spent building trust with the community, even as an insider.

During this period, I was uncertain why I was encountering so many obstacles, but in December 2016, the manager of Refugee Women of Bristol (RWoB) advised me that this was principally because of the research subject (FGM). Sydor (2013) states that the sensitivity of a research topic is what often makes populations hard to reach (see also Ellard-Gray et al., 2015). The conversation I had with the manager prompted me to

change the language I was using while recruiting, thinking that perhaps mothers were worried due to language barriers. Yancey et al., (2006) recommend using lay terms, for example, instead of the word 'research' they suggest using the words 'dialogue' or 'conversation' because, while still being clear about the aims of the study, this shift may sound less intimidating. In my case, I explained to the parents that my aim was to use creative participatory tools 'with' young people, instead of conducting research 'on' them, to find out what and where they had learned about FGM, what they thought about the practice, as well as their opinions about approaches they had encountered, for instance, in schools. This seemed to make it easier for parents to understand and I was able to build conversations.

While this shift in language was useful, I also underestimated the importance of fully engaging with the key contacts I had within community organisations (gatekeepers) and the relationships that had taken years to build. McFayden and Rankin (2016) encourage researchers to continuously use such gatekeepers, further illustrating their crucial role in successful recruitment. Moreover, rather than merely using gatekeepers for recruitment, this methodology enabled me to work closely with the gatekeepers throughout my research process.

By the end of August 2016, I had recruited two co-researchers, although I intended to recruit ten. I persisted with another meeting with the manager of RWoB to ask for further assistance in recruitment. As the principal gatekeeper, she agreed to help and started by contacting parents to discuss their child's possible involvement. Following that meeting, I arranged to meet the parents to explain the research as well as the training that the co-researchers would be involved in. The manager of RWoB is also a Somali interpreter. She agreed to assist in explaining the research to parents who did not understand or could not read English, subsequently enabling parents to understand and consent to their children being involved. The young people were not present at these preliminary meetings, as I only approached them once their parents had consented.

In November 2016, I hosted the first introductory meeting with the co-researchers. By that point, I had recruited five co-researchers through RWoB. It was vital that I established rapport and trust, even at this initial contact stage (Manoranjitham et al.,

2007; Elam, 2003), as well as clarifying mutual aims and ideas about participation. This process was necessary, as it would later aid in the successful attainment of research outcomes, as well as leading to three further co-researchers joining the group.

4.7.2 Cardiff

The recruitment of co-researchers in Cardiff was undertaken concurrently with Bristol. While I had an established relationship and trust with the community in Bristol, having no established contacts in Cardiff presented an issue when attempting to recruit. I started the process by contacting an organisation I was working with at the time, the Foundation for Women's Health Research and Development (FORWARD), based in London. My contacts there agreed to assist in the recruitment and introduced me to two organisations in Cardiff.

I made initial contact with these organisations through emails, describing my research and selection criteria for co-researchers as well as requesting a meeting. One of the organisations replied and, following several meetings that required me to drive to Cardiff to meet with the gatekeeper, they agreed to assist. After a meeting with my university supervisors, a decision was made to start recruiting co-researchers in the city and aim to start running training workshops there in November 2016. However, several meetings followed, which were unsuccessful, and due to time constraints, I was unable to recruit co-researchers at the specified time. As a result, the decision was made not to recruit and train co-researchers in Cardiff but rather to concentrate on recruiting participants there.

Consequently, following the introductory meeting in Bristol with co-researchers, they were encouraged to identify or recommend other young people they knew who would fit the selection criteria. This snowball technique was very productive, and by January 2017 five young people who were recommended by the initial group of co-researchers expressed an interest in joining. Four were recruited, because one did not meet the selection criteria, not being from an FGM-affected community. In the end, having obtained parental consent and the young people's assent, eight of the young people who had expressed an interest were recruited as co-researchers (all girls). Their training commenced in November 2016 and continued until March 2017.

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Because all these co-researchers were female, it felt important that I attempt to recruit young men as well, in the interest of balance, and to bring forth their perspectives. I was introduced to a youth worker in Bristol who worked with young Somali men in Bristol. Following an initial phone conversation, he agreed to meet me and my supervisors to discuss potential procedures for recruiting young men. A meeting was arranged for July 2016, and the youth worker appeared interested in the research and agreed to help in recruiting.

He explained that he would recruit five young men and arrange for me to meet them. Two weeks later, when I contacted him to try and arrange a meeting, he advised a meeting on a Saturday afternoon at a community centre in Bristol. When I arrived, I was greeted by the youth worker, but no young men were present. He proceeded to make a few phone calls, but the meeting was unsuccessful. This happened again for the next three weeks, where no one would show up for the meetings, I decided to discuss with the youth worker how we could improve this effort. He suggested that it might be due to the age restriction I had imposed, as a few young men wanted to join, but they were only 15.

Therefore, following a discussion with my supervisors, a decision was made to apply for ethics approval to reduce the age of the co-researchers. An ethics amendment form was completed, having decided to decrease the age range from 16-18 to 15-18 years. Unfortunately, I was still unable to recruit any young men from the youth worker.

Thus, I decided to contact the manager from RWoB, who advised me to speak to a community advocate I had worked with previously. As a result, one male co-researcher was recruited through the specialist organisation in Bristol. However, he was not able to attend the training workshops; therefore, he assisted me in recruiting male participants in Bristol and was present as a facilitator in interviews and focus groups.

4.8   Phase Two: Accessing and recruiting participants

Phase Two of the research involved the recruitment of participants in Bristol, Cardiff and Milton Keynes. The inclusion criteria for the participants were:

- 13-15 years old
- Parents from FGM-affected communities
- Born or have lived in high-income counties
- Now live in Bristol, Cardiff and Milton Keynes
- Male and female

4.8.1 Bristol

Following the successful recruitment and ongoing training of co-researchers, the aim here was to recruit only those who were born in high-income countries (as defined by the World Bank). However, due to difficulties in reaching the desired recruitment levels, the supervisory team and I decided also to include young people who had migrated to high-income countries at a young age, as opposed to just those who were born there. This age range was chosen due to the dearth in research with young people age 13-15.

To recruit participants in Bristol, I sought support from the co-researchers as well as a specialist organisation. A similar process to recruiting co-researchers was followed, in which the gatekeeper from the organisation would contact parents, and then I would contact the parents to arrange a meeting. The co-researchers would also recommend young people who met the selection criteria, and I would seek to contact their parents before approaching the participants. It was important to me that I recruited both young girls and boys, to enable both voices to be heard in the research. In Bristol, we recruited eleven participants.

4.8.2 Cardiff

The organisation that initially assisted in recruiting co-researchers was the primary gatekeeper in Cardiff who also helped me recruit participants. However, this process was prolonged for several reasons. The first reason was that I had not yet built a rapport with this organisation as aforementioned in contrast, to the years it had taken me to build in Bristol. Therefore, it was difficult for women to trust me as a researcher. According to Ellard-Gray et al. (2015), gatekeepers mediate researchers' access to communities and play an important role when researching communities that do not trust researchers, by protecting and informing the vulnerable population. This process is heightened when the research subject is of a sensitive nature. Therefore, forming and

maintaining a relationship with gatekeepers is not an easy one, but the trust relationship between the researcher and gatekeeper is critical (Clark, 2011).

Nevertheless, accessing participants remained a considerable challenge and took much longer than initially anticipated. The process of building trust took one year, from November 2016 to October 2017, during which there were repeated contacts, visits to Cardiff and sustained interactions, to earn the gatekeeper's trust. Throughout my interactions with the gatekeeper, I felt it was important to demonstrate respect and a willingness to learn and consider new things. Eventually, because of this effort, by October 2017 I had recruited five participants.

4.8.3   Milton Keynes

The third place, Milton Keynes, was added following the challenges faced in Cardiff. Having lived in Milton Keynes and established relationships, I aimed to recruit up to five participants there, as I had done in Cardiff. I proceeded to contact Milton Keynes' Council, as well as community organisations working with black and minority groups. It is important to note here that, in contrast to Bristol and Cardiff, Milton Keynes had no established community organisation for FGM at the time, therefore, apart from the Council, there was no relevant organisation I could contact. In addition to this, one of the co-researchers from Bristol had contacts in Milton Keynes and was able to assist in recruitment. Ultimately, we recruited three participants from the town.

No	Gender	Parents country of origin	Location
1	Female	Sudanese	Bristol
2	Male	Somalian	Bristol
3	Male	Nigerian	Bristol
4	Male	Sudanese	Bristol
5	Female	Egyptian	Cardiff
6	Male	Nigerian	Milton Keynes
7	Male	Somalian	Bristol
8	Female	Somaliland and Kuwait	Cardiff
9	Male	Nigerian	Milton Keynes
10	Male	Somalian	Bristol
11	Female	Somalian	Cardiff
12	Female	Somalian	Milton Keynes
13	Female	Somalian	Cardiff
14	Male	Sudanese	Bristol
15	Female	Somalian	Cardiff
16	Male	Sudanese	Bristol
17	Female	Sudanese	Bristol
18	Male	Yemeni and Saudi Arabian	Bristol
19	Male	Somalian	Bristol
20	Male	Somalian	Bristol
21	Female	Somalian	Bristol
22	Female	Nigerian	Bristol
23	Female	Somalian	Bristol
24	Female	Somalian	Bristol
25	Female	Somalian	Bristol
26	Female	Somalian	Bristol
27	Female	Somalian	Bristol
28	Female	Somalian	Bristol
29	Female	Somalian	Bristol

Table 4.1: Demographics of the 20 participants and nine co-researchers.

As Table 4.1 shows, the research sample is distributed across the three locations: eleven from Bristol, five from Cardiff and three from Milton Keynes. The participants in Bristol and Milton Keynes were a mix of male and female; however, in Cardiff, only female participants were recruited, due to restrictions imposed by the gatekeeper. Co-researchers have been included on the table above as the data collected in the training sessions were also analysed.

4.8.4   Personal disclosure

Throughout the process of recruitment, I had to address and respond to a number of issues raised by the gatekeepers. I realised that developing meaningful relationships with gatekeepers to gain access to participants was based on a number of ethical concerns. McAreavey and Das (2013) explore the role of power, ethics, and trust associated with recruitment through gatekeepers. As such, one of the critical ethical questions the gatekeepers asked me was about myself, who I was, my background and also why I was interested in conducting the study with young people. The gatekeeper in Cardiff was interested to know my thoughts about the subject, as she held her views and interests relating to FGM (Eide and Allen, 2005). She made it clear that she thought that FGM was not being practiced in Cardiff, and her view was that it had ceased in the 1980s. Although this statement made me uncomfortable, knowing that FGM remains prevalent, it was important that I remained neutral rather than challenge her assertion, as I felt that my answer would have had the potential to jeopardise support for recruitment.

Although it would have been more honest for me to state my position instead, I used my judgment to evaluate the situation, to exercise patience and listen openly to her views (Rice et al., 1999). The skills learnt in the initial research stages were significant and assisted me throughout the research process, enabling me to consider the diversity of views in relation to FGM. Therefore, I decided to choose what to disclose about myself selectively, perhaps the most important aspect being that I was from an FGM-practicing community, as well as the work I was involved in Bristol, mentoring and training young people. This selectivity was significant because, according to McAreavey and Das (2013),

disclosing too much could risk being undermined as a researcher. On the other hand, establishing trust was vital.

As a result, the gatekeeper saw me as a positive figure that young people could 'look up to', as she put it. She introduced me to the group as the 'half Somali attending university'; this seemed to be important in the introduction. The first few questions from participants were about my journey in academia; they followed by highlighting the subjects they wanted to study at university and their future aspirations. This was an interesting discussion to have, and the young people became more comfortable talking as time elapsed. Through this process of dialogue as well as being reflexive, I was able to gain insights as well as clarify my own personal and professional agendas. The process of building trust enabled gatekeepers and participants to gain confidence in sharing information openly, although I did explain that my intention was not to ask sensitive questions or seek disclosures around the subject.

4.9   Sampling approach

According to Morse (2011), sampling is the deliberate selection of the most suitable participants to be included in a study. Palys (2012) asserts that the sampling strategy will depend on the particular context in which the researchers are working and the nature of the research objectives. The attention to sampling, however, is crucial in attaining rigour within a qualitative study (Morse, 1991). This study utilised a combination of purposive and snowball sampling to recruit participants; in this type of sampling, study participants are chosen based on the purpose of their involvement in the study. Purposive sampling is the most commonly employed approach for qualitative research, also known as judgment sampling (Guest et al., 2017), often adding a snowball aspect by asking participants to recommend others (Atkinson and Delamont, 2010). According to Patton (2007), the logic and power of purposive sampling lies in selecting rich-information cases for the study.

Guest et al. (2017) state that the research inclusion criteria often relies on several factors. Initially, it is essential that a researcher reviews their research objective and questions. Usually, the sample units are clearly stated within the objectives, as in this study, which has a specific community and age. In addition to this, there are other

pertinent factors to consider when attempting to provide a holistic picture of a phenomenon. As such, it is essential to include knowledgeable individuals in a study (Guest et al., 2017); in other words, the research must include people affected by a given phenomenon.

This study located participants with particular characteristics, selected from a study population of interest to form a sample (Silverman, 2013; Denzin and Lincoln, 2008). A snowball technique (Patton, 2007) was also used, as the study sought to identify other young people who shared relevant experiences, i.e. were of a certain age, from high-income countries and had parents from FGM-affected communities. The snowball technique is known to be helpful because of its ability to recruit hard to reach or reluctant groups (Streeton and Cook, 2004). This technique is also useful when investigating sensitive issues, thus making it suitable for this particular research. In addition, snowballing also offered credibility to me as the researcher, by allowing the use of named contacts to form other networks, creating a three-dimensional matrix of confirmable information (Streeton and Cook, 2004).

There are disadvantages to the sampling approach adopted: one is that it may not lead to a group which has a wide range of experiences akin to the range in the broader population (Magnusson and Marecek, 2015). Nonetheless, Guba and Lincoln (1998) assert that qualitative research provides rich insights into human behaviour, rather than necessarily data that are generalisable to the broader population. Thus, to ensure some diversity in experience, this study recruited young people from three different locations, Bristol, Cardiff and Milton Keynes, and from a range of ethnic backgrounds. This was enabled by the co-researchers' networks of friends from various ethnic backgrounds and genders.

4.9.1.1   Sample size

The primary foundation of qualitative research is selecting an appropriate research topic. Research design, the second important factor in qualitative research, means obtaining an adequate sample size. What is often said to be *enough* (my italics) data is a precursor to credible analysis and reporting of one's research project (Marshall et al., 2014). However, very few researchers provide the rationale for sample size, and very few methodologies provide guidelines for assessing sample size. The question of how

much is enough is, therefore often debatable. This section aims to discuss this issue, consequently offering a rationale for the choice of sample size used in this study.

Several factors determine sample size in a research study. The central concept of sample size in qualitative studies is saturation which, although linked to several qualitative studies, has been inconsistently applied (Siersma et al., 2015; Morse, 1991). Saturation entails the continuous inclusion of new subjects into a study until the dataset is complete, often indicated by redundancy (when nothing new is being added). However, very few guidelines exist regarding assessing saturation, so it becomes subjective. Strauss and Corbin (1998) agree with this notion, stating that saturation is a matter of degree. Thus, the longer a researcher examines the data, the more themes will emerge. Charmaz (2006) adds that the aims of the study are the primary drivers of sample size, suggesting that a small study with modest claims (Charmaz, 2006, p.114) may only need a small sample to achieve saturation.

According to Guest et al. (2006), saturation is helpful at a conceptual level, but it provides very little practical guidance when attempting to estimate a sample size that meets robust standards of qualitative research. In a systematic review conducted by Guest et al. (2006), seven guidelines were listed to determine optimal sample size, dependent on methodology, Bertaux (1981 cited in Guest et al., 2006) suggested that 15 is the smallest acceptable sample number for all qualitative research. Warren (2002) states that a qualitative study requires at least 20 to 30 interviews to be of publishable quality. Gerson (2002) argued that fewer than 60 interviews are unable to support conclusions and more than 150 yield too much data. Therefore, the researcher is unable to analyse their data effectively. Adler and Adler (2012) suggested a range of subjects between 12-60 and a mean of 30. This confusion on how much is 'enough' implies the subjective nature of qualitative studies and thus adds to the complexity for new researchers in judging what is 'enough' in terms of their sample size.

Therefore, for Sobal (2001), the question of how many is 'enough' is dependent on several factors, such as: what the researcher wants to know, the purpose of their inquiry, what is at stake, what will be useful, and what will have credibility. Baker et al. (2012) add that a small number of subjects may be extremely valuable and represent sufficient subjects for a research project if the topic under study is of a hidden nature or

with hard to access populations. This resonates with my project, since FGM is a sensitive subject, and it was very challenging to recruit young people from FGM-affected communities. Baker et al. (2012) suggest that, in these cases, a small number of six to twelve is often sufficient. Therefore, although saturation is seen as the main factor in data sampling, Guest et al. (2006) and Straus and Corbin (1998) assert that, within a PhD study, several factors can influence the sample size. Such as the availability of participants and the time restriction of funded studies, students do not have the luxury of what he calls the 'open-ended research' that saturation requires, therefore students are forced to settle for a theoretical scheme that is less ideal than desired.

Having provided an in-depth critical discussion of the question of how much is 'enough', this study adhered to Bertaux's (1981 cited in Guest et al., 2006) guidelines of 15 being the smallest acceptable sample size in any qualitative study, irrespective of methodology, and Strauss and Corwin's (1990) assertion that reaching theoretical saturation requires at least 10-12 interviews. Therefore, although my initial aim was to recruit 40 participants between the three locations (Bristol, Cardiff and Milton Keynes), this study succeeded in recruiting 20 participants who were involved in semi-structured interviews and focus groups. This was due to several factors: the hidden nature of the study and the participants' age were both barriers to recruitment (Baker, 2012). It is, however, important to note that the co-researchers also consented as participants. Therefore, the data collected in the training sessions were also analysed, bringing the total sample size for this research up to 29, including the male co-researcher.

Having discussed the sampling method utilised for this study, the following section provides detailed accounts of Phase one and Phase two of this research.

4.10 The formal data collection

The methods used in this study were intended to build dialogue between the co-researchers and young people, creating a coherent narrative that provides an insight into the research questions identified in the early planning phase as well as any issues that arose over the duration of the study. The co-researchers were involved in the methods selection and the research design, as well as delivery of the interviews and focus groups. However, in order to plan and progress the project over the first 12

months, I worked closely with a participatory research consultant on participatory research methods (see Chapter 5).

Researching with young people often requires the creation of innovative techniques or the adaptation of traditional ones in order to fit in with young people's different life experiences and competencies (James and Christensen, 2000; Parker, 1984). Adding to this, a level of flexibility is often required when utilising participatory methods. This research used semi-structured interviews and focus groups as methods of collecting data. Further details of each are given below. The benefit of using more than one method of data collection is that it enhances the richness of the research findings (Punch, 2002; Lambert and Loiselle, 2008), also provides an opportunity for young people to express themselves in different ways.

4.10.1 Location

In Bristol, the parents were encouraged to propose a suitable location for the interviews and focus groups, and they suggested community centres close to their homes. The focus groups were held in the afternoons, in community centres, near participants' homes, at their parent's request. This strategy also helped at the recruitment stage, because parents knew they would be able to bring their children at previously agreed times, allowing for a relaxed atmosphere. In Cardiff, the interviews and focus group were held at the community organisation, after school. In Milton Keynes, interviews were also held at community centres. Further highlighting the importance of 'space', Denzin and Lincoln (2005) advocate for the use of community, rather than 'official', spaces. The process of going into the community highlights the researcher's intellectual commitment to working 'with' communities and helping the community to take responsibility over issues that affect them.

4.10.2 Focus groups

As a research technique, focus groups enable the collection of data through group interaction on a topic determined by the researcher (Morgan, 1996). Furthermore, focus groups are defined as carefully planned discussions, designed to obtain people's

worldviews on a phenomenon, a form of group interview, with the distinguishing feature of group interaction (Kitzinger, 1994). In comparison to interviews, Focus groups are helpful for generating new ideas formed within a social context. Although useful, interviews probe individual experiences and encourage self-reflection on issues that could sometimes be inaccurate if pressure is placed on an individual. Nonetheless, focus groups and interviews both generate qualitative data which can be recorded, transcribed and analysed.

Denzin and Lincoln (2011) highlight three primary and overlapping functions of focus groups: pedagogy, politics, and inquiry. According to Bourdieu and Wacquant (1992, cited in Denzin and Lincoln, 2011, p.547), focus groups involve a:

> "Likeminded group of people in unofficial spaces [who] collectively function to identify, interrogate and challenge specific lived contradictions that have been rendered invincible by hegemonic power and knowledge regimes."

This pedagogical approach is akin to Freire (1970), who believed that humans live both 'in' the world, and 'with' the world and, for that reason, they are active participants in making history. Therefore, within Freirean pedagogies, the development and use of dialogue and phrases and the cultivation of concientisation are enacted in the context of '*study circles*' (or focus groups). The goal of the facilitator within pedagogical focus groups is to engage with people in their lived realities, often leading to reflection, concientisation and praxis (transformation). According to this notion, focus groups are concerned with how people narrate their own lives more effectively and challenging them to take action.

Similarly, Skop (2006) and Madriz (2000) stress the importance of focus groups in empowering participants, by providing opportunities for marginalised groups to discuss issues relevant to their lives and share experiences with others from similar social positions to theirs. Freire (1970) adds that the dialogue should not only discuss problems that challenge them at an intellectual level, but also those that require them to take action. Furthermore, Denzin and Lincoln (2005) assert that the collective nature of focus groups enables the researcher to explore true meaning, thus diverting from interpreting 'weak evidence' due to the ability to moderate and adjust the conversations that take place.

According to Kitzinger (1994) and Krueger and Casey (2014), in order to run a successful focus group, participants should share similar characteristics and be acquainted with each other. Additionally, the interaction between participants, rather than that of researcher and participants, enables the generation of knowledge, as participants can question one another (Bagnoli and Clark, [2010). As a consequence, Hayden and Bulow (2003, p.104) argue that the data generated in focus groups lie not in the production of individual-level data, but rather in the production of data through social interaction.

A range of approaches, including drawing and writing techniques, were used, forming the 'participatory' element of the focus groups in this research, capturing the breadth and depth of young people's views, which may otherwise have been difficult to obtain through the use of any single technique (Marrieman and Guerin, 2006). Additionally, the use of such techniques has been described as a flexible method that offers young people the opportunity to share in their own words, not the words chosen by the researcher (Pridmore and Bendelow, 1995). These techniques may also support the young person's sense of control (Hanney and Kozlowska, 2002) and may reduce power imbalances between adult and child, break down barriers and allow powerful emotions to be expressed (Pridmore and Lansdown, 1997; Foucault, 1997). On a practical level, the attractiveness of using drawing with young people was perceived to have been enjoyable and non-threatening, unlike some other techniques, encouraging the use of these techniques with the participants (Merriman and Guerin, 2006).

In this way, images from the drawing exercises could be either the starting point for the production of research data or be one form of data produced by the research (Warren, 2002; Gourlay, 2010; Pink, 2007; Vince and Warren, 2012). In this research, they were both, as participants were encouraged to discuss what they had produced but, even if they did not, the drawings were used as data. Visual methods can provide a means of facilitating the exploration of subtle, abstract and challenging themes in a creative way. This was particularly evident in this research, where the participants were able to write down what they knew or thought about FGM, which in parts formed an in-depth discussion in subsequent interviews, thus enabling rich data that may not have been accessible through conventional focus group methods (Warren, 2002).

4.10.2.1 Moderator role

According to Kingry et al. (1990, cited in Gibson, 2007), a focus group employs interviewing techniques with discussion taking place under the guidance of a moderator. The moderator facilitates in dialogue that is 'non-directive' and 'unbiased', using prearranged questions. A second moderator is often present, acting as a note-taker and observing group interactions. In the case of this research, the co-researchers wanted to conduct the focus groups in pairs, each having specific questions and helping each other in the process. The lead researcher (myself), acted as an observer in all the focus groups. In addition, Hennessy and Heary (2005) outline three important functions of a moderator: to make the group feel comfortable, to keep the group discussion focused, and to ensure that all participants have the opportunity to contribute. As an observer, I noted an important element that transpired in this research; this was the ability for the co-researchers to join group discussions and ice-breakers; this assisted in the breakdown of power. Effective moderators also need to apply their knowledge of interviewing techniques, leadership skills and group dynamics (Stewart and Shamdasani, 2014).

4.10.3 Running the focus groups

4.10.3.1 Bristol

In 2017, two co-researchers conducted one focus group in Bristol, and the researcher ran one in Cardiff, all with young people aged 13-15. According to Kennedy et al. (2001), age should dictate the number of people involved in a focus group and, with children above the age of 10 years, larger groups of up to eight are possible. Hill (2006) add that both single and mixed-gender focus groups can be successful. However, researchers are advised to make the decision on numbers and gender mix based on the nature of their own research. As such, although this had not been intended, the last-minute decision to have a mixed-gender group was made, appeared feasible and was welcomed by both the parents and young people. In Bristol, therefore, the focus groups consisted of seven mixed-gender participants. Subsequently, the lead researcher moderated the focus group in Cardiff, which was all girls due to the gatekeeper's restrictions and my inability

to recruit outside the organisation, because of a lack of contacts in Cardiff and time constraints.

The co-researchers introduced themselves, followed with a confidentiality and disclosure statement:

> "What's said in the room stays in the room. However, we need to make you aware that, if anything is disclosed that we think may harm you or another, we will have to break confidentiality" (Co-researcher, Bristol).

Following a discussion on confidentiality, the co-researchers commenced with ice-breaker exercises. According to Coyne and Carter (2018), when researching with young people, along with general introductions, ice-breakers have been found as a useful method to put young people at ease with their participants and moderators. The focus group participants started by getting to know each other's names (key in disguising speakers in audio recordings). The icebreakers' aim was to promote free-flowing conversations (Doswell and Vandestienne, 1996). The exercises included such questions as, 'if you could be an animal, what animal would you be and why?' and 'what is your favourite TV programme?' The young people responded well to these questions, with some of the answers being:

> "I'd be a bird so I could fly" (Male, 14)
>
> "I'd be a lion because I like to stay in control" (Female, 13).
>
> "I'd be a cheetah because I like running" (Male, 14).

These discussions then transitioned to young people envisioning a 'healthy self', and what that meant to them.

> "Now, everyone has a paper each; we would like what you visualise a happy young man or woman to be and label it, consider who is around them, where they live, dress code, body language, what makes you healthy and happy" (Co-researcher, Bristol).

Several images transpired from this exercise, where young people had the opportunity to discuss what they had drawn (see Image 4.1). These images illustrate young people's thoughts and beliefs about what they viewed as a happy self.
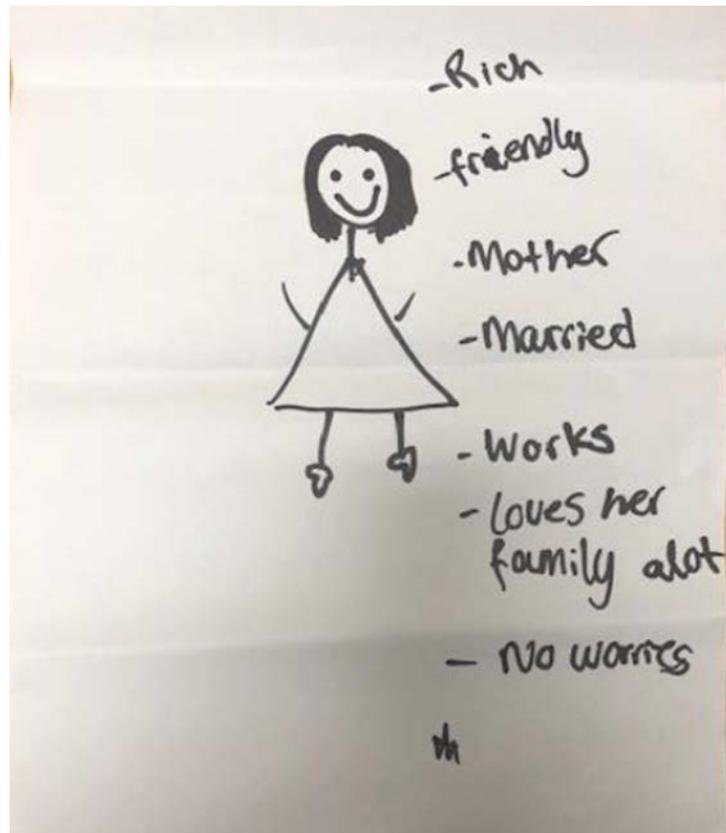
Image 4:1: A healthy version of self. Female, 14

Each focus group progressed with the co-researchers asking the participants open questions, like, 'what do other people say about FGM?' The co-researchers framed questions in the third person (asking what do *other people* say or do about FGM), to avoid eliciting personal disclosures of experience (Appendix D). Young people were encouraged to use a range of participatory tools. Initially, the majority wrote a brief nondescriptive note, which then evolved into a drawing. This method is appropriate when discussing sensitive issues, and it was of added benefit while discussing FGM with young people.

These methods were used due to the sensitivity of the subject; the answers were anonymous as they were advised to write their note and put in upside down on the floor without their names on. The pictures were then used as a point of discussion with the whole group. An example is given in Image 4.2 below.
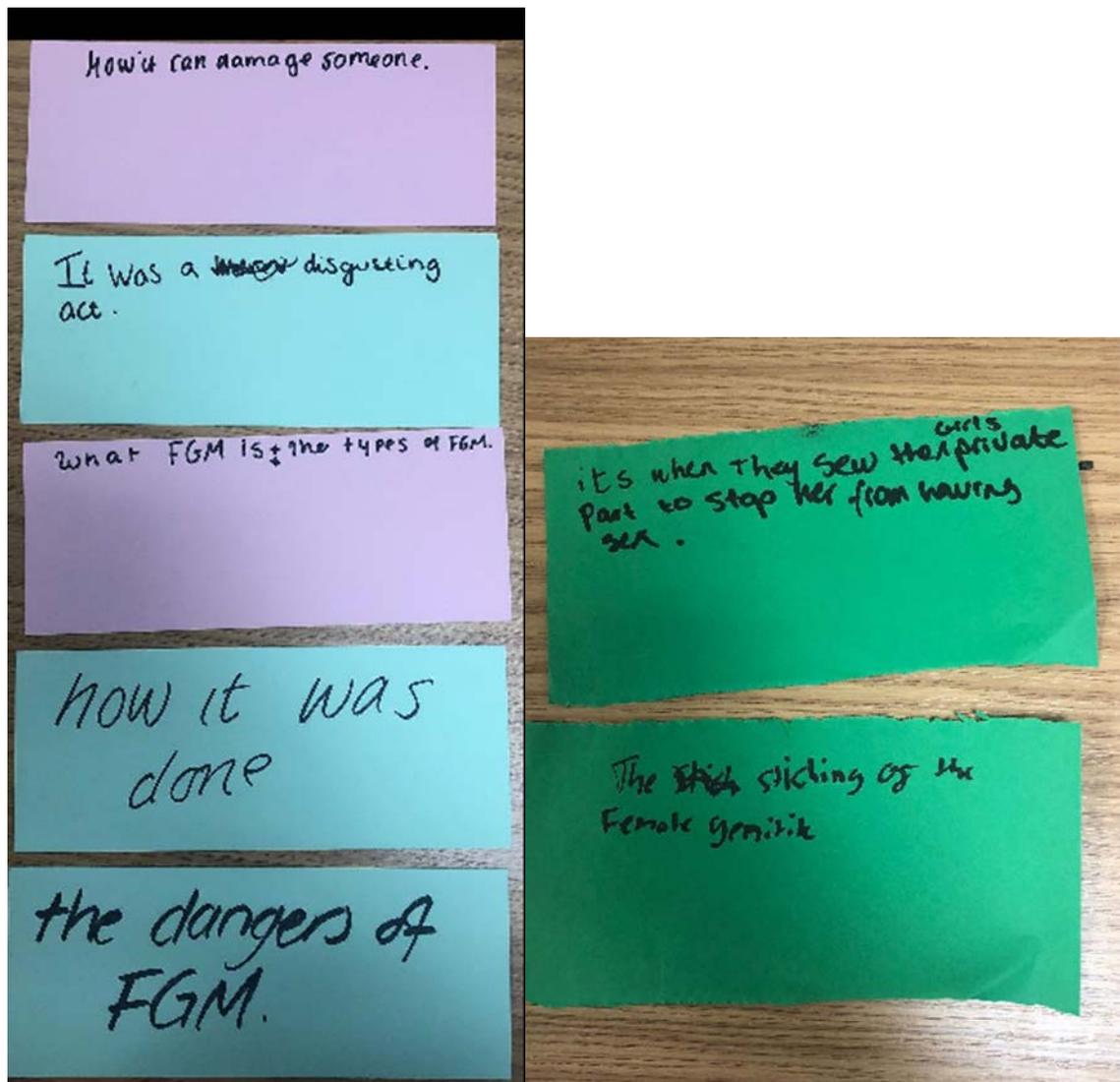
Image 4:2: Answers to question- 'Have you heard of FGM before, if so, where and what?'

The co-researchers encouraged the participants to engage in discussions by asking questions about the written notes, e.g. 'someone wrote "the dangers of FGM", what do we think this means?'

The researcher and co-researchers conducted a debrief at the end of each session, which included a discussion on thoughts about interactions with participants, unexpected findings and any ethical dilemmas that had emerged. This technique was used to enable the co-researchers to reflect on their facilitation technique as well as any changes that should be built into the next session. An example debriefing is given below.

Debriefing with co-researchers Zuli and Rwaida:

> Researcher: How do you think the focus group went?
>
> Zuli: I think it was really good, I realised that they were shy, to begin with, but I think the icebreakers really helped.
>
> Rwaida: Yes, I agree. I was sceptical about mixing the boys and girls, but it worked well.
>
> Researcher: Were there any important ideas that were discussed?
>
> Zuli: It was interesting that most of the young people didn't know about FGM unless they had overheard from family and friends.
>
> Rwaida: To me, it was how vocal they were; both genders were really open and saw this as a learning process.
>
> Researcher: Should we do anything different next time?
>
> Zuli: Maybe a different location, it was very hot in the room, and we couldn't open the windows.
>
> Rwaida: Maybe also to get them to write more and then discuss, that worked well, and also more time maybe.

4.10.3.2 Cardiff

The group in Cardiff followed a similar approach; although none of the co-researchers were able to travel to Cardiff, I facilitated the focus groups. I discussed the information sheets with young people, followed by a discussion on confidentiality and disclosure. This group consisted of all girls, some of whom were friends. The discussion was conducted in a room within the organisation. To enable a transitional period, food and drinks were provided along with an ice-breaker, similar to the one utilised in Bristol.

Perhaps as a result of only including girls in the discussion, this group appeared more vocal about their knowledge of the subject and shared information about close relatives who had experienced the practice; in Bristol, this was only evident in interviews. The focus group in Bristol appeared to be more formal than the one in Cardiff, which consisted of banter and sharing stories. The young girls were not afraid of talking about the issue, one mentioning: '*it's when they cut you innit*' during the discussion of what they knew about FGM and where they had heard of it. Some key issues also emerged from these discussions. One main point was raised in both focus groups, which was choice or lack thereof; the young people shared strong views on the difference between being 'forced' to practice FGM and having the 'choice' to do so. To them, having a choice

meant it should, therefore, be legal. This was followed by a discussion on 'safety,' which was context-specific. The United Kingdom seemed to appear a safer option for FGM, where they use *'cleaner equipment'*.

Having experienced being a facilitator in Cardiff and a silent observer in Bristol, it was clear that young people were willing to talk about the issue if given the right platform. The focus groups were useful in terms of understanding the group dynamics in mixed-gender groups (Bristol) as well as a single-sex group (Cardiff), and the content that surfaced from the discussions. Then, subsequent focus groups would be mixed-gender, discussing the issues that arose in the initial discussions; perhaps this would have yielded some more interesting material on the interpretation of FGM amongst young people.

Focus groups are often recommended to people who are trying to orientate themselves to a new field. I started this research into young people's views on FGM having conducted an extensive literature review and finding that there was no existing research on people of this age group and FGM, so I did not know how young people would respond to the questions – or even the subject. Focus groups with a participatory element provided me with an excellent opportunity to gather the preliminary information that would go on to inform the one-to-one interviews.

4.10.3.3 Semi-structured interviews

According to Dunn (2005), interviews are verbal exchanges where the interviewer attempts to collect information from the interviewee. Additionally, interviews are often used to examine the social construction of meaning, while focus groups are used to explore a range of personal views and experiences. However, both methods allow for a conversational and informal open response from participants.

Prior to commencing the interviews, the parents and young people present were encouraged to ask questions about anything they were unclear of and to ascertain if they were happy with the information provided. Upon arrival at the interview site, all participants were encouraged once again to ask any questions they had and were reminded of their right to withdraw at any time. After the interview, participants were reminded of the support services they could access.

The interview schedule was designed in accordance with Braun and Clarke's (2013) guidelines. In particular, attention was paid to developing questions that were open-ended and sequenced in a logical order that showed respect to issues of sensitivity (i.e. potentially emotive questions were asked later in the interview when the interviewee was more likely to be relaxed). The initial question schedule was developed through a combination of brainstorming and discussions with my supervisors, insights acquired through literature, as well as knowledge gained from my personal practices and experiences. The schedule was not, however, fixed, and additional questions were added by the co-researchers (i.e. 'do you think attitudes differ between males and females regarding FGM?'), and amendments were made following consultation with my co-researchers and supervisors (see appendix D).

The interviews took place over a space of ten months; this was due to the flexibility that was required for the co-researchers. Each interview lasted approximately fifty minutes to an hour. Co-researchers were encouraged to give interviewees sufficient space and time to respond in as much detail as they wished, recognising that their role was to facilitate and guide (using probing were necessary to encourage richer, fuller answers (Doody and Noonan, 2013; Smith et al., 2017). Interviews were conducted by the co-researchers with myself as an observer, and, when they were not available, I completed the interviews. They were tape-recorded for transcription.

As the interviews proceeded, I noticed the difference between my approach and that of the co-researchers. Although all had received training, it was often difficult for them to probe for more answers, sometimes leading to single-word answers that required greater input. This was difficult for me to rectify due to my inability to interfere in the interview process. However, similar to the focus groups, the co-researchers and I completed a debriefing session at the end of each interview; this seemed to help their interview techniques to evolve and develop. Below is an extract from an interview debriefing with Suraya, a co-researcher:

Post-interview debrief with lead researcher and co-researcher:

> Researcher: How do you think that went?
>
> Suraya: Not much to talk about, it was harder to bring out conversation. I rushed through it because, when he did not know the answers, I wanted to go to the

next question. I should've created more leading questions to make more conversation.

Researcher: You did use leading questions, is there anything else you would like to add to the questions?

Suraya: Maybe more questions that would help build a rapport?

Researcher: Can you think of any we could add?

Suraya: Not now, but I will let you know.

Researcher: Great, thank you.

The debriefing and my role as an observer contributed to evolving and developing the interviewing technique. The initial attempts were overly structured, to the point of not allowing any time to build a rapport or ease the interviewee into the difficult questions, as expressed by Suraya. Noticing this, I decided to meet my supervisor, who suggested a number of questions we could incorporate in the beginning to help relax the participants and build rapport, including talking about school, family and peers, as well as hobbies. These suggestions were shared with the co-researchers, who were happy with the amendments.

4.10.4 Audio recording

All the interviews, focus groups and workshops were audio-recorded, and transcripts of each were produced. Audio recording is considered an efficient way to capture the richness and detail of an interview or focus group (Gill et al., 2008). While video recording was considered for the training workshops and focus groups, this was considered too intrusive and would not be able to guarantee anonymity, therefore was ethically challenging.

The transcribed data were stored under the University of West England's research data management policy (2015) and Guide to the General Data Protection (GDPR, 2018); backed up and stored in a secure university network drive to which the researcher only had access. OneDrive was also used to back up data and share only with the supervision team and the transcriber.

A transcriber was employed to assist in the transcription process. Transcription involved the typing up of all verbatim data produced from training workshops, focus groups, and interviews. Each transcript was anonymised using a pseudonym for each participant and co-researchers. Pseudonyms were also used for any names mentioned within transcripts. The researcher then checked each typed transcript against the audio recordings to ensure accuracy and to become familiar with the data, aiding in the data analysis.

Transcripts of the interviews, focus groups and training workshops were entered into a qualitative data analysis package NVivo to allow a thematic analysis to be undertaken.

4.11 Data analysis

The requirement for trustworthiness in qualitative research was discussed extensively earlier in this chapter. To be accepted as trustworthy, qualitative researchers must demonstrate that their data analysis has been conducted in a precise, consistent and exhaustive manner. Therefore, researchers should describe their data collection and analysis in enough detail to enable the reader to determine whether the process was credible (Nowell et al., 2017). According to Silver and Lewis (2014), qualitative data analysis is not linear, but is best described as a process, which is iterative (going back and forth) and recursive (returning to a previous point), as such, the data collection and analysis were conducted simultaneously.

4.11.1 Thematic analysis

Braun and Clarke (2006) describe thematic analysis (TA) as a method for identifying, analysing and reporting patterns that arise from qualitative data (p.79). Thematic analysis is suitable for use on a wide range of data collection methods, including interviews and focus groups. They claim that the flexibility of thematic analysis means that it can be applied across a range of epistemological and theoretical positions. For example, TA can be essentialist (reporting experiences, meanings and the realities of participants, p.81), constructionist (examining ways in which events, realities, meanings

and experiences are the effects of discourses operating in society, p.91) or contextualist (a method sitting between the two poles of essentialism and constructionism, p.81).

According to Nowell et al. (2017), TA is useful for summarising key features of a large dataset, as it forces the researcher to follow a structured approach to handling data, thus producing a clear and organised final report. He adds that this process aids in creating sensitive, insightful, rich and trustworthy research findings (Nowell et al., 2017, p.2). These qualities of TA were deemed to be important in this study since the aim was to explore and give voice to the young people's perspectives on the studied topic, so thematic analysis enabled a consistent description of their experiences and views (see also Braun and Clarke, 2012).

Nevertheless, it is acknowledged that, like all qualitative analysis methods, TA is not without its limitations (Nowell et al., 2017) and, although steps can be taken throughout the research process to minimise these constraints, it is not possible to overcome them all. Despite being widely used in qualitative research, there was no clear conceptualisation or explanation of thematic analysis in most of the literature I reviewed. Such a lack of clarity may reduce the trustworthiness of a study, a criticism which is usually linked with TA (Holloway and Todres, 2003). In order to overcome this issue, my research followed the six-phase process (see section 4.11.1.3) advocated by Braun and Clarke (2006), which created a coherent trail of how the analysis was conducted in the aim of improving the quality of the data. In addition to this, Braun and Clarke (2012) argue that the disadvantages of TA are linked with a poorly conducted analysis or unsuitable questions, rather than the method itself.

To provide clarity of the data analysis process, Braun and Clarke (2012) call for several issues to be considered throughout the research process, ideally including an ongoing reflexive dialogue between the researcher and co-researchers regarding these issues. These matters will be discussed here prior to providing a clear trail of how my data analysis was conducted.

4.11.1.1 What counts as a theme?

Braun et al. (2018) define a theme as something that captures important aspects relating to the research question; it also represents some level of patterned response or meaning within the dataset. When deciding what constitutes a theme, Braun and Clarke (2012) argue that the number of instances something is referred to do not necessarily correlate to how crucial a theme is. Thus, researcher judgment is necessary. In this research, a theme was included if it captured something 'important' in relation to the overall research question, or if it provided a detailed account of one particular aspect of the topic under study.

While deciding on which analytic method to use for this research, it became apparent that other methods for data analysis that seek to describe patterns within qualitative data are 'theoretically bounded' (Braun and Clarke, 2012). For example, constructionist grounded theory, in particular, is underpinned by a relativist position and expressed through the assumption that the researcher constructs a theory as an outcome of their interpretation of the participants' stories.

Although there are similarities between grounded theory and thematic analysis, such as the ability to search for themes and patterns across an entire dataset, the thematic analysis aims to summarise data into themes which are explained in turn, rather than attempting to develop theories in relation to the data (Ryan and Bernard, 2000). Additionally, TA can highlight similarities as well as differences across datasets, generate unanticipated insights, allow for social and psychological interpretations of data and produce outcomes that may inform policy development (Ryan and Bernard, 2000, p.97); thus I decided to analyse my data using TA.

4.11.1.2 Inductive and deductive thematic analysis

According to Braun and Clarke (2012), thematic data analysis can be approached in one of two primary ways: an inductive (bottom-up) approach, or a deductive (top-down) approach. Inductive coding and theme development requires the researcher to work 'bottom-up' from the data, in which codes and themes are developed using the data as a starting point. A deductive approach relies on the researcher bringing in existing

theoretical concepts or theories as a basis of how researchers see the data and what meanings are coded (Braun et al., 2015).

This research took an inductive approach to analyse data. However, it is important to recognise that this research started with a deductive approach, from the creation of a research question and the initial analysis of literature, which were influenced by my chosen theoretical framework. However, though following repeated reading and emersion of the data, it became clear that my coding was moving beyond the surface level to a more inductive approach. (I discuss how my analysis evolved on section 4.11.2). As Terry et al. (2017) assert, analysis is something created by the researcher, at the intersection of the data, their theoretical and conceptual framework, their background or experiences as well as their research skills. Therefore, analysis cannot be strictly inductive and thus, themes cannot merely 'emerge' from data. To add, when researchers claim to have taken an inductive approach to data analysis, Braun and Clarke (2019), proclaim the significance of quality, researchers are encouraged to follow quality assurance frameworks, such as being reflective and reviewing themes, both of which have been discussed in this thesis (see Chapter 7).

The data collected through the co-researcher workshops, FGs and interviews were analysed in the following way. First, I prepared the data for analysis by transcribing it and reducing the data into themes through the process of coding and representing the data (Creswell, 2007; Miles and Huberman, 1984). Further details are given below. According to Braun and Clarke (2006), patterns are identified through a process of data familiarisation, data coding, theme development and revision. The analysis of the three data corpora was conducted using NVivo software. Although Silver and Lewis (2014) maintain that conducting a robust analysis does not often require the use of a customised software, its use enables a transparency about how researchers go about their data analysis, by more easily illustrating the tasks we engage in, their sequence, role, and documentation (Silver and Lewis, 2014, pp.11-12). Richards and Richards (1991, cited in Welsh, 2002) claim that the use of software in the data analysis process adds to the rigour of qualitative research, adding that a computer-assisted interrogation of data is far more accurate than attempting to search for terms manually.

However, Ishak and Bakar (2012) warn against relying on electronic or manual methods of analysis, advising researchers to combine the best features of each method. Consequently, I decided to use an alternative manual method to double-check the data analysis. I selected two interview transcripts which myself and the co-researchers could re-code. This manual re-checking did not take much time because I was already familiar with the content of the transcripts. I met with one of the co-researchers to go through the coded data, which found the same outcomes as my first data analysis.

4.11.1.3 Thematic analysis process

The data analysis for each phase of data collection followed the six-phase thematic analysis (TA) process described by Braun and Clarke (2006):

Phase one: Becoming familiar with the data	Phase four: Reviewing themes
Phase two: Generating initial codes	Phase five: Defining themes
Phase three: Searching for themes	Phase six: Writing up

Table 4.2: Braun and Clarke's (2006) six-phase framework for doing thematic analysis.

To enable a thick description of the analysis process, there is, therefore, a need to ensure rigour. This section explains how this was achieved in my study, and is divided into six phases of data analysis, each employed in the workshop, focus group and interview data. The first discusses the process by which the data from the training workshops were analysed. This is followed by the same information for the focus groups and interview data. The last part of this section merges the themes and subthemes to create an overarching representation of my data analysis, illustrated in Table 4.2.

4.11.2 Data analysis process

Phase One: Familiarisation with the data

The audio recording and transcripts of the co-researchers' training workshops, focus groups and interviews, were first imported into NVivo. I then commenced the process of editing, reading and re-reading and re-listening to each transcript, checking for accuracy and identifying provisional analytic ideas (Terry et al., 2018). This process enabled contemplation of the expressions and meanings conveyed by research participants and involved keeping notes and memos of ideas, which I referred back to in the later stages of analysis, NVivo was a vital tool used in the organisation of data for this project.

Phase Two: Generating initial codes

Having developed a sense of the overall dataset and noting casual observation notes in the initial phase, Phase two involved the generation of codes. The process of coding refers to labelling and systemising data (Terry et al., 2018; Gibson and Andre, 2010); it is an active process of identifying relevant data within each data set and helps the researcher in making sense of the data, develop insight, as well as provide a rigorous and thorough foundation for analysis (Terry et al., 2018. P. 26). I, therefore, began coding by identifying segments that had meaning and were relevant to the research question, here I focused on identifying relevant data within each data item (interviews, workshop, and FGs). Using NVivo, I then tagged the codes with a phrase that captured the meaning of that data segment.

I coded at a latent level; this meant that the analysis went beyond just describing the data to identify the underlying ideas, assumptions and conceptualisations, thus aiming for a deeper understanding of the data, that is, beyond description to interpretation. I was guided by open-ended questions like 'what is happening here?' (Creswell, 2007, p.153). The data were analysed inclusively (I retained contextualising data surrounding the coded data extracts when appropriate). At this point, it was necessary to allow the data to speak for itself rather than being prematurely reinterpreted. I coded exhaustively (I did not limit the number of codes a data extract could have and used more than one when appropriate), for example, data that belonged in the data segment of 'education' was also tagged in the data segment of 'education about FGM'.

This stage was vital in helping me organise and reduce my data into patterns. Therefore, I ensure all my codes had enough information about the content of the data but also

had enough analytical interpretation, Braun and Clarke (2013), called this 'take away data'. After coding all the data items, I compiled and developed a list of coded data, which identified both patterns and meaning of the dataset.

Initial codes	Data segment	Exploratory comments
Gender roles	"If you compare it to boys, girls would have more complications than boys. Boys would agree until they know more about it then they would be disgusted and disappointed.	•Seems to be comparing male circumcision to FGM. •Boy's may be in favour of FGM because they do not know about it? •General idea that boys may not be aware of the practice, therefore, have differing views.
Interpretations of FGM	"And also in my religion obviously I believe in Allah so I believe that he is the only one that can change stuff in your body and you are not the one that, erm you are not able to do that. He is the only powerful one because he's obviously created you the way you are, and he does not want you to change that. It's like you getting like plastic surgery just because you don't like the way you look. That's how Allah created you, and you can't do anything about that".	RELIGION- against the practice: 'That's how Allah created you, and you can't do nothing about that'.
Identity and status	"I don't know, because it's not something that concerns me, because I'm not like, none of my family relatives have gone through it, and it can't happen to me ((thank God)). But like I guess I would learn a bit more because it's something that's happening and shouldn't be happening and ways to prevent it".	It cannot happen to me Not our problem Sex discussions- uncomfortable Men don't have to go through the pain women do (FGM) The concept of Othering- Not my problem/ I don't have that body part.

Table 4.3: Example of the coding process.

Phase Three: Searching for themes

According to Braun and Clarke (2013), an overarching theme is an umbrella concept under which different themes might be developed. Subthemes are clustered underneath themes, sharing the same central organising concept as the theme they sit beneath but developing one distinct aspect or element of it, which is often useful when there are notable aspects worth highlighting. The aim was to analyse each data corpus individually and create a thematic map, and this visual presentation of candidate themes, aided in identifying patterns across the whole dataset. The themes and subthemes were further refined following discussions with the supervision team, resulting in the themes and subthemes discussed in Chapter 6.

As there were multiple ways in which the codes could be combined into overarching themes, I spent some time considering alternative groupings and tried to be flexible and creative with my thinking whilst also, crucially, being methodical and careful with the data. The aim here was to maintain an overall sense of how the material presented itself, as well as a level of open-mindedness about the crossover of themes. This was a difficult task because of the frequent overlapping of the themes and subthemes, resulting in data being categorised more than once between the datasets. Throughout the coding process, I used a constant comparative method; this meant that I compared data applicable to each code, renaming or adding them to existing codes.

An overarching thematic map was used to depict all themes and subthemes within a data category for each of the three data corpora (Interviews, focus groups and workshops) I did this for each separately to start with to enable me to identify potential themes across the whole data set visually. The preliminary thematic map below (Figure 4.3) shows the initial themes and subthemes from the workshop data, illustrating four central points with several branches coming off them.

For example, in the preliminary thematic map (Figure 4.3) below, the theme 1, was 'it's a cultural thing' with the subthemes 'can't talk to parents' and of 'unspoken taboo'. The words not in boxes represent parts of the raw data from participants. While these themes and subthemes were broad at this stage, the process of visualising the data helped in conceptualising the data.
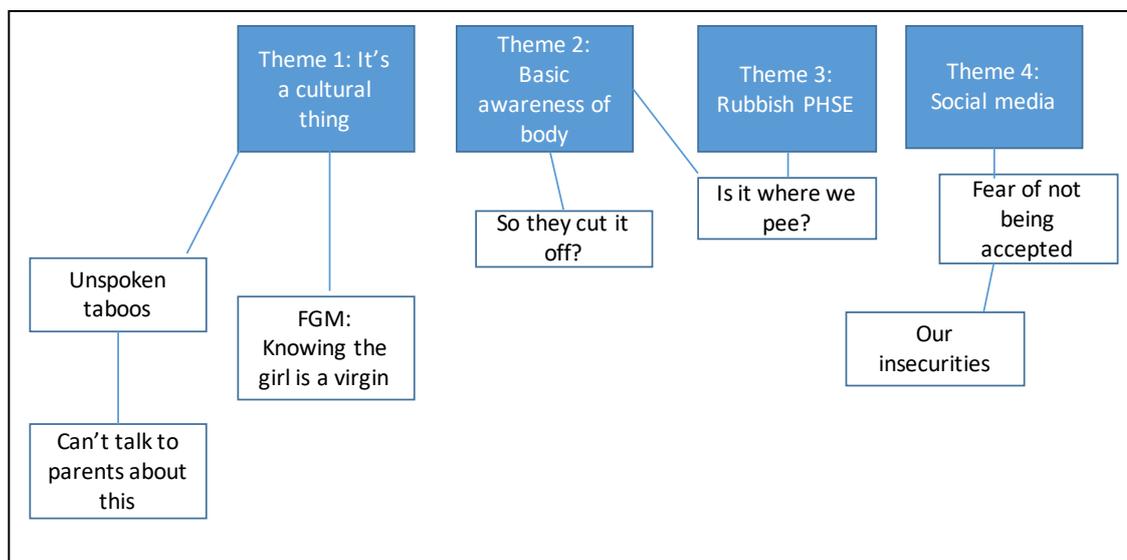
Figure 4:3: Preliminary thematic map of workshop data.

Preliminary Focus group and Interview thematic map

The focus groups followed the same process: Phases One to Four. A thematic map (shown below) was utilised to visualise the themes and subthemes that emerged from the analysis. The themes identified were: 'control of female sexuality', 'inadequate PSHE', and 'the law can't stop people doing it', with subthemes around '*safety*.'
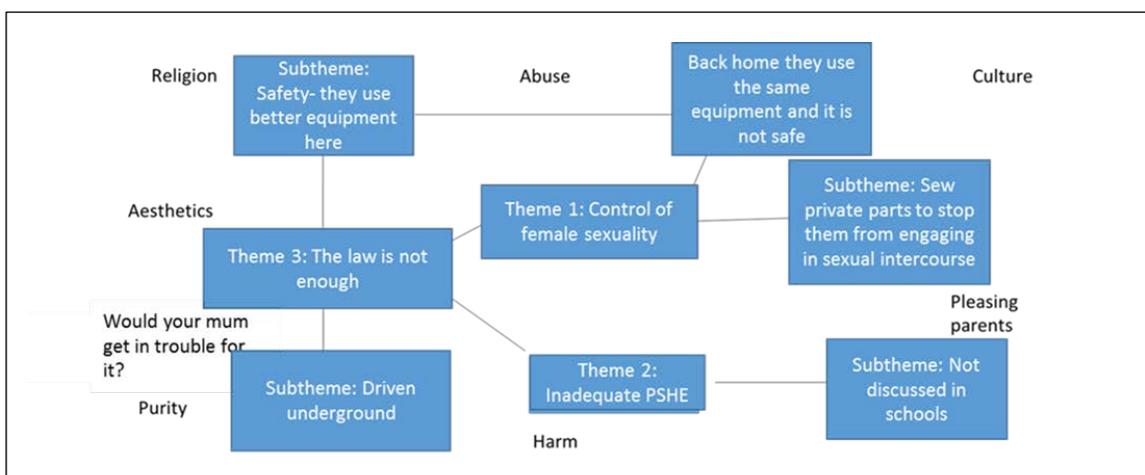
Figure 4:4: Preliminary thematic map of the focus group.

Interview data analysis

Figure 4.5 below shows several themes that emerged from the interview data; at this stage, it was important that the data speak for itself rather than being prematurely interpreted. Therefore, the thematic map retains the original language used by participants; for instance, 'I don't have that body part' was a direct quote from one of the interviewees.
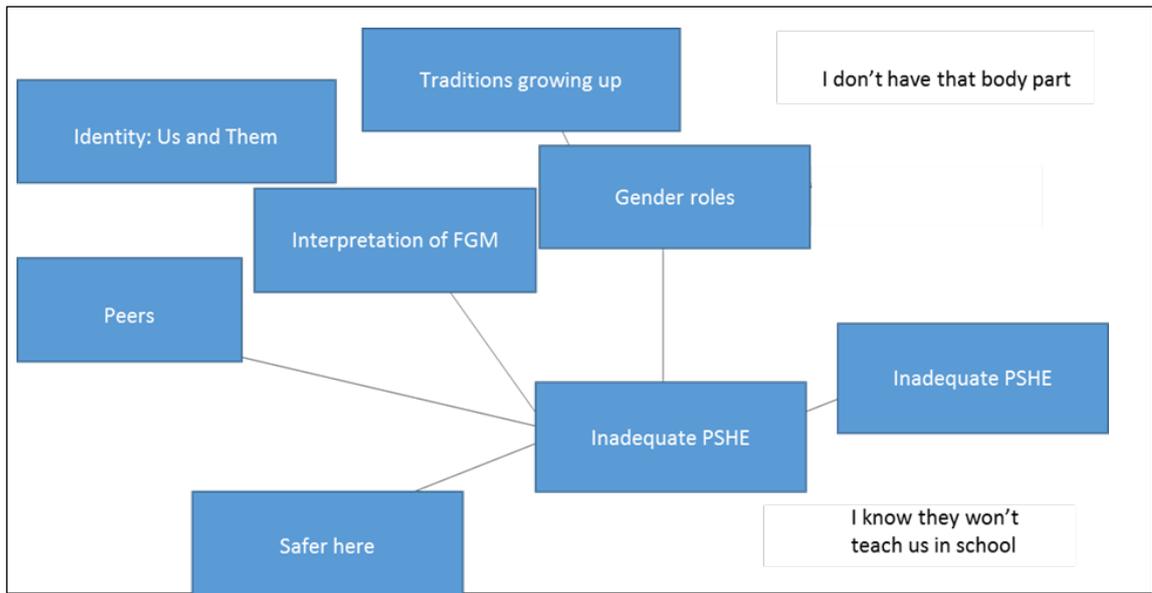
Figure 4:5: Preliminary thematic map of interview data.

Phase Four: Reviewing themes

Following a review of these initial themes arising from the co-researcher training workshops, the focus groups and interviews, in discussion with my PhD supervisors. At this stage, we reviewed candidate themes highlighted and going back to the whole data set, rather than merely reviewing the thematic maps, asking questions like do the themes capture the meaning in the collated, coded segments?' (Terry et al., 2019).

 While meeting with the supervision team and following their feedback, I repeatedly refined the themes, rejecting some and modifying or collapsing others into subthemes.

I become conscious that my coding strategy was descriptive and required a deeper-level interpretation. To achieve this, I returned to the initial codes and recoded using specific words, looking for similarities across the three data corpora. For example, 'gender roles' was initially a theme. However, closer attention to the language used by the interviewees uncovered a more in-depth interpretation which led to the overarching theme of 'meaning and interpretation of FGM', with one of the sub-themes being 'cultural beliefs and interpretations', developing a more in-depth interpretation of the data.

I reviewed the accuracy of the themes repeatedly at the level of the individually coded data extracts, examining whether my interpretations across the data reflected what had

emerged at the individual participant level, meaning that the initial codebook was updated, adding and removing codes. Additionally, as a form of data triangulation, I compared and cross-checked the data from interviews, workshops and focus groups. According to Braun and Clarke (2013), triangulation within a constructivist theoretical framework aids in obtaining multiple perspectives, because it enables the researcher to gather multiple viewpoints on the phenomenon of interest and to amplify the participants' perspectives. Therefore, it allows for a deeper understanding of the research question and explores multiple realities in relation to it.

Phase Five: Defining and naming themes

According to Terry et al., (2019), the researcher needs to consider whether the story told through the themes answers their research question, if it the analysis is rich and captures the meaning of the data well, but does not answer the research question, then the researcher must tweak the research question, rather than restarting the analysis. Here, I reviewed my research aims, one of which involved developing a tool for young people to learn about FGM. I quickly realised that my data did not meet this aim, I, therefore, modified the aim to *use a CBPR approach to explore with young people the acceptability and value of current FGM prevention approaches and to gather their ideas and suggestions for improving and developing these.* This flexibility and openness are key features of qualitative research.

I then proceeded to define the naming themes ensuring there was clarity about what each of the themes was and what it was not—delving deeper into the data, to a more interpretive orientation rather than simply listing the codes. This involved telling writing the analysis, by telling a story and defining each theme, this involved writing a summary of what each theme meant 'like an abstract for each theme' (Terry et al., 2019. P.30) ensuring clarity, cohesion and quality of the analysis process and that each theme has enough depth and detail and can stand alone as a key chapter. Terry et al. (2019), also discuss the importance of theme names, where researchers sometimes come up with witty theme names even though a closer look may reveal that they do not work well with the data. For example, in this research, the theme 'telling it like it is' was initially 'heard it through the grapevine'. However, following meetings with other members of

the supervision team and developing my analysis helped define this theme more clearly, it was apparent that 'heard it through the grapevine' did not capture the depth of the data, young people in this theme were exploring how they learnt about FGM, what they wanted to learn and who they wanted to teach them'. Therefore, the title 'tell it like it is' suited the content of the data.

The results were categorised and subdivided into themes and subthemes containing units of data (quotations). The overarching themes are depicted in Figure 4.6 below.

Overarching Themes and subthemes.

Theme1 :Meanings and interpretations of FGM.	Theme 2: Interpretation of the legal context.	Theme 3: Identity and status.	Theme 4: Leaning about FGM.	Theme 5: Telling it like it is.
Subtheme: Cultural belief and interpretations.	Subtheme: It's a crime.	Subtheme: Us/them.	Subtheme: Parent-child relations.	Subtheme: Where I want to learn.
Subtheme: Control over women's sexuality.	Subtheme: Injustice.	Subtheme: Emotional reactions to FGM.	Subtheme: Mixed information.	Subtheme: When I want to learn.
Subtheme: Safer here.	Subtheme: Choice.		Subtheme: Younger generations educating mother.	Subtheme: What I want to learn
				Subtheme: Who I want to teach me.

Figure 4:6: Overarching themes and subthemes.

I produced a narrative account for each theme and subtheme, which occurs in the analysis provided in Chapter 6. The data themes and subthemes were reviewed and discussed with my supervision team and one co-researcher, in the process of member-checking to improve robustness. As such, this helped me maintain the quality and rigour of my analysis and to develop an account of the data that was meaningful and informative.

Phase Six: Producing the report

This point involves producing the final report. Having written my analysis early on, this meant bringing together my familiarisation notes, codes, theme abstracts and analysis.

All these documents aided in weaving together data, analysis, and linking this back to my literature review. According to Terry et al., (2019), the analysis evolves from simply being analytic to coming back to the bigger picture of the overall project.

4.12 Research quality and rigour

A careful and detailed approach to analysis and theorisation forms the basis of my claim to research rigour. A detailed description of how the research evolved and how my methodological choices were made, as well as the way the study critically considered how participation was framed in relation to young people discussed in the earlier sections of this chapter. In this subsection, I highlight the quality criteria used in this study.

When collecting data in collaborative research, it is important that researchers ensure the quality of their data. Waterman (1998) has argued that rigour in CBPR is illustrated by maintaining the philosophical ideals of CBPR; in other words, the researcher must conduct research that is ethical and sensitive to participants' lives. When judging trustworthiness in qualitative research, Seale and Silverman (1997) claim that it cannot be determined using terms like validity, which is often linked to a positivistic approach; therefore, Patton (1999) recommends using the criteria of trustworthiness in relation to qualitative data. Trustworthy research is that which is conducted fairly and ethically, and whose findings represent the participants' experiences as closely as possible (Padgett, 2008). Lincoln and Guba (1985) have developed criteria for assessing trustworthiness, which includes: credibility, transferability, dependability, and confirmability. These criteria for judging qualitative research are outlined below, along with a discussion of how these are evidenced in this study.

Credibility is assessed by the data being perceived as credible and believable from the perspectives of those who participated in the study. This can be verified in several ways, for example, according to Thomas and Magilvy (2011) the researcher should seek to present an accurate description or interpretation of the phenomenon under study that would allow others who have shared the same experience to relate with the findings. There are several ways in which a research project can establish credibility. This research utilised the following strategies: reflexivity, researcher debriefing (discussion of findings with co-researchers) and prolonged engagement (developing trust between researcher

and research participants) (Stinger, 2007). Furthermore, the interview and focus group techniques used were in line with CBPR principles, and the final report provides the participants' accounts by citing their own words (in vivo).

Due to the nature of the study and the inability to reach some participants after the interviews and focus groups, it was difficult to share my findings with the participants to ensure accuracy. Therefore, member checking (Thomas and Magivly, 2011; Birt et al., 2016) was difficult to complete. This was due to several reasons: firstly, due to the sampling method used, the researcher utilised opportunity or otherwise purposeful sampling to gain access, and therefore, the young people were mostly only able to meet once for interviews and once for a focus group.

Transferability refers to presenting research findings in such a detailed way that there is enough information for the reader to apply them in another research context. For instance, Guba and Lincoln (1985) recommend providing a thick description of the methodology and data about participants (demographics) and the context in which the data has been collected. Although this description is plausible, Hammersley (2007) suggests that a researcher's account will only be one representation of that reality, rather than reproductions of it. Additionally, Wallerstein and Duran (2011) observe that the primary goal of CBPR research is to create knowledge and produce social change in local communities because each community is unique and complex. As such, the results might aid in building interventions as well as an understanding of the phenomenon that informs practice.

What is transferable, however, is the description of the research process rather than the findings. I acknowledge that another researcher may undertake a similar study and make a different interpretation of the responses, which is equally valid. Gross (1998, cited in Shanton, 2004) believed that her study of multiple environments provided a baseline understanding of the phenomenon under study and that preceding work should be compared with it. Shanton (2004) adds that her aim is not for future researchers to achieve the same results but for the research design to be viewed as a 'prototype model' (p.71).

Dependability is concerned with whether other researchers could draw the same conclusions based on the data. Therefore, it requires a description of a clear audit trail

of the research process, and this also establishes confirmability (Guba and Lincoln, 1982). This includes documenting and describing *all stages* (emphasis added) of the research process, including data collection and analysis and interpretations. This is achieved by a) describing the specific purpose of the study; b) discussing how and why participants were selected for the study; c) describing how the data were collected and how long the data collection lasted; d) explaining how the data were reduced for analysis; e) discussing the interpretation and presentation of the research findings; and f) communicating the specific techniques used to determine the credibility of the data (Thomas and Magilvy, 2011, p.153). This process is discussed in the research process section of this chapter.

4.12.1 Triangulation

In qualitative research, triangulation is defined as the ability to explore problems from several vantage points to strengthen the reliability of results (Hastings, 2010). Denzin (2009) notes that triangulation involves the employment of multiple external methods of data collection, as well as the analysis of that data. Moreover, it can involve correlating the findings with multiple researchers (investigator triangulation), using and correlating multiple theoretical strategies (theory triangulation), multiple data collection methods (methodological triangulation) and correlating people, time and space (data triangulation). This means that information can be checked at different levels to enable a reasonably accurate interpretation (Denzin, 2009). Investigator triangulation and data triangulation were used as ways to test the validity of the data through the convergence of information from different sources (Denzin, 2009; Patton, 1999; Golafshani, 2003).

This research sought to involve the co-researchers in all the data collection methods, allowing for the confirmation of findings from different perspectives and adding breadth to the phenomenon of interest. Although the intention to achieve full involvement was evident, due to time and other limitations, the co-researchers were unable to be present in all the interviews and focus groups.

Chapter 5 Facilitating active learning processes for co-researchers

5.1   Introduction

Having discussed the methodology and methods utilised in this thesis, this chapter describes Phase One of my research, the process of engagement with the co-researchers and the training developed to prepare them for the Phase Two fieldwork. It explains and reflects upon the participatory process used to engage with and train the co-researchers. I have already discussed recruitment and gaining consent in Chapter 4. The participatory approach discussed in Chapter 4 was used to foster a collaborative process of co-production, in which individuals recruited as co-researchers became progressively involved and empowered to shape and deliver the Phase Two research with other young people, recruited from their peer group. It was, therefore, essential to approach these co-researcher recruits on an equal basis, valuing their status and contribution and forging a relationship with them based on trust and reciprocity.

According to Connolly (2008), training that prepares young people for their researcher role is required in participatory research. While this is true, I propose the term a 'collaborative process of co-production' be used, thus highlighting the process of building trust and reciprocity, where the individuals recruited become empowered partners within the research process. Simply 'training' young people alludes to an intrusive, standardised and deterministic approach that risks becoming less participatory and more adult-led, thus potentially even 'tokenistic'. Therefore, although the term 'training' is used in this section, it represents the collaborative process of co-production.

5.2   Team building processes

A growing body of literature on community partnerships calls for attention to be paid to group dynamics (Becker et al., 2005) yet, according to Wallerstein et al. (2005), group dynamics in relation to CBPR is understudied. Johnson and Johnson (2014) suggest that

group dynamics involve the nature of groups' behaviour and group development, as well as interactions between groups and individuals. Having knowledge of group dynamics enables researchers to understand ways in which groups function, as well as ways to improve their interactions. Wallerstein et al. (2008) add that there is no effective technique for developing a CBPR partnership. Therefore, this research draws upon Johnson and Johnson's (2014) guidelines for creating effective groups which state that, 'for groups to be effective, they must do three things: achieve their goals, maintain partnerships and be adaptable' (Johnson and Johnson, 2014, p.23; see also Wallerstein et al., 2005, p.383).

Moreover, groups develop and evolve, therefore, to enable a discussion of the developmental stages in this group, I utilise Johnson and Johnson's (2014) life cycle model, which builds on Tuckman's (1965) linear progressive theory. They identified seven stages of development: defining and structuring procedures, conforming to procedures and getting acquainted, recognising mutuality and building trust, rebelling and differentiating, committing to and taking ownership of the goals, functioning maturely and productively, and terminating.

Due to the sensitive nature of this project, it was important to create an environment that would foster positive group relations. This was important for three reasons: firstly, given the profile of the co-researchers, I anticipated that most of them would share some common ground, and therefore would be able to share their anxieties with each other and also give advice. Secondly, from a learning perspective, it was assumed that they would be willing to participate in exercises, as well as discuss sensitive issues if they felt secure and knew each other. Johnson and Johnson (2003) explain the importance of supportive group dynamics, stating that this will assist the decision-making or problem-solving processes. Thirdly, it was essential to keep up the momentum of the project, so as to deter anyone from dropping out. In this sense, I hoped that they would develop friendships and might, therefore, encourage each other to attend the sessions.

At the early stages, consideration of time was vital, since I was faced with university deadlines as well as the need to follow the core principles of CBPR, that is, to develop structures that support trust and partnerships, which required time. I was aware that once the foundation of trust was developed, setbacks within the group could be seen as

part of the long term process of co-learning, thus improving the credibility of the research and avoiding bringing the whole project to a halt (Hanckock and Minkler, 2012, cited in Wallerstein et al., 2015).

Although time is an important element in CBPR partnerships, Bradbury-Jones and Taylor (2015) argue that the process of co-production is context-specific. Therefore, time and frequency depend on a number of variables; including the duration of the study and the scope of involvement. Although generally, programmes that engage in co-productive research range from 12 weekly sessions to a one-week workshop (Kellett, 2005; Porter et al., 2010), in this research, the co-productive process (Phase One) took place over a period of five months, followed by Phase Two lasting one year and a half, that is, two years altogether.

It may be argued that five months was insufficient, however, according to Wallerstein et al. (2011), building research relationships is often easier when the researcher has previous relationships with the communities under study. As explained above, I had previously worked with two of the co-researchers in projects, and this enabled the continuation of forming trust with the other members. Therefore, the time needed to build relationships was perhaps minimised in this situation.

I must acknowledge that the period required to build such trust must not be taken for granted, however, having worked with the community for a number of years and with some of the parents of the co-researchers, I found that these prior relationships enabled both parents and co-researchers to gain a vested interest in this project.

5.2.1.1   Culture circles

The training aimed to engage with the core values and principles of CBPR, advocating respect for multiple sources of knowledge, while also enabling group development processes. Therefore, there was no hierarchy where anyone was considered more knowledgeable than any other, rather, a sense of equity and collectiveness was formed, to create the shift into collaborative partnerships. According to Freire (1970), culture circles are dynamic spaces of learning and knowledge exchange which value the group experience and promote participation in the construction of a collective, contextualised

knowledge that is committed to social change. The application of this method requires researchers to serve as learners within the group, going against the traditionalist researcher-researched role.

The goal was to maximise the involvement of co-researchers in the research process (Heron and Reason, cited in Reason and Bradbury, 2001). Therefore, this team-building stage required a model that privileges young people's experiences in the participatory process, granting them the power of speech and freedom of expression, utilising culture circles, thus preparing them for the second phase of the research. According to Souto-Manning (2010), there is no predetermined formula for the implementation of culture circles. Drawing on Freire's (1970) culture circles framework, the seven stages of the team-building process are now summarised and discussed as prioritising goals and objectives, building group membership, participatory decision making, negotiating power and developing trust.

5.2.2 The context and setting

To enable the facilitation of effective culture circles, I approached a participatory development consultant, whom I knew from previous projects. Following a discussion with the supervision team, the consultant was chosen due to her experience working with marginalised groups on sensitive issues, including FGM. Our first meeting was in August 2016, and our aim was to discuss the length and content of the training. Boyden and Annew (1997) emphasise the importance of facilitators allocating sufficient time together, as this aids in facilitating an active learning process that meets their specific interests, experiences, and group expectations. Subsequent to this meeting and extensive literature review, an initial structure for the training was developed. An important component of this research was my ability to reflect on the processes as they evolved, as shown in the extract below from my reflective diary, written in 2016.

Reflective journal extract:

> This draft training plan is developed for training a group of young people from FGM practising communities, as researchers who will adopt participatory research

methods. It is in draft outline as it will develop throughout the training process with the young people as much will depend on early sessions and recognition of needs of the particular group of young people. Furthermore, the sessions may be run as three hourly sessions or a number of sessions running together as a full-day training

Image 5:1: The planning phase

The meetings held with the consultant produced a number of brainstorming ideas (see Image 5.1). I began to envision the practical requirements involved in engaging young people in the design and implementation of the project:

Reflective journal extract, October 2016:

> What is a suitable time for young people, will they be too tired after school? Are 12 weeks enough? It is wintertime, are they safe to go home late? Where is the best location?

These ideas had a significant bearing, not only in the way the research was conducted but also on the initial feasibility of the project. It was likely that constraints and compromises would be imposed by several of these issues from the start. It was, therefore, important to consider these issues and discuss them with the co-researchers.

5.2.3 Prioritising goals and objectives

By the time the co-researcher group was formed, myself, the PhD supervision team, and the external consultant had spent several weeks framing the research project. The goal upon meeting with the co-researchers was to facilitate a research project that was co-produced; therefore, young people were encouraged and aided to make decisions about the project throughout, by reviewing the proposed training content and discussing the timeframe as well as the practical issues. Bergold and Thomas (2012) emphasise the importance of equitable roles within the research process, enabling opportunities to rethink and question the processes.

Freire (1970) stipulates that the initial step in developing culture circles is generating a problem that is socially and culturally relevant to individuals' lives. This problem is then employed in dialogues within the circles. In line with this approach, an initial consultation was held with the co-researchers to help define and consolidate the research design. This preliminary consultation also aimed to respond to more ethical and inclusive research with young people, which goes beyond tokenism to meaningful participation during the research process (see also Graham et al., 2013).

I proceeded to contact the prospective co-researchers to discuss the time and location of the first meeting. The group agreed to meet at the University of the West of England. It was during school holidays; therefore, we had some flexibility in time and decided to meet at 3 pm. Five co-researchers attended on the first day, two of whom knew each other from previous projects.

Reflective journal extract, 2017:

> The meeting was planned for 15.00 start, myself and the other facilitator were first to arrive. The room was set up like a typical classroom; we decided to create a more engaging atmosphere because we did not want the room to feel like a classroom. Retrospectively, due to the meeting being held at the university, this meeting felt more controlled by myself and the facilitator. When the co-researchers entered the room, not all at once, they sat down in a semi-circle, while we stood at the lectern, unconsciously mimicking the teacher-student environment, which we were attempting to undo.

According to Johnson and Johnson (2014), the initial step is to discuss group expectations. Following the group's self-introduction, we began the session with expectations and functions of the group, as well as reiterating general issues around consent and the right to withdraw. The co-researchers were also given a resource pack that included a notebook, pens, and leaflets from relevant organisations, as well as contact details of FGM centres. It was important that the co-researchers were aware of such places that provide help to those affected by the practice since it was envisaged that these could be passed on to their peers as well as family members, and the co-researchers could also seek help from them if required.

Reflective journal extract, 2017:

> As the day proceeded, I noticed that some of the co-researchers were reserved and not participating in discussions. One assumes this was due to unfamiliarity; they were new to this and new to the group, time was required to create a sense of belonging and to build the group membership.

Johnson and Johnson (2014) argue that positive relationships among groups promoted by supportive efforts often result in high levels of group cohesion. Group cohesion is defined as the mutual attraction between group members that promotes the desire for individuals to remain in the group (Turner, 2001). Enabling group cohesion creates a greater likelihood of goal achievement between groups and group attainment, as well as group success at recruiting new members (Levine and Moreland, 1998; Mobley et al., 1979; Sprink and Carron, 1994, cited in Johnson and Johnson, 2014).

Reflective journal extract, 2017:

> On this day, in an attempt to engage the co-researchers. We suggested we sit on the floor and work together. However, they did not want to do so; the co-researchers sat on chairs, mimicking a classroom (teacher/student) scenario.

To enable and facilitate group cohesion, we adopted a range of creative techniques, combined with activities and exercises, and built breaks into the sessions. Boyden and Annew (1997) emphasise the importance of using warm-ups and cool-downs to create a participatory atmosphere and improve group solidarity. However, the authors also warn that these activities may present problems, unless facilitators make sure they are handled accordingly, stating that warm-ups should:

- Be non-threatening
- Be culture, religion, and gender appropriate
- Be non-competitive
- Challenge the power imbalance
- Be inclusive
- Be within the physical capabilities of all participants

The rationale for these activities was to break down tensions and foster an open, participatory environment. We started with a game called the 'teen talk jar', to aid in stimulating conversations. Each person was given a question which they were encouraged to answer, for example:

"If you could give up TV for one year, what would you do with your time?"

Some answers included:

"I would talk to my siblings probably, annoy my brothers more."

"I would read, I don't watch TV anyway, too much school work."

It was important to encourage participation and enable the process of co-learning, therefore both co-researcher facilitators engaged in the discussions. Researcher involvement can aid co-researchers to feel more comfortable in sharing information and close the hierarchical gap between researcher and co-researcher that traditional research encourages (Bergen, 1993; Oakley, 1981), thus promoting dialogue rather than an interrogation.

Following introductions and the ice-breakers, the co-researchers were encouraged to make choices about ground rules, thus also establishing group norms. Johnson and Johnson (2014) state that norms are rules established by groups to regulate behaviours

of all members, adding that norms cannot be imposed in a group, rather, they are formed through a process of interaction among members.

In our group, conversations also included discussing confidentiality and disclosures. In reality, 'a conversation' on confidentiality and disclosures, became a central theme that was periodically revisited and redefined throughout the training. An example of these discussions are given below, followed by the norms the group agreed upon.

> Facilitator: "So, we wanted to have a quick conversation with you all around some thoughts and ideas of what you might suggest for ways that we can ensure that this is a safe space for everyone, Is that OK with everyone?"

- We discussed the importance of communication; that is, if someone was unable to attend a session, they should notify the group beforehand.
- Timekeeping was also an important aspect of the training. Young people recognised that part of the process was learning about time management.
- The group engaged in an open discussion about confidentiality and disclosures, and what this meant to them.
- Respect, which included looking out for each other.

The establishment of these group norms was central to influencing group behaviour. Johnson and Johnson (2014, p.17) assert that most groups tend to adhere to their group norms; this might be due to rewards at the initial stages of the group's formation. However, the individual then internalises the norms and conforms to them automatically, even when others in the group are not present.

The session then proceeded to discuss learning objectives as well as the practicalities of co-production. Merves et al. (2015) encourage researchers to acknowledge the development needs and capacities of their co-researchers. Therefore, the aim here was to orient the co-researchers and to communicate with them the purpose of the training as well as to discuss expectations. It was recognised early on that this process would be slower-paced and often process orientated to the co-researchers' abilities as well as interests at that time. The young people were encouraged to contribute to the discussion:

Facilitator: "This is an open space, so please feedback on your thoughts about the contents and if we need to add anything. In this group, we are working together and learning together. Therefore, I need to know what works for you and vice versa."

At this stage, the body language of the group remained guarded and perhaps apprehensive about what the process entailed. The seating arrangement resembled that of a classroom rather than a culture circle of a group working together. Perhaps due to the group's tensions and the lack of familiarity, it was natural to sit this way. Throughout this process, the co-researchers provided limited input and did not demand a larger role; they appeared to be content listening and taking the roles of students. Undoubtedly, co-researcher expectations were conditioned by their limited involvements in the previous planning or the research; in other words, their lack of involvement from the inception might have contributed at this stage.

As the session evolved, we engaged in a second ice-breaker game called 'Elephant, temple and flower'. For this game, participants were split into pairs, the game involved no speaking or prior planning, and each pair had to draw an elephant, a temple and a flower together.

The co-researchers had met for the first time that day, so, although they did not know each other, this task was fruitful in creating an engaging atmosphere between them. According to Johnson and Johnson (2014), tasks that involve collaborations result in greater continuing motivation for working together.

It was recognised early on that the co-researchers were effectively taking on a dual role, both as students in their own right and as researchers on an active research project. Therefore, they not only began with anxieties about being a researcher, particularly in the first few sessions, but they also vocalised concerns about conducting the researcher role, and the need to balance their co-researcher role with their college or schoolwork. The co-researchers were thus encouraged to express their hopes, expectations, and concerns about the training (Israel et al., 2008; Jewkes and Murcott, 1998). This input would be used at the end of the training as a method of evaluation, together with the four-dimensional cube developed by Gibson et al. (2017), discussed in the subsequent section of this chapter.

Expectations and worries expressed by the co-researchers were to:

- Gain knowledge of FGM within the community.

- Gain new skills such as research methods.

- Ability to discuss what they had learned with others, specifically on FGM.

- Worries about conducting interviews and FGs alone.

- Prioritising college/university and research (time commitments).

The first day also involved discussing the logistics of the training. This session formed the foundation of all subsequent sessions; it was, therefore, essential to discuss practical matters such as location and time of future sessions. The group decided to meet at a central location, which would enable them to travel by bus, and their transport costs would be reimbursed. We also decided to meet on Mondays and, considering this would be after school, food and drinks were provided in each meeting.

We also discussed the ways we would communicate. The co-researchers decided to start a WhatsApp group where they would all communicate about the project and discuss other issues they were facing. They decided to add the researcher to the main WhatsApp chat but also to have another one which I was not a member of.

5.2.4 Building group membership

There are several challenges in the development and maintenance of successful group partnerships, such as lack of trust or respect, as well as unequal power relations (Israel et al., 2008; Sullivan et al., 2003). Therefore, it was essential to recognise these processes during the initial phase, including how the group worked together; this stage also included rebelling and differentiating (Johnson and Johnson, 2014).

It is often articulated that, in CBPR research, researchers have the ultimate power in the project. DeVito (1993) offers an alternative to this principle, noting that, in relationships, the more powerful person is the one who can exit a project without difficulty, has less need for rewards and can easily endure other's punishment. Therefore, the more a person needs the relationship, the less power they have. This is an interesting shift in ideas of power relations and, if applied to this project, means that the researcher holds less power, as the project's success was dependent on the co-researchers' willingness

to participate, holding power to exit or not participate at any time, which sometimes left me as the researcher powerless.

Ultimately, however, there was no real way to avoid tension associated with the ongoing negotiation of power. There were times during the project where I would send a communication through the WhatsApp group to arrange meetings, and would not receive a reply. In fact, a lot of time was spent trying to arrange meetings and sending messages to no avail. At times one co-researcher would respond as an attempt to reach the others. For example, I would send:

> "Hi all, I hope you are well. We need to arrange a group meeting, is (x) date or weekend, OK?"

No one would reply, I would then follow up:

> "Guys, can you please let me know when you are free?"

Then a co-researcher would reply:

> "When is everyone free…? Guys can you reply, or I'll start calling you all."

This led to unanimous reply, negotiating a date amongst themselves. Foucault (1980) states that power is inherently unstable and, therefore, able to be challenged. Habermas (1979, p.97) adds that 'dialogue is a gentle, but obstinate, never silent, although seldom redeemed claim to reason'. This research required respect, truth and a willingness to learn, removing all preconceptions, thus reducing both overt and subtle forms of power. Having discussed my insider role within the community in Chapter 3, this is a clear example of how power relations can evolve during the research process. By recognising my privileges, I was able to form an authentic partnership that also enabled the co-researchers to make their own decisions within the project.

Upon reflection, this was a frustrating time for me, partly due to impending deadlines and time constraints. However, it yielded meaningful learning for myself. Having read several articles about the practices of participation, this provided a more practical experience. It also illustrates the several ways we negotiated as a group and shows how people's roles transitioned over time. Wallerstein et al. (2011) highlight the need for

initiating, nurturing and maintaining partnerships. Although I agree with this statement, the role of maintaining these partnerships should be imposed on the whole team rather than the researcher alone. As the WhatsApp example shows, I as the researcher was unable to control the process, since the co-production required a working partnership.

As the training continued, it became apparent that equitable engagement does not imply that all partners will engage in every aspect of the research. An underlying assumption behind a collaborative approach is that each partner is unique and, because of this, they bring their perspectives and skills. During this training, it became evident that not all co-researchers were contributing to discussions; in fact, the introverts in the group remained guarded and silent. Therefore, the facilitators' roles were to recognise the uniqueness of each member, engaging them in other activities which they could contribute to, rather than alienating them. For example, drawing and group work activities generated significant findings.

5.2.4.1 Learning about FGM

In this research, it was essential to ascertain the level of knowledge the co-researchers had about FGM in a sensitive way; this was challenging, especially within a large group. Definitions and concepts of 'sensitive' research highlight the inherent threat to those involved, stemming from the personal nature of an issue such as FGM, which meant that discussing this had the potential to cause embarrassment, offence or disclosures. Adding to this, Tonkiss (2012) argues that, when discussing sensitive topics, individuals rather than groups are appropriate. However, it will also depend on the nature of the group. Although Tonkiss (2012) presents a valid argument, Wilkinson (2004) challenged the misconception that group activities are inappropriate for researching sensitive topics, instead, stressing the interpersonal dynamics within groups that would enable mutual comfort and reassurance.

Therefore, to facilitate a discussion in a later session, co-researchers were encouraged to draw a young girl before and after being educated about the subject of FGM. The instructions, as described to the co-researchers are shown in Image 5.2 below.
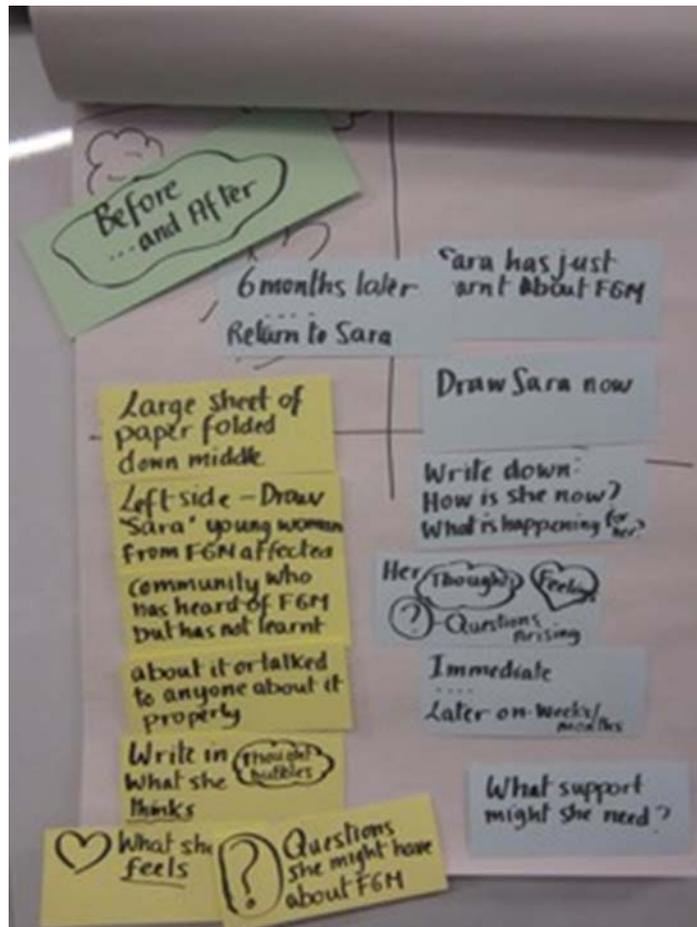
Image 5:2: Sarah, before and after exercise.

The co-researchers were not required to share their drawings with the group but were given the opportunity to do so if they wished. These results are discussed in depth in the findings in Chapter 6. However, during the session, each member was allocated fifteen minutes to share their images without interruption.

Researcher: "Would anyone like to share their drawing?"

The group was set up in such a way that the co-researchers did not feel pressured to share or present their work. Therefore, some declined, and no one questioned these decisions. It was evident that some of the group members were more engaged than others. Johnson and Johnson (2014) suggest several factors that may hinder group member engagement, for example, status and level of education. The co-researchers

who engaged at the beginning were those that had prior involvement in groups and those that were at university. The others were happy to listen but less willing to share.

The exercise was divided into two sections; the first involved the co-researchers drawing Sarah as being unaware of FGM, the second drawing was after they had completed the FGM session. Therefore, following the initial drawing, we proceeded with a group discussion about FGM:

> Researcher: "So, having completed the first stage, I think we should discuss what FGM means, so can anyone tell me their thoughts, what it means to you?"
>
> Rwaida: "What, the long one or a short one?"
>
> [Group laughs]
>
> Researcher: "However, you understand it. How would you describe FGM to your peers?"
>
> Rwaida: "Umm… I'd say, any form of harm to the female genital area, for non-medical reasons."
>
> Uba: "Well, I've heard this girl in my class, we were talking about it in sociology, and then she told me that it's a way of the men knowing that the girls are virgins".

The conversation then evolved into discussions surrounding the context in which the practice occurs.

> Uba: "I've heard it happens in Africa."
>
> Suraya: "It also happens in Kenya, Ghana."

This led on to labelling the external female genitalia. Here, I present the discussions that the co-researchers engaged in during this exercise.

> Facilitator: "The next step is to try and label the female genitalia."
>
> [Group giggles]
>
> Rwaida: "Oh my God!"
>
> [Group laughs]
>
> [Rwaida speaking to Uba]: "You need a pen too, trying to make me do all the work!"
>
> [Uba laughs]

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Uba: "The peeing hole" [referring to the urethra]

Dolla Sign: "The period hole? Like, this is gross to me"

Zuli: "We actually didn't do this in sex ED… Shows what the teachers do at school, right?"

Rwaida: "This is harder than my A-levels!" [Laughs]

Facilitator: "OK, what is that?" [Pointing to the clitoris]

Rwaida: "The clitoris."

Facilitator: "What does it do?"

Zuli: "I don't know, it's just chilling!"

[Group laughs]

Considering that this was the second day of the training, the group dynamics had begun to form. It was evident that these discussions were less formal, due to group banter and laughs, which made discussing FGM engaging and created an open learning environment. Although it was clear that the co-researchers were not aware of the anatomy and physiology, they were open to learning from each other. As my reflections reveal:

Reflective journal extract:

> Davina was rather quiet again. After a conversation with her today, she expressed willingness to join conversations but felt that her reserved nature made it difficult.

As the session continued and, in-between group exercises, the co-researchers engaged in their own discussions. Colucci (2007) recommends periods of 'free narratives' which help young people to settle in and provides an open environment where sensitive subjects can be discussed. For example, Valentine's Day was in the week prior to the session and the conversation during a break, was about this:

Uba: "So what did you guys do on Valentine's Day?"

Rwaida: "I got flowers!"

Facilitator: "Oh, from whom? Did it have a name or just random?"

Rwaida: "From my sideman."

[Group laughs]

Suraya: "Her side piece…"

[Group laughs]

Rwaida: "And perfume!"

Dolla Sign: "Let me know if he has a brother…"

At the time, the banter the group members shared helped form open and trusting relationships. The aim was to create an environment that was not necessarily controlled by myself, but one that enabled open dialogue, even though the conversation had moved away from the content at hand. The co-researchers saw this as a place to discuss their issues; therefore, they were free to form these dialogues, which illustrates the level of trust that was starting to form.

Following this session, I noted:

Reflective journal extract:

Today Davina was more willing to contribute; although she is not very vocal, she expresses her views through drawing and in group work.

5.2.5 Participatory decision making

Displaying trustworthiness and gaining trust are essential components in CBPR research. Israel et al. (2008) state that this is an ongoing process which must be continually earned and maintained. After the introductory session and the training on FGM, the co-researchers had already begun to form friendships; this was illustrated by meeting at college and walking to the training together and by the conversations they had during the training, for example, in between activities, the co-researchers discussed their school activities and exams:

Zuli: "I was so ill, I didn't do any revision. I was like, all this mock, I don't really care about the mock. But the teacher is really good."

Rwaida: "She is, I know. I managed to get 68 per cent in one of the mocks."

Although these two girls went to the same school, they had not spoken to each other until they formally met in training. These conversations illustrate the groups forming and perhaps bonding, due to similarities in their experiences, such as their lifestyle characteristics, shared beliefs, interests and religious backgrounds (see also Johnson and Johnson, 2014).

Possibly the most critical aspect of the culture circles was the commitment shown by the co-researchers and the ways that they bonded with each other. For instance, on one occasion, even though a co-researcher was celebrating her birthday, she had decided to attend the training after school. The other co-researchers and facilitators decided to celebrate with her on the day, and this is when we could see a sense of kinship develop.

> Rwaida: "Looks yummy, what type of cake is it? Does this have actual carrots in? I didn't know that carrots go in cakes."
>
> Zuli: "Yes, it's carrot cake."
>
> Rwaida: "It's actually got carrots [Rah!]"

The group developed a sense of togetherness. This is important because, as Israel et al. (2013) assert, an active group refers to mutual recognition among members as well as having a sense of belonging to the group. This belonging can be in the form of shared social norms, values and a sense of shared purpose, nurturing a sense of membership (Israel et al., 2003). In relation to this research, the group was composed of eight young people, a small number, which may have made forming relationships easier.

In addition to forming relationships, Brown and Lohr (1987) argue that young people may identify with groups to develop a sense of identity. Therefore, group names that young people give themselves illustrate shared beliefs and interests. As such, the co-researchers felt that they needed a name for their group and, by discussing amongst themselves, the 'Blossom Gang' was born.

5.2.6 Negotiating power and developing trust

Each week the co-researchers were encouraged to discuss amongst themselves and provide feedback on previous sessions. The co-researchers would interact through WhatsApp; then two would present the feedback to the group and facilitators:

> Suraya: "Hi, guys!"
>
> Group respond: "Hey."
>
> Suraya: "Hope you all had a good week and a good weekend. So we did the feedback as you know, and surprisingly, no improvement needed.
>
> Zuli: "So, we will start with the positive, as no negatives this week. We liked the case studies, it makes it more personal, and we can emphasise with them. It gave us a better understanding of the facts."
>
> Suraya: "Most of the people liked the interactive group work. We felt this helps to develop skills that we can use at work and school."
>
> Zuli: "And also, although we met each other three weeks ago, we are learning to work with each other. This prepares us in the future, like being able to adapt to any situation… Also, I learned something new about FGM that I didn't know and hearing other people's perspectives was great."
>
> Suraya: "That's all for the feedback. Does anyone have any questions or like things to add?"
>
> Group responds: "No."

5.2.7 Functioning maturely and productively

The co-researchers also had to undertake practical exercises in all the sessions, and it was envisaged that this would facilitate a level of confidence in conducting interviews and focus groups. This was the sixth session, co-researchers reviewed the topic guides for interviews and focus groups, then developed the guides by providing feedback relating to the language used. For example, one of the initial focus group questions was about interventions. The co-researchers were asked if they had seen or heard of any interventions aimed at preventing FGM, and the response was:

> "No, wait I have a question, what are interventions?" (Uba, Female, 17).

This meant that the use of the word 'intervention' was problematic because young people would not understand it. We continued with a discussion of what it might mean

to them; however, none of the co-researchers understood what this meant. We then decided to google the words: 'intervention in health promotion' and this was the definition we found:

> "Prevention includes a wide range of activities — known as "interventions" — aimed at reducing risks or threats to health" (Institute for Work and Health, Toronto, 2015).

What followed was a discussion on what alternative words were more accessible to young people:

> "I don't think young people would understand what interventions are, maybe like just be direct and ask what you think can be done to prevent so and so" (Uba).

> "What FGM involvement have you seen or heard of maybe? And you can add examples like social media, media, schools, and stuff" (Dolla Sign).

This process yielded a useful discussion on language when developing topic guides so that they would be easily accessible to young people. Kolucki and Lemish (2011), highlight the importance of utilising age-appropriate language when interacting with young people. This led to significant modifications of the language used in the topic guides.

Following these discussions, the co-researchers were able to formulate the research questions as well as plan the methods of collecting data, processes advocated by Coad and Evans (2008). They discussed the use of participatory methods, which led to a discussion about the characteristics and common principles of participatory approaches. The words used to discuss participatory methods enabled a better understanding amongst young people:

- From verbal to visual
- Group learning
- Multiple perspectives/diversity
- Context-specific (adaptable)
- 'Handing over the stick.'
- Attitudes and behaviour

Following a discussion of participatory methods, the co-researchers decided which methods they wanted to use in focus groups and interviews. Some found the use of images and role play aided in breaking down barriers in conversation.

5.2.7.1 Group exercise: young people's concerns

Adhering to the ethos of co-production, the co-researchers were encouraged to engage in group work that enabled the discussion of issues they felt were important to them at the time. This was seen as an important process, perhaps highlighting the need for further research in the future with young people from minority groups. The co-researchers felt that there were specific concerns that young women from Black Asian Minority groups faced:

> Uba: "Not fitting in, not being accepted... being different. I think it depends on where you grow up. For example, if I live in Easton and go to school in Easton, I would be more accepted as opposed to living in Easton but going to like Colston."

> Suraya: "I don't think it's just about where you live, though. I feel like, it is most of a societal issue you could be accepted in your community... but like if you apply for a job and they see your name is different, they are not going to really invite you."

> Dolla Sign: 'We were talking about how your hair affects the jobs you get as well. You are often forced to have your hair slicked back or in braids, not an afro, so that you did 'look' a certain way."

> Rwaida: "Relationships and worrying that you will not be loved. This includes all kinds of relationships, not just romantic... Like jobs, relationships with teachers and parents."

> Zuli: "Money is another concern for young women, but I think this is relative. For example, if young people have a family providing for them or if they have to work to provide for themselves."

> Maimuna: "Mental health is a huge issue for young people in this day and age, I think, like depression and anxiety."

> Suraya: "Like even yesterday, this girl committed suicide, like I don't know if she was suffering from depression, but like you don't know what people are going through. Even like at universities in Bristol, we have had like four suicides since the beginning of September. So, I think it is an issue, but because of the stigma surrounding black people and mental health, like how they perceive it, I feel like

the stigma makes it a taboo subject and they don't really identify with it… these are very much real problems."

These issues were the central concerns at that time in their lives. One questions whether FGM was, or is, any part of the problems they perceive as important. Clearly, racial profiling, mental health, money issues, and identity were the most important issues to them at that point. Having openly discussed these problems, they continued to complete the exercise.

Towards the end of the training, it was important to ascertain the co-researchers' level of confidence in conducting the interviews and focus groups; this was in the form of a Table, Image 5.14 below shows that the co-researchers felt a level of confidence. However, they expressed concerns in conducting focus groups alone and emphasised the need to work in pairs, which was agreed.
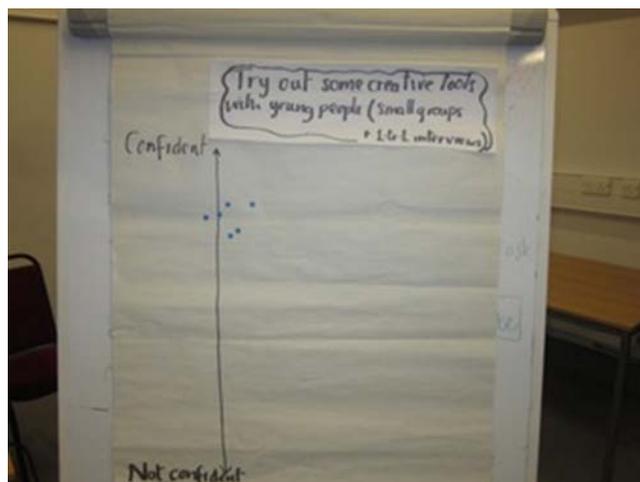
Image 5:3: Co-researcher's level of confidence after training.

On the last day of Phase One, each member was given a name at random and was encouraged to say something positive about that person's contribution to our group:

Zuli: "Thank you, Suraya, for always being friendly and engaging in the group."

Suraya: "To [Researcher], for letting us participate and allowing us to learn things we wouldn't learn at school, and for the KFC!"

Uba: "Rwaida, for being funny and cheering everyone up after a long day."

Following this, the members planned the dates and times to commence Phase Two, which is discussed in the research process, Chapter 4. The following section provides an evaluation of Phase One, which was conducted with the co-researchers at the end of the data collection.

5.3 An analysis of the active learning process for co-researchers

5.3.1 Introduction

It is proposed that the knowledge created between communities and researchers provides a broader and more autonomous form of discipline, as well as enhances rigour within the research process by providing the ability to inform social action and aid in assessing the quality of the study (Israel et al., 1998). I have adapted a version of the theoretical model developed by Gibson et al. (2017) for evaluating Patient and Public Involvement (PPI). This framework has been used to facilitate PPI evaluations within a healthcare setting. Although novel to the field of youth research, it appeared to fit well as a framework for evaluating the training and involvement of the co-researchers in this study. The reason for this was twofold: firstly, the framework enabled the co-researchers to explore the costs and benefits involved in CBPR participation. Secondly, analysing the degree to which participation was achieved in this study contributes to the learning processes in identifying what works and what does not, in the context of young people.

5.3.2 Theoretical framework

In this study, the co-researchers were invited to attend a three-hour workshop, five months after completion of the focus groups and interviews. Five of the nine co-researchers attended. The first 45 minutes were used to explain the framework and assess the co-researchers understanding of the language used. They were then asked to think about their individual experiences as co-researchers and map these along the dimensions given (see Table 5.1 below). Because only three of the five present had been

involved in the interviews, the evaluation was split into two. Group 1 (all co-researchers) were encouraged to map their experiences of the training and reflect on any issues that may have hindered their participation in interviews and focus groups. Group 2 (co-researchers involved in training and fieldwork), were invited to think about their experience of conducting interviews and focus groups. The co-researchers and I then discussed and interpreted the results. In the final part of the workshop, the co-researchers were encouraged to review their initial hopes and expectations formulated at the beginning of the training and discuss whether they had been met, as well as discuss their future directions, following this training.

Gibson et al. (2017) encourage the use of an iterative process when evaluating, as this allows a review of the language used and enables necessary alterations prior to the final feedback session. However, due to the lack of time and the co-researchers' availability, this was not possible, the evaluation was therefore conducted in one day. It was acknowledged that the language used could limit the co-researchers understanding; therefore, in the beginning, we spent time reviewing their understanding and explaining any concepts that were alien to them. To provide more clarity, the alterations are listed in Table 5.1 below.

Original dimension	Final workshop indicator	Explanation
Weak voice/strong voice	Weak voice/strong voice	Do you feel like you had an equal opportunity to influence change? A weak voice is one that may discuss issues, but have little chance in influencing change. A strong voice is one where not only is concerned, but the co-researcher has the ability to influence change.
One way to be involved/many ways to be involved	One way to be involved/many ways to be involved	This is closely linked to Bourdieu's work on social capital, in that, the knowledge can take different forms but, they may not be equally valued. Therefore, it is important to use different participatory tools.
Organisation concern/public concern	Research concerns/co-researchers	This is closely linked to Habermas's lifeworld /system dimension. In this, the lifeworld (co-researchers), are characterised by social action, including, norms, values, experiences and beliefs. The system (university), Is characterised by material reproduction of society therefore, instrumental change.
Organisation changes/organisation resists change	Changes made to the research/No changes made	The degree in which the researcher was willing or able to respond to issues, raised by the co-researchers. According to Gibson et al. This is dependant on many factors, ranging from limited resources as well as policies within the institution.

Table 5.1: Final workshop indicators. Adapted from Gibson et al. (2017).

As illustrated in the table, some of the phrases were similar to those used by Gibson et al. (2017), while some changes were made. The idea of two distinct social spheres of the lifeworld (expressive) and system (instrumental), developed by Habermas (1987), was altered to 'research concerns/co-researchers' concerns'. Although keeping the same principles, this made it easier for the co-researchers to put the concepts into perspective. Lastly, the dimension of 'organisation changes/organisation resists change' proposed by Gibson et al. (2017), was reworded to 'changes made to the research/no changes made'.

5.4 Findings

The results of the evaluation process described above are presented in this section, with the key findings reported under each workshop indicator, namely: 'weak/strong voice', 'one way to be involved/many ways to be involved', 'research concerns/co-researchers' concerns' and 'changes made to the research/no changes made.' These findings will be supported by quotes to provide a more coherent narrative of the accounts.

Prior to the completion of the workshop, co-researchers were invited to discuss individual views regarding their experience of participation. This ensured that diverse individual experiences were captured, rather than following the group perspective. Although I cannot be sure that co-researchers' responses were not lost within the broader group dynamics, due to the dominant nature of some co-researchers, everyone was given a fair chance to communicate or write down their thoughts. That way, those who felt unable to speak were able to express themselves in writing.

During the training phase, co-researchers decided to name the group and therefore, gain ownership of the process. They discussed among themselves and decided on 'Blossom Gang'. It was important then, to ascertain why they decided on this name and also what this meant to them. By using the term 'blossom,' it almost indicated that they felt a sense of confidence instilled by the process of becoming co-researchers. They gave various responses to this, some of which reflect on their identities as young females as well as the developing nature of the training, with some of the responses including:

> "Blossom symbolises flowers, growth, nature, and development. This links to FGM, sexual health, and female's relationships. Firstly, because female's private parts are often referred to as a flower. Secondly, sexual health awareness requires growth and development of people's understanding… and lastly,

relationships are about growth and feelings blossoming. On the other hand, while Gang is usually applied in a negative context, it can be used to represent youthfulness and informal relationships, it can be used to symbolise unity and togetherness" (Zuli).

"Blossom Gang means we have grown as individuals. When it comes to a flower, there needs to be soil, sunlight, and water… Sunlight is the confidence; we were given time to shine and have our own opinion on the topic. Water represents the knowledge we gained in training; we did not know a lot beforehand about the topic and soil was our own opinions and thoughts on activities and topics to give different perspectives" (Suraya).

5.4.1 Weak voice /strong voice

Following the initial feedback, a wall chart with short explanatory notes was provided (see Image 5.4 below). Each co-researcher was given sticky notes and a pen to use, to indicate which point along the continuum they felt best represented their own participation experience. Co-researchers were also invited to write comments on the sticky notes explaining the reason for their arrow placement. This was conducted anonymously, and the flip chart was hidden from the lead researcher when they were inputting their answers.

This initial feedback was general, with the aim being to understand the co-researchers' reflections on their own level of participation, perhaps in terms of 'full participation' compared to 'tokenistic' (Hart,1979). Although this was a small group of five people, the information gathered from this meeting was useful, because it enabled me to conceptualise levels of participation in this training. Following this, they also wrote their thoughts on sticky notes, explaining why they had decided to place their arrows on specific places along the scale.
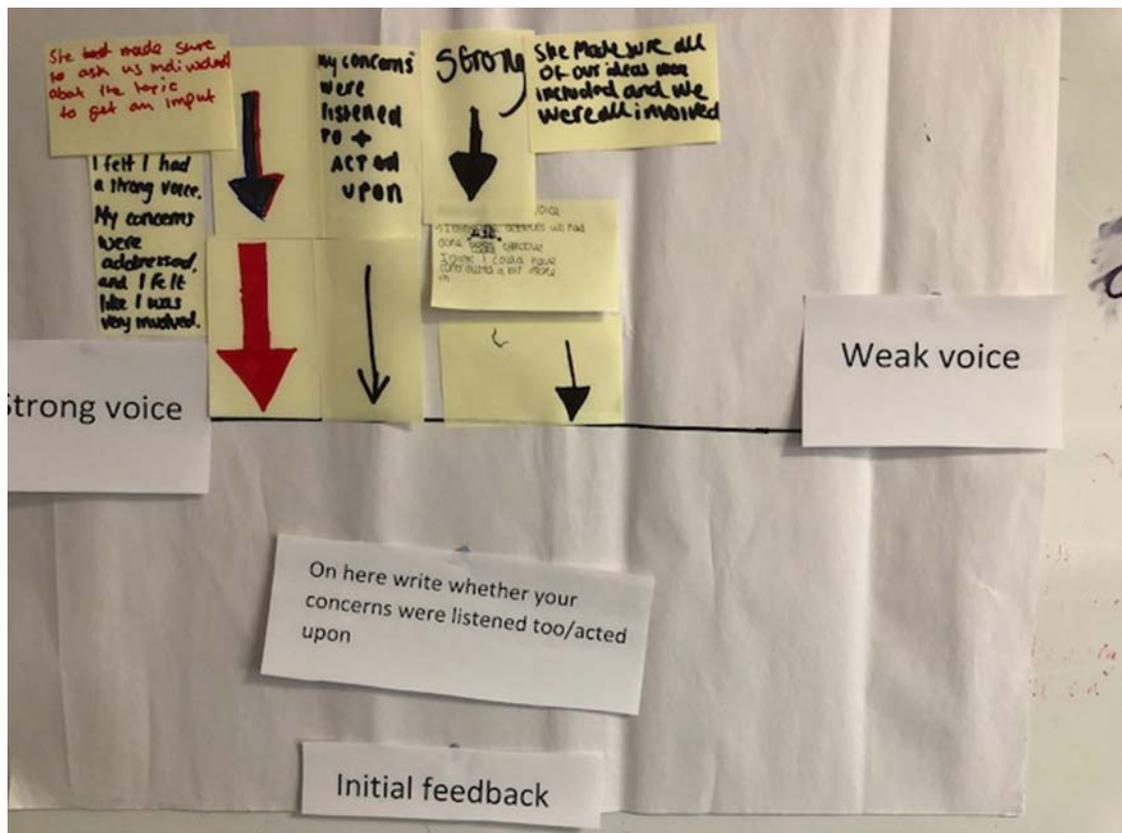
Image 5:4: Initial feedback from co-researchers.

To provide a more accurate interpretation and enable visibility, the findings are illustrated in a diagrammatic image below. Which represents the different positions where the co-researchers felt they belonged along the continuum.
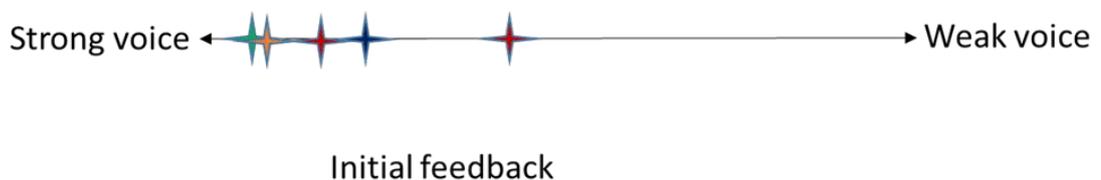
Figure 5:1: Stage 1. Results of initial feedback. Representing the strong/weak voice domain.

Although the majority of these initial responses were clustered towards the strong voice end of the scale, there were also deviating opinions amongst the co-researchers. This was reflected in some of the comments that accompanied their responses, for example, in support of 'the strong voice' and 'middle voice,' co-researchers wrote:

> "She [lead researcher] made sure to ask for individual opinions on how we felt about the research topic" (Zuli).

> "My concerns were listened to and acted upon" (Rwaida).

> "Middle voice. I think activities that were done were effective, but I think I could've contributed more" (Davina).

Figure 5.1 above, taken together with the initial comments, paints a picture of co-researchers' subjective experiences of their involvement in this project, although none indicated any immediate changes in the research at this stage.

Stage Two of the evaluation process required the co-researchers to reflect on their experiences of the whole research process, from the training to data collection and analysis, using the aforementioned workshop indicators. Image 5.5 below illustrates this. The feedback is presented individually below.
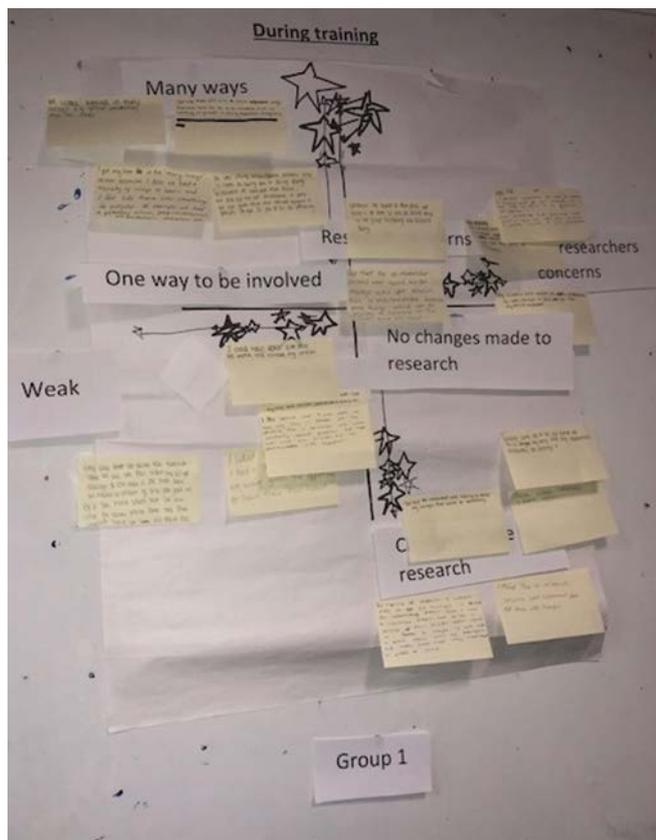
Image 5:5: Co-researcher's feedback using the workshop indicators.
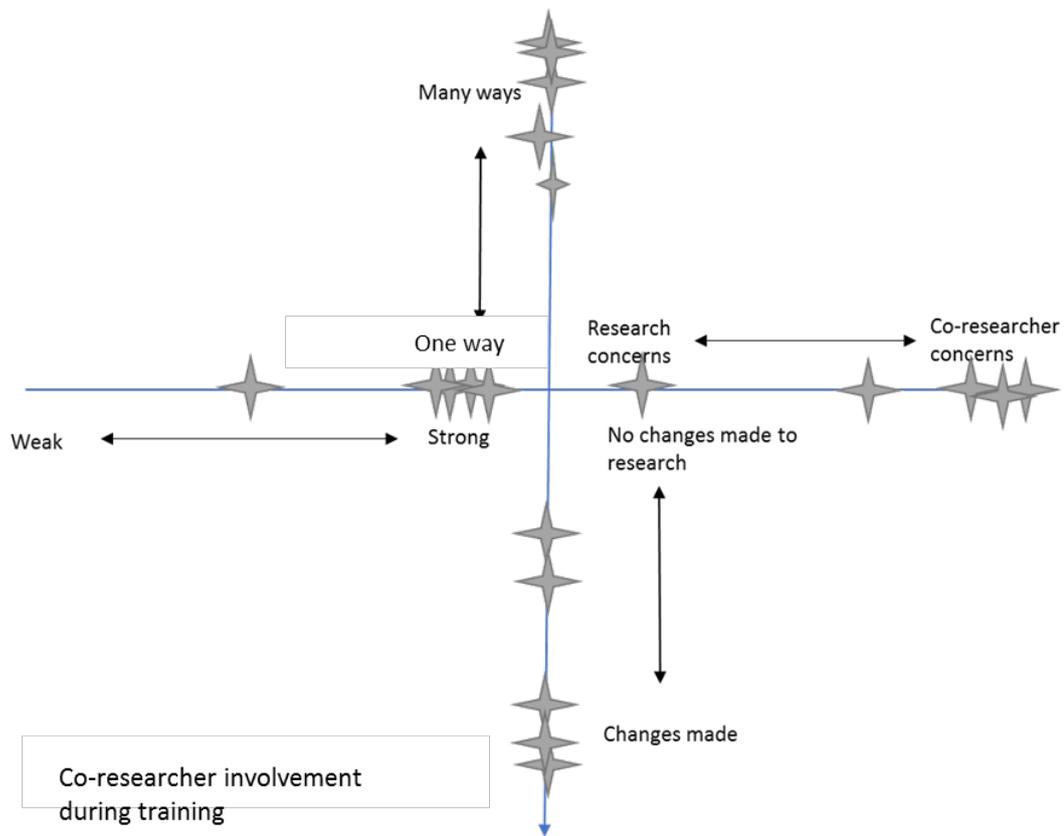
Figure 5:2: Co-researcher involvement during training.

The feedback depicted in Figure 5.2 shows diverse views. Although some people thought they had given positive input throughout the training and research, other co-researchers felt that their concerns had not been addressed. Regarding 'voice', the majority felt they had been heard. However, relating to their ability to make changes, the results were more clustered. This is illustrated in the feedback that accompanied the results.

> "I felt that my concerns were heard but not always acted upon… this is understandable because some things would not be possible to add in the short timeframe we had" (Suraya).

This statement illustrates the fact that the time restrictions had a negative influence on conducting the training, and also shows the co-researchers reflecting on the limitations of the study. As well as the diagrammatic feedback, the co-researchers were encouraged to discuss their own experiences of the research process. Below is a discussion of the

themes that arose from this discussion, which were: 'group dynamics and behaviours' and 'sisterhood'.

<u>Group dynamics and behaviours</u>

As per Johnson and Johnsons (2014) life cycle model, 'recognising mutuality and building trust', co-researchers articulated feeling 'comfortable' within the group, highlighting their own private space. According to Bales (1965), people often seek a balance between task completions and building interpersonal relationships in groups, at one point the focus may be the former, at another on the latter. Bales (1965) argued that group development is not linear; this was visible within the co-researcher group development process. The time that was taken at the beginning of the training to get to know each other played an essential role in *building trust* the group, therefore, enabling the discussion of sensitive topics. One of the co-researchers stresses this point:

> "… I think in the first few sessions, we had quite a lot of ice breakers, and we had the chance to get to know each other as well. We had the activity where we got to know each other, compare what we had in common, and what we didn't. Just getting to know everyone and getting comfortable, 'cause obviously, we would be speaking about quite intimate topics and things that people might not be comfortable to talk about… but being able to know each other and being comfortable in that private space made it a lot easier to actually settle us and get our voices out" (Dolla sign).

The size of the group also played a role in the group development. Although the initial goal was to recruit up to ten co-researchers, the eight that were recruited appeared to be sufficient. Perhaps due to the size of the group, they operated by consensus rather than by appointing a leader, and therefore kept to the principles of community-based participatory research (Israel et al., 2008). Consequently, Brown (2009) argues that, in such groups, no decisions are made unless all members agree with it. If one disagrees, the group continues discussions until they reach a consensus. This was apparent in this group, as all the members had access to WhatsApp chat, where they would discuss options and reach a consensus before deciding to act. The main advantage of this was the ability for everyone to have a voice; however, the stronger voices within the groups sometimes appeared to dominate discussions and occasionally determine the

consensus. A further disadvantage was that it sometimes took a long time to reach a decision. Overall, though, the process of acknowledging and encouraging participation was found to be effective.

> "We were all able to say stuff from the beginning, there weren't that many people, so everyone was confident enough to say something that they weren't that shy" (Suraya).

> "We were all comfortable because when we first met each other, the researcher, along with everyone played a game. We got to know each other's names... also like before every session we would like warm-up so not be frigid I guess, and that made us more comfortable and made communicating easier" (Uba).

Sisterhood

Another interesting factor that arose from the feedback was the sense of belonging and the potential to form long-lasting friendships that might extend beyond this project. This may have fostered the ability to discuss sensitive subjects. However, it perhaps created a slight confusion about the relationships being formed as, interestingly, the co-researchers saw me as a sister rather than a fellow researcher:

> "I think the activities for me were one of the helpful things for me, for making it comfortable. So, it was a really nice experience like I became really good friends with one of the girls in the first few days. I met her because of getting to know each other through the activities, and now she can't get rid of me, and I can't get rid of her, and we are good friends now. We sort of become like a little family, haven't we? The group chat is amazing [WhatsApp], and yeah, even with [researcher] she is like our big sister, it makes it even better to like talk about FGM and other stuff" (Rwaida).

> "I knew some of the girls before like I've seen one of the girls from school, but I don't think I would've spoken to her really, until this group. I got to know the girl's personality and all the activities were enjoyable at the beginning of each session, 'cause most of us came from school, and we were bit tired, and it raised our spirits playing the games, and the KFC was good as well! (Zuli).

The importance of building trust was apparent here. Uba mentions that she felt able to talk about her concerns because she knew the researcher. As such, the level of historical trust between partners is a critical component, especially when discussing sensitive topics.

> "I agree with her, I mean the first half we all became friends after a while of meeting each other, so communicating with each other was easy and being able

to talk about our concerns were easy as well considering we were close to [researcher] as well" (Uba).

Maimuna notes the importance of 'friendships,' which fostered a 'voice' amongst all the co-researchers.

> "I felt like we could all voice our opinions and we were not afraid of each other since we all became friends" (Maimuna).

5.4.2 One way to be involved/many ways to be involved

5.4.2.1 Developing skills and confidence: voice

The co-researchers spoke with praise about the many ways they learned within the group. They recollected the activities they had done and discussed how this aided their learning processes. Although they recognised that some sessions were not fully participatory, it was evident that they were developing their own voices.

> "…we had so many different ways of learning. Like people would do a presentation at the beginning of each session, just to reflect on prior sessions, and we used to take it in turns to present. I thought that was really good. That allowed everyone to reflect equally and get their voice out… we even had like diagrams and sessions that felt like we were spoken at, but that wasn't necessarily a bad thing because some people might find that better and we had sessions where [lead researcher] stepped back and let us do the talking. So I thought the variety was really good and that would've appealed to at least everyone" (Maimuna).

The co-researchers recognised that the training was somewhat beneficial. Zuli, a 17-year old, describes how the process aided in her development:

> "Basically, it was therapeutic, learning about yourself in the process of learning about FGM."

On the other hand, Dolla Sign, also 17, discussed how liberated she felt during some of the group activities, the drawing process:

> "For me, every day felt different; we never did the same thing every day. I remember we had to draw, and I haven't done any drawing since primary school, so it was nice to like, go back to try different learning styles, I remember we had to draw before and after what someone knew about FGM".

Some of the training sessions appear to have stood out for others, which shows the importance of incorporating games into learning.

> "For me, my favourite session was Pictionary, the words had to relate to the topic we were talking about, I think that session was on FGM, and it was really funny because the people drawing and couldn't speak, it showed us who was good at art and who was good at guessing. I really enjoyed the session; it was memorable for me even though it was a while ago…" (Suraya).

The drawings produced during this exercise are shown in the following chapter, particularly, the young people's ideas of what it is to be a young woman, which formed the theme, 'identity and status'.

> "To add to that, we had to draw what your ideal woman was, and I thought that was a really good way to think about it 'cause I would never have… if you just said to me 'oh what's your ideal woman', I wouldn't have put down as much as I put down. It was nice to think of role models and think of things that you yourself like, qualities you have that you think an ideal woman or confident woman should have and what other people have, and putting all that into one I thought was really nice" (Rwaida).

5.4.3 Research concerns/co-researchers' concerns.'

The co-researchers highlighted the need for more ways of collecting data. Although the project was already set up to use a qualitative methodology, the co-researchers felt that other ways of collecting data, such as Skype calls or questionnaires, would have appealed more to some of the participants. This is a key point because not all co-researchers would have been qualitatively inclined, which was, therefore, another limitation of this study. However, the qualitative comments also show that the co-researchers felt like they had a voice in parts of this project:

> "During conducting the research there were a few ways to be involved, but I think it could've been made better, like different ways to collect data, for example, Skype calls or questionnaires" (Rwaida).

Furthermore, the nature of the group enabled free dialogue. Uba mentions how raising concerns was made easier due to the relationships formed.

"…I mean the first half we all became friends after a while of meeting each other. So communicating with each other was easy and being able to talk about our concerns where easy as well considering we were close to [researcher] as well."(Uba)

Similarly, Zuli reflects on the post-interview debrief (see page 105).

"After the interview, I was able to change things that I felt could improve the research" (Zuli).

Overall, the feedback suggests that, although the co-researchers involved in the study felt they were able to voice their concerns, it was also evident that they understood the restrictions of the research, as this had been clearly communicated from the beginning. There were various times in the research that we had debriefing sessions after an interview or focus group, where the co-researchers reflected on their experience during those sessions, as well as suggesting ways to improve the research.

5.4.4   Changes made to the research/no changes made

The co-researchers could rationalise the time restrictions involved with this research. They commented that, although they did want to change some things, this was unlikely to happen due to the time restrictions. In hindsight, following up on the issues raised in the process of conducting a PhD using CPBR, time was indeed sometimes a contributing factor. Although I attempted to negotiate it at the time, the fluid nature of this thesis meant that it was not always possible.

"I think there were a few changes made to the research, but I don't think it was something that was that negotiable because it was already set. But I don't think we wanted to change what was being done, I feel like the main thing was the structure of the 10-week training and I think that was listened to" (Zuli)

However, the co-researchers acknowledge that, although there were restrictions, I as the researcher was able to discuss some changes with them, such as the language used in interviews and focus groups, which meant that the research was more accessible to young people:

"…she [the researcher] would come to us and ask if anything needed to be improved, for example, the language. Like I remember, we asked to change the term 'interventions' because we did not know what that meant" (Maimuna).

5.4.5 Hopes and expectations

In addition to the evaluation utilising Gibson et al.'s (2017) framework, it was also important to review the hopes and expectations noted at the beginning of this training and discuss with co-researchers, if these were met. At this stage, I reminded the co-researchers of the expectations they had written down at the beginning, we then discussed each one, to ascertain the effectiveness of the training. These were:

- Gain knowledge of FGM within the community.

- Gain new skills such as research methods.

- Ability to discuss what we learn with others, specifically on FGM.

- Worries about conducting interviews and FGs alone.

- Prioritising college/university and research (time commitments).

The co-researchers expressed the importance of forming groups that share similar backgrounds or experiences, articulating the ability to share their understanding and knowledge of FGM.

"I think because all of us come from FGM-practicing communities, we got to see everyone's perspective… because not everyone was on the same level of knowledge and everyone wrote anonymously, so we got to see what people thought without it being staged because it was anonymous" (Zuli).

The training was also viewed as a way of sharing knowledge. Several of the young women shared their knowledge of the practice, and it seems that this process made it easier for them to talk about the issue.

"Also knowing that this was so closely linked to the community and knowing different cultures and countries that are affected. I only thought it happened in Africa, so getting to know it happened outside of my own culture is refreshing" (Uba).

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When discussing whether the training enabled co-researchers to gain new skills, such as research methods, it was apparent from their answers that they identified the skills they had learned and understood these were going to be transformed into practice.

> "We had different ways to learn, and it improved my communication skills" (Zuli).

> "These were skills that would help us beyond this, for example for job interviews we could use like the skills learned so they won't go to waste, and they have helped me in school as well" (Suraya).

Co-researchers also used the training, specifically the talk on FGM, to talk to their peers and parents.

> "I think now because we have learned so much about FGM in the community and the different types of research methods, we get to use that and teach it to other people, like friends and family" (Zuli).

> "Overall, I feel like we gained skills, like research skills and conducting interviews as well as knowledge of FGM" (Dolla Sign).

The concept of forming friendships and togetherness is apparent in the following quote:

> "I think now we are in a better place than when we started because I think some of us may have known about FGM or heard about it... but we have progressed to some extent at least, not just learning about FGM, but what goes on in the community and also learning about how to talk about this sort of thing, even when we had the session about relationships. I feel like we have covered a lot from being in a room with people you don't really know to be in a room with people you have become close to but also grown and developed together" (Suraya).

In general, although there were limitations to the process, the co-researchers appear to have met their initial goals. This is illustrated below, where the co-researchers describe how the skills gained were utilised beyond the training.

5.4.6   Impact: beyond the training

Central to the entire discipline of CBPR is the concept of impact (Minkler and Wallerstein, 2011). Having discussed and evaluated the training, the co-researchers and I engaged in a discussion regarding the usefulness of the training in their everyday lives. Wallerstain and Duran (2003) extend this notion by arguing that the process of

meaningful participation should be transformative. Through active engagement, communities should become more empowered and better equipped to make long-term personal and social change. The question of 'who benefits' from the training and research was an important one for me. Having worked with community organisations, I would often hear their frustrations of feeling 'used by universities', where their names would be included in funding applications to obtain grants but, once that was successful, they would have limited involvement in projects.

It was interesting to hear that the skills they had learned were being transferred to college, as Dolla Sign, comments:

> "At school, 'cause I do health and social care, I do get asked questions like how would you interact with other people if certain things would happen in your community, stuff like that would come up, and I'd know how to answer it… recently we did FGM, and they were giving information to others, and I was able to give extended information to them because they didn't know as much as I do now, so that helped."

Zuli mentions the skills she used during her summer job. Although she had worked with young people before, this training provided a level of confidence.

> "For my summer job, I have to talk to young people, and even though I have been doing it before, I wasn't as confident, and I couldn't really… I struggled to communicate with young people effectively. Like we had to teach them leadership skills, this research allowed me the confidence to do so… I thought about planning sessions and what sort of things you could do for different learners. For example, I like, prefer presentations, but when talking to young people, I am not just going to use presentations. I thought about other ways to learn, and I thought this project really helped me in that. I am a lot more confident in public speaking and doing presentations. So, it's not just helped during the research but outside as well."

Similarly, Rwaida discusses the use of learning styles and how she has used this in higher education.

> "We had this module in university on learning styles, and I remembered the work we did here, and I put all that in, like physical learning styles and the use of models."

Likewise, Uba used her skills to study for her law degree at university:

"For one of my assessments at university we had to do a mediation interview with clients, and the interviews we did during the research and focus groups, as well as questioning styles, helped me a lot. We learned a lot about open, closed and leading questions during the research and actually being able to apply that to my degree and getting a first-class in that; I thought that was something really good because it gave me an advantage."

This chapter has illustrated the process of co-production successfully achieved the aims of facilitated learning, and participants believed that they acquired new skills and benefited personally from their participation.

Chapter 6 Research findings

6.1 Introduction

This chapter is divided into five sections, each discussing the main themes identified from the data as outlined in Chapter 4: 1) meanings and interpretations of FGM, 2) interpretation of the legal context, 3) identity and status, 4) learning about FGM and 5) telling it like it is. Table 6.1 below presents a summary of the themes and subthemes from the interviews, workshop data and focus groups. Each section starts with an introduction, then presents the themes and subthemes identified through my data analysis. In each section, the data is presented alongside relevant literature. The findings chapter presents the data from the three data corpora, namely: Interviews, focus groups and co-researcher workshops. Table 6.1 below presents the five themes to be discussed in this Chapter.

Theme 1: Meanings and Interpretations of FGM.	Theme 3: Identity and status
• Cultural belief and interpretations. • Control over women's sexuality • Safer here. **Theme 2: Interpretation of the legal context.** • It's a crime. • Injustice. • Choice	• Us/them. • Emotional reactions to FGM. **Theme 4: Learning about FGM**. • Parent-child relations. • Mixed information. • Younger generations educating mother. **Theme 5: Telling it like it is.** • Where I want to learn • When I want to learn • What I want to learn • Who I want to teach me.

Table 6.1: Presenting the five themes and subthemes.

6.2 Meanings and Interpretations of FGM

This section explores the themes and subthemes relating to the theme of '*Meanings and interpretations of FGM'*. The findings in this theme reveal that young people define FGM within the context of their cultures, and reveal how traditional social and gender norms may lead to power imbalances within the Western context. Participants also identify reasons connected to the practice's continuation, such as control of women's sexuality linked to notions of purity, trust and pleasure. The data presented in this section illustrates their uncertainty in understanding the historical roots of the practice, as participants frequently used terms like 'I think', 'I don't know', or 'I have heard from others'. They associate FGM as a medical phenomenon which, if practised in the right context (high-income countries), should still be allowed and is safe. Furthermore, although some of the participants link the practice to controlling women's sexuality, very few associate FGM with known medical risks of removing the female genitalia.

6.2.1 Cultural beliefs and interpretations

The theme 'cultural beliefs and interpretations' refers to the beliefs and assumptions young people hold associated with the practice. Historically, FGM has been interpreted as a representation of gender behaviour, generally associated with femininity and sexuality and incorporated as a result of social norms, which are often context-specific. According to Shell-Duncan et al. (2018), culture is often cast as a justification for the continuation of practices rooted in history. Likewise, due to its historical roots, FGM has proven difficult to eliminate, posing a barrier to social transformation and intervention efforts across the globe. It is important to emphasise the fluidity of social norms and cultural practices, where FGM becomes associated with meanings that can accumulate, be lost or changed within specific social contexts, which thus may perpetuate, reduce or disregard the practice. This highlights that social norms are not static nor homogenous, but instead varied and subject to constant change, through the process of 'cultural borrowing', best explained by Hernland (2003). Using the metaphor of a 'winnowing basket', he described the process through which people actively negotiate which aspects

of culture should be retained and which should be disregarded in light of present or shifting social realities.

In the interview extract presented below, Halimo acknowledges that culture does indeed play a role in the perpetuation of the practice of FGM.

> "I am not going to lie; I am Somali. I am African. So, it is in my culture to do it [FGM]… it happened years ago, and it probably happened to my grandmother, but she is probably educated about it now and knows what it is. However, she wouldn't want it to happen to younger people like me, because it is not really healthy. And I think she would want me to have a good childhood and that would probably just ruin it… Because you would just be traumatised" (Halimo, 14. Female. Cardiff).

Halimo also discusses the role of immediate family and communities in guarding these cultural norms that sustain the practice. It is argued that this is how the practice is maintained and upheld as a tradition (Shell-Duncan et al., 2018). Therefore, it is also through this mode that behaviours can be altered or shifted. Moreover, although Halimo acknowledges the historic nature of the practice, highlighting that through awareness, views towards the practice have changed, she also states that, though grandmothers remain an important figure within the household, they are now concerned with enriching their grandchildren's childhood experiences, rather than 'traumatising' them, as Halimo interprets the practice.

Although Halimo's quote above illustrates the shift in practice, Ikram mentions the celebrations that exist to mark the completion of the practice, revealing the preservation of culture.

> "I know in Sudan, they dress up in traditional clothing and go to the doctors and have it [FGM] done, they then come home and have a party to show it has been done… I don't know what it symbolises. My sister did it because my grandma wanted her to do it and my mum went on with it because my grandmother wanted it. I think I hadn't been born yet or was too young to remember" (Ikram, 15. Female. Bristol).

In addition, Ikram highlights the intergenerational hierarchy of power amongst women, how a mother's FGM usually occurred within her family and her grandmother's role in instigating the practice. Several studies have shown that women support the practice more than their male counterparts. For example, In Guinea and Eritrea (Horowitz, 1997),

the continuing practice is used to convince other circumcised women that a girl has been trained to respect her elders' authority and is therefore worthy of inclusion within that social network. Thus, FGM in this context upholds bio-political control of sexuality within the family, where the family is in charge of gender and sex-role socialisation of children, to guarantee social order.

It is essential, however, to understand FGM in the context within which being practised. In the following extract, Sophia highlights the expectations that were placed on girls to continue with the practice that perhaps remain to this day. However, note how Sophia's use of language illustrates that, while it used to be – 'was' – normal, expectations have changed:

> "… After it [FGM] was done, people would bring you like presents and gifts and tell you well done, and they would make it like some kind of festival or something… I don't know; maybe it's part of the culture I guess" (Sophia, 15. Female. Cardiff).

In the extract below, Sabrin highlights this shift in the practice, acknowledging that it 'was' done for cultural reasons, but is becoming 'forbidden' and 'unacceptable':

> "It [FGM] used to happen, I heard that, because it was done for cultural reasons, but now they've stopped it and are trying to stop it even more. Like obviously, back in my nan's day and nan's mum, it was a normal thing to get it done… it's just part of the culture, but now it's seen as *haram*, like unacceptable and forbidden" (Sabrin, 14. Female. Cardiff).

Although previous quotes present a homogenous explanation of the FGM as a cultural practice that has evolved around religious and social norms, Felicia (below), presents a distinct and different view of FGM, otherwise known as a deviant case (Creswell, 2009), likening the practice to aesthetics.

> "I think if someone has low self-esteem, she would probably tell people she had it done to make herself feel better and for people to like her. I think it can happen anywhere, not just in Cardiff. It's mostly done because of culture really. Some women do it to make themselves look good down there and like make themselves clean and neater down below. Also, some men don't want women to have sex with other people" (Felicia, 15. Female. Cardiff. Focus group).

Felicia mentions 'self-esteem' and the desire to make oneself 'feel better'. Although it has been argued that women feel pressured to conform within practising communities, once they migrate to other environments these views change (Gele et al., 2015, Shell-Duncan et al., 2018). Hosken (1979) asserts that compliance with the practice is used to convey the idea of purity and cleanliness which, in turn, would allow women to carry food, i.e., become a full member of society. In contrast, an uncircumcised woman is therefore seen, as undesirable and ugly. However, these pressures may also be present within a Western context amongst young people, maybe shifting from issues of cleanliness to self-esteem and body image. In fact, however, a study conducted in Sudan and Somalia revealed long-term adverse effects on self-esteem and self-identity amongst survivors of FGM (Rahman and Toubia, 2000). Therefore, here, we see the shift in how FGM is perceived, wherein practising countries low self-esteem and identity are a result of the practice, in contrast, Felicia suggests that if someone has 'low self-esteem' they will do it too.

It is important to highlight that cultural practices are also prominent in the West and, although in this context Felicia is describing FGM, it is easy to see how self-esteem and social pressure may influence certain rituals of body modification. To this end, the critique of FGM in Africa in Western discourses can be deemed hypocritical, since there are similar rituals being practised in the West although, as argued in Chapter 2 of this thesis, these are conveniently termed 'vaginoplasty' or 'labiaplasty'.

6.2.1.1   A religious interpretation

Religion has been associated with the perpetuation of the practice linked to the Hadith in Islam (Toubia and Rahman, 2000). However, Bradley (2011) provides the compelling argument that, when religious leaders discuss FGM, religion and culture are often viewed as separate entities. Nevertheless, he claims that they are linked, in that religion often supports the subordination of women (see also Mernissi, 1991). In her research among Somali communities in London, Abukadir et al. (2004) interviewed religious leaders (Imam) to ascertain their views on FGM. The Imams' arguments regarding the discontinuation of FGM was that it was being *against Islam to shed another person's blood'.* Abukadir highlights the Imams' inability to link FGM to Islam's deeply-rooted gender inequalities, claiming that religion often supports the patriarchal dominance and

gender ideology that leads to the continuation of the practice. The argument here is that the separation of culture and religion enables Imams to 'turn a blind eye' to the practice.

The data displayed in this subtheme illustrates a confusion between religion and culture amongst young people. As Bradley (2011) noted, the distinction between 'what is culture' and 'what religion is' is unclear, as is especially evident when discussing issues such as FGM.

In the extract below, Sophia explains the shift in perceptions due to differing interpretations.

> "My mum told me that FGM did happen, like in Somaliland, from the Egyptians and they believed it was right... but actually, when they went to check in the Quran, they believed it was cultural... Like as you have like culture dances and like traditional dresses and stuff like that, but she went into this, they found out it's not right obviously" [Sophia, 15. Female. Cardiff. Interview).

Johnsdotter's (2003) research on Somali women in exile showed that, by interacting with Muslims who do not practice FGM, Somali Muslims in exile re-examined their Islamic beliefs and sources and, therefore, upon realising that the practice is a cultural norm rather than a religious mandate, many decided to abandon the practice.

In contrast, Ikram interprets FGM as a religious requirement for girls that is linked with pleasing their parents.

> "I think they also do it because of religious reasons... she would do it to please her parents, and maybe she is religious and always praying, reading the Quran, then she would do it" (Ikram, 15. Female. Bristol).

Johnsdotter (2003) argues that, although culture is subject to change, many followers hold the view that religion is unchangeable; therefore, practices and values associated with religion may not be easily abandoned. Although associating the practice with Islam has been widely disproved, as FGM was present before religion arrived in Africa, certain religious groups remain strong advocates for the practice (Rahman and Toubia, 2000).

There are several reasons why social norms are persistent and difficult to change. One is the normative culture of silence (Bicchieri and Hugo, 2014) or, in this context, locating FGM as one of the many religious obligations a devout female Muslim should adhere to.

In all societies, norms suppressing sexual activities exist, including retaining power over women's bodies by controlling their reproductive lives (Foucault, 1976; Mernissi, 1991). Therefore, openly talking about sexual activity has been prohibited and limited in many cultures. Thus, young people may hold minimal knowledge about intercourse before marriage since their communities also bar them from any sexual activity before marriage. However, they may be still vulnerable to engaging in sexual activities. Although Mo disagrees with the practice of FGM, his words show that bio-power remains evident, since it is a way to discipline women's body to reduce their sexuality. In fact, Mo appears to be in favour of this kind of control, but in a more subtle way, 'other things could be done to stop that':

> "I know like in my religion, you have to get married first before sex, but they don't say like do this and then when you get married you can have sex, I don't think that's right. I think other things could be done to stop that instead of FGM (Mo, 13. Male. Bristol)

> "I think it is something to do with religion and to prevent girls from being sexually active. In some parts of the world, it is ritual" (Maria, 13. Female. Milton Keynes).

In the extract below, Aaliyah recognises the broader power structures that are often associated with FGM. Moreover, she acknowledges that FGM is not explicitly mentioned in the Quran, and also disagrees, to an extent, with altering one's own body to conform to patriarchal pressures in society, not necessarily linking religion with the subordination of women:

> "Like it's not like, I get like some cultures like is it Somalis used to do it? But a lot of Somali people are Muslims. I know it says nothing bad about it in the Quran. But it says in the Quran that you should not try to like making yourself look good to impress boys. Which I get like how you present yourself in public is fine, but like, stuff like this [FGM] I feel like it's way out of line" (Aaliyah, 13. Female. Cardiff).

Although the majority of participants in this research were Muslim, some of the young people self-identified as Christians, hence the extract below:

> "I have heard about FGM at church when the pastor preached against the act of Female Circumcision, saying it's a wicked act" (Ade, 13. Male. Bristol).

It is evident that religious leaders preach against the practice by defining it as a 'wicked act' which, in Christianity, means a 'sinful, evil human act' and a violation of God (Adamo, 2008). In direct contrast with Ade, Halimo, below, mentions that she has never heard of FGM being spoken about within a religious context, amongst her Sheikh (Islamic leaders):

> "To feel like, people say Sunna, but I have never heard any evidence of it. Like none of the Sheikhs talk about it, like preach about it. I have never heard… I have been practising Islam all my life and never in my life had I ever heard of it up until a year or two ago" (Halimo, 14. Female. Cardiff).

Lucy argues that FGM does is not practiced in Sudan due to the Islamic inclinations of the country:

> "…I guess because it's [Sudan] an Islamic country it's completely forbidden, I haven't heard of any reports of cases or FGM happening in Sudan" (Lucy, 13. Female. Bristol).

Though data illustrates the practice is endemic in Sudan, (Elduma, 2018; UNICEF, 2016). Lucy demonstrates the shift from perceiving the practice as a religious requirement to one that is not spoken about within religious requirements. Perhaps this paradigm shift may encourage mothers who associate FGM with religion to abandon the practice, as Farid adds:

> "Well, she [mum] said to me that we are not allowed to do it in Islam, and we should not do it" (Farid, 14. Male. Bristol).

6.2.1.2 Gender roles and expectations

Gender is something that one does or enacts, not the biology one has (West and Zimmerman, 1987), maintained through constantly reified practices (Butler, 1988). Gender regimes and the boundaries between what counts as male or female must be constantly marked and regulated by the gendering process (Connell, 1987) in order to be maintained. 'Doing' gender performance is, therefore, implicit and the way through which we also contribute to reproducing the gender regime (Butler, 1988). Having

argued that gender is a social construction in Chapter 2, this subtheme demonstrates that maintaining gender roles stems from policy and structures in schools, communities and broader cultural aspects (such as music, religion, media and fashion), as well as through every day repeated actions.

The young people in this research articulated a sexual division of labour within their households, where the men and women are seen as complementary opposites, men being the breadwinners and women taking care of the family and home (Visser, 2002), as the following extract illustrates. Zack has explicit opinions, sharing the particular set of practices and societal norms that are seen as masculine. This gender performance indirectly shows how masculinity constructs dominance and remains in control and, for Zack, this is demonstrated within the household:

> "Well sometimes I do the cleaning, but I think it's mostly like the girls that do it. Like for example, when I grow up and have a family, I think the girls would be like in charge of things to do with the household and the boys would be like outside of the household. Like working, earning money and stuff like that" (Zack, 13. Male. Bristol).

However, he goes on to acknowledge that, in this context, gender roles are constructed within a cultural framework, that it is a 'kind of a tradition'. This links to the view that bodies are not pre-given, in biology, nature or culture, but are continually produced and differentiated through complex historical, social and political relations of power (Mayall and Zeiher, 2003). According to Connell (1987), men are structurally superior and benefit from this superiority, but they do have a choice as to whether they should embody the male roles that sustain hegemonic masculinity. To this end, there are individual-level interventions that force young men to reflect on the implications of these gender roles, as well as changing these ideals at a societal level. Zack continues:

> "I think it has something to do with your parents. Like my dad takes out the rubbish and my mum made us clean and cook. I think mostly in the Somali community we are brought up like that; it's mainly the female's job to clean the house, kind of a tradition" (Zack, 13. Male. Bristol).

Women living in FGM-practicing communities often have few personal expectations for the future; they perceive their life cycle as being predictable and fixed by those in

positions of control; commonly, the immediate family members. Young people are therefore pressurised to believe that FGM is part of the tradition and a rite of passage which guarantees marriage (WHO, 2008), therefore, generally, girls have less freedom as Mohammed explains:

> "…Overall I think girls have less freedom in most places". (Mohammed 14. Male. Bristol).

Rwaida appears to agree with the notion that, in the West, girls are pressured to study whilst boys are allowed to wander.

> "I think girls mostly stay at home and revise and parents are stricter, like with Somali boys, you see them on the road all the time, where girls are told to stay at home." (Rwaida, 17. Female. Bristol).

Butler's (1988) ideas on how gender is performed and enforced can illuminate how girls perform gender within the family unit. That is, to be recognised as a female 'subject' a girl must 'do girl' by embodying and reproducing normative femininity (Bordo, 1993). Gender is enacted here through the process of power, which may be interpreted as young girls being seen as powerless beings in need of protection, therefore needing to remain at home while young boys are free to socialise. In the US, Kasinitz et al. (2009) argue that the more structured and monitored lives of second-generation young girls have positive effects on their educational attainment.

In the extract below, Aaliyah attempts to deconstruct the 'norms' set by society, arguing in essence that, although gender differences exist, not only at a biological sex level but also at a social level, these are all constructed and thus can be deconstructed (see also West and Zimmerman, 1987). As sex determination sets the stage for a lifelong process of gendering, as a child becomes, and learns to be, male or female, symbolic resources such as clothing and names are used to support a consistent, ongoing gender attribution. Aaliyah argues for a less stereotyped system:

> "You know when people have a baby and the bedroom or the baby stuff that they bring, blue for a boy and pink for a girl. I think that is just kind of, I know it's the norm, but it's so like, so stereotypical for people to think that blue is for a boy and pink is for a girl, because some people like the other. I feel like boys and girls should be equal in every way even if they don't look the same or don't act

the same and don't have the same genitals, which make them a boy or a girl. I think they should be on the same level and not get like stereotyped if they like something else" (Aaliyah, 13. Female. Cardiff).

In the following extracts, Aaliyah and Jack both explore how these differential treatments teach boys and girls to be different, thus leading to unequal power distribution:

"…a lot of people think that women shouldn't get the same chances as men. They think by doing this [FGM] it will make some people think it will make them lower because they have no power now, they can't have like a natural birth, they can't be on their periods normally like they think that will make a woman lower than them, instead of like the same level equal" (Aaliyah, 13. Female. Cardiff).

Jack appears to describe men as having more autonomy to make decisions, whereas a woman is influenced by social pressure; thus even though in a Western country, she may 'go abroad and have it done':

"Yes, I guess 'cause men sort of like, they are more direct about what they want, you know what I mean, it's like, men seem to want something done their way. I don't know if that came out offensive, but they want things done their way, and if they don't like it, they would happily change it. I guess that's what's happening over there as well [Africa], they like it their way. If the man is not happy with his parents, the man would be direct and say I am not happy and we need to change it. Therefore the woman gets self-conscious and thinks, 'I need to get this done if this is what people do, I want it too,' so they are going to go abroad and have it done" (Jack, 14. Male. Bristol).

The representations of gendered behaviour that are generally linked to masculinity and femininity are a result of learning processes since, from a young age, children learn how to 'perform' gender. This is encouraged by enforced norms, thus to be one gender or the other is often linked to how well a person performs that role (Butler, 2009). Additionally, women's subjugation, liberation or emancipation is heavily embedded within the power relations that interplay at a micro, meso and macro-level (Mohanty, 2001).

<u>6.2.1.3</u>   <u>What makes a girl</u>

Aaliyah discusses her ideologies about appropriate gender behaviour, asserting that being a 'girl' is confirmed at the start of menarche; therefore, to her, sex is a biological entity. She also acknowledges how FGM may be compared to self-harm, although argues that removing the genitals is far more detrimental than self-harm, 'taking away' what makes an individual a girl.

> "It feels like, when you start your period, you finally feel like, a lot of people around you have started it already, and you feel like I am really a girl now, I can do this. But when this [FGM] happens, they are taking everything that makes a girl… Like female, everything that you have on your body, it's kind of gone… I found out that there were some girls in my year that self-harm, some people would look at FGM like that basically, just self-harm, but it's much more than that really because you are taking away your genitals. It's not just making marks or scars on your body. It's literally taking away what makes you a girl. (Aaliyah, 13. Female. Cardiff).

This is similar to how many societies view young girls and their sexual maturity, where the onset of menstruation and the development of breasts often signals the end of a girl's childhood and the start of her womanhood (see also, Althaus, 1997; WHO, 2008; Wood, 2001).

Although Beauvoir (1949), argues that that one is not born a woman but made a woman, in this study, Aaliyah suggests broadening gender boundaries; she believes that sex determines the gender of an individual:

> "I think physically as well; it's like what you have on you. I am not saying to people that are like transgender, 'well you are not a girl… because you don't have this', but I am saying that literally a girl, born a girl, this is how you are" (Aaliyah, 13. Female. Cardiff).

She argues that female genitals are what confirms one's sexuality to others:

> "…I know a lot of people in my school feel like uncomfortable because they are the only people that haven't started their periods and they think… 'I am not a girl'… but there are a lot of people that haven't started their periods, but they are still girls, they still have their genitals which gives everyone proof that they are a girl (Aaliyah, 13. Female. Cardiff).

In FGM-practicing communities, reproduction is the most important role for the woman, while the man is expected to provide economically for the household as the sole source of income (Althaus, 1997). This is one way in which inequality has been manifested and embedded in structures of the social (WHO, 2008).

6.2.2   Control over women's sexuality

The social norms that perpetuate this practice differ between practising countries. The previous section examined how young people interpreted the practice. The participants felt that FGM was practised to stop girls from sexual intercourse, "It is when they sew the girls' private parts to stop them from having sex" (Image 6.1), therefore controlling women's sexuality. Furthermore, young people in this study maintained their disapproval of the practice, although their definition of FGM was the 'severe' form of infibulation as defined by the WHO (2008). Image 6.1 below illustrates some of the definitions young people gave when asked their views:
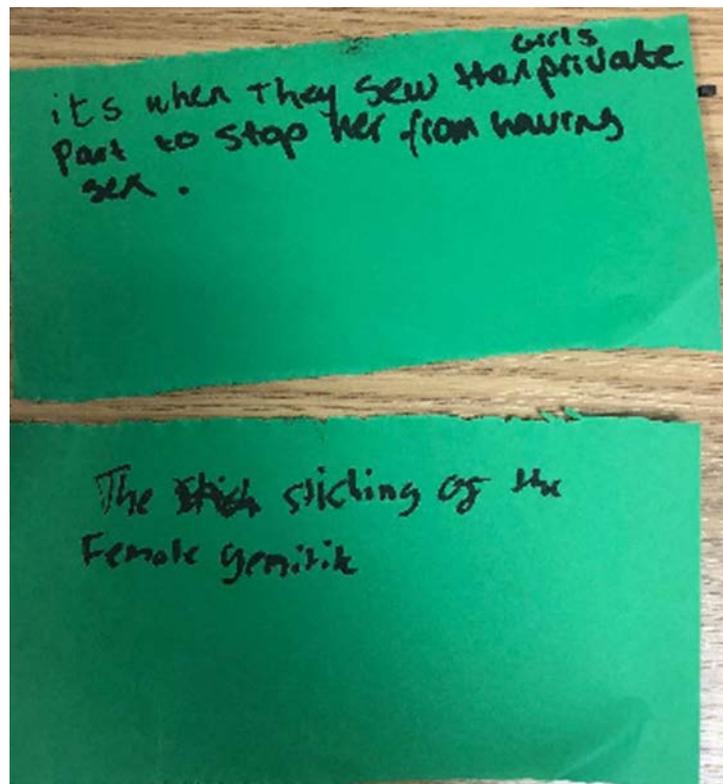

Image 6:1: Young people's views about the practice of FGM

Within various interpretations of FGM, the importance of the body is central, in that the lived-in body is the means by which moral and social norms are peculiar to a person's particular cultural and familial background and inform their activity (Diprose, 1994). The body has become a site of power struggles within the context of FGM-practicing communities, for example, where control of women's sexuality is often seen as the key motivation for its continuation; as Felicia notes:

> "It is a lot to do with male domination and control over women. You see that all over the world, they control female sexuality. Sometimes they also use religion to say it is to do with religion" (Felicia, 15. Female. Cardiff).

Foucault's (1997) concept of bio-politics illustrates this notion of power, where power is presented not merely as hierarchical and oppressive, but as horizontally produced and subtly embedded in a society's language, cultural and social practices. Akin to Foucault, Harcourt (2013) draws connections between knowledge, power and the body, asserting that, if we understand that our knowledge of bodies is irreducibly interwoven with other discourses, being social, colonial and economical, we can strategically reconceptualise bodies as cultural products on which the play of powers, knowledge's and resistances are worked out. In the extract above, Felicia associates this power with the social. Similarly, a study conducted amongst women in Egypt found that men were afraid that, if their wives had not undergone FGM, there could be a risk in maintaining their sexual desires within the marriage, for example, the woman's sexual demands could be beyond their capabilities (Fahmy et al., 2010).

Within the ongoing debates about FGM in this study, young people demonstrated the internal conflicts they may have with their parents; for instance, Mike questions how loving parents can essentially 'harm' their children.

> "It made me wonder why people do this to their child that they are meant to love and care for and not hurt and ruin their lives and everything… like, when the parents try to stop their children from doing bad stuff, but then it might harm them even more, and stop them from having families, kids and everything… Maybe like the father or parents may think oh, you're not allowed to have sex until you're married and then, when you're married you can take off the surgery the thing, yeah" (Mike, 13. Male. Bristol).

Mike also uses the term 'surgery' to signify FGM and suggests that one may be able to simply 'take [it] off' once married, showing a lack of knowledge regarding the practice and its complications. Research conducted with FGM-practicing communities in the United States has shown that Somali women believe that, if FGM is not carried out, girls risks being abused by the community, considered useless or not be able to be married (McNeely and Jong, 2016), a view which objectifies the female body into whose sole purpose is marriage.

The extract below alludes to Lucy agreeing with the notion of controlling girls, in terms of stopping them talking to boys, but she suggests other ways to do this, for instance, another form of 'control' which is conceivably, to her, a more subtle version and effective method.

> "Confused. Like why would they do that? Instead of like doing this procedure, they could literally just find another way to stop that girl from having any [bad] behaviour towards boys. Like not letting her out of the house by herself, she can be accompanied by someone else" (Lucy, 13. Female. Bristol).

Similarly, Mo appears to agree with this 'lesser' form of control:

> "But they don't say like do this and then when you get married you can have sex, I don't think that's right. I think other things could be done to stop that instead of FGM" (Mo, 13. Male. Bristol)

The objectification of female bodies is visible in the literature and images that attempt to define FGM. Sophia shared her experience when she attempted to watch it on TV, aged 14:

> "I think my mum and sister were speaking about it and I just heard FGM in a sentence. Then I saw it on TV, and I cannot believe these people are doing something like this. Like people sewing up a young girl's private areas… and it stops them from having sex until when they are older" (Sophia, 15. Female. Cardiff).

Again, here, Sophia associates FGM to stopping girls from having sex until they are old, not necessarily discussing the health effects associated with the practice. Arguably, young people share an understanding of FGM linked to patriarchal power resulting in the oppression of women. According to Foucault (1976), the 'pedagogization' of

children's sex is believed to be essential, as children are thought to be highly sexualised and in need of control. He argues that the body is a symbol of reified power relationships because social connections within society also find expressions of corporeal images. Control over women's bodies is, therefore, parallel to the expression of social control being exercised within society.

6.2.2.1   Purity

In many cultures, women are seen as being vulnerable and in need of protection from men's sexual advances. FGM is seen as a way of protecting a girl's virginity and is therefore highly regarded and linked to a family's ability to arrange a suitable marriage and maintain their social status (Mackie, 1996). In the extract below, Ikram acknowledges the implications associated with FGM, but she appears to agree with controlling girls in other ways.

> "She had never heard of it before [mum]. Our older sister had it [FGM] when she was young, and some of our family members had FGM done as well. My sister asked me if I would ever do it to my children and I said NO! I get why it's done, but I don't want my children to go through that pain. I know purity is one of the reasons why it's done, but I am sure there are other ways, like to stop girls from having sexual intercourse" (Ikram, 15. Female. Bristol).

Ikram does not mention the choices young girls should be awarded over their bodies but rather views the body as an object, a machine that is both controlled by, and limits, the mind. This notion harks back to literature from the 17th century, such as the work of Spinoza (1989), which argued that society and culture were coextensive in the biology of the body, refuting the postulation of subversive sexuality which could be free from the law. In recent times, Butler (1993) and Bordo (1989) have also explored ways in which bodies are shaped and gendered by culture.

Ibo interprets FGM as an act of protection but also of control; he uses the word 'sew' to signify his awareness of the act that represents Type III FGM:

> "They protect the woman's genital parts umm because they may be from a certain tribe or something and they don't want them to have intercourse, so they sew it up or whatever" (Ibo, 13. Male. Milton Keynes).

Similarly, Ikram acknowledges that men often want to find a wife who is pure, but 'they' (men) would not understand the complications associated with purity.

> "…Some people think girls should be purified and not allowed to have sex. I think the men would want their children, not their children, their wives to like be a virgin… Because they just think that, the girl I marry, as long as she had it then she is purified. But then they won't understand like the diseases it could cause. Like traumatise the girls and like what they have done just from wanting that [purity]" (Ikram, 13. Female. Bristol).

Equally, in their research, McNeely and Jong (2016) conducted research in the United States, exploring Somali refugees' perspectives of FGM. In that research, participants described an act which a man would perform if he were not satisfied with the closure of his wife's vagina. The man would dig a hole in front of his tent which the villagers would fall into while walking in the morning. This signified his wife's openness and allowed the man to divorce her. In other words, if a girl were closed and could satisfy her husband, it would bring 'glory' to her family, however, when she was slightly open, this would bring 'shame'. The women in McNeely and Jong's study expressed discontent in being controlled by men in terms of religion and culture, where the man decides if the woman is closed enough.

Sophia also perceives men as lacking understanding of the 'dangers' associated with the practice, stating:

> "Well women might see it like, I think women would have more chance of understanding it because obviously, it happens to them. But some men might, especially the ones that believe in it, might feel like an honour, I want my wife to have this because then they will know she is a virgin. They don't really see the dangers of it. The men wouldn't see the danger of it" (Sophia, 15. Female. Cardiff).

In the various interpretations of FGM, the importance of the body is central, in that the lived-in body is a means to moral and social norms linked to cultural and familial backgrounds which inform our choices. Therefore, the cultural value of female virginity

is highly regarded in FGM-practicing communities and, through history, has become the norm. To this end, although young people were not able to clearly articulate the origins of the practice, they associate the practice with purity:

> "Cause like, I don't understand a lot of it, but I know it's a bad thing. I've heard like [it's] to stop girls from having sex before marriage and stuff" (Zack, 13. Male. Bristol).

Although young people in this study seem to disagree with the practice of FGM, it appears that 'stopping' girls from having sexual intercourse' before marriage is accepted.

6.2.2.2 Trust

Young people perceive the lack of trust as a contributing factor to FGM. Ikram stresses that this lack of trust may inadvertently force young people to 'do something bad'. In this context, 'something bad' means engaging in sexual relations:

> "Yeah, that it's something to do with the female genitals, to stop them from having sex. I understand why they would do that, but they should have more trust. I think parents should just trust their girls because I think if they feel they are not trusted, it might force them to do something bad" (Ikram, 15. Female. Bristol).

Among many practising communities, FGM is thought to restrain sexual desire and prevent deviant behaviour (Gruenbaum, 2006; Hernlund, 2003; UN, 2008). Parental trust in their daughters, therefore, becomes an important aspect, as is illustrated by several tribes who practice FGM, such as the Yacouba tribe in Cote d'Ivoire, where parents, stress the importance of lack of choice: 'my daughter has no choice. I decided. Her viewpoint is not important' (Althaus, 1997).

As mentioned earlier, FGM is linked to the control of women's sexuality, which leads to the woman's body being treated as an object. The extract below validates the claim that, without trust, FGM is inevitable within marriage. Aaliyah views this as a form of control:

> "I feel like if you really trust who you are with, then it [FGM] wouldn't happen. But then it is like this man is trying to hurt you. If he is really thinking, 'I don't want her to go off with anyone else'. If you really think about it, you are not just

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making sure she doesn't go off with anyone else, you are hurting the lady. If this happened to me because of who I was with, I would never be able to look them in the eye ever again… because it's just, it's like basically taking away the trust you have towards that person. Because there are different types of men. Some people can have trust, they can be like loyal to like they think their wife or the person they are with is loyal and trustworthy, but some are too controlling I think" (Aaliyah, 13. Female. Cardiff).

A study conducted in Egypt among parents found that men viewed female circumcision as being equally important after marriage as before, stating that this 'safeguards' their daughter from engaging in extramarital relations (Abdelshahid and Campbell, 2015).

Halimo attempts to distinguish the different natures of a type of African man in relation to 'white man', where she argues that the African would support the practice, whereas it is not the 'norm' in the West, therefore, the white man's views would differ:

> "Depending on what kind of man you are speaking to, there are different types of people in the world. People have got different points. If you were speaking to, say, if you were speaking to an African man who knows about it, he would probably want his wife to have it. And if his fiancée or whatever didn't have it, he would probably most likely not want her. If you were speaking to a white man, a white man wouldn't want the woman who has had it done because it's not in his life, it's not the norm for him" (Halimo, 14. Female. Cardiff).

6.2.2.3 Pleasure

Young people associate FGM with a lack of female pleasure, as seen in the following extracts:

> "Personally, I believe that it's wrong because men take all the pleasure. I think that's wrong because everyone gets a little bit and like vice versa because as the man wants it. He should think about the woman. Because obviously there's not going to be any excitement either. Like they want all the pleasure for what reason? Like why can't a woman get at least a little, I find that just foul" (Felicia, 15. Female. Cardiff).

> "It's an illegal procedure that people do to younger girls or older, and they do it so they can prevent them from having the pleasure of intercourse from, yeah" (Halimo, 14. Female. Cardiff).

According to Fahmy et al. (2010), in FGM-practicing communities, the practice is linked to a misconception of female sexuality. The clitoris is generally regarded as a source of sexual desire rather than sexual pleasure. In other words, FGM is believed to reduce a woman's sexual desire rather than sexual pleasure. Moreover, the clitoris is seen as a masculine part of the body, which should be removed (Asaad, 1980). However, removal or injury to female genitalia has been linked to diminishing female sexual pleasure (Shell-Duncan, 2001), although Catania et al. (2007) argue that – although infibulation does not necessarily lead to lack of pleasure, because anatomically, the erectile structures fundamental to orgasm have not been removed.

6.2.3   Safer here

Historically, several methods have been utilised to reduce the harm associated with FGM. It has been argued that the medicalisation of FGM is contributing towards its abandonment (Kimani, 2018; Shell-Duncan, 2001). In 1994, Egypt's Ministry of Health required medical professionals to set aside one day a week to perform the practice (Kimani, 2018). It was anticipated that moving from community cutters to the hospital would reduce the medical risks associated with the practice (Kimani, 2018). However, following international efforts to eradicate FGM, the practice was officially banned in 1997 in Egypt (Modrek and Liu, 2013). A fundamental problem associated with the harm reduction approach is that it legalises and gives FGM power by biomedical discourse.

Both young men and young women shared similar views on safety in relation to the practice of FGM. It was suggested that FGM is safer when performed by 'best trained' doctors in the UK. This was discussed in contrast, to third world countries, where the practice was perceived to involve risk that may lead to 'life-changing problems'. Participants articulated stereotypes of the Third World othering where those in the West are considered to be much more advanced.

> "With vaginoplasty, I guess here is much safer because we are a high-income country, we have NHS and best-trained doctors, so I guess it's much safer, but in low-income countries life expectancy is lower, so it can be a risk, and it can lead to like life-changing problems" (Mo, 13. Male. Bristol).

Foucault's (1998) concept of bio-politics is particularly useful here in considering the construction of young people's knowledge about the body in Western scientific discourse. Biomedicine holds privilege in propagating ideas of the body and its functions (Diprose, 1994). The hegemony of biomedicine is apparent in the extracts here, where medicine has been legitimised by scientific evidence, and people often comply with those in power, in the extract above, doctors, have been legitimised as being safer people to perform the practice.

Similarly, Lucy articulates the processes in FGM-practicing communities, where the parent would take the child to her doctor:

> "She [Mum] said that if a mother would really want her child to have it, she would take her to a doctor. I don't think the doctors perform the procedure any more but yeah only if you really want your child to go through this, but I don't think any mother would want their child to go through that" (Lucy, 13. Female. Bristol).

Although the practice of FGM is illegal and is not performed within hospital settings in the UK, it is important to acknowledge that medical professionals may perform FGM in private (Dorkenoo, 1994), an example is the recent conviction (Summers and Ratcliffe, 2019), and that the practice is also medicalised in some FGM-practising countries.

> "Low-income countries, I don't know which countries, I don't know but low-income countries. It happens because the regard to safety and life expectancy is really low, so it's easy to get away with it or easier for it to be done without like it's done with a blind eye, people don't really see it" (Jack, 14. Male. Bristol).

Similarly, Maria notes:

> "I think for girls before she makes the decision to have it, she should ask the doctor, and if the doctor said okay, then she would do it to please her parents…" (Maria, 15. Female, Milton Keynes).

This interpretation of safety risks young people continuing the practice in the UK. A clear example is given in the extract below, where Sabrin explains that FGM is practised in this country, and appears to accept that this is due to it being 'safer':

> "It happens in this country, a few years ago, but it's different from the ones you get done back home… they use better equipment, and it's like safer… In Cardiff, but I don't know where" (Sabrin, 14. Female. Cardiff).

Again, young people in this research perceive safety with the use of cleaner equipment, not to future complications associated with the practice. Maybe these perceptions are a result of hearing discussions from family, but also, how the practice has been framed in the West, here Sabrin shares her experience:

> "I think I heard it last year, my family was talking about it, some of them agreed and like, and the others didn't… Some of them were like, its *haram*, and the other was like, and they believed it was Sunna or something…" (Sabrin, 14. Female. Cardiff).

The following extract builds on the previous question of whether FGM can be performed without risk, or should there be an element of harm reduction that enables people to decide whether to undergo the procedure or not:

> "When it comes to FGM itself, I don't think its right. But if she feels like she must do it, as long as it's safe and no problems will come from it, then she can, but it should not be risky" (Lucy, 13. Female. Bristol).

6.3   Interpretation of the legal context

6.3.1   Introduction

Interpretation of the legal context formed the second theme from the analysis of my findings. Young people view the practice as illegal and are aware of its prohibition in the UK. They also convey an awareness that although FGM is illegal in most practising countries, it continues covertly. Young people link FGM to injustice due to a lack of choice, as well as the process of harming another.

6.3.2   It's a crime

In relation to this subsection, young people discussed the fact that FGM is illegal. However, they explained that in some countries, the system might indirectly allow its continuation. Furthermore, the use of language in the extract below illustrates how Jack identifies himself as British, using terms like 'over here… *we* are good' [my italics], advocating that stricter laws should be applied to migrants who want to come into the UK.

> "I know FGM is illegal here, and it's not legal there either, but I think they do it illegally. I think having the law is useful. Because there are no records here of someone having it done because of the law, but over there I think more needs to be done like towards security in countries where it's illegal and still happens. But over here I think we are good. Maybe higher prosecution, stricter laws, and people who come [here from] abroad need to ask questions like 'why are you coming to this country?'" (Jack, 14. Male. Bristol).

Others felt that performing the act without consent was a crime, conceding that perhaps though if someone chooses to have FGM, it is not as bad?

> "I think it's a crime… because defacing someone's body without their consent is a crime" (Ibo, 14. Male. Milton Keynes).

Young people associate their understanding of the practice to community sources of FGM. Here Ade, who identifies as Christian, illustrates the importance of religion in his

life. This includes his religious leader, who is seen as an authoritative figure. Because 'the pastor' says it is illegal, therefore, he considers that it is.

> "I think the people that do this to their kids should be arrested and put in prison because the pastor said it's illegal" (Ade, 13. Male. Bristol).

This demonstrates another aspect of Foucault's (1979) power exerted over the body, in its capacity to constitute individuals in a particular way. Ahmed et al., (2018) explain that religious leaders are influential actors in changing behaviours of FGM, though they also may contribute to its perpetuation.

> "I'd say it's an illegal surgery that is done, mutilating the women's genitals. It's illegal and can be life-changing (Jack, 14. Male. Bristol).

Although Jack interprets the practice as a kind of 'surgery', he acknowledges the complications that may be associated with 'mutilating' a woman's genitals, and therefore should be illegal. This is an interesting finding and coincides with O'Neil et al.'s (2016) findings, where the research term attempted to understand men's views of FGM in the UK, Netherlands, and Belgium. The study found that older men were more reluctant to discuss the issue whereas younger men, specifically from West Africa, were more open to the dialogue. It is important to note, however, that the term used to describe FGM in that research was being 'cut' or 'circumcised', Female Genital Circumcision (FGC). Therefore, despite utilising FGC/FGM interchangeably, young people appeared to be more accepting with using the term 'FGM'.

In the same vein, Ade states that:

> "FGM, Female genital mutilation, is the illegal act of the stitching of the female genitals" (Ade, 13. Female. Bristol).

Zack notes he often hears the term FGM, rather than FC.

> "I think it was my mum, but she might have said it in more detail, but I wasn't really listening, to be honest, so I am not sure. I often hear people call it FGM, not circumcision" (Zack, 13. Male. Bristol).

Whereas Mohammed is more inclined to use the term 'female circumcision.'

"FGM is female circumcision; it's like from our culture and stuff rather than religious stuff, it is when they circumcise female genitals" (Mohammed, 14. Male. Bristol).

Mike appears to recognise the apparent lack of knowledge in relation to the law, within the UK context.

"I think the law is important, because if they do know they wouldn't do it. Because they wouldn't want to go to prison, so like yeah I think it's a good thing" (Mike, 13. Male. Bristol).

In their research, however, O'Neill et al. (2016) found that, across the UK, Netherlands, and Belgium, men were aware of the law against FGM in both their countries of residence and of origin. The study also found that, in the UK, men supported punitive punishment, which should involve the removal of children from perpetrators.

Maria provides an interesting perspective on law, stating that, although parents are aware that FGM is illegal, children are taken abroad to 'have it done'.

"But I think we should also hear it from the media because I feel like it still happens today and like I've heard my parents telling me about like people like children my age being sent off to Somalia, for example, to have it [FGM] done 'cause obviously, it's not legal here… My sister told me about it. I think it's good that it's not legal here. I'm not sure if it still is okay in Somalia, maybe it is, but I know it still happens" (Maria, 15. Female. Milton Keynes).

Research in this area is scarce, as encouraging children to report their parents to the police is a complex issue. According to Berer (2015), from the inception of the FGC Act 1985 to its amendment in 2003, there were no young women reported to have undergone FGM to the police; although there has been a recent conviction, not directly linked to a young women reporting to the police, but rather from medical complications which led the mother of the three-year-old contacting paramedics. Therefore, one could argue that either the law is sufficient, or that it plays a role in driving the practice underground, as Maria suggests.

Farid is unaware of the law in the UK but understands the potential implications of the practice:

"That is illegal in this country, right? Well, I heard it is illegal in this country, and so much for a woman, it's painful for them" (Farid, 14. Male. Bristol).

In the extract below, Halimo's sisters likened FGM to male circumcision, although highlighting that FGM is illegal and male circumcision is not:

"I asked my mother about it, and she told me about it. But I wanted a bit more information, so I went to my sisters, and that's how I learned about it. They [sisters] said, you know how, they said for example like my nephews, my two nephews got circumcised the day before I asked them and she just said it's like that but for girls and against the law though" (Halimo, 14. Female. Cardiff).

Earp (2015) compares male circumcision and FGM, asserting that these procedures, which often involve the removal or alteration of children's genitals, are discussed under disparate ethical discourses. For girls the term FGM is used, typically described as 'barbaric', whereas for boys we conveniently refer to it as male circumcision, often also claiming it to be benign and beneficial. He calls for an ethical framework that is based upon considerations of bodily autonomy and informed consent, rather than sex or gender. Although Njambi, situating FGM within a cultural framework, argues that the "cultural practices involved the female genital modifications in Africa, appears to have a unique history of the meaning of their own, outside what is already understood in the west to be male circumcision" (Njambi, 2004, p. 283).

6.3.2.1   The law is not enough

Young people express the need for rehabilitation rather than the 'tough' approach taken by authorities in the UK:

"I think saying 14 years is not enough, as they might serve then come out without changing. I think some kind of rehabilitation is needed" [For perpetrators] (Lucy, 13. Female, Bristol. Focus group).

Another young girl from the focus group discussion explains the reasons why education is important:

> "I think education is the best way to educate people rather than the law. It gives the new generation an understanding of what it is and how we can stop it." (Ikram, 15. Female. Bristol).

This notion appeared to be unanimous within the focus groups discussions:

> "I think it's useful to have the law, but sometimes that is not enough, like teach young people in school" (Zuli, 17. Co-researcher).

Young people also show their lack of awareness regarding the law. This participant enquires about her mother, presumably wondering whether she would be convicted:

> "A lot of people listen to their mum, like for example if your mum told you to do it but you don't want to get it done but to please her you get it done, like can people get help after? Would your mum get in trouble for it?" (Aaliyah, 13. Female. Cardiff. Focus group).

6.3.3 Injustice

When asked to explain how they feel when they hear about the practice, young people express feelings of 'anger', articulating the lack of choice that some girls may have. It is also important to highlight that all of the young people expressed their concern on issues of injustice, lack of choice and the act of being forced.

> "Also, it makes me feel a bit angry because it's just like, why would you do that to someone if you don't even know them if you have never heard their point of view. Just because you believe in it, it doesn't mean everyone else believes in it. They might not even believe in anything, and they are just forcing them to fit into their culture. Just because that's the way you have grown up, not other people. I just don't think it's fair" (Sabrin, 14. Female. Cardiff).

6.3.3.1 Force

This subtheme, '*force*', comprises the negative perceptions the participants associated with FGM. Their argument is that no young girl should be forced to comply with the practice; they should be enabled to have their own free will.

> "I heard it's different; I think there's like two types and one of it you get sewed up, like the ones here [UK] you don't get sewn, not sure what they do… In my opinion, It's like torture. It shouldn't be done if the person doesn't want it. They shouldn't be forced. Even if they wanted it, they shouldn't be forced because there's no point" (Sabrin, 14. Female. Cardiff).

Sabrin notes the different forms of the practice, the possibly 'accepted' version (in the UK) in comparison to being 'sewn', also known as infibulation, which, in her version, is practised in Africa. This presumption risks the practice continuing in the West. Sabrin clearly asserts that it is torture, however, clarifies that she only considers this to be the case if a girl does not want to go through it.

The age of which it happens is also debatable, while some participants in this research are pro-choice, Ikram states the young the better:

> "In Sudan, my mum told me can have it like a baby because she doesn't move around a lot and it won't be painful; I think the younger, the better" (Ikram, 15. Female. Bristol).

Indeed, according to Althaus (1997), young girls in FGM-practicing communities have no choice in the matter. Given their age and lack of education, they are forced to depend economically first on their parents and then their husbands; therefore, FGM is inevitable.

Maria states how girls would be 'held down'; this illustrates the forceful nature of the practice:

> "In Somalia, it was like expected of girls to have FGM practised on them, even if like I don't know, my mum would tell me how they would like hold you down as they did it" (Maria, 15. Female. Milton Keynes).

In practising communities, girls who have not undergone the practice often feel insecure and different from everyone else, again, illustrating the power of the social context. Therefore, here we see the different types of forces used to sustain FGM: that of the physical when a girl is held down, and that of the social, where FGM is rooted in traditional social-cultural influences that force a woman to both undergo the practice and to *want* to go through it to fit in.

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In the following extract, Aaliyah discusses the need to please her parents. However, questions whether agreeing to have FGM is a step 'too far', in that if it were to happen to her, she would say no:

> "…I can see if you are forced into, well I feel that no one should be forced into something they don't want to do and if someone was trying to force me to do it, I wouldn't, I would be like, no straight away even if it was my mum. I try to, well I believe that even if my mum is not talking to me, I think I should try to please her but I think that doing something like this is too far" (Aaliyah, 13. Female. Cardiff).

Sophia agrees that in a Western context, FGM would make a person 'feel hurt and insecure':

> "They shouldn't be forced. Even if they wanted it, they shouldn't be forced because there's no point… the girl that's been forced would feel hurt and insecure like she will feel weird and different to everyone else" (Sophia, 15. Female. Cardiff).

6.3.3.2 <u>Victimising</u>

Having discussed the concept of free will and autonomy, some respondents in this study considered the criminalisation of FGM to be victimising and discriminative. This subtheme illustrates young people's views about the law and how the banning of FGM can lead to victimisation. This subtheme reflects Halimo's experience and feelings after being stopped at an airport. Halimo, 13 years at the time, was stopped at the airport after coming back from Somalia. She describes her experience:

> "Well, I went to Somaliland for six months. When I was getting off the plane when I was coming back to the UK… I was at Heathrow in London airport, I came off a 9-hour flight, so I wasn't really walking like I usually do. I was walking a little bit you know, weird, 'cause I was sitting down for the whole 9 hours, never got up. A lady pushed me to the side, and she was like… I don't know what she said exactly, because it was a couple of months ago. But she said, 'have you ever got FGM done because you are walking weird and you have been gone for six months'" (Halimo, 14. Female. Cardiff).

The identities and lives of minorities, like the participants, are also complicated by the way they are viewed by the wider society. Padilla (2006) argues that, no matter how second-generation youth identify themselves, the state and public may assign them with ethnic labels. In relation to FGM, there has been a long-standing debate regarding the labelling of FGM-practicing groups as 'suspect communities' due to certain of their characteristics, for example, ethnicity, race, and culture (Pantazis and Pemberton, 2009, cited in Karlsen et al., 2019; Braun, 2009). This categorisation forms a social identity which people become accustomed to and may act upon (Brewer, 2001; Breen-Smyth, 2014).

> "At that time it was February and school had already started, and she was like, 'school has already started, it is an unusual time to go'… but something had happened back home, and that's why we had to stay longer" (Halimo, 14. Female. Cardiff).

Similar results were echoed in a recent study amongst the Somali communities in Bristol age 18 and over (Karlsen et al., 2019), where women expressed their discontent with Safeguarding law, expressing feelings of being targeted, stigmatised and experiencing a sense of unfairness of safeguarding system in the UK. However, this research by Karlsen et al. (2019) represents the older Somali generation in Bristol and is limited to one ethnic minority. Young people in this study echoed similar issues, for instance 'othering' and, in this context, 'victimisation'.

An important factor to consider here is whether Halimo was stopped because she was walking 'weird', or was it due to her characteristics, as previously discussed? According to the UK Border Force (Bolt, 2014), Metropolitan police undertake educational and enforcement activities which include training officers at airports to identify victims of possible offences and take action, for example in Heathrow airport 10,000 people were stopped of which five were arrested, and four girls were taken into police protection. The date of these actions is unclear in their report.

It is apparent from Halimo's recollection of that day that the matter was not handled in a sensitive way. Halimo continues recounting her experience, stating that the officer would not let her voice her opinions. This attitude then obscures the true dialogue that

would essentially take place if Halimo was not already characterised as a Somali, young girl; therefore, an 'oppressed victim'.

> "Originally, I was only going to stay for four months, but we ended up staying for six months… I felt the way she was speaking to me was rude; she wouldn't really let me speak" (Halimo, 14. Female. Cardiff).

Although it is against the law to remove children from school for an extended period unless permission has been given (Department for Education, 2019), at 13, Halimo may not have been aware of this it is clear that Halimo has been upset by this experience, and one may conclude that the questions asked were insensitive:

> "She was asking, 'has it ever happened to you? Do you have siblings? Were you and your mum the only people who went?'… Just like personal questions, she didn't really need to know. She was asking what school I went to and stuff, stuff that had nothing to do with her" (Halimo, 14. Female. Cardiff).

By allocating time to discuss the issue in a safe and sensitive environment, the questioning could have been carried out in a manner that did not alienate young people. I argue that this kind of dialogue must be reconstructed to one that is neither condemnatory nor demeaning but stems from a careful understanding of the complexities of diverse cultures. In fact, Halimo explains that this was the first time she had ever heard about the practice:

> "I was there [in Somalia] for six or seven months, and I'd never heard about it till Heathrow when the woman came up to me" (Halimo, 14. Female. Cardiff).

6.3.4 Choice

In relation to the arguments about cosmetic surgery and FGM, the perception is that the difference is one of choice. In this research, Sabrin argues that surely it would be better if FGM was made legal. She maintains her strong disapproval of the practice but calls for 'choice'. This approach may be seen as harm-reduction where, due to choice, people would be able to speak out openly about it more:

> "It should be legal for those who want it done. It's better that way. But I am completely against it, but it's better that way, 'cause they have a choice, they haven't been forced to get it done" (Sabrin, 14. Female. Cardiff).

FGM is often carried out on children below the age of legal consent, while cosmetic surgery is carried out on consenting adults. Yet in practice, 'choice' is not what distinguishes FGM from other non-therapeutic surgeries. Several adult women choose to undergo circumcision and, due to inaccurate statistics, it is difficult to ascertain the age at which circumcision occurs. An example of this is a study by Allotey et al. (2001) in Australia, which identified women arguing for the right to be reinfibulated following childbirth, to restore their genitals to what they perceived as normal. When they were denied this right by the law, they viewed it as institutional racism, in the context of tolerating clitoral piercing.

A respondent in this study, Felicia, distinguishes between free will and force, noting that the fundamental issue is how choice is seen to operate.

> "People have a choice to do whatever they want, and others should not make that choice for you" (Felicia, 15. Female. Cardiff).

Therefore, if this notion of choice is free from coercion and encouragement from others, fully informed of risks and complications should it be allowed? Several studies (see Braun, 2009; Jonsdotter and Essen, 2010) have highlighted contradictory notions, arguing the link between agency and autonomy in western women who choose to have female cosmetic surgery and women from FGM-affected communities are unable to choose such painful procedures for themselves. Implying that the latter must either be too young to refuse the procedure, under social pressure to conform, or afraid of male rejection and therefore lack agency.

Universalists argue that FGM is a violation of individuals' human rights and an infringement of the right to freedom from violence (Articles 25 and 3 of the UN Universal Declaration on Human Rights, 1948), implying that women who undergo FGM are not free to choose what happens to their body because the practice is forced upon them. Njambi (2011, p.294), shares her experience as a Kikuyu woman from Kenya, who chose and went through what she calls 'irua ria atumia', a circumcision ritual that marks a girl's

passage into womanhood. Njambi discusses going against her parents' advice not to undergo the practice, explaining that the procedure entailed the *'hood of the clitoris being cut through its apex which caused the hood to split open, exposing the clitoris'* (p.294), and contending that this exposure is associated with enhanced sexual pleasure. The ethno-sexuality and embodiment of Western norms, along with feminist fetishisation of the clitoris' role in female pleasure (Shell-Duncan and Hernlund, 2000) prevents outsiders from perceiving African women as anything but sexually harmed, even if a woman reports experiencing sexual pleasure after the procure, as in Njambi's case (2011).

Sophia provides an additional element to this debate around individual agency, the fact that some people lack choice. This is indeed the case when FGM is practised on young girls who do not have the capacity to decide, therefore, in that context, the practice is considered a form of child abuse (WHO, 2016):

> "It [FGM] just causes harm to yourself for the rest of your life really. It's not really going to grow back. As well, imagine when you are older, it could go worse, and it's just sad thinking that people could go through that. Like some people don't have a choice and yeah" (Sophia, 13. Female. Cardiff).

Mitchum (2012) points out that, concerning FGM, women do not have a choice but are given a decision; this is whether to undergo the procedure and deprive herself of sexual autonomy or refuse to and face potential shame from her family and community. Therefore, within the context of 'control of women's sexuality', females in FGM-affected communities are regarded as victims in Western discourses, even though, as Njambi (2004) illustrates, some women do decide what happens to their body.

However, what it means to make a choice depends on a range of diverse circumstances. In the context of this study, this involves, the availability of information or education that may enable young people to make informed choices. It was apparent in participant's responses that there is a general naivety of what FGM entails and its long term impacts. Furthermore, in their emphasis on 'choice', participants did not acknowledge how 'age' may be a factor. In this context, then, perhaps the most definite aversion toward female genital mutilation is based on the wish to protect children. A focus on the rights of children stresses their right to bodily integrity until they have

reached the age where they may give consent. Therefore, in their discussion on the politics of genital modifications, Johnsdotter and Essen (2010) argue that if the main concern is the protection of young children's rights, the law banning FGM should clearly state that all adults, irrespective of their race or background, have the right to decide what happens to their bodies.

6.4 Identity and status

6.4.1 Introduction

As people pass through different stages in life, their identities form and reform (Erikson, 1995; Gee, 2000). In children, self-awareness grows and alters, while in young people this awareness of 'who I am' becomes heightened and more complex as it begins to take shape within the physical, cognitive and social spheres (Erikson, 1995). This section discusses identities which the young people constructed, showing that most of my study participants described themselves with a hyphenated British identity, using terms like British Muslim, while some identified as Black African. Because of this double-identity, the process of their ethnic self-identification is more complex than British people from non-migrant families and often entails juggling competing allegiances to their parents and those of the wider community (Portes and Rumbaut, 2001). Therefore, situated in between two cultures, they must define themselves in relation to multiple reference groups and to the classifications into which they are placed by their native peers and schools, as well as ethnic communities and society at large.

6.4.2 Us/them

For second-generation young British people, it might be assumed that an element of 'cultural defensiveness' would be visible, where they cling to their cultural background when taken away from its source. Nevertheless, the findings from my study suggest that young people are reflexive actors who respond by constructing their own 'identities', by developing alternative models of ethnic identities that take into account local and regional identities. This contributes to formulating the concept of 'otherness' by differentiating themselves, utilising terms such as 'we/they' and 'us/them' and changing the narrative from FGM being something we do, to something other people do, by place, age, and gender. Lister (2004, cited in Jensen, 2011) defines othering as a process of differentiation and demarcation, by which the line is drawn between 'us' and 'them'.

The images provided in this section illustrate how young people identify themselves and the elements that they perceive constitute a 'healthy, happy self'. The narratives presented by young people are important here because, although they appear to distance themselves from FGM and practising countries, in identifying themselves as 'British Muslims', they also remain close to their culture, as is evidenced in their dress code and mannerisms.
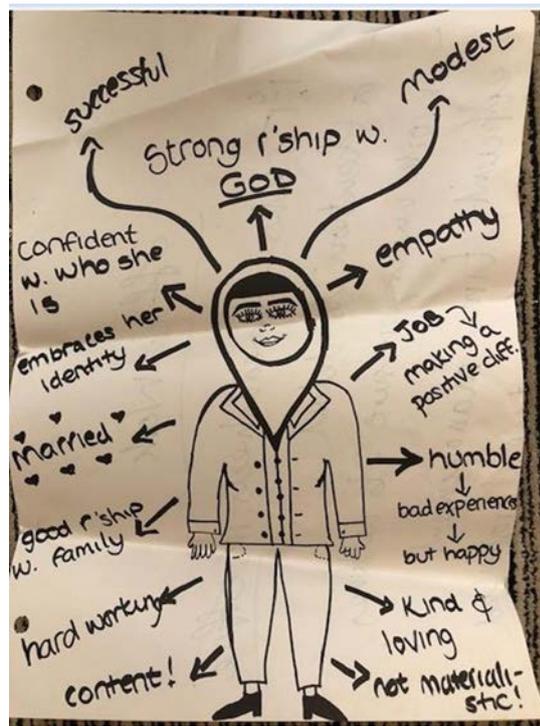
Image 6:2:Healthy, happy self. Zuli, 17

Image 6.2 above depicts a picture of a young girl wearing a 'hijab' (a head covering worn in public by Muslim women for religious reasons), who has a 'strong relationship with God' and also 'embraces her identity'. The duality of her two identities is also visible: it is not common practice for Muslim women to wear trousers. However, the young woman in this drawing 'embraces her identity' by incorporating a 'Westernised' dress code, wearing trousers. Furthermore, the family remains close to her, and she lists being 'married' as a prerequisite of a healthy and happy self.

In direct contrast to the image above, Image 6.3 illustrates how 'identity' is influenced by context, in other words, in particular situations individuals actively seek out which identity to inhabit in each particular context. Swann (2005) argues that, in many cases, individuals occupy the identity that helps them verify their existing views of themselves. The young people who created the picture below appear to have removed the social identity of being a Muslim from the public to the personal, as is apparent in terms of dress code and life decisions. It is important to note that, although both these girls identified themselves as Muslims and were wearing hijabs during the focus group, religion does not appear to be an important factor in the identity of the young girl Rwaida drew, claiming the girl 'dresses how she wants':
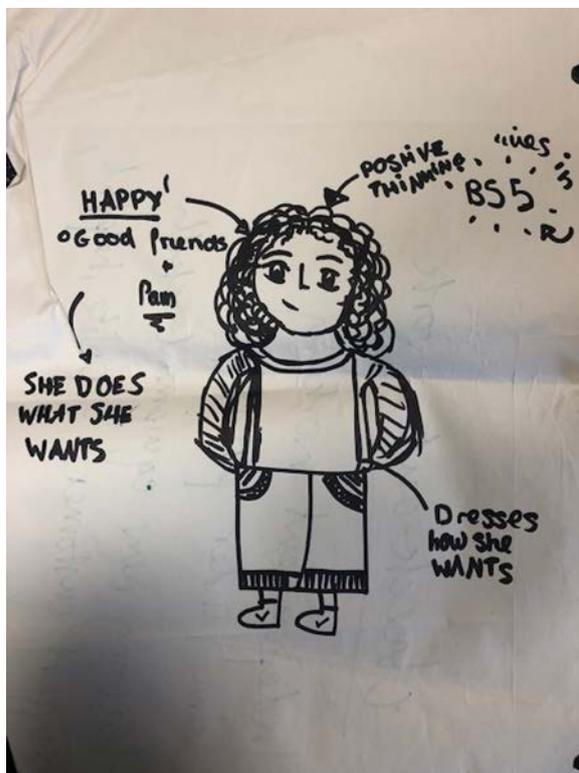
Image 6:3: Healthy, happy Self. Rwaida, 18.

Image 6.4, on the other hand, is by a young male, and his version of a healthy, happy self appears to be linked to material possessions, a 'new car'. Indeed, according to Schwartz et al., (2010), beyond the realms of their individual, relational and collective distinctiveness, people may also occupy material identities, while also fulfilling their role in life.
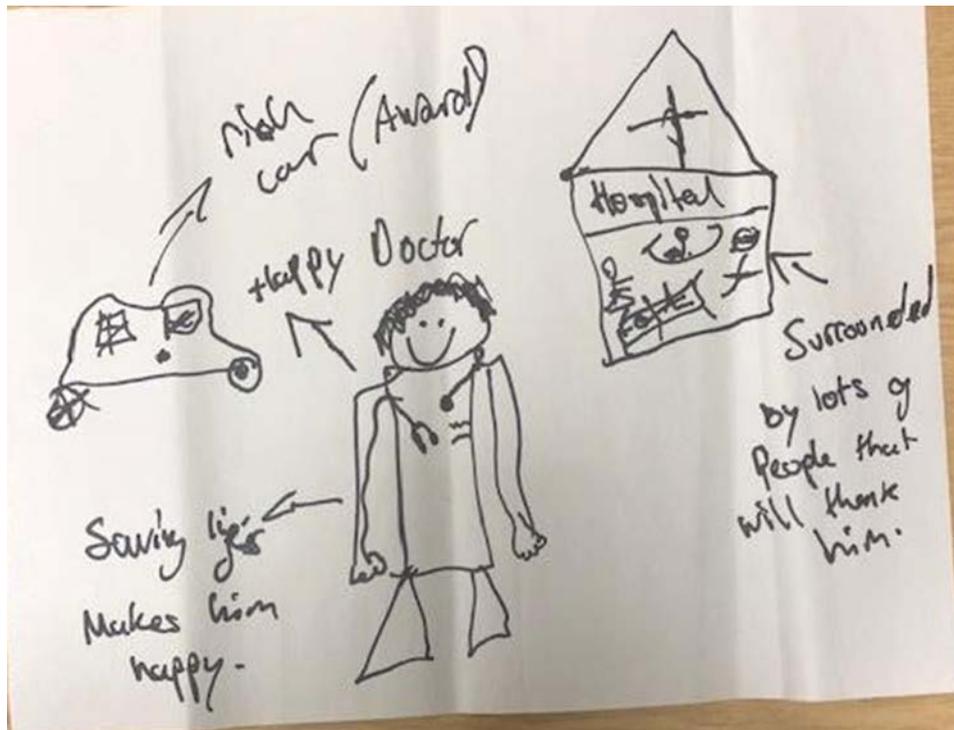
Image 6:4 Healthy, happy self. Mo, 13.

In addition to the drawings from participants, the discussion on identity also arose during the training workshops. Here, Uba expressed issues of not fitting in with the mainstream society.

> "Not fitting in, not being accepted… being different. I think it depends on where you grow up. For example, if I live in Easton and go to school in Easton, I would be more accepted as opposed to living in Easton but going to like Colston" (Uba, 17. Female. Bristol).

In the following quote, Suraya highlights issues of racial inequality and employment:

> "I don't think it's just about where you live though. I feel like, it is most of a societal issue you could be accepted in your community… but like if you apply for a job and they see your name is different, they are not going to really invite you" (Suraya, 17. Female. Bristol).

A US study by Bertrand and Mullainathan (2004), examined the differential treatment from employers due to the names of applicants. Similarly, Dolla Sign explains how everyday choices, such as how one wears their hair, may affect how they are viewed.

> 'We were talking about how your hair affects the jobs you get as well. You are often forced to have your hair slicked back or in braids, not an afro, so that you did 'look' a certain way" (Dolla Sign, 17. Female. Bristol).

The process of identity formation requires valuing the significance of young people's myriad individual, social and cultural interactions. Commentators such as Stryker (1980) assert that identity is social rather than individual because the self is always embedded within a specific society. According to Hall (2006), a person's identity is fixed to space and social environment at any given time. Thus, it is possible for young people to hold multiple identities, each having a particular dynamic of its own with different identities intersecting on many occasions. Therefore, identities are multiple, fluid and subject to change (Agnew, 2005).

6.4.2.1 It happens elsewhere

Further to constructing their own identities, the young people also 'othered' FGM, saying that it happened to immigrants. When attempting to discuss his views on the practice, Jack highlights the importance of how it has been framed so far in Western public discourse, i.e. that it is viewed as something that happens to immigrants and not English people. This belief that FGM only happens in African countries or to immigrants is interesting and may reveal a level of vulnerability in young people in this country.

> "…cause they think like… 'We are English, they aren't going to come here, they won't do it here'…, 'cause I haven't heard of a case that it's happened to an English person, they think, 'ah it's these immigrants, it's happening to them so why do we have to worry about it', they are really naïve about it, thinking they don't want anything from them immigrant's (Jack, 14. Male. Bristol).

This misconception that FGM is only practised in 'low-income' countries leads to a form of 'othering' reminiscent of colonial-era stereotyping of a homogeneous, African woman (Boddy, 2007). In this particular interview, Mo specifically states that it 'happened in Africa', distancing himself by location.

> "Well, my mum talks about it a lot, but apparently, it [FGM] happened in Africa" (Mo, 13. Male. Bristol).

Similarly, Jack explains that it happens in 'low-income countries', not necessarily aware of the counties affected.

> "Low-income countries, I don't know which countries, I don't know but low-income countries. It happens in low-income countries" (Jack, 14. Male. Bristol).

It was apparent from the interviews that FGM is seen as an African issue. According to the research conducted in Bristol amongst the Somali community, parents were concerned that the current statutory approaches to education around FGM in schools could make the young people feel bad about themselves and 'hate' their communities (Kalsen et al., 2019, p.42).

> "Most of my friends are British, and some from Somaliland but they were born here, so they don't know much about FGM" (Mohammed, 14. Male. Bristol).

> "I don't think their background would have that thing going on, like where they are from like the countries where their families are from" (Ade, 13. Male. Bristol).

Maria expresses gratitude that FGM does not happen in the UK, as it is outdated. This clearly illustrates the power of the individual's social environment in influencing their attitudes towards FGM:

> "It's just not something that I hear that goes on in the UK, and I've never like, it's not a common thing for me to hear about... makes me think like if I was still living in Somalia would that like happen to me? I don't know; it makes me feel grateful that I live in the UK where it's more outdated and stuff" (Maria, 15. Female. Milton Keynes).

Here, Ibo critiques the messages that he has been exposed to, asserting the importance of framing FGM as a problem that 'could happen to anyone'.

> "Tell them it's reality and that it's becoming a problem, that some may be affected, then they would start to listen and understand, that this is not just happening to people who are not like them, that it could happen to anyone" (Ibo, 14, Male. Milton Keynes).

6.4.2.2   Not my body, not my problem

The young men in this research were clear about their views on the practice, by distancing selves by gender. This phenomenon is not new, as women are often positioned as the 'other' to men (O'Neill et al., 2016).

The subject of FGM and its very explicit nature is one that does not sit comfortably with many people. According to Gruenbaum (2001), the taboo nature of the practice, linked

to sexuality and anatomy, makes it an unlikely subject of discussion. Mohammed is clear about this when he says:

> "It's seen as a bad thing but not spoken about. I wouldn't talk about it with my friends. It's just not nice to talk about. It's just for females. My friends wouldn't know about it, I guess, I don't think it's important to talk about" (Mohammed, 14. Male. Bristol).

Conceivably because decisions about FGM are often made by women, the practice is frequently described as 'women's business' (O'Neill, 2013; O'Neil et al., 2017; Dilley, 2005). Fuad clearly states:

> "Because it's mostly to do with females so they take it more seriously because it could happen to them, but for males, sorry it will never happen because again we don't have that body part so yeah… I don't think it would affect me as a male as I get older, no… Probably the fact like I have nothing to do with it because I am not female of course and I think that's about it (Fuad, 14. Male. Bristol).

Similarly, the lack of 'that body part' is crucial here since, as Ibo and Bello mention, it could not happen to them:

> "I don't know because it's not something that concerns me… it can't happen to me (thank God)" (Ibo, 14. Male. Milton Keynes).

> "To be fair, not much because like I know it doesn't really apply to me since yeah I haven't got that body part, but I mean I guess 'cause my mum works in that area it should mean a lot I guess" (Bello, 13. Male. Bristol).

The lack of knowledge about and the secretive nature of the practise creates a barrier to young men learning about FGM.

> "…I think attitudes differ between male and female because if you're a female, it's more personal to you because there is a chance it could happen to you. Whereas it wouldn't happen to a male, I think men lack the knowledge, and it would affect females more" (Zack, 13. Male. Bristol).

This view is interesting, in that, there is no insight into the impact if may have on men who are married to women with health problems from FGM. A study conducted in Sudan revealed that men did not accurately understand FGM, as it was not until they were

married that they experienced the consequences with their wives (Berggren et al., 2006).

Sophia agrees with the personal nature of the practice:

> "Well women might see it like, I think women would have more chance of understanding it because obviously, they are girls but some men might just think, oh no, especially the ones that believe in it, might feel like honour, 'I want my wife to have this' because then they'll know she is a virgin. They don't really see the dangers of it. The men wouldn't see the danger of it" (Sophia, 15. Female. Cardiff).

The lack of space to discuss this issue leads to young women stating that men would not understand and that men would even see it as 'something good':

> "Yeah, 'cause like men wouldn't understand, like women they would understand each other. But like men, they are different from us. So they wouldn't get it, they would probably just think it was something good" (Sabrin, 14. Female. Cardiff).

In relation to this, the absence of knowledge and dialogue clearly leads to young men interpreting the practice as something good, like Jack stating that it would make the 'vagina look better'. Therefore, due to this line of thought, young men are less likely to try to stop it:

> "I think women would care more about stopping it more than men. Because men haven't gone through it and men, don't know how it works, what changes it, and how it can affect the body. What men think is that it makes the vagina look better, that's it. So they are less likely to stop it, compared to the people that have gone through it, or if they have friends and families that have gone through it, they know the dangers of what's happening" (Jack, 14. Male. Bristol).

6.4.2.3   Old vs the younger generation

Young people find themselves in a position of tension, where they attempt to remain loyal to their parents and elders and the boundaries in which they have been brought up while fitting in with the wider local society. While simultaneously being exposed to ideas of universal human rights, other cultures and ideals, they thus find themselves questioning such harmful practices, which many in the older generation may continue to support. The extract below illustrates the diverse interpretations of FGM, where

Mike, whose mother is a Somali refugee, interprets the practice as tradition. His friends, on the other hand, condemn the practice as child abuse. Mike's comment illustrates the shift in how the second generation perceives FGM.

> "She [Mum] just said that it's a tradition. My friends told me it was illegal, and it is a type of child abuse; it could change people's lives" (Mike, 13. Male. Bristol).

Gele et al., (2015) discusses this among young Somalis age 16-22, in his qualitative research in Norway, describing how the meaning of the practice appears to have changed as migrants gained new knowledge about the practice in their host countries. Similarly, Norman et al. (2016) found that attitudes were changing amongst the new generation.

Whereas Mike distinguishes the change in beliefs, from 'tradition' to 'child abuse', Maria explains this shift of the old generation versus the younger ones, citing the context and social circumstances as being responsible for this shift. She describes young people becoming liberated in the UK and empowered to question such practices:

> "When I say women, I feel like it's the old women. For a long time, my grandma glorified it, and now I feel like her views have changed, and I guess it because we live in the UK now and she learned like how it's not right anymore. I think it's because of like her grandchildren have been raised in the UK, and we don't have the same opinions as they do in Somalia. Even like today with topics that are not to do with FGM or are controversial, like my sister or anyone else in the family would talk about it and say like no, this is not how it's supposed to be" (Maria, 15. Female. Milton Keynes).

In the same vein, Halimo and Ikram describe how they are now 'open' to discussing these issues:

> "My generation and kids younger than me, we are more open to this stuff than how people are like your age, how they were when they were my age" (Halimo, 14. Female. Cardiff).

> "I think we need to talk about it more; I guess just explaining what it was and explaining, I don't know showing how times have changed because it's not really like that anymore. I think parents or family members or some kind of community centre is set up, just to talk about it" (Ikram, 13. Female. Bristol).

Maria also notes that her ability to talk about FGM with her brother is due to being raised in 'modern country like the UK'.

> "Like they would want to talk about it. I have a brother, and I know he is definitely not pro-FGM, but in general, I know not a lot of men would agree with it, especially if they are raised in a modern country like the UK" (Maria, 15. Female. Milton Keynes).

6.4.3 Emotional reactions to FGM

This subtheme presents the emotional reactions of young people when asked 'how did learning about FGM make you feel?' Some internalised the meanings and felt that they would feel embarrassed tell anyone it had happened to them 'except for my parents'.

> "It's kind of as well, imagine it happens to you or like I have to think of like how I would feel like if it happened to me. I would feel really embarrassed to tell anyone that it had happened to me except for my parents. I couldn't tell anyone, even close friends that it's happened. Because you would feel like, I know they will always support you and everything, but you still feel uncomfortable with yourself and embarrassed" (Sophia, 15. Female. Cardiff).

> "Not to upset other people or some of my friends can be shy and think it's gross or disgusting" (Ade, 13. Male. Bristol).

> "The first conversation with my family about it I was embarrassed because it's awkward talking about it with parents, but I learned about it... also, it might have happened to someone in school. It's very unlikely, but it happens, and they might not want to talk about it. It is too sensitive for school" (Mike, 13. Male. Bristol).

Participants also felt an emotional reaction, feeling sorry for their mothers, who were FGM survivors.

> "I feel like sorry for my mum obviously she didn't have the option of choosing if it should happen to her and my grandma has actually said that if she could turn back time then you know like she wouldn't encourage my mum to do it 'cause she doesn't think it's right anymore" (Felicia, 15. Female. Cardiff).

Participants in this study shared their emotional reactions towards survivors of the practice. Although some described feeling 'sorry' for their mother, others felt embarrassed and uncomfortable talking about FGM.

6.5 Learning about FGM

This theme presents young people's narratives of *learning about FGM*, illustrating ways in which young people gained information about FGM; participants also discussed learning about sex. In their explanations, sex appears to be something of a physical nature, as opposed to an all-encompassing emotional, physical and mental act. Participants use words such as 'it' to represent sex as well as FGM, describing it as 'something that is not discussed in the household'. Furthermore, in discussions with young people, the term 'sex' appears to have meant specifically penetrative rather than non-penetrative sex, oral or anal sex. Young people express their need to talk to their parents about FGM and sex but feel that these are not always welcome subjects. Therefore, young people gain their information from other sources, such as peers, the media, 'inappropriate people' (see Figure 5.5), and social media, which tend to provide one-sided explanations, which is evident in how young people define and explain the practice.

The images presented in this section are a result of creative activities used in focus groups and workshops. Young people wrote down their primary sources of information around FGM as well as sex onto pieces of coloured paper, then organised them in order of influence. Image 6.5 represents one group's primary sources, where the bigger the circle, the more significant the influence. It appears that friends, family and the media play a significant role in shaping young people's knowledge.

When answering the question, 'how did you learn about FGM, sex and relationships?' young people note the range of sources seen in Image 6.5. Although family and friends are in one of the bigger circles, interestingly, parents were not mentioned, as Rwaida highlights:

> "I feel like if you recognise, like if adults recognise that there is a platform that young people are getting most of their information from then you don't restrict them getting the information but change what's being exposed to them like. I don't think that's the best way of getting information. Like if you look at what we have written on here, parents are not included at all as sources of sex education and information, it's shocking" (Rwaida, 18. Bristol, Workshop).

"The news is very big, but I don't watch the news that much, and when I do, I've never seen any news about FGM. There is hardly any media coverage on FGM" (Zuli, 17. Female. Workshop).
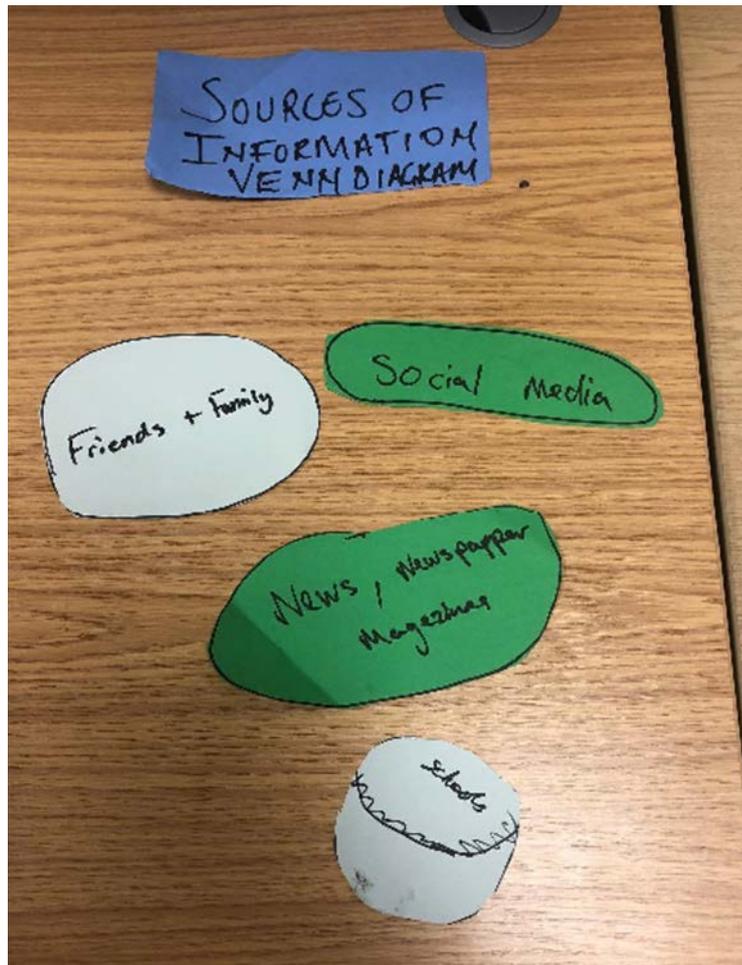
Image 6:5: Showing sources of information about FGM.

6.5.1 Parent-child relations

Parents can have a significant effect on their children's understanding of sex and relationships, as well as FGM. This subtheme explores young people's perceptions and practices of learning about sex from their parents and illustrates that interventions aimed at encouraging parents to talk to their children about sex and FGM should first enhance the parents' understanding of the young person's sexual development, as well as introducing strategies which would encourage such conversations.

The following extracts illustrate that participants found it easier to discuss FGM with their mother than other family members. For example, following a focus group with the young people for this research, Ikram shares how the focus group experience led her and her sibling to discuss FGM with their mother:

> "I was 13 in the focus group. But after that, I came back home and spoke to my older sister and mother about it. We asked my mother if we were ever in that situation would you ever do it [FGM] to us, and she said no" (Ikram, 15. Female. Bristol).

In the REPLACE study discussed in Chapter 3 of this thesis, Alhassan et al. (2016) found similar results amongst 18-23-year-olds first generation living in the UK. The authors suggest that FGM is not discussed because at times it is seen as a social norm, one that is expected for young people to be circumcised, there remains a culture of silence amongst practising communities. However, Alitolppa-Niitamo (2010) suggests that parents are often concerned about raising good Muslims and worried about their children assuming Western values. This may contribute to a lack of discussion about sex as well as FGM, as they assume these discussions would lead to young people experimenting and having sexual relations, whereas, in Islam, premarital sex is forbidden.

Maria shares her experience while discussing FGM with her mother:

> "I was surprised to hear it happened to my mum and grandmum. 'Yeah', she said. It was kind of remonetised; it was kind of expected and seen as good. It was like they would have gifts brought to them" (Maria, 14. Female. Milton Keynes).

Felicia discusses how it was difficult for her to talk to her mother, in fear of maybe re-traumatising. She notes it was easier to speak to her sisters:

> "She gave me a little story about it… My mum, she told me how it happened to her. But like, she never gave me enough for me to know about it. I couldn't ask my mum how it felt because I don't know if that would hit, like, make her feel sad or something, so I had to go to my sisters. I know my sisters would know, but at the time I didn't really know anything. I was really young, like 10 or 9, you don't really know that much at that age" (Felicia, 15. Female. Cardiff).

Sophia explains her discussion with her mother, were she notes 'they would hold you

down' and then young girls would receive presents.

> "In Somalia, it was like expected of girls to have FGM practiced on them. Even if like I don't know, my mum would tell me how they would like hold you down as they did it, and after it [FGM] was done, people would bring you like presents and gifts and tell you well done, and they would make it like some kind of festival or something" (Sophia, 15. Female. Cardiff).

In the Western world, the mention of sex depicts excitement and, at times, a mystery. Sex means pleasure and intimacy, but it can also seem taboo and forbidden. This was partly because, as some participants explained, parents would not engage in discussions about the subject.

> "I feel like parents should do more, because if you're not teaching your children what's going on and they find out from somewhere else… Like it's just safer if you're learning from your parents…" (Suraya, 17. Female. Workshop).

> "I think parents [should talk to you about sex] because they understand you. Like they can put it in a way that you can understand. Whereas if they do it, school, they might do it in a different direction" (Mohammed, 14. Male. Bristol).

Mbugua (2007) claims that any discussion of sex between parents and their children is forbidden in an African household, for example, it is forbidden for those who have undergone the initiation rite [FGM] to attain adulthood to discuss any matters pertaining to sex with those uninitiated. Similarly, the findings of a study by Crichton et al. (2010) on mother and daughter communication about sexual development in Kenya suggest that mothers felt barriers such as cultural taboos, embarrassment, lack of information and uncertainty prohibited them from discussing such issues. According to my study participants, the situation was the same in their homes in the UK.

The extract below illustrates the diverse views about learning about FGM, where all three participants are of Somali heritage:

> "I was young when my mum was explaining it, I don't think she wanted me to learn about it at that age, but my sister was like she should learn about these things…" (Lucy, 13. Female. Bristol).

Zuli associates FGM with embarrassment and being awkward to discuss with her mother:

> "I don't think there's like an age when you're like, yeah I could go and talk to my mum about this, it's like I feel like that's when you're an adult… but even then, it would still be awkward" (Zuli, 17. Female. Workshop).

> "Maybe other people, because I know parents, especially like Somalian parents, they don't really like talking to their children about things like that…" (Rwaida, 18. Female. Workshop).

In Islam premarital sex is 'haram' (forbidden) and socially unacceptable (Gerholm, 2003), as a consequence Muslim parents may be opposed to their children learning about such issues at an early age. However, different ethnic minorities have differing attitudes towards learning about FGM within a sexual context. As I noted in the literature review, sex education in Uganda commences before marriage, at the start of menarche (Nobelius et al., 2010). In contrast, in Kenya, amongst the Kikuyu tribe, after FGM, young people of both sexes are encouraged to experiment in certain sexual activities before marriage, although penetration and masturbation are not allowed (Kenyatta, 1953). This shows the varying nature of culture.

Furthermore, several barriers lead to a lack of effective parent-child communication. Apart from age, another factor is the parents' lack of role models, because their parents did not talk to them about these issues.

> "Like parents are the ones to tell you not to do things. Like personally, my dad never spoke to me about anything, my mum was like, 'don't do anything wait till marriage' and she never really spoke about it… and her parents never spoke to her neither; I don't know if it's like a cultural thing but parents don't really talk to us" (Zuli, 17. Female. Workshop).

A US study by Nguyen and Rosengrens (2004) with parents of children aged 3-4 and 5-6 identified that parents were reluctant to talk about sex because they perceived their children to be too young for the subject. On the other hand, parents may be uncomfortable talking about sex and relationships they are reluctant to initiate such conversations. As a result, young people may not approach their parents, as this participant explains:

> "…young people would be more inclined to ask their parents if their parents were more open with them. Like if they don't talk about it at all, they would feel like they shouldn't either. Like unsaid taboos, you just sense, like this is not to be

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talked about" (Mo, 13. Male. Bristol).

In general, parent-child communication about sex varies significantly between mothers and fathers, as well as across ethnic and racial groups. Therefore, there may be diverse barriers at play in different populations, such as religion (Tabatabaie, 2015), culture and, at times, language barriers.

> "Yeah, I think it's always going to be awkward with family. Because I don't think anyone wants to like picture sex and family in the same context" (Suraya, 17. Female. Workshop).

In this study, participants discussing sex within the family appears to be unchartered territory. Young people seem to consider sex as simply a physical act, rather than being informed about the emotional and social complexities, or the fact that sex includes a myriad of issues that require careful explanations for young people.

6.5.1.1 Father-son relations

The inability of young men to discuss the issue, then adds to the silent culture around the practice, which may cause a barrier to change behaviours. This silence may be due to the issue of sexuality, which is still a taboo subject in many non-Western nations. Mo observes how awkward it is to talk about FGM, even amongst his male counterparts, in this instance, his dad:

> "I find it awkward when they talk about it, maybe because I'm a male. But sometimes my dad does something like that, but I think my brother finds it awkward so yeah" (Mo, 13. Male. Bristol).

The findings from a systematic review by Wildman et al. (2016) suggest that there are indeed gender differences in open parent-child communication about sex, in that mothers play a more vital role than fathers. However, the dearth of studies that have specifically explored father-child communication or the role of the mother in relation to FGM makes this relationship difficult to understand.

This young male explains the difficulties he would face in discussing FGM, saying that it

would make more sense for him to talk to his mother about it:

> "Just mum and sister not comfortable talking to my dad. It would make the conversation awkward; I think it's better talking to a female 'cause they could understand better" (Fuad, 14. Male. Bristol).

> "I spoke to my mum about it. Like both my parents they understand it, but my mum is more the one in the house, my dad is usually working. He is busy, and I am more open with my mum than dad. My mum would know more about it" (Mike, 13. Male. Bristol).

Others find that conversations with their mother flow better because, as Mike says, the mother is always at home and therefore, approachable. This is corroborated by a qualitative study by Walker (2001), which suggests that mothers feel more comfortable than fathers talking to their daughters about sexual matters.

> "For me with my mum, it's just like banter. I could joke about it with my mum. But no, not my dad... With my dad, I act like I know nothing like, 'what's porn?' [Laughs] (Dolla Sign, 17, Female. Workshop).

In general, young people expressed several barriers in discussing sex, relationships and FGM with their parents. As a result, it was difficult for them to initiate conversations and at times, more comfortable for them to pretend they did not know about these issues.

6.5.1.2 Sibling relationships

Young people express a strong desire to get sexual information from their parents. However, most of the young women shared that this was not possible as their parents were quick to dismiss their concerns. At times, young people expressed the emotional difficulties of discussing FGM issues with their mothers who were FGM survivors, due to the fear of re-traumatising them. Therefore, it was easier to interact with their siblings.

> "Also older siblings, I feel like if you have an older sister, they might have experienced it, so yeah" (Sophia, 15. Female. Cardiff).

> "They [sisters] told me like, back in Somalia, girls were expected to have FGM practiced on them" (Maria, 15. Female. Milton Keynes).

Halimo discusses the inability to speak about FGM with her brothers, noting that it is easier to speak to female, even strangers because they can relate.

> "I am close to my brothers, but we wouldn't. We are not as close as to talk about stuff like [FGM] that. I would probably feel embarrassed. It's just awkward. It's an awkward topic to speak about. Especially to boys… It's easier to speak to females about it instead of men… because we have the parts, you know, and like it's easier to speak about because we would relate much more, you know. I feel much more comfortable speaking to you about it than my brothers, but I have known my brothers all my life, and they are all older than me, so they raised me. But you, I have just met you, but it's easier speaking to you about it" (Halimo, 14. Female. Cardiff).

In relation to discussions regarding sex, Rwaida highlights the need to appear ignorant in front of the family due to the fear of being questioned by parents. As a consequence, is unable to talk to her young siblings about sex.

> "Especially like younger siblings find something out like a word, and they're like, 'Oh, what's this?' and you don't want to explain it 'cause you don't want to say you know it but also like, where do they hear this from?" (Rwaida, 18. Female. Workshop).

On the other hand, Ikram notes the ability to learn from siblings; this is due to the way the information is being framed.

> "Yes, like you get different information from like siblings, it's more informative, where parents it's like more facts, like don't do this" (Ikram, 15. Female. Bristol).

6.5.1.3   Peers

Young people expressed that they were able to learn about FGM from their peers. However, this was sometimes difficult if they were from a different background, as Mike states:

> "Like, I don't really talk about it, I can get serious if I want to, but I am not generally that serious, and it's kind of awkward sometimes. My friends wouldn't really understand or take it seriously. I wouldn't really talk about it" (Mike, 13. Male. Bristol).

Ikram explains learning about FGM from a YouTube documentary with friends:

> "I don't think any of my friends knew what it was; we just made it up as we went along, we also watched some YouTube documentary, I can't remember what it's called" (Ikram, 15. Male. Bristol).

The culture of silence appears to transfer to friendships. Mohammed explains how his upbringing has created barriers to learning:

> "Not at all, I don't think they know about it [friends]. I've grown up knowing we don't talk about it [FGM]" (Mohammed, 14. Male. Bristol).

> "…it was my friends talking about it [FGM]; they were like… 'have you heard this?' and I was like 'yeah,' and they were like on 'posters and everything'… they told me what it was because I still kind of didn't know what it was, but then yeah, they told me why they did it and everything… It was after this I went to my mum…" (Mohammed 14. Male. Bristol).

There have been several interpretations of sex education and to Islam (Smerecnik et al., 2010; Tabatabaie, 2015) and, according to Benner (2007), educating young people about sex within an Islamic society is problematic because it is assumed that, as a result of cultural, sexual taboos, sex is seen as something bad. Therefore, the ideal young Muslim is one who transitions asexually from birth to puberty and remains non-sexual after puberty until marriage (Tabatabaie, 2015), in contrast to their non-Muslim Western peers, as Mo states:

> "Most of my friends already have done it [sex], if I am honest with you. It just doesn't feel right to speak to them, especially because they are not Muslim like I am. They don't know as most of my atheist friends have already done it and like it's not right if I ask them because they don't have the same views. I would probably use the helpline [Child line] to talk about sex" (Mo, 13. Male. Bristol).

According to Robinson (2013), the hegemonic discourse of childhood in the West, that they are innocent and need protection, often renders children's sexual subjectivities invisible by denying children access to relevant knowledge about sex and sexuality. Therefore, young people may gain information elsewhere, which may be mixed, inconsistent, and inaccurate or even dangerous (e.g. pornographic images that depict distorted versions of sex using special effects). In fact, the new Sex and Relationships Education (SRE) guidance (Department for Education, DfE, 2019) acknowledges that,

given the rise of online resources, young people may turn to inappropriate sources of information, which may render them vulnerable to misleading or frightening material.

6.5.2   Mixed information

The cultural ambivalence of sexuality is present in the media – in television, films, radio, the internet, newspapers and magazines – as well as computer games and novels. In contemporary Britain, young people also gain information from social media, where they often identify with, i.e., body image issues. This subtheme illustrates how the information young people obtain about sex and FGM is mixed, inconsistent and unreliable. Young people at one of the focus groups wrote down the sources they use to seek information on these subjects (see Image 6.6). Though social media presents a platform for learning, the limited capacity of self-regulation and online peer pressure presents a risk to some young people. For example, child exploitation or paedophiles, grooming children (Whittle et al., 2013). The following extracts are linked with Figure 5.6, which illustrates the discussion the young people had when choosing to specify those particular sources.

> "I think social media is the biggest, but also linking with social media, we have media itself, so like, music videos, adverts, TV shows… but also inappropriate people, like obviously with females we all know how inappropriate comments go and so some of that happens on social media as well as with boys and men, mostly boys lead to inappropriate comments… hearing stuff you don't really ask to hear…" (Suraya, 17. Female. Workshop].
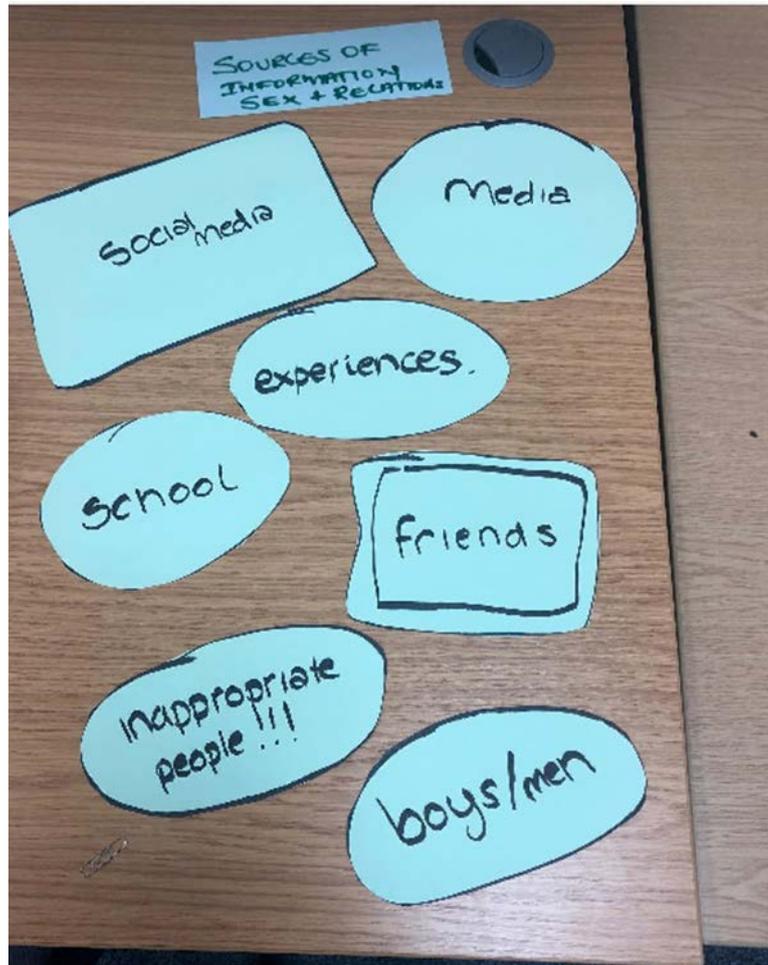
Image 6:6: Sex and relationships sources of information.

These inconsistencies are also evident in their interpretations of the practice, where young people describe FGM as a 'disease' or a 'mutation', as well as a necessary surgical process. Perhaps this was what the parents had told Jack, although he clearly shows his lack of awareness:

> "It is an illegal thing where some women are told I think it's surgery. They are lied to, told they would be cured of their disease, and then they go and have it done. It's like mutation an illegal surgery done to cut off, umm I don't know but yeah pretty much. I heard about it when I was 14 from my mum" (Jack, 14. Male. Bristol).

Similarly, Mike defines FGM as:

> "I think about like, dangerous disease, bad mostly negative, nothing positive. I would think like harm, abuse, stuff like that" (Mike, 13. Male. Bristol).

Despite the claims that FGM is taboo and not spoken about, Mohammed explains that he has heard the topic being discussed in Easton. Easton is a very diverse urban area in Bristol that includes large communities from FGM-practising countries (Williams, 2013).

> "It was years ago, in Easton. I think I was around 8 or 10 years old. I remember hearing people say it was illegal and it shouldn't be done. But I don't remember anything else" (Mohammed, 14. Male. Bristol).

> "…I have never really heard anything about the topic, to be honest with you. I just know what my mum and sisters have told me" (Halima, 14. Female. Cardiff).

6.5.2.1   Inadequate or lack of PSHE

As highlighted in Chapter 2, section 2.2, the literature review, there is a paucity of research that examines the views of young people related to their experiences of learning about FGM. The findings from my study illustrate the need for a re-examination of SRE in schools. Indeed, the Department for Education (2019) has recently published guidance on Relationships and Sex Education, which will become compulsory in 2020 and will require all schools in England to teach Relationship and Sex Education tailored to the needs of their pupils. However, it acknowledges that some communities may perceive this as an unsolicited top-down educational approach. Hence, the Department for Education stresses the importance of working with parents to establish acceptable content, though this is not always achievable in practice, as there remains a great deal of controversy and prejudice surrounding sex education. The Muslim council (2019) claims concerned parents have approached them to request guidance, due to their fear of potential exposure of young children to graphic and sexual images.

At present, FGM education in schools has been outsourced through organisations that offer peer training as well as adult-led training in other contexts. Below, a participant describes his experience in peer learning that was provided at a school. Young people want the subject to reflect reality, here:

> "The school session did not tell us why it [FGM] was done. They just told us it is illegal. They also showed us a video, which was pretty much pointless. I remember it was adults singing a song… I think the song was a waste of time… It is awkward to say the song; it's so weird and cringe if I say it… It's something like… uhhh… it's so cringy! You can watch it on YouTube if you want… I can't talk

to my friends or other girls about it, it's cringy. I don't know the name of the song, but the lyrics are, 'My clitoris belongs to me'. The song gives us a hint to what it means, but it doesn't cover the more important and fragile terms of what it is. It doesn't explain what happens, what they [girls] are told and how it [the clitoris] gets there" (Mo, 13. Male. Bristol).

Similarly, Bello critiques the reductive nature of FGM awareness lessons:

"First time I heard about it, I was 14 or 13, not sure. I was confused to what the point was, I was interested to know the reasons behind it, what it does. At the time they [school] didn't tell us that some people choose to do it. We were told the part where they are lied to, told their lives will be made better" (Bello, 14. Male. Bristol).

Including FGM sessions in assemblies, are subsequently overly reductive approaches, as Mohammed explains:

"We had something in assembly, but it wasn't interesting, so I don't remember" (Mohammed, 14. Male. Bristol. Focus group).

Some of the young people in this study criticise the sex education they receive as part of their compulsory Personal, Social, Health and Economic (PSHE) lessons for being too biological and for depicting sex as a scientific activity, deeming this approach as basic and repetitive, narrowly focused and, above all, irrelevant and therefore 'rubbish'.

"Like with school we learn basic biology and like really rubbish PSHE and friends tell you stuff we don't want to know… like teen pregnancies, my friends have gone through that" (Rwaida, 18. Female. Bristol, workshop).

"I think we should have more of this kind of stuff. Even in PSHE, we don't learn a lot of stuff, just like your body and sex… (Jack, 14. Male. Bristol).

This approach tends to de-eroticise and disembody sex (Allen, 2011), therefore denying young people the space to learn about concepts such as consent, negotiation, and acknowledgement of pleasure, as well as the complexities of sexualities. Though it appears that not all experiences of PHSE are negative, here Mo describes the all-encompassing nature of the lessons, which includes consent as well as sexually transmitted disease.

"In PSHE they would talk about sexually-transmitted diseases, and they would say it's okay to have sex before 18 if it's safe. They tell us ways to stop getting pregnant and ways to prevent sexually-transmitted diseases and um consent… if the other partner is giving consent. If she is under, you know, if she has given consent, and they said which ways someone can give consent. So if she is drunk and she says 'yes', that does not mean consent. If she's passed out, that's not consent. If she is awake and can talk for herself and she says 'yes', then that's consent!" (Mo, 13. Male. Bristol).

Along with PSHE being 'rubbish', participants in this study feel there is a lack of specific content about FGM. Zack explains that he learned about the practice from a poster. Although posters do play a role in raising awareness, young people are not given the resources to question what they have seen, or even how they have interpreted them:

"It was Year 7 I think, so that would have been like 11 or 12 years old, heard it in school. Well, it wasn't really a lesson, it was just one time I was walking through the corridor, and there was a poster on the wall saying… 'Stop female genital mutilation'. I was reading it, but it didn't really have much information on there. I had PSHE, but it didn't really cover that neither, we covered about puberty and hormones and how we develop and stuff like that" (Zack, 13. Male. Bristol).

The content of these lessons may contribute to the 'othering' that was discussed earlier, where young people are taught that FGM does not happen in this country, despite a recent legal conviction (Summers and Ratcliffe, 2019) proving otherwise. Young people like Jack are aware that the practice is an issue in the UK as well:

"It was 50 minutes; I was like 11 or 12 years; I don't remember what they said. They spoke about the bad stuff about it [FGM], they just said it was illegal, and it didn't happen here, and it was illegal everywhere, but people felt it was still happening to people here" (Jack, 14. Male. Bristol).

Mo discusses how a supply teacher lacked the necessary knowledge. One could argue that, since sexual health is inherently a sensitive topic, which requires attention from teachers to enable effective learning, this lack of knowledge and training, sometimes worsened by feelings of embarrassment, may hinder students' learning in such an important topic.

"We did PSHE this year, but I cannot remember what we learned about. I think a teacher did it, but she had to get knowledge from other teachers, as our main

teacher wasn't in. We had to get a supply [teacher] to talk to us about sex and relationships… I think our teacher would've been better because people take advantage of supply teachers. That's the reason I forgot because we were messing about. If it was our main teacher, she would be strict, and we would be quiet and listen, maybe I would remember more" (Mo, 13. Male. Bristol).

In their comparison study in Leeds and Australia, on the experiences of teachers and parents roles in sex education; Walker and Milton (2006) assert that teachers display a lack of knowledge regarding sexual health; while Wight et al. (2002) maintain that their own training is sometimes limited. Although both of these reports are over ten years old, the extract above shows that PSHE education is not a familiar territory for all teachers. However, the additional cost of training teachers to provide sex education may be unaffordable for many schools, which are already struggling to cope with year-on-year budget cuts.

However, although Mo argues for a familiar face to teach him the subject:

"Also, you know schools, like you learn more from your classmates because they always gossip, and you'll hear it and stuff rather than like teachers, teachers you don't really engage, it's like what they are teaching does not feel relevant, and it's better to hear it from my friends, they make it more interesting" (Maimuna, 17. Female workshop).

Alldred (2007) suggest that students find it easier to talk about sex with teachers they are not used to because that familiarity led to embarrassment, which sometimes disrupted the relationships students had with their teachers.

Young people also comment on the lack of engagement from teachers. Mike, critiques the role of the teacher, he also mentions the ease of talking with his peers:

"I don't feel like teachers do a lot like we don't really engage with them; it's just better to hear it from friends" (Mike, 13. Male. Bristol).

However, according to Forest et al. (2002), this might be because teachers are often embarrassed about discussions sex with students, which may contribute to the quality of the lessons.

The idea of an external presenter thus appears feasible for Mo in the extract below; this may be due to the need for confidentiality. Mo continues by acknowledging this awareness of provision of such services:

> "There's only like Childline that I know of, someone came and did a presentation about safe sex… you can get a condom for free no matter what your age they wouldn't ask any questions. It's like a sex helpline, you can either book it or just show up, and you'll have a chat on how to keep safe, and they give you a condom no matter what age you are. Let's say I go in and I say 'can I have a condom'… they will give it to you no problem, but they will also explain how to keep safe if you're going to do it [sex], what's safe and consent. There is one sex and relationship centre; it's located in the centre of town. I know where it is. They said they could talk to you about anything to do with sex; they would only tell the police if they think you are being harmed or if the person you are talking to could be harmed. So anything to do with sex really" (Mo, 13. Male. Bristol).

Receiving advice and condoms from external sources may be ideal for young men as it reduces embarrassment or the fear that what they talk about might get back to their parents. Though in his research, Coleman (2001) found that the judgmental attitude of some service providers may hinder access. To add, SRE has always been a contentious topic, the political sensitivity coupled with socio-cultural biases surrounding the provision of such services to young people; presents challenges that schools must acknowledge. For example, some parents may object to their children learning about sex and relationships because they worry that such knowledge might encourage young people to experiment sexually, despite evidence suggesting the contrary (Shaw, 2009). Furthermore, parents perceive that PSHE challenges the transmission of Islamic values (Orgocka, 2004). As a result, several parents withdraw their children from such lessons.

6.5.2.2 Ignorance of bodily functions

In this study, young women were provided with a drawing of the female genitalia and encouraged to label them. The answers to this exercise were used to access their awareness of their body. Most of the young women produced inadequate information about their reproductive organs. This subtheme represents young women's interpretation of female genitalia. It appears that the vagina has both symbolic and material meaning for young women (see also Braun and Wilkinson. 2001).

Uba explains her conceptualisation of the vagina as an 'oven', in that its function is merely a reproductive one, not acknowledging the organ as a source of pleasure. She also recognises her lack of knowledge, in that she did not know about the 'urethra', this view is conveyed by all four extracts below.

> "Someone told me it's where babies come out [referring to the vaginal opening], so I called it the 'oven'. The whole thing to me was a bum to me. I don't know my own body; I just found out there are two holes" [referring to the urethra and vaginal opening] (Uba, 17. Female. Workshop).

> "I didn't know there were two; it's very confusing. I didn't know there were two holes" (Rwaida, 17. Female. Workshop).

At 18 years old, Suraya has just found out about what Maimuna calls the urethra – her vagina. Although there is a lack of research into it, literature in this area has found that many women believe they urinate through their vagina (Friday, 1996; Rosenbaum, 1979).

> "How far did you guys get? Did you write pee? [giggles]. Is it known as the vagina [referring to the urethra] this really is the hardest thing" (Maimuna, 17. Female. Workshop).

> "I was talking to her, and we were shocked… I was like, hold on. I have two holes, so three altogether? I'm so confused!!" (Suraya, 18. Female. Workshop).

Culturally, specific names are often used to refer to the vagina, and other sexual organs and, in a Western context, euphemisms are often employed to refer to the genitalia, as Gartell and Mosbacher (1984) explain, such as 'bits'. Along with lack of knowledge about the anatomy, young people were unaware of the physiology, as Maimuna explains, the clitoris 'chills' implying that it is useless:

> "The clitoris, it just chills" (Maimuna, 17. Female. Workshop).

The euphemism was also evident within an ethnic household, as Suraya calls the clitoris the 'Outer wee-wee'. The absence of such discussions leads to ignorance about the genitals and their functions, as Beauvoir (1953, p.362) explains: the 'feminine sex organ is mysterious even to the woman herself'. This mystic nature of the woman's body can lead to vulnerability, as this ignorance of the functions may lead to women undergoing

practices such as FGM in a false belief that the removed parts do not have any function, as shown in the above extract, where Maimuna, believes that the clitoris has no function.

> "Outer wee" (Suraya, 18. Female workshop).

This lack of awareness may be due to several factors, one being the lack of private discussions. In this research, these conversations provoked laughter and embarrassment.

> "Are those like the inner lips? [Giggling]… Ah, what's this? I don't know how to spell it" (Dolla Sign, 17. Female. Workshop).

> "I don't think I know any other parts of the genitals. Okay, this is a peeing area; this is the oven" (Uba, 17. Female. Workshop).

As this chapter has shown, a woman's body has been, and remains, a site of struggle for definition and control. With specific reference to FGM, the female 'African body' has been reduced to isolated body parts that are subjected to judgement, alteration, and violence. Furthermore, while anatomical literature is widely available, any discussion of the vagina is generally absent in the UK, in public and private discourse, specifically amongst minorities. Despite this absence of comprehensive attention to the topic of the vagina, there are diverse paradoxical socio-cultural representations. Thus far, the topics of both sex as a physical act and the vagina itself have remained taboo subjects, easy to say but seemingly difficult to talk about (Ensler, 1998 cited in Braun, 1999). From a social constructionist viewpoint, it can be assumed that the meanings ascribed to a young person's body are constructed by the socio-cultural and practices they are exposed to, which change across time and context. Furthermore, participants represent their bodies as being both symbolic and material, a cultural phenomenon, and a biological entity.

6.5.2.3   Social media

The young people in my study claimed that, with the absence of comprehensive and useful sex education, social media has become their leading source of sex education.

However, this exposure may also lead to vulnerabilities; this subtheme discusses the issues young people face on social media today, from vulnerability and lack of control over what they are exposed to, as Rwaida illustrates:

> "Social media was like one of the big ones as well. And we were talking about how even if you're not like wanting to see it, it can pop up anyway, like on Instagram" (Rwaida, 18. Female. Workshop).

There is a growing concern about young people's exposure to sexual content via social media since, with the use of electronic devices such as mobile phones, content is easily accessible (Gruber, 2000). Young people are particularly vulnerable, being at risk of sexual exploitation and grooming on social media, a point Maimuna recognises:

> ''Cause most of the time, it's the 'dark side of social media' that is not really useful to us" (Maimuna, 17. Female. Workshop).

Similarly, Suraya adds:

> "Social media is more important to young people like for Somalis like on Facebook I get random Somalis. I feel like there's a wider issue" (Suraya, 18. Female. Workshop).

Due to the inability to learn about FGM in a safe environment, Sabrin inquisition led to her watching the procedure online. One would ask then, does lack of conversation amongst parents and teachers in this area, and serve as a protective measure or one that leads to an unsafe learning environment at a young age?

> "I was watching something, and women were holding the girls down, it was like on a table and women held the girl down" (Sabrin, 14. Female. Cardiff).

6.5.2.4   FGM, not talked about

The absence of discourse about female sexuality and the body, in particular, create an environment that discourages young women from engaging in open dialogue about their sexuality. This subtheme describes situations in which young people are surrounded by silence about FGM, thus being forced to remain silent, as Ikram states:

> "It's not really spoken about, so they [friends] don't really know what it is. I feel like not many people understand what it is" (Ikram, 13. Female. Bristol).

Therefore, the biggest challenge in eradicating the practice is the lack of dialogue or misinformation surrounding the issue. Many young people explained that FGM is a taboo subject, but most did not understand why.

> "I feel like people whose families have had FGM, it's not really spoken about, and so they don't really know what it is. I feel like not many people understand what it is" (Maria, 15. Female. Milton Keynes).

> "Not that much, it's not spoken of, it's like taboo really" (Zack, 14. Male. Bristol).

This view contradicts those of several researchers who claim that FGM is losing its taboo status within the practising communities (Finke, 2006; Norman et al., 2016), this might be so but does not seem to have extended to families and arguably, young people. Moreover, parents from FGM-affected communities do not see the need to discuss such issues, because they feel their children are not at risk of it or are too young to learn about the issue (Karlsen et al., 2019).

Along with the silenced nature of FGM, young people feel unable to discuss the issue with others in fear of being judged as victims of the practice. Thus, mentioning it made them feel uncomfortable and insecure:

> "Someone from the FGM community can't talk about it, they would feel insecure, like would feel uncomfortable, 'cause nobody really talks about it and probably get, like mad questions thrown at them like, 'have you got it done or something?'" (Sabrin, 14. Female. Cardiff).

Similarly, Lucy explains that young people may not see FGM as an issue to them. Therefore, there are 'a million things in the world' to discuss, and to them, perhaps FGM is not one of them:

> "…just talking about it, it would just be awkward because there are a million things in the world you could talk about and you choose that thing [FGM]" (Lucy, 13. Female. Bristol).

Feeling 'uncomfortable' is also a barrier to some young women, as Aaliyah explains:

> "…it can make people feel very uncomfortable. I don't think, knowing my friends, I don't think they would want to speak about stuff like this" (Aaliyah, 13. Female. Cardiff).

The lack of dialogue in this area could be due to several reasons. For instance, if mothers decide not to extend the practice to their daughters, they might feel that talking about the issue is not relevant (Karlsen et al., 2019). Others could feel that they are protecting their children by not exposing them to the practice and, although this may play a role in abandoning FGM, it may also create a level of vulnerability amongst young people growing up in the West.

6.5.3 Younger generations educating mothers

As previously stated, due to this lack of role models, the mother may have not discussed FGM with her own parents and, therefore, is reluctant to do so with her children. However, the young people in this research appeared willing to 'teach' their mothers about the issues caused by the practice.

> "My mum didn't know a lot about what happens after FGM. But we taught her after the session. She knew it was to stop sexual behaviour from girls and boys and how FGM happens… but she didn't know the side effects, and we taught her" (Lucy, 13. Female. Bristol).

> "After the focus group, I spoke to my mum, and she asked me what it was. She asked what it was in English as my mum only knows it in Arabic [*Dhohol*]. She spoke to me about the health impacts, like infection and disease, which can affect the woman's future…" (Ikram, 15. Female. Bristol).

However, Ikram acknowledges that this kind of parent-child dialogue could influence a young person to comply with the practice:

> "Um, some people get influenced by the people. For example, if someone has done it, like parents, and you believe obviously that your parents do the right thing. Because they tell you what's right and what's wrong. And they do it [FGM] because they know they have to listen to their mum or parents" (Ikram, 13. Female).

This theme has highlighted the complexities that surround young women and men in discussing their sexuality. The inability to talk about sex and relationships with their parents presents the first hurdle in young people's lives. Young people, therefore, rely on social media, which at time s presents mixed information.

6.6 Telling it like it is

Despite the Department for Education's (2019) guidance for all school children to receive comprehensive sex and relationship education, as theme 4 in this chapter has shown, the information received by young people is reductive and, at times, ill-informed theme 5 describes the preferences the young people in my study had around sex education, including FGM. This, therefore, provides a youth-centred approach which values and prioritises young people and their ideas. Recognising that young people can identify the information they need themselves contributes towards enabling them to make positive, informed decisions. Participant narratives in this theme identified where, when, what and who they would like this information to come from. The findings here suggest that, along with the need to learn from parents, young people feel that schools are an ideal environment to find out about such issues, while some mention social media and learning from FGM survivors. Most of the young people feel it is important to establish an unbiased FGM information and support centre that focuses on intergenerational dialogue around the subject:

> "Documentary, people's accounts, like people it's happened to. I don't think school is the right place to learn about it, I think somewhere else. Like, I don't know if they had like an FGM centre where they learn and talk about it, I would go there. People find school boring, so they tend not to listen, but if you take them to a trip somewhere they haven't been they would be more eager to know what's going on. I've never heard of any FGM centres" (Maria, 15. Female. Milton Keynes).

6.6.1 Where I want to learn

Young people express the need to learn about sex and relationships as well as FGM from their parents. As an initial point of contact, parents are the prime educators in these matters. This subtheme presents 'where' young people would prefer to learn about these issues, which ranges from parents to religious institutions and community centres.

"Initially I think parents need to talk to us, 'cause I trust them, and they know what's best for me. They tell me what I need to know or what I shouldn't know so yeah" (Ade, 13. Male. Bristol).

"I'd like try to form a close bond with my child, enough for them to be like… 'What is this?', or enough confidence to ask me something, but in the end I would actually say, 'I don't know, ask your sibling'. I'd still be uncomfortable with it, but I'd still like them to ask me" (Suraya, 17. Female. Workshop).

Suraya notes that engaging parents to engage with the school curriculum may present opportunities for conversations at home-'Like if they're learning from school, at home you can bring it up, not like sit down with them and be like'. The UK education policy guidance has stipulated the parental involvement with the SRE curriculum (Department for Education, 2019), though this has been the case of several years (see DFE, 2001), in their survey Buston et al., (2001) found that very few parents actually engaged.

"Personally I would like to look at a syllabus on what is running at school like I know in primary school they send a letter home on when they are going to start teaching kids about sex and reproduction, and then you know like that's the point where you should kind of like interact with them. Like if they're learning from school, at home you can bring it up, not like sit down with them and be like, 'so the birds and the bees', but like talk to them like, 'so what did you learn from school today?' and they would be like, 'cause obviously you know what they've learned… But if you do that with everything they learned so like stay engaged in their like education then it's not awkward when it comes to sex and stuff, so I feel like just be actively involved in your kid's life like overall holistically, then things wouldn't be so awkward" (Suraya, 17. Female. Workshop).

Equally, Sophia explains:

"If we have like a lesson in school, then we would be comfortable speaking to our parents about it. I'd go home and ask my parents like how and why" (Sophia, 15. Female. Cardiff).

Young people also prefer the focus group format used in this study, as opposed to formal school settings, as Halimo and Ikram explain:

"I would probably do a group discussion and like talk about it, like when you did the group discussion. I would mix the group; I think it would make the discussion stronger" (Halimo, 14. Female. Cardiff)

"I think sessions like this one would be good for like support sessions for us" (Ikram, 15. Female. Bristol).

The participants expressed the need for a safe space for these discussions:

> "I think although we just met each other today, everyone here is talking about it, and I think that should be done more often" (Felicia, 15. Female. Cardiff).

Similarly, these young girls and men state that space for dialogue is essential; Fuad notes that he has never been allowed to talk about these issues before:

> "Yes, so everyone can talk about it… this is very interesting though, we have never had this before" (Fuad, 14. Male. Bristol).

Moreover, Mohammed notes that a mixed group is better, providing opportunities for mixed conversations:

> "I'd do it in a mixed group because it shows it's not all about women and that men care as well" (Mohammed, 14. Male. Bristol).

In this study, Ade is the only person that explains the role of religious institutions:

> "Okay, so because I heard it first in my church, can you not tell all other pastors in other churches to talk about it, because I think everyone listens to the pastor in the church?" (Ade, 13. Male. Bristol).

6.6.1.1 Teach us in schools

Schools also have an important role in enabling young people to feel safe and learn about issues that may affect them. This chapter has shown, however, that most of the lessons are not diverse enough to engage certain members of the communities. Most of the young people in this study articulate the need for schools to engage more. Historically, however, professionals were unaware of the practice of FGM or lack the necessary training to teach discussions on FGM.

> "If we were learning about it in the classroom and were having a class talk, I think they [peers] would want to speak about it" (Ibo, 14. Male. Milton Keynes).

Ikram notes what he would like to learn about in school in relation to FGM:

> "On an FGM session, I'd like them to cover the reason behind it and what it does to the person and how the tradition started. I think school is the best way to learn 'cause media twists stuff and makes it more interesting and hides the truth" (Ikram, 15. Female. Bristol).

In 2013, a YouGov survey of 1,002 teachers across England and Wales showed that four out of five teachers had not received child protection training and 68% were unaware of safeguarding policies around the practice, while one out of six did not even know that FGM is illegal. This lack of information creates a barrier, in that teachers, are unable to talk about the issue because they lack the necessary awareness or training to do so. Young people, however, feel that school is the ideal place for this, and the Department for Education (2019) guidelines stress the importance of young people learning about the practice in schools.

> "Yes, I think if they taught us in school and it was out in the open, then we would know and also know about choice so that they are not forced into it… so everyone can talk about it" (Rwaida, 18. Female. Workshop).

> "Also, like sexual health clinics or in school assemblies about a special injection [HPV] that was going to happen, and they tell us about it, like to stop things. Also, nurses that come in let you know what's going to happen or what is happening from like the community and how to keep safe" (Maria, 15. Female. Milton Keynes).

The new DfE guidance also provides schools with the agency to determine the content delivered, based on the needs of their pupils. The guidance also allows parents to remove their children from lessons up to the age of 16. Therefore, in the context of parental rights, although sex and relationship education is essential in UK schools, teachers anxiety that parents may be hostile and they may be accused of delivering content that is not age-specific (Alldred et al., 2016); deters them from providing effective lessons. This hostility stems from parents and other religious bodies campaigning to eliminate the 'sex' elements from the statutory guidance.

Young people articulated the importance of having FGM as a standalone topic, not one that is covered briefly once in ten minutes, arguing that that would not provide sufficient information.

> "I think to make it part of the curriculum, like in PSHE you have topics and, instead of putting FGM within sex education, have it as a standalone, so you have more time and lessons to talk about it. Our lessons are like 50 minutes and 10 minutes for every topic, so that's not much time to learn. I think a whole 50 minutes on the topic would be good for FGM" (Mo, 13. Male. Bristol).

Bello explains that lessons must be mandatory and every week:

> "I think to stop it, put it in lessons, like make it mandatory. Every week we have like an assembly, and I think they should do it there… If not then, in lessons someone should come and talk to us about it" (Bello, 14. Male. Milton Keynes).

Again, simply 'ticking the box' by mentioning FGM once or having a poster is inadequate and may create a culture of silence and an ineffective learning environment. Lucy also advocates for a conversation that includes 'everyone'.

> "Like, put it in lessons, maybe like in PSHE, because that's about wellbeing and everything and people know about this more. I've seen this in our room for PSHE, but we haven't really talked about it, but I've seen the poster in the room. So maybe say it in a way that doesn't make everyone silent, try and include everyone and everything" (Lucy, 13. Female. Bristol).

Young people acknowledge ways in which schools can include FGM in sessions. In one focus group, Sabrin suggests that tutor groups may be an appropriate time to include these discussions:

> "Every day we have like tutor group for 20 mins and every Wednesday we change topics, like drugs, sex, and I think FGM should be included in this session… We used to do year groups, but we don't anymore. That could've worked well, I think. Or even workshops, I'd also prefer to hear it from a teacher that I see every day but not a stranger. If I know my friend is definitely at risk; I would talk to my tutor" (Sabrin, 14. Female. Cardiff).

6.6.1.2   Media

This subtheme illustrates ways in which young people have accessed information about sex and relationships, demonstrating the ease of access and the important point that these discussions are anonymous.

> "Like WhatsApp, Instagram, Facebook and Snapchat, also billboards would be good 'cause they would see it and might not know what it is, but they could be like, 'oh yeah, I see that on the bus' and it would get them talking about it and involved and stuff" (Maimuna, 17. Female. Workshop).

Most young people in the UK now find it easy to access media online, including social media, which allows interaction (O'Keeffe et al., 2011). Platforms such as Twitter,

Facebook, Instagram, and YouTube offer young people a portal to exchange ideas and create environments for peer learning, as well as offering opportunities for self-expression and experimentation with their identities.

The young people in my study also expressed a preference for learning about sex and relationships through social media. However, they acknowledge the lack of interactions amongst FGM-affected communities in these forums, including young people. Suraya explores the need for a similar platform but for the younger generation:

> "Has anyone heard about BKChat London? You know, shows like that, I feel like if they… obviously, it might not be them… but I feel like if there is some sort of platform where young people can teach younger people about the realities of life, because the show talks about like relationships and dating and like sex, but I feel like if they had like debates that were more informative in a way so maybe like sex, relationships, and dating but for younger audiences… (Suraya, 17. Female. Bristol).

In 2013, the University of Coventry (Barrett et al., 2013) launched an app for young people and professionals known as Petals, a platform which aimed to provide advice and support for FGM survivors. However, it appears that young people in the three cities under study were not aware of the platform, or they preferred one that offered interaction. As the extract from Suraya shows, young people utilised a British-based web series known as BKChat (Backchat) London. These platforms aim to represent black British people, where young men and women in their 20s debate issues such as body image and racism (Bkchat, 2017).

Participants express the need for an online platform that enables them to seek advice that is relevant to them. Although many sites offer advice about sex and relationships, they either do not consider them useful, or lack awareness of how to access them.

> "Like there needs to be a website, to get like people to call or even like message their issues and get advice" (Mo, 13. Male. Bristol).

Additionally, according to Blanchard et al. (2008) and O'Mara et al. (2010), social media may be particularly useful for young people from refugee backgrounds, who are unable to access sexual health information from their parents or communities. Maimuna shares

her opinion that BKChat London offers a platform where youths can also explore their identity and views 'in a more productive and informative way':

> "Like, if you're not having sex, or like, 'do you have to have sex in relationships?' stuff like that. There are people with so many different opinions; some people have really bad opinions. But it gives you the chance to have an opinion as well. Also, explore topics we don't really explore in everyday life. Like some people would have opinions and think… 'Like no one is going to agree with me'… but you kind of see like you are not the only person who doesn't, or like share the same opinion, So it's kind of like media or social media but in a more productive and informative way. (Maimuna, 17. Female. Workshop).

The use of Twitter and radio was also highlighted as effective by 17-year-old Rwaida:

> "There's this radio thing I used to tune into. I can't remember the name, but like people would vote for a question on Twitter and then you would have two hours in the evening to call in or text with your opinions to the questions… this was interesting because it was all realistic stuff… Like do you have to have sex in relationships, it's interesting I tune in every Wednesday" (Rwaida, 17. Female. Workshop).

Public transport, as Zuli explains, provides a platform for promoting safety for young people:

> "Also, I think it's good like on public transport like buses; it has like chlamydia testing like those adverts. Like, even if you're not actively going out there and researching yourself, it's good to see it. It's like promoting safety, and that's good" (Zuli, 17. Female. Workshop).

To date, several TV programmes have discussed FGM and the issues surrounding the practice (see Chapter 3, p.39), however, there is little discussion on the subject generally available for young people.

> "I think huge billboard adverts, TV and on social media where people can see it and pay attention to it… I think that would be useful. Like on TV, try and get sponsored by programmes or like adverts like the UNICEF ones. They capture other people, like not a short one but not a long one saying this is FGM, and the reasons why it should be stopped, instead of a long story like that could be left for the like seminar, and I've never seen anything like that" (Mo, 13. Male. Bristol).

There appears to be a lack of age-appropriate films as well. Ade explains that this medium could be used as an intervention allowing young people to talk about the issues after watching the movie:

> "I think if there was a film about it we can all talk about the film and then talk about what happened in the film and the reason it was made, to tell us more about FGM" (Ade, 13. Male. Bristol).

6.6.2 When I want to learn

This subtheme presents my participants' thoughts on the right age to learn about things like FGM, sex, and relationships. Jack explains that education about sex, relationships and FGM should start at puberty because this is the age when 'boys find girls more attractive'. He adds that most young people may perceive FGM as a myth or 'fairy-tale' that does not happen in this country, but that young person should be given facts about it that enable them to understand the risks:

> "Around the start of puberty, around 13 or 14, that's when boys find girls more attractive and that stuff, so around 13 or 14 years. If young people understand this is not just a fairy-tale, this is actually going on, and giving them facts like… '3 out of 10 women would have it [FGM] done'… (Jack, 14. Male. Bristol).

FGM-awareness sessions are usually delivered in secondary schools, while primary school stresses the importance of body-awareness utilising the NSPCC's PANTS campaign (NSPCC, 2019), a tool that enables parents and teachers to talk to young people about their body. As mentioned in the literature review, several other organisations have engaged young people in learning about such issues (see Chapter 3). However, young people are aware that such information needs to be age-appropriate. UNESCO (2014) asserts that puberty in boys is linked to the onset of sexual desire.

Although Jack argues that puberty is the appropriate age, the extracts below recognises that maturity is a more important factor than age:

> "I think it's something to do with maturity as well because some people will take it seriously and some won't, depends on how mature they are; this is to do with young boys. I think 13 might be too young to talk about FGM. I think the older you are, the better. Like I think we are doing the subject next year, my brother is

14, and he has learned about it in school already. We did PSHE this year, but I cannot remember what we learned about" (Mohammed, 14. Male. Bristol).

"Because I don't know. Year 7 I was really curious myself, I think, to be honest, they [schools] should start it in Year 5 actually because nowadays, this generation, they are very curious. They have social media, and if you hear children nowadays, they are swearing a lot or using bad language, watching stuff, they are not supposed to be watching or playing games like GTA [Grand Theft Auto] they are not supposed to be playing" (Zuli, 17. Female. Workshop).

6.6.3   What I want to learn

Young people require SRE that is tailored to their needs; this will enable them to make healthy choices. The prior subthemes in this chapter have so far illustrated perceptions and beliefs, as well as sources of information for young people. This subtheme represents *what* young people feel they need to learn. This information will aid in creating tailored SRE education that includes FGM and benefits, young people.

Image 6.7 below is by 13-year old Sara, who attempts to articulate the questions she has about FGM. In the drawing, Sara asks, 'why won't anyone tell me?' and 'is it really happening to these girls?' this reveals that, although young people want to learn, they are either unsure of whom to ask or feel the lack of safe spaces in which to learn.
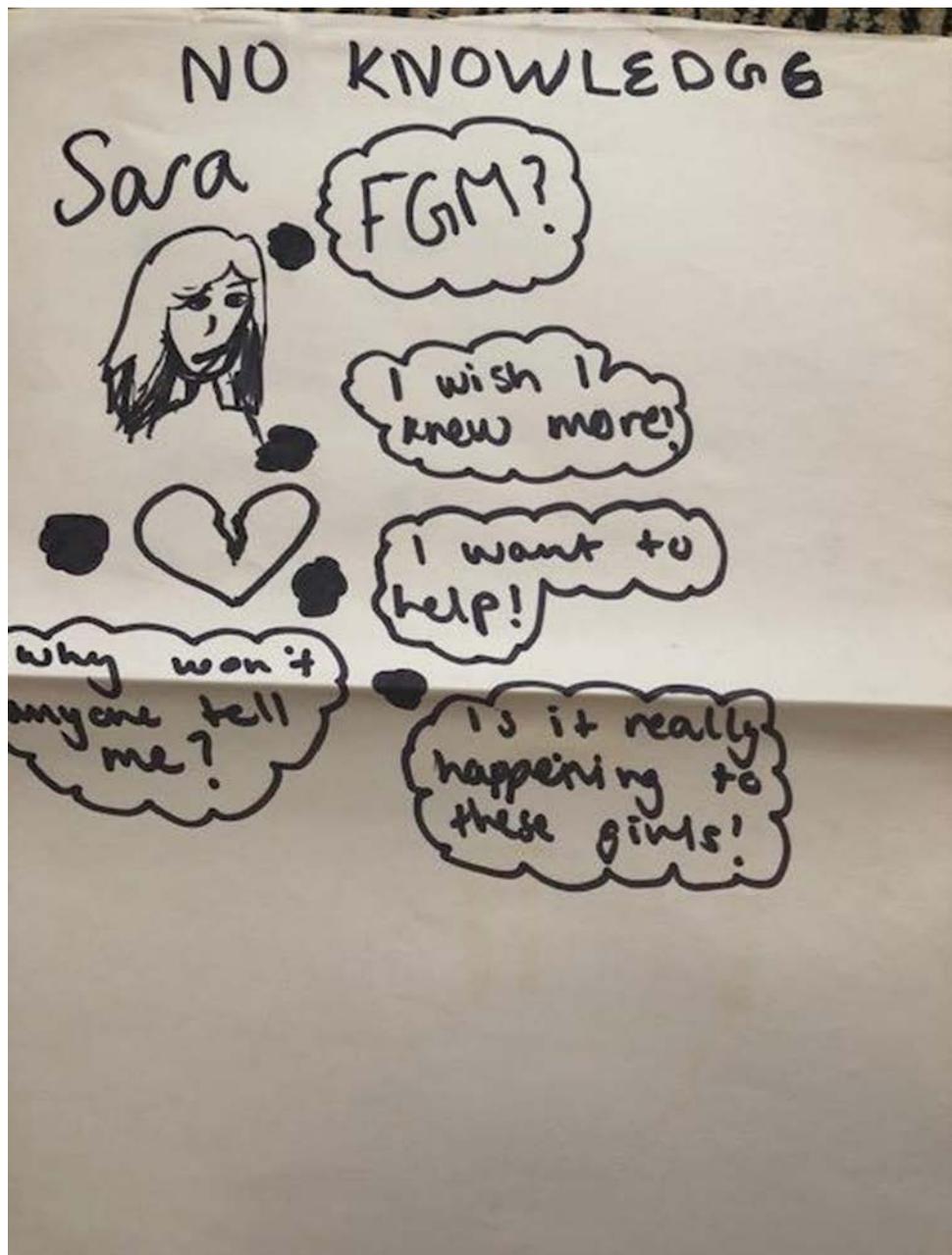
Image 6:7: What I want to learn – Sara.

Along with the drawings made in the focus groups, young people were encouraged to discuss the questions they had about FGM at the time. Several questions emerged, some of which are presented below.

> "What happens after FGM? Is it legal? Who does it? Are you like allowed to take your daughter to another country to have it done?" (Mo, 13. Male. Bristol. Focus group).

The participants were also keen to understand their roles since the silent nature of the practice meant that they were unsure if they had the ability to refuse to undergo FGM.

> "…tell us if we have a say in this. Are we included in this conversation, and how can we say no, like my choices in this and where I can go for help? Also, meet someone who's had it, I'd ask why they did it" (Maimuna, 17. Female. Workshop).

Others had more personal questions, indicating their lack of awareness of the law, as well as the health implications associated with the practice:

> "Can you get pregnant? Would your mum get in trouble for it?" (Sabrin, 14. Female. Cardiff. Focus group).

Perhaps the most important finding is the misinterpretation or lack of understanding about the law and the notion of what is safe, as Mike explains:

> "Like, what it is and what it stands for, and we will tell them it's when you get the female genitals mutilation thing; we'll tell them how it happens, and we will also tell them it's illegal and they do it because you know they're lied to, or they would like to do it to get that picture-perfect look. Start with the basics then get to the deeper stuff, like how it affects the body and how can it affect them (Mike, 14. Male. Bristol).

6.6.4 Who I want to teach me

When learning about FGM, young people feel that survivors' narratives may provide an effective way to deliver health-related messages. According to KickBusch (2002) and Nutbeam (2000), young people should receive health messages that develop their skills and abilities, thus empowering them to make informed decisions.

> "If you had someone to go to, if you're like worried, rather than feel trapped and find out on websites and stuff" (Rwaida, 18. Female. Workshop).

> "I think someone else apart from school and family should talk about it… bring someone who survived FGM and let the young people talk to them" (Mohammed, 14. Male. Bristol. Focus group).

Survivors of the practice were, at most times, seen as 'experts', since they had experienced the practice and therefore would be able to interact with young people on

the subject:

> "I'd go to people I trust that know something about it, like an expert in the subject so I can ask a lot of questions" (Mo, 13. Male. Bristol).

Sabrin agrees with Mo, identifying the importance of representation. She explains that a person who has experienced FGM is best suited to talk about it to young people.

> "If I talk to someone about it, I'd rather someone I know and trust rather than a face I've never seen before. If someone from outside was to come and talk about it, I think people who have experienced it rather than a doctor. It's not the same; it feels like it's a distance thing, and you would think they haven't even helped someone who has been through it. But if you speak to someone whom it's happened too, it opens your eyes" (Sabrin, 14. Female. Cardiff).

Young people also feel that external organisations may an ideal way of learning about FGM. Indeed, schools utilise organisations such as Integrate UK and FORWARD to do this, although less attention has been given in evaluating the effectiveness of such resources.

> "I'd rather get someone who knows what she is saying like from a personal account like tells us what's going on. I would probably do it at an NHS centre, someone they would feel more interested to learn like why they are there. I think to learn about FGM or sex, it's better to have a day out, 'cause with schools, it doesn't feel professional; they are just told to say things. But if you go to an NHS centre they can really tell you what the risks are because they are doctors, they know what they are doing, they have met people who have had it, they know what's going on, so speak to them" (Fuad, 14. Male. Bristol).

> "They should also do activities on it like at community centres, places like that. Well, suitable for people my age and younger. Also, someone who had experience of it went through that would be more useful than teachers" (Mike, 13. Male. Bristol).

Peer education is also seen as a key resource for learning, since young people feel that adults tend to cause arguments and disagree, creating a negative learning environment. Therefore, there appears to be an appetite for creating opportunities for youth dialogue around FGM:

> "Like do seminars or sessions, like one day you can have people talk about FGM, make it for young kids, so adults don't come, 'cause they [adults] normally ask

questions and make huge arguments about it, so just young kids I think would be good" (Mo, 13. Male. Bristol).

"I think if young people came and spoke to us about it, then that would be helpful because they are similar to us and are students like us. I would ask more questions since they are students and they know where you're coming from, so I think young people would be good. We have this week in school that people come and talk to us. Maybe like people who work in that subject, like in school, we have people who work in specific areas who come and talk to us, so maybe something like that. I think young people would be good to talk about sex and sexual health, we have got a school nurse, but doesn't really help, I haven't been yet" (Mo, 13. Male. Bristol).

Some of the males feel that sports could be used as a way of learning. However, none of the young women expressed interest in this:

"I am an active person. I don't like sitting down and listening to people; I'd rather it be incorporated in sports like football and like free food (giggles). So like some game that is active, has a goal, ask you a question you have to kick at the answer or something active to get us learning would be good" (Zack, 13. Male. Bristol).

6.6.5 Conclusion

This section has presented data and analysis of co-researcher workshop data, semi-structured interviews and focus groups with second-generation young people from FGM practising communities in Bristol, Cardiff and Milton Keynes. The data highlights that there is a generalised lack of knowledge amongst young people in this study. However, participants articulated that the motivations behind the practice are diverse, ranging from cultural beliefs and interpretations, control over women's sexuality as well as perceiving that the practice is safer in the West due to highly trained doctors.

While some participants rejected the practice, others expressed the importance of choice and its function as a strategy to reduce harm. Young people reflected on their experiences with the law and how it can victimise people. The concept identity and status was also apparent in this study; participants provided a rich understanding of their experiences navigating between two cultures and how experiences of intersectional issues of gender, race, nationality, culture and religion are apparent in the West.

Participants discussed their sources of information regarding sex, relationships and FGM, acknowledging the lack of dialogue within the home as well as the reductive nature school-based SRE. The mixed information young people receive from social media presents several risks, one of which is the continuation of the practice. However, participants praised online sources governed by their peers as effective ways to learn about sensitive issues. Having detailed how they learned about these issues, young people explained ways in which current approaches can be improved and developed in the theme 'tell it like it is'.

In the following section, I critically reflect on my experience as a researcher, from collaborating with young people to engaging in practical safeguarding issues that arose in fieldwork.

Chapter 7 Reflexivity

Braun and Clarke (2013) explain that, at its basic level, reflexivity should include a researcher's account of themselves and their identity, and how these may have influenced their choices. In Chapter 4, I introduced the concept of reflexivity as a tool in qualitative research. In this chapter, I begin by exploring my background and experiences and how these may have influenced the decisions I made in this project—followed with a discussion of how I utilised a journal to report and reflect on the choices made throughout this research. I provide vignettes of thoughts, feelings and assumptions surrounding the research process, as I continue to reflect on decisions I made from choosing the research topic, recruitment, data analysis and also, my transition, from an activist to an academic researcher.

My awareness of FGM (female genital mutilation) began when, aged 23 years old and working as a nurse in a paediatric accident and emergency unit, I came across a mother from an FGM-affected community who had brought her child in for other medical-related issues. While reviewing her records, I came across a red mark that signified that the child was 'at risk.' At the time, it did not specify the risk. Therefore, I discussed this with my colleagues. One of the nurses explained that it was FGM but did not know what that was and, likewise, had not encountered this before.

Three years later, while studying for my Master's degree in Public Health, I was given an assignment as part of a health promotion module. I decided to focus my presentation on FGM and community empowerment. I then asked my mother to review the content, naively not knowing about her experience. Before reading my work, my mother promptly admitted to me:

> "I remember when I had it [FC]. I will never forget or forgive my aunt for doing that to me."

My mother sharing her experience gave me the impetus to start campaigning against FGM. I had seen the pain in my mother's eyes and knew that, until that moment confiding in me, she had not discussed it with anyone, suffering in silence. That was the

first and last time my mother ever spoke about her experience. Perhaps I should have continued the conversation, although having the courage to speak to a parent about this issue is difficult.

With the help of my academic supervisor, I was introduced to a local organisation in Bristol and to Layla Ismail, who recruited and trained women from FGM-practicing communities to become advocates for the prevention of FGM. I completed their advocacy training and met women who had experienced FGM and spoke openly about their experiences. I was raised in the UK while my parents were first-generation migrants from Somalia; my 'second generation' status evidently helped me to begin to feel accepted by women in this community and to start to build relations with them. Prior to this, I would have considered myself an outsider but, as I got to know women in the Bristol Somali community, I started to recognise myself as one of them, with a legitimate voice and able to campaign against FGM. I imagine that many second-generation young people find this a challenge and a barrier when they feel one step removed from the experiences of their parents, which was partly why I felt compelled to undertake this research for my PhD.

My mother's experience, coupled with the early engagement with the Bristol Somali community enabled me to commence a career working with the Foundation for Women's Health Research and Development (FORWARD). Where I became involved in mentoring and training young people from FGM-affected communities. I quickly noticed the lack of knowledge and dialogue about this issue amongst parents and their children. Working in this area fuelled my interest in researching FGM so, for my dissertation for my Master's degree in Public Health, I completed a systematic review on post-traumatic stress disorder caused by FGM, which marked my transition from community advocate to researcher. McLachlan (1994) has referred to such experiences as 'extra-textual frames', through which one accumulates knowledge that gradually informs and modifies one's view of the world. The experiences I describe above have shaped my perspective on the world today. According to Grbich (2007), awareness of these 'frames' are essential for how one then engages as a researcher and begins to interpret the experiences and phenomena one encounters.

7.1   Research topic

As I began this research and commenced negotiations with the community, I embraced my position as an insider. Padgett (2008) asserted that studying the familiar provides a more accessible entry point and a head start in knowing about the topic. Having worked with young people in previous projects, and completed my Masters' dissertation in this subject, it was a natural progression to commencing my PhD on prevention of FGM in the UK. Though I realise now that although FGM remained a pertinent topic to explore due to my personal experiences, it may not have been seen as a priority for the young people in this community.

Indeed, scholars have argued that participatory projects should ideally be initiated by members of the marginalised groups (Arnstein, 1969; Hart, 1992). However, Maguire (1993) and Moore (2004), acknowledge that this pinnacle of participation is particularly challenging for doctoral students. Indeed, due to the several milestones, I was set to reach, it was difficult not to pre-empt how my project would unfold. Although this troubled me in the early stages of this project, I found that it did not jeopardise my intentions and research outcomes.

Whilst this research has added to the current knowledge of FGM, especially from young people of the second generation, I acknowledge that there were several limitations (See Chapter 9) and that if I had approached young people, they might not have chosen FGM as a topic of interest. This was evident in my findings, where young people noted several issues that were affecting them, such as, mental health, finances as well as conflicts regarding their identity of being Black British.

7.2   Recruitment

 I started to engage in this research keeping close to the ethos of CBPR close, in that, CBPR should be collaborative, participatory, empowering and have a fundamental goal of stimulating social change to advance social justice (Holkup et al., 2004; Minkler, 2004). Due to the age at which FGM generally occurs, young people are best placed to provide information as well as guidance on how these efforts can be improved to enable effective services and prevention strategies. Willow (1997) argues that neglecting to

involve young people in research fails to consider their views as future citizens, rendering them voiceless. Therefore, my decision to work with young people age 13-18 years was due to the extensive literature review I had conducted but also consultations with the community on what they felt was the gap, keeping in line with the CBPR principles. As such, although the subject area was predetermined, working with young people, was a collaborative decision with key organisations, my supervision team, as well as my personal experiences working in this area.

Consequently, engaging in culturally appropriate CBPR involved being committed as a researcher and the gaining commitment from the community. I embraced this early on, by attending conferences and volunteering, to build relations. But it remained apparent that using schools as gatekeepers at the initial recruitment stage (see Chapter 4, section 4.8), was not the right decision. As with any developing researcher, I was anxious and felt dejected at times, due to the inability to recruit research participants. However, I learnt a valuable lesson from this experience, one that helped me build and maintain long term relationships with the community. Community engagement should extend beyond the reach of whom we view as key decision-makers and include the broader community, this means, working with grassroots organisations and viewing them as experts in their lives and experiences. I started working with key charities for the project, I made friends and acquaintances, both of which were instrumental in the recruitment process.

I started working with gatekeepers from charities in Bristol, Cardiff and Milton Keynes, all of whom saw me as a positive role model for young people. For example, I was introduced as a Somali who is attending university. Young people, therefore, saw me as a role model. I recall noting in my journal how this made me feel and how it may impact on the research process.

Reflexive journal extract:

> Today I was introduced as a role model; I am not sure how I can now transition to an equitable research partner. My aim is to enable young people to engage fully in this research process. I do not want to be viewed in a position of power, but one that learns from young people experiences.

Through time and relationship building during the two years of fieldwork, I endeavoured to foster a collaborative team, and this was visible in how I worked with young people and articulated in Chapter 5 of this thesis. By adhering to the principles of CBPR, I engaged in an empowering process with the co-researchers. The young people were able to express themselves, and this process enabled me to step back and position co-researchers as experts in their own lives.

Although I used several CBPR strategies in this project, the full engagement of co-researchers in an equal partnership in all aspects of the study was not possible. Indeed, I agree that CBPR is about negotiation and communication (see Chapter 5), where sometimes young people would lead, by reviewing the research questions, aims as well as developing participatory tools and I followed, and at times I took the lead (analysis, choosing research subject). Ultimately, it was about openly communicating expectations and how to put plans into action that lead to the successful completion of this project.

7.3   Data analysis

Here, I provide a reflexive account of my data analysis. This enables me to consider how my interests mentioned above may have impacted on how I analysed my data.

My data analysis followed an iterative (going back and forth) and recursive (returning to a previous point), as such, the data collection and analysis were conducted simultaneously. This meant that, at times, when I was conducting my analysis, I was also reading and updating my literature review. As a result, a lot of what I was experiencing from my personal life, as an FGM activist, along with my engagement with literature, had the potential to influence my analysis and I started to understand this as I progressed through the process. Below, I give an example of my reflective account during phase one (familiarisation) of data analysis.

> This stage was difficult for me; I started this project with pre-existing ideas and experiences, therefore when familiarising myself with the data, I realised that I was quick to identify segments that might not have captured meaning to the research question, but ones I thought were important. For example, I noted that 'participants were articulating the medicalisation of the practice if done by a highly trained doctor in the UK'. This stood out to me and meant that participants were discussing the medicalisation of FGM in the UK.

Having a supervision team with experience in analysis was necessary at this stage. I was able to meet with them and examine my interpretation of the data. By bringing their input and insights as well as various social positions, they were able to highlight that the segment of data, was not referring to medicalisation but rather the participant's perfection of safety. At this stage, I decided to take a step back and read through the codes again. This allowed me to capture the essence of the data, rather than to impose my preconceived ideas, and this meant that I was moving away from a deductive approach towards an inductive one, where the data spoke for itself. The theme, 'medicalisation' was changed to 'safety', where participants discussed a procedure they felt was safer to do if done in the UK, by Doctors.

Upon reflection, I realise that I was at risk of 'cherry-picking' from my data and that my analysis was shallow, as I was choosing to interpret the data to suit an argument (Braun et al., 2018), based on my preconceived ideas. Although the idea that I pulled from the data was useful, I quickly grasped that this was a minuscule part of the overall picture. As I continued with through the systematic work of coding and delving deeper into getting to understand and know my data, I was able to identify a meaningful pattern with greater explanatory power, one that told a story (Braun et al., 2019).

7.4   Disclosures: a practical example

The nature of this research meant that there was always a safeguarding risk linked to disclosure, as discussed previously. This section illustrates this issue, using an example from my research, which was documented in my reflective journal. In accordance with the researcher's duty of confidentiality, the names and cities of the persons involved have been redacted. I will start by providing a context of the incident, then describe the measures I took.

Reflexive journal extract:

> As part of my research project, I had to interview and conduct focus groups with young people in the city (xx). I had been introduced to an organisation who worked in matters of women's health research and development. I managed to

contact the organisation and arrange a meeting with one of the workers to discuss my research and the need to recruit participants; they agreed to assist me in this. In November 2017, I conducted interviews and focus groups with young females, who were from different backgrounds. While having a discussion around FGM and ascertaining their beliefs and attitudes surrounding the practice, one of the participants stated:

"I think I heard it last year, my family was talking about it, some of them agreed and like, and the others didn't… Some of them were like 'it's haram', and the other was like; they believed it was Sunna or something… my cousin also had it here two years ago… she was 18 years old" (Female, 13).

Two issues automatically came to my attention: firstly, this participant had disclosed that a relative, 18 years old at the time, had had FGM in this country; secondly, the participant, a 13-year-old was a minor, who may also be 'at risk'. When reviewing the extract above, the young person did not directly state that she was at risk, even after the focus group had finished.

As a result of this disclosure, I followed the safeguarding pathway highlighted in Figure 4.2 (pg.87). This led to discussions with the local safeguarding lead and subsequently resulted in further discussions with a Detective Chief Inspector, who is the designated lead for responses to FGM. Following these discussions, a decision was made to notify the gatekeepers and raise concerns; an email was sent to the relevant person. The gatekeeper then contacted me to assure me that the young girl was safe.

After these discussions, I was contacted by a police officer from the city in question, requesting further information about the incident above. This presented several challenges: firstly, maintaining confidentiality was an integral part of this research and, by adhering to the safeguarding pathway, I had fulfilled my duty as a researcher. Corti et al. (2000, p.3) state:

"That there is no legal obligation to disclose information received relating to criminal activities unless legal proceedings or an investigation are underway".

An essential component of ethical practice is the ability to ensure participants anonymity (Grinyer, 2009). Following several phone calls and emails from this officer, I notified my Director of Studies who advised me to contact the chair of the university's

ethics committee and provide a statement. A decision was made not to give more information to the police, not to breach of confidentiality.

Furthermore, the choice made to inform the gatekeeper, who was a social worker, was seen as effective. Admittedly, it was difficult for me to detach myself from the situation due to my personal and professional background. Naturally, I wanted to help and protect the young person. By discussing this with my supervisor and keeping to my role as a researcher, I believe the choices made with this issue were sufficient and appropriate.

7.5 Transition: Activist to Researcher.

At the beginning of this chapter, I engaged in a critical reflective account of how my background led me to do a Masters dissertation on FGM and PhD. Here, I engage in how my identity, views and assumptions have evolved.

I started this work as an activist, and naturally, I held (and still do), strong thoughts and feelings about female cosmetic surgery in comparison to FGM. In other words, how can women from FGM practising countries be seen as the 'other' having no agency- whilst women from the West have autonomy over their bodies? Emphasis on the term 'women', I do not agree with young people being subjected to this practice. To collaborate and care deeply about this perhaps illustrates my activist nature. That being said, I acknowledge how my attitude and views have evolved. Having completed an in-depth literature review, I became more aware of the challenges both practices cause, and believe that although women, of all colours, should have the right to choose what happens to their bodies, they should also be provided with enough information so that they make informed choices.

The findings of this research project also highlighted the notion of choice and how young people felt that 'choice' was an important concept when practising FGM. However, their interpretation did not consider the different types of FGM or age. Type III FGM, even when conducted within a hospital setting, using cleaner equipment, would cause health complications (Khaja et al., 2010; WHO, 2008). As such, young people did not have enough knowledge about the issue to make informed choices.

The impact of these critical reflections on my research have been twofold. First, I have become much more aware of how my ontological, epistemological and other assumptions may have informed my research and in particular, how I interpreted young people's accounts of their lives. According to Mauthner and Doucet (2003), there are limits to reflexivity and the extent to which we can be aware of the influences on our research at the time of conducting it and in the future. That is, we can merely operate a degree of reflexivity, as some influences would be more natural to grasp at the time of researching while some may take time and detachment from the research to identify. I acknowledge that reflexivity is a journey, one that is not limited to this chapter alone, but one that has been articulated throughout this thesis, and I will bring this understanding and insight to my work as a researcher in the future.

Chapter 8 Discussion

8.1 Introduction

The previous chapter presented a synthesis of the key findings from the empirical data of 19 interviews, two focus groups and ten workshops with young people. In this chapter, I review the key findings and how they agree or disagree with previous research in this field, and in relation to the theoretical perspective discussed in Chapter 2. The differences are teased out, and the unique contributions this research makes to the body of knowledge are proposed. The latter sections of this chapter discuss the strengths and limitations of this study and provide recommendations for future research and policy. This thesis also attempts to provide a theoretical contribution; I discuss how a holistic Intersectional approach is required to aid in effective approaches to prevent the practice among young people. Intersectionality, according to Davis (2008), is the interaction between gender, race and other categories of difference in individual lives, social practices, cultural ideologies and how these interactions influence power (Davies, 2008).

8.2 Key findings: a young person's perspective

One objective of this study was to ascertain young people's beliefs, perceptions and attitudes around female genital mutilation to obtain tangible knowledge to build upon theoretical perspectives around FGM. As discussed in Chapter 2, second-generation youth are faced with complexities about how to identify in the society they live in. Having membership of both their heritage culture and mainstream culture is significant in how young people position themselves and their interpretations of the practice.

The results of this current study, suggest that young people's identities and their interpretation of the practice, just like any other, are socially constructed, and generated around norms which help individuals to define appropriate and inappropriate behaviours — adhering to normative expectations aids in fulfilling a person's need to

belong (Deutsch and Gerard, 1995). The layered levels of interacting systems outlined by Bronfenbrenner (1979) suggest that human development is shaped by norms and values embedded not only in micro settings (family, peers and schools) but also in broader social and cultural contexts. In relation to this research, second-generation youngsters have access to two sets of norms, one from their tradition, learnt from their parents and wider family networks, and the other from the mainstream culture, acquired through peers, schools and the broader social context.

This is consistent with Gele et al.'s (2014) study in Norway, which argued that acculturation is an essential factor towards the discontinuation of the practice. They found that the Somali second-generation young participants in their study were more comfortable speaking Norwegian than Somali, and probably had a limited understanding of aspects of Somali culture, including FGM, thus are at a lower risk of the practice. Similarly, Morison et al. (2004) used a mixed-methods approach to investigate experiences and attitudes of FGM among Somalis aged 16-22 in London. They found that living in Britain from a young age is associated with the abandonment of the practice (see also Norman et al., 2009; Alhassan et al., 2016; Johnsdotter, 2009). Neither of these authors distinguishes between the first and second generation and their results do not address the complexities second-generation youth face when attempting to 'fit in'.

I argue that, due to their limited knowledge of FGM, young people have 'othered' the practice, through distancing it as historic or one that is practised in African countries. In addition to distancing themselves by place (FGM happens in Africa), young boys in this study appear to have also distanced themselves from the practice, claiming the inability to relate due to the lack of that body part. They also revealed a lack of dialogue with their parents on issues such as sexual or reproductive health. Consequently, boys expressed positions both in favour and against the continuation of FGM. Similar results were found in a systematic review conducted by Varol et al. (2015).

The findings from my research highlight the tensions young second-generation people face in belonging, taking on a bicultural perspective (Berry, 2006; Thompson, 2005). This perspective provides young people with the option to select and discard whichever cultural values and traditions they feel are not appropriate in certain situations. As a

result, their identities shift due to the continuous interaction between self and mainstream, in line with Sodhi's (2008) explanation that second-generation youngsters develop different identities in order to accommodate different situations (i.e. Somalian at home, mainstream Black African at school).

On the other hand, LaFromboise et al. (1993) argue that individuals who live in between two cultures should be considered as marginal people. He goes on to claim that this marginality could lead to internal psychological conflict and personal identity crises, that living in between two cultures may present undesirable complexities associated with dual identities, generating confusion for young people (LaFromboise et al., 1993. See also Berry et al., 2006). Therefore, young people need to have strong personal identities in order to function as culturally competent individuals who are able to negotiate between these cultural groups. This perspective suggests that, when the traditions of their parents' home country and mainstream norms clash, cultural conflicts arise (Giguere et al., 2007). This kind of conflict appeared in my study, where, for example, life decisions about dating often did not involve negotiation with parents. According to Barry et al. (2009), such stressors can contribute to the pressures second-generation individuals face in their quest to navigate between the two cultures, which may lead to feeling alienated from one or both cultures.

France et al. (2013) assert that cultural conflict occurs at different levels in the lives of the second generation. At the group level, young people may experience discrimination, because they are not perceived as fitting into the mainstream society due to their skin colour and/or appearance (Giguere et al., 2010). In this study, participants articulate their constant struggles while attempting to navigate between two cultures, and how experiences of intersectional issues of gender, race, nationality, culture and religion are apparent in the West.

Additionally, at a peer level, interpersonal conflicts occur when traditional cultural practices and Western cultural norms are incompatible. According to Giguere et al. (2010), family and relationships are often issues that cause major conflict between first and second-generation immigrants. For example, in this study, participants explained the difference in how friends viewed premarital sex in comparison to a young Muslim, who believed in sex after marriage. Similar results were echoes in an exploratory study

on Muslim adolescent's views on sexuality by Smerecnik et al. (2010) in the Netherlands, where sex before marriage was frowned upon among Muslim participants. These types of cultural conflicts may create confusion and stress that can lead to young people experimenting or engaging in sexual relations without prior knowledge of safety.

8.2.1 Who young people want to teach them about FGM

Understanding the ecological factors associated with the continuation of the practice, within a given context, provides unique opportunities to develop more effective health promotion approaches. By making Sex and Relationships Education (SRE) compulsory in all schools in England from September 2020, schools are now required to meet this need. Understanding what helps young people engage in SRE is, therefore, vital to its success. This research builds on knowledge around components of effective SRE (see also Pound et al., 2017). The results suggest that current SRE is limited; young people complained about the inability to learn about real-life issues, with the subject too biological.

The complexities of pedagogic practice in school-based SRE, within the teacher-pupil power dynamics as well as the vast differences in cultural backgrounds, produced barriers for the young people in this study. Moreover, according to Pound et al. (2017), more than a third of schools in England lack effective SRE; in their literature review, they found some young people willing to be taught about SRE by teachers, whilst others called for a less familiar face, due to feeling awkward or being unable to discuss such issues with teachers. Similarly, in this study, young people thought effective SRE in schools to be beneficial when learning about topics such as FGM. However, they would like a more holistic approach, where they are able to also speak to parents about FGM.

However, the culture of silence within the family unit creates a barrier to discussing it with their parents. When learning about FGM, young people feel that survivors' narratives may provide an effective way to deliver health-related messages. According to KickBusch (2002) and Nutbeam (2008), young people should receive health messages that develop their own skills and abilities, thus empowering them to make informed

decisions. How then, can young people learn about such a sensitive issue, without feeling embarrassed?

Mass media campaigns that convey messages about FGM to large populations via television, radio, the internet, newspapers and other materials could be a useful route in raising awareness on FGM. However, it requires a culturally sensitive approach that is grounded in the views of affected communities. One such platform that was discussed by the participants in this study is BKChat London, a British-based web series that enables young people of colour to debate on issues of sexuality and race. These campaigns can affect behaviour indirectly by stimulating changes in perceptions of social or cultural norms related to FGM through social interactions. Media campaigns have been successfully employed previously to address a wide range of health issues, such as practising safe sex and reducing domestic violence (Wellings and Macdowall, 2000).

8.2.2 How can effective approaches to preventing FGM be developed? A holistic, intersectional approach

The findings from this study provide a valuable contribution to research on FGM, specifically, second-generation young people's perceptions, attitudes, and beliefs around the practice. Additionally, by exploring the initiatives already in place intending to prevent FGM amongst young people, the participants have been able to gather their own ideas and suggestions for improving and developing these, as illustrated in Theme 6.6 in Chapter 6 of this thesis.

Some scholars such as Gele et al. (2015) assert that FGM-practicing communities that immigrate to the West undergo a shift in beliefs towards the practice. However, others like Naidoo and Davis (1988) disagree, stating that first-generation immigrants are more likely to hold on to their cultural practises because they have experienced their culture first hand (i.e. in schools, media) and at an interpersonal level (family and peers). Hence, their self-concept is, therefore, well-rooted in that culture. However, situating FGM within a cultural framework reinforces the reductive view of FGM as a cultural practice. Consequently, stakeholders, the media and educational systems condemn it as a barbaric cultural custom, one that is only practised in African countries. These narratives

influence how young people interpret FGM, whereby they consider that, if is practised in the UK, it something different, not barbaric, but safer.

Dustin (2010) argued for a shift towards framing immigrant cultural practices within the framework of violence against women and girls. He asserts that redefining FGM as violence against women and girls rather than a cultural practice would prevent the stigmatisation of communities as violent abusers of girls and women. While it is essential to acknowledge that FGM is a practice originating from traditions, violence against women is a complex and multidimensional phenomenon. Against this backdrop, I argue that, amongst the second generation, the practice is entangled within a web of complex behaviours, influenced at multiple levels, ranging from individual knowledge, attitudes, emotions, and risk perceptions, to social issues, including body image, and victimisation, linked to policies that make FGM a priority issue. Therefore, presenting the issue within the violence against women framework is reductive due to the failure in accounting for the complexities young people face in the West, which may encourage them to cling onto traditions and practices that are harmful to them.

I, therefore, argue for a holistic, intersectional approach. A core principle for an intersectional approach is that knowledge development must come from the perspective of the oppressed, not the dominant group (see also Freire, 1970). Such an upstream approach responds to the social constructions of race, class and gender being unequal in social relationships, and would be more effective than an approach simply limited to prevention and lifestyle, which excludes the importance of the social dimension. Therefore, we should strive for negotiated (Beattie, 1991) and community-focused, rather than authoritative initiatives, to empower people to make healthier choices (Tones and Tilford, 2001; Naidoo and Wills, 2009; Dines and Cribb, 1993). I argue for the use of activities focused on the ability to strengthen collective participation and action, which is perhaps identical to the broad tradition of community development and, in particular, the 'bottom-up/collective' approach that Beattie (1991) terms as community action. This would consolidate, challenge and reverse the core motivations for the practice, from a second-generation perspective.

Therefore the design of approaches to prevent FGM need be locally attuned and address shifting contexts of the practice. This notion is especially true in the Western

community. Because, as the reasons for the practice vary across different communities, interventions must also address these reasons. As a result, it is difficult to build a 'one size fits all' programme. A starting point may be engaging with young people, as articulated in this study. Young people in this study clearly expressed the need for a comprehensive Sex and relationships curricula, one that engages parents as well as young people.

8.3   Recommendations for practice and policy

A number of recommendations have emerged from this study. These are summarised below.

1. The Serious Crime Act (2015) should also require regulated professionals, including teachers, police officers and health professionals to receive mandatory training about FGM during their professional training. This training should focus on community empowerment, which will enable community members and young people to deliver this training. This will facilitate awareness of the context-specific issues that surround the practice and attempt to eliminate the 'otherness' discourses that are currently in place.

2. The Department for Education's PSHE proposals requires a more holistic approach. One that supports the appropriate use of language used by teachers and external speakers when discussing FGM. Such an approach will ensure that the communities are not viewed as barbaric, uncivilised 'others'. The impact of poorly chosen rhetoric can have adverse effects when attempting to prevent the practice, such as driving the practice underground or becoming medicalised and, therefore, acceptable.

3. Following conversations with young people in this research, there is an apparent lack of 'space' for young people from marginalised groups to talk freely about sexual health issues; participants shared the need for such places. Therefore, given the preference expressed by young people in this study for on-line

information, it would be helpful to develop high quality authoritative on-line interactive material that sits alongside resources on sexual health, targeted at young people.

4. The young men in this research have illustrated their lack of awareness around the practice of FGM. Therefore, information targeted at young people should be framed in such a way that will allow men to realise the impact of the practice on the health and sex lives of their future wives and their daughters.

5. Results from this thesis outline a need for parent skills-building programmes to enable open conversations with their children on issues such as sexual development, and FGM. A community-based network that enables health professionals, academics, first and second-generation individuals from FGM-practicing communities is needed to create and use such resources.

6. The CBPR approach utilised in this study highlighted that for this group of young people, there are actually real issues for them as to how they navigate being young female, British Muslims, which is much broader than FGM. Such issues which include identity, discrimination and body image, should be acknowledged and engaged within key policies aimed at preventing FGM. There is a need for further research that examines the relationship between these issues and FGM in the West.

Chapter 9 Undertaking a PhD using CBPR methodology.

9.1 Challenges

Doctoral researchers seeking to engage in community-based participatory research (CBPR) have raised questions about how the purpose of their research for a PhD influences the co-production of knowledge. Indeed, the thesis examination criteria, based on proving academic knowledge and authority, may present direct challenges to the CBPR principles of co-research (Altwood, 1997; Cassara, 1987; Maguire, 1993). Birch and Miller (2002) draw upon Walker's (1992) ethics of responsibility to examine the tension between PhD requirements and CBPR, highlighting the sense of responsibility needed to sustain engagement with co-researchers throughout the research. They also identify the impact of time pressures, funding requirements, professional interests and academic regulations on the process of discontinuing contact with co-researchers in the final stages. These elements will be discussed in depth in this section, using personal accounts and reflections on the process throughout the three years of my study.

Reason and Bradbury (2015) suggest that the overarching purpose of CBPR is defined by its engagement with issues of pressing concern to certain people. Thus, members of marginalised groups would ideally initiate projects of this kind. This aspect of participation has been challenging for doctoral projects to achieve (Maguire, 1993; Altwood, 1997). PhD researchers are required to meet certain milestones: for this project, for instance, I was awarded a studentship, and a broad proposal had already been developed before I commenced the study. In addition to this, I was required to submit a further, more refined proposal within three months of the research start date. This creates a fundamental challenge for the CBPR methodology, in which researchers are not supposed to pre-empt how projects will unfold (Cornwall, 2008; Gibbon, 2002; Reason and Bradbury, 2015).

The linear process described above posed a challenge in the early stages of this PhD project. Although I am from an FGM-affected community, and a second-generation immigrant in the UK, it felt inappropriate to write the proposal and the ethics application

without prior consultation with the young people who would take part in the research. Ultimately, there were several reasons why this approach did not jeopardise the study. Firstly, it is permissible to build uncertainty into research proposals and ethics applications, and I discussed and confirmed this several times with my PhD supervisors. Adding to this, Herr and Anderson (2005) emphasise that social sciences research is often emergent in design. In my role as the researcher, I sought to ensure that the voices of the young people taking part were heard throughout the research. Furthermore, once my ethics application had been accepted, and co-researchers recruited, the co-researchers and I discussed the project's aims and objectives and space was given to reword or change them as a consequence.

Secondly, as Maguire (1987) has asserted, individuals engaged in the tasks of their daily lives are unlikely to consider research as a priority. Working with young people presented another layer of difficulty in this respect, as the participants were concerned with school exams and applying to university, rather than initiating research. Consequently, as Maguire (1987) asserts, students conducting CBPR should be given some flexibility, acknowledging that community-initiated projects are rare and that it is acceptable for academic researchers to initiate participatory endeavours.

Conducting a CBPR project is also often time-consuming (Cammeron, 2007; Moss, 2009). The process of building partnerships and working with co-researchers can be complicated and lengthy. However, the funding that PhD students receive is often conditional on them completing their projects within three years, and researchers may also face other financial challenges that may limit the time they can devote to a PhD (Moss, 2009). Although this issue is generic to most doctoral students, it can pose a challenge for those conducting participatory research. I faced specific challenges, in that working collaboratively with young people was time-consuming and often messy, and it was difficult to know at what stage co-researchers or participants would become empowered or transformed, or how their aspirations concerning school and university would fit with the PhD submission time of three years. This was later understood through the evaluation of the training (Chapter 5).

A further limitation, as Moss (2009) argues, is that the time given for doctoral degrees is hardly long enough to complete a participatory project. Time was a pressing concern

in this project during partnership building and with particular respect to co-researcher availability. Although I had already established relationships within relevant organisations in Bristol and Milton Keynes, making it slightly easier to recruit and attain co-researchers, careful consideration needed to be taken not to exploit young people in conducting interviews and meetings, and to negotiate effectively with them on these matters. It is important to note that it took longer than expected to build relationships in Cardiff because of the absence of 'trust' (further discussed in Chapter 4), and the sensitive nature of the project (Manoranjitham et al., 2007; Elam, 2003). Nonetheless, these relationships eventually formed, and I was able to commence fieldwork.

Co-researcher availability was challenging throughout this study, and I had to arrange interviews subject to their availability. Many of the co-researchers had other activities going on at the start of the project, which meant that they understandably prioritised their own lives and studies over the needs of my PhD. Therefore, careful negotiations had to be undertaken so that the interviews and focus groups could be completed without affecting the young people's work. The lack of availability and time pressure made it difficult to consult young people when analysis the data, although an attempt to do so was made.

Moreover, there were some probable limitations in recruitment. It is possible that parents who may have subjected their daughters to the practice would have been less likely to allow their children to engage in this project. Therefore, the study reflects the perceptions of a limited number of young people who participated in this study. As such, the results may not reflect the entire second-generation population in the UK. Most of the views and opinions were, however, repeatedly expressed across the three sites and in interviews, focus groups and workshop data, thereby increasing the rigour of the study.

In hindsight, although the use of CBPR presented challenges, unique opportunities also arose whilst collaborating with young people. Although the objectives of this study were ambitious, some were achieved. During the initial stages of conducting this project, an objective was to ascertain the effectiveness of existing anti-FGM interventions, as well as devising ways in which they could be developed and improved. This output has partly been achieved, as young people expressed the need for better PSHE education that

included learning about FGM (see section 6.5 in findings chapter), such approach require further, long term, studies to ascertain their effectiveness. Given more time and resources to repeat the process, the focus groups would initially be conducted in single-sex groups to see what issues emerged from the two groups.

9.2 Conclusion

The aim of this study was to examine how young people directly or indirectly affected by FGM interpret and understand the practice and what their views are on current approaches aimed at preventing the practice in the UK. My conclusion is that, although conducting this research was challenging; I felt that a collaborative research approach efficacious, as it yielded important findings that contributed to the knowledge of FGM in the West. Further research that engages communities is required and will aid in the development of effective approaches.

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Appendix A: Example of a search strategy

Information required	Values, beliefs, perceptions and interpretations of female genital mutilation among young people from affected communities in high-income countries. No date limits were applied, the restriction was applied to high-income countries (as defined by the World Bank)				
Databases	Medline, web of science, Ebsco				
EBSCO, MEDLINE, CINHAL, Child development and adolescent studies	Search terms	Hits	Relevant	Date of search	
	Female OR woman OR girl	S1=(7,476,628)		01/02/2016	
	Mutilation or circumcise* OR cutting OR FGM OR sunna OR clitoridectom* OR Infibulat*	S2=(33,953)			
	adolescent OR youth OR child OR boy OR girl or teenager OR young person	S3=(2,864,993)			
	S1 AND S2 AND S3	(3,210) Restricted to High income countries= (1)	(0)		

Information required	**What behaviour change interventions have been utilised in the prevention of female genital mutilation among young people in Europe?** No date limits were applied to this initial search.				
Databases	Medline, web of science, Ebsco				
EBSCO, MEDLINE, CINHAL, Child development and adolescent studies	Search terms	Hits	Relevant	Date of search	
	Female OR woman OR girl	S1= (1,356,001)		01/02/2016	
	Mutilation or circumcise* OR cutting OR FGM OR sunna OR clitoridectom* OR Infibulat*	S2= (5,211)		01/02/2016	
	Intervention OR Mediation OR involvement OR behaviour change OR Prevention	S3=(1,356,001)			
	S1 AND S2 AND S3	401	7		

Appendix C: Co-researcher and participants information sheet and consent forms

Co-researcher information sheet

You are being invited to take part in a research study. Before you decide whether to take part, it is important to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

My name is Saadye Ali. I am a postgraduate student in the Department of Health and Social Sciences at the University of the West of England (UWE), Bristol, currently undertaking a PhD. My Doctoral research involves recruiting young people, like yourself, to explore attitudes and beliefs about female genital mutilation (FGM) and to develop with yourselves new approaches to prevent FGM. I am recruiting young people from affected communities in Bristol and Cardiff. The approach I am using will involve participants in the design and organisation of the research and is called the "community participatory action research" approach (CBPR).

Why am I inviting you to take part?

I am inviting young people aged 16-18 years and born in the United Kingdom or another high-income country to take part in this research. I am looking for individuals who are keen to learn new skills and to represent the views of their peers. You will need to feel confident sharing ideas and opinions with others. You will be invited to join a steering group to help me in the design and organisation of the project, and then to become a co-researcher in the project. The steering group will include other likeminded young people of similar ages, backgrounds and interests to you and you will provide advice and support to the research team on how best to proceed with the research from a young person's perspective.

Do you have to take part?

Participation is voluntary. Individuals will be invited to join the group if they express interest and are able to make the necessary commitments. You will be asked to attend meetings in Bristol and Cardiff. If you are unable to make specific meetings, I will meet with you individually on a one-to-one basis as is appropriate. All your travel expenses will be reimbursed. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you agree to take part, you will still be free to withdraw from the project at any time and will not be required to give a reason. In recruiting volunteers to the steering group, I will be aiming to be as representative as possible with regard to gender, ethnicity and religion.

If you decide to take part, what will you be asked to do?

1. Assist in the recruitment of other co-researchers to the research project.
2. Lead discussion groups and workshops with young people of a similar age and background to you.
3. Share in the planning, development and delivery of the research, including recruiting and selecting participants, discussion groups, creative workshops and interviews.
4. Become involved in publishing and promoting the research findings.
5. Have the opportunity to share your views and beliefs on issues that you feel strongly about.
6. Become involved in building stronger links within the community between the project, partner organisations and young people.
7. Become involved in developing forums for discussion and debate of FGM issues within the local community.
8. Support the project in finding effective ways to undertake research involving young people in relation to sensitive issues like FGM.
9. Due to the nature of the research, you will be asked to complete a disclosure check before you start, costs for this will be covered by the research team.

What are the possible benefits of taking part?

You will have the opportunity to learn many new research and communication skills. Initially, you will receive Safeguarding Level 2 training, then training in how to conduct interviews, focus groups and participatory workshops. You will become involved in the delivery and organisation of a research project aimed at educating about and preventing FGM.

What if I need help or support to take part?

The researcher (Saadye Ali) will be present in all the workshops and interviews you lead or are involved with. All sessions will involve debriefing afterwards to give you the opportunity to provide and receive feedback on how you felt the sessions went, to raise any concerns and to plan for future sessions.

What if something goes wrong?

If at any stage of the process, there is something you feel unhappy with relating to the study, then you can contact either myself or my Director of Studies, Professor Selena Gray.

Thank you for taking the time to read this information sheet. If you have any questions, please contact me:

Saadye Ali
PhD student
The University of the West of England
Email: Saadye.ali@uwe.ac.uk

Director of Studies
Professor Selena Gray
Professor of Public Health
Email: Selena.gray@uwe.ac.uk

Co-researcher consent form

PART A TO BE COMPLETED BY THE YOUNG PERSON.

Please read the following statement and tick the box if you agree:

I have received the information sheet for this study and have had the opportunity to ask questions about it

I understand that my participation is voluntary and that I can withdraw at any time, without giving any reason.

I have received the terms of reference and have had the opportunity to ask   questions

I understand that should I decide to withdraw from the study during or after the focus group, interviews or workshops takes place my contribution will be withdrawn

I agree with the use of camera and for the use of the pictures

I agree to take part in:

Interviews

Focus groups

Please note that the research team has a responsibility to report anything that is illegal or that has the potential to bring harm to children, young people, other vulnerable adults or yourself.

Your personal details (e.g. name, identity) will not be used or shared at any stage of the research, nor after the research has been completed unless you have consented to the use of your photos.

Name/Identification number —————————————

Signature   ————————————   Age   ————————————

Parent/Guardian Name   —————————————

Signature

—————————————

Participant information sheet

You are being invited to take part in a research study. Before you decide whether to take part, it is important to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

My name is Saadye Ali. I am a postgraduate student in the Department of Health and Social Sciences at the University of the West of England (UWE), Bristol, currently undertaking a PhD. My Doctoral research involves recruiting young people, like yourself, to explore attitudes and beliefs about female genital mutilation (FGM) and to develop with yourselves new approaches to prevent FGM. I am recruiting young people from affected communities in Bristol, Cardiff and Milton Keynes. The approach I am using will involve young people in the design and organisation of the research and is called "community participatory action research" approach (CBPR).

Why are we inviting you to take part?

If you are a young person aged 13-15 years, born in the United Kingdom or another high-income country, I would value your input to the study, so that we can better understand the effectiveness of current tools designed to tackle FGM. Your involvement is very important in this research as it will give you a unique opportunity to have your voices heard in this matter, as well as aid in the development of interventions that could help prevent FGM in the future.

Do you have to take part?

Taking part in this research is entirely voluntary; it is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. You would also have the opportunity to withdraw all or part of your interview/focus group and participation workshop material from the study for up to one month after the interview has taken place.

If you decide to take part, what will you be asked to do?

If you decide to take part, you will be expected to keep this information sheet as a reminder of what the study involves.

1. You and your parent/guardian will be asked to sign a consent form to take part.

2. You will be invited to take part in an initial meeting with the researcher and fellow participants.

3. The researcher will invite you to take part in a face to face interview. This is a conversation that will last approximately 1hr, depending on how much you have to say. The interviews will be audio-recorded and transcribed and will take place in the venue of your choice.

4. You will also be asked to take part in focus groups, where you will have a discussion with other young people the same age as you; where you can voice use creative activities of your choice to voice your views.

During the interviews, focus groups and workshops you will be asked:

- To explore your perceptions and experiences of approaches aimed at preventing FGM.

- To explore the usefulness of current approaches for the prevention of FGM.

- Understanding these approaches and if they can be developed.

What are the possible disadvantages or risks of taking part in this study?

Every care will be taken to support you and avoid this being a stressful process. We will not require you to respond to questions that are stressful, or that might upset you. If at any point in the process, you feel unhappy with the questions we are asking, we will stop the interview.

What are the possible benefits of taking part?

By becoming involved in this research, your views and opinions will help contribute to future approaches that could prevent FGC. It will be an opportunity for your voice to be heard and presented in the research.

What if I need help or support to take part?

The researcher will provide one-to-one support while you complete the consent form. I will ensure you are not pressured or coerced into taking part. I will help you make sense

of any confusing or difficult questions and ensure you feel able to respond confidently to anything we ask you. All travel expenses will be reimbursed to and from meetings.

What if something goes wrong?

If, at any stage of the process, there is something you feel unhappy with relating to the study, then please contact the project Director of Studies, Professor Selena Gray.

Will my involvement in this study be kept confidential?

All information you provide in the research including your name will not be used or any other information that would identify you to your family, friends or community. Identifying information will be changed, and a code name will be given to any of your data used in publications arising from this research.

Please note that the researcher responsibility to report anything that is illegal or that has the potential to bring harm to children, young people, other vulnerable adults or yourself.

All electronic data gathered during the study (audio recordings) will be uploaded and stored on a password-protected computer at the University of the West of England, Bristol, to which only I will have access. All hardcopy/paper data (transcribed interviews, completed questionnaires and consent forms) will be stored in a locked filing cabinet in the researchers' office.

What will happen to the results of the research?

The findings of the research will be written up into a PhD thesis and will be made available on the University of the West of England publications. The study might also be published in academic journals, which will enable professionals to hear your voices in this matter.

Thank you for taking the time to read this information sheet. If you have any questions, please contact:

Saadye Ali

PhD student

The University of the West of England

Email: Saadye.ali@uwe.ac.uk

Director of Studies

Professor Selena Gray

Professor of Public Health

Email: Selena.gray@uwe.ac.uk

Parent and Participant consent form

PART A TO BE COMPLETED BY THE YOUNG PERSON.
Please read the following statement and tick the box if you agree:

I have received the information sheet for this study and have had the opportunity to ask questions about it ☐

I understand that my participation is voluntary and that I have the right to withdraw from the study at any point prior to the evaluation of the data, without giving any reason. ☐

I agree to my views being audio-recorded and stored for three years after the project is complete ☐

I understand that my views will be kept anonymous, meaning I cannot be identified from the research data. I consent to these anonymised data then being used by the researcher during the write up of the research and in subsequent publications ☐

I understand that should I decide to withdraw from the study during or after the focus group, interviews or workshops takes place my contribution will be withdrawn ☐

I agree to take part in the above research ☐
I agree to take part in focus groups, interviews or workshops. ☐

Please note that the research team has a responsibility to report anything that is illegal or that has the potential to bring harm to children, young people, other vulnerable adults or yourself.

Your personal details (e.g. name, identity) will not be used or shared at any stage of the research, nor after the research has been completed.

Recording

1. **The recording of the interview will be stored in a locked cabinet and in a password protected storage site by the interviewers and will be stored for three years after the project.**
2. **Only the researcher and the members of the supervisory team will have access to the recording for analysing the data.**

Name/Identification number ⎯⎯⎯⎯⎯⎯⎯⎯⎯⎯

Signature ⎯⎯⎯⎯⎯⎯⎯⎯ Age ⎯⎯⎯⎯⎯⎯⎯⎯

PART B TO BE COMPLETED BY THE PARENT/GUARDIAN

I have read and understood the accompanying letter and give permission for the young person (named above) to be included.

Name _____

Relationship to the young person _____

Signature _____

Appendix D: Focus group and interview guides

Focus group guide- Allow 2 hours

Welcome and Introduction

Thank you all for agreeing to attend this focus group today, my name is (x) I am a doctoral student at the University of the West of England, and the people running this discussion today is. Alternatively, my name is (x) I am a co-researcher working with a doctoral student at the University of the West of England (continue as above).

Our topic is, preventing female genital mutilation in affected communities in the UK: A community-based participatory action research study, and today we would like to hear more about your understanding, perceptions, and experiences in relation to Female genital mutilation/female circumcision.

You have been selected to join this group because we value your opinion, and we would like to hear the voices of individuals like yourself. There are no right or wrong answers or opinions, only different points of view, so I want to request that during this session, we try hard to respect and value each other's' opinions. We certainly do not have to agree with each other, but it is really important that we try to respect each other's points of view.

You've probably noticed the microphone. I am audio recording the session because I do not want to miss any of your comments. People often say very helpful things in these discussions, and it is always difficult to write everything down and participate at the same time. We will be on a first-name basis today, although I should stress that I will not use any names in the reporting of the research. You may be assured of complete confidentiality. This means that any information that could potentially identify individuals will be removed from the interview transcripts and findings. Your responses will be used to develop a better understanding of your views, and those of your peers, in explaining, interpreting and developing new interventions that seek to prevent FGM and to support those affected by it.

I need to remind that you signed a consent form to participate in this session, and that – as stated on the form – you are free to leave the project at any stage and to seek support from me should you need to. If you have any questions about this, please do feel free to speak with me following the session.

Confidentiality statement:

What is said in the room stays in the room. However, we need to make you aware that, if anything is disclosed that we think may harm you or another, we will have to break confidentiality.

Discuss what confidentiality means.

Establishing Ground Rules (Approximately 15 minutes)

The first discussion will be used to establish the group's "ground rules" and to refer to the ethical requirements regarding confidentiality, respect and data protection.

First-round (Approximately 15 minutes)

Well, let us begin with an icebreaker. We have placed name cards on the table in front of you to help us remember each other's names and in pairs can you introduce each other (name, where you are from). This will help us find out some more about each other —Followed by an icebreaker. Now we have introduced each other, can you say briefly, why you volunteered to join this focus group?

Healthy-self drawing game

Now, everyone has a paper each; we would like what you visualise a happy young man or woman to be and label it, consider who is around them, where they live, dress code, body language, what makes you healthy and happy.

Second round (Approximately 30 minutes)

Then anonymously I have placed post-it notes on the table, I would now I would like you to write know firstly if you have heard of the term FGM, what did you hear? (True or False).

The focus group will begin exploring the young people's perceptions, attitudes and beliefs around FGM and then continue with a discussion around the key interventions currently being used.

- Now, what do other people say about FGM? If they were to explain it to their peers, what terms would they use? Write them down and then place them on the floor upside down.

We would like you to draw a young person who has never heard of it what questions would they have and how would it make them feel? Write down their thoughts, feelings and questions they might have.

Then have a discussion of what FGM is. As a group.

Also, now a draw a person who has heard of it, how do they feel, what questions would they have.

- Where have you learned what you know about FGM? Write down and place on the floor — Venn Diagrams (the bigger the circle, the more significant).

    Approaches
    What involvement have you seen or heard being down about FGC?

- Formal classroom education- PSHE experiences (What have you heard about FGM in school?

    Prompt: Was this through a lesson? What did you think of it?

- Community projects- have you had contact with any Campaigning groups?

  Prompt: Which ones were they? What do you think about this?

- Human rights framework- Violence against women and girls (What do you know about the human rights law and FGM?) (Human Rights – can have a copy of the ECHR and ask which one(s) FGM could/should be under).

- Legal mechanisms- The FGM Act 2003, Serious Crime Act 2015 (Where do you think the law stands in terms of FGM? Why do you think it is?

- Health Risks: discussion- FGM and health implications- game

  Prompts: What do you know or have heard?

- Positive deviance- Peer to peer education (Have any of your peers discussed FGM with you? What was the discussion? How old were you when you heard about FGM?

The above will be used to start discussions.

Semi-structured Interview guide

Thank you for your participation today. My name (insert your name) and I am a co-researcher supporting a Doctoral student at the University of the West of England researching on FGM/female circumcision. This interview will last approximately 1 hour and 30 minutes and will include questions on your experience and perceptions of interventions designed to prevent FGC. I would like your permission to tape-record this interview so that I can accurately document the information you convey. If at any time during this interview you wish to discontinue the use of the recorder for the interview itself, please feel free to let me know. All the responses you provide today will be confidential, and this means we will remove all personal identification information from the transcripts, your responses will be used to better understand you and your peer's interpretation of these interventions and whether or not you see them as useful or if they need improving.

I would like to remind you of your consent to participate in this interview; you have signed and dated a copy, specifying your participation in the research. You will receive a copy, and I will keep the other in a locked cabinet, separate from your reported responses.

Your participation is voluntary. If at any time you need to stop, take a break or need time to a particular question, please let me know. You may also withdraw your participation at any time without consequence. Do you have any questions before I begin? Then with your permission, I will begin the interview.

Participant characteristics

- Gender

- Age

- Place of birth

- Ethnic Background

General questions

1. My name is (co-researcher name), I will be conducting the interview today, let with your name?

2. Tell me about yourself?
- What school do you go to?
- What do you enjoy doing?
- What about home, how many brothers and sisters do you have?
- What about friends? Any that you have at school and at home?
- What do you think are the expectations of you growing up?

- What things do you worry about growing up?
- Have you done sex and relationship lessons at school?
- Do you think girls and boys differ? In terms of treatment? How are they treated in school and home?
- Any fears of things that may happen as you grow up? Traditions you need to follow?

Beliefs and perceptions around FGM

1. Have you heard of the term FGM OR Female circumcision? What have you heard?

2. Do you remember how old you were when you learnt about the term?
3. Where did you hear of it?
4. In your opinion, what is your understanding of the term? What does it mean to you?

Section B: Attitudes

1. So, when you first heard about it, how did you feel?

2. Do you think attitudes to FGM differ between females and males? If so, how?

Section C: Relationships (Family dynamics)

1. Have you spoken about FGM with anyone in your family?

2. If so, how did you find the conversation went? Whom did you speak to?

3. From your background, i.e. where your parents are from, have you heard any rules or expectations on FGM?

4. Whom would you talk to about the subject? Why?

Section D: Barriers and challenges

1. What, in your opinion, would be the main barrier in talking about FGM with people your age? In other words, what would stop you from talking about it?

2. How do you think we can overcome this? (How can it be made easy for young people like you to talk about it)?

3. How do you think we could help people like you know or understand more about FGM?

   Imagine someone who has never heard about this subject, how can we make them understand it? What questions do you think they would have?
   - Any suggestions on how to approach you, people, teach them?
   - How would you have liked to learn about it?

4. Would you talk about FGM with your friends? If so, why? If not, why?

Section E: Any other issues

- I think that is everything I had to ask you to talk about, have you got anything else you would like to say or any final thoughts or anything you would like to follow up that I have not asked you

End of Interview- Thank interviewee for their time.

Appendix E: Initial coding illustration

Tentative codebook illustrating themes and exploratory comments.

Initial codes	Data	Exploratory comments
Gender roles	If you compare it to boys, girls would have more complications than boys. Boys would agree until they know more about it then they would be disgusted and disappointed.	• Seems to be comparing male circumcision to FGM. • Boy's may be in favour of FGM because they do not know about it? • Gender differences in terms of circumcision as well as those who 'agree' with the practice.
	Well sometimes I do the cleaning, but I think it's mostly like the girls that do it. Like for example, I know like, for example, when I grow up and have a family I think the girls would be like in charge of things to do with the household and the boys would be like outside of the household. Like working, earning money and stuff like that. I think it has something to do with your parents. Like my dad takes out the rubbish and my mum made us clean and cook…	• Masculinity and gender roles: Women belong in the house and men earn money (Economy). • Links awareness of gender roles to family and tradition- Socially constructed. • Something parents do-mom cleans, and dad takes rubbish out. • Gender roles linked to economy, culture, tradition.
Interpretations of FGM	And also in my religion obviously I believe in Allah so I believe that he is the only one that can change stuff in your body and you are not the one that, erm you are not able to do that. He is the only powerful one because he's obviously created you the way you are, and he does not want you to change that. It's like you getting like plastic surgery just because you don't like the way you look. That's how Allah created you, and you can't do anything about that.	• RELIGION- against the practice: 'That's how Allah created you, and you can't do nothing about that'.

Identity and status	I don't know, because it's not something that concerns me, because I'm not like, none of my family relatives have gone through it, and it can't happen to me ((thank God)). But like I guess I would learn a bit more because it's something that's happening and shouldn't be happening and ways to prevent it	• It cannot happen to me • Not our problem • Sex discussions- uncomfortable • Men don't have to go through the pain women do (FGM) The concept of Othering- Not my problem/ I don't have that body part
Lack of awareness	Like it wasn't a nice thing to do, and I did not know why they did it. I think attitudes differ between make and female because if you're a female its more personal to you because there is a chance it could happen to you whereas it wouldn't happen to a male, I think male lack the knowledge, and it would affect females more.	• Do we presume all young people know what FGM stands for? Maybe our use of language or explanations need to change • General lack of knowledge about FGM.

Appendix F: Conference presentations

Ali. S (2017) Preventing female genital mutilation (FGM) in affected communities in the United Kingdom: A community-based participatory research study. Justice, Inequality and Gender based Violence Conference. University of Bristol.

Ali. S (2018) Collaborating with communities towards the prevention of FGM. Bologna. University of Bristol.

Ali. S (2020) Demonstrating evidence-based activism to end FGM: Zero Tolerance day. Bristol community conference. Refugee Women of Bristol.

Ali .S (2017) Our Journey to Empowerment END FGM Summer Campaign Launch. Bristol Community sharing good practice to end FGM.