Addressing Female Genital Mutilation/Cutting in Scotland:

A Soft Systems Approach

Elizabeth Mayen Inyang

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MRC/CSO Social and Public Health Sciences Unit

School of Health and Wellbeing

College of Medical, Veterinary and Life Sciences

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Abstract:

FGM/C is an important issue which could have life changing implications for girls and families. In the UK, strategies aimed to address FGM/C have provided a necessary service to women affected by it, but they have also been seen to inadvertently stigmatise affected communities, causing suffering to families unjustly accused of FGM and loss of trust between communities and service providers. Scottish Policy calls for a greater involvement of affected communities in shaping and leading measures to prevent FGM/C, however community members have stated that they have been consulted in a 'tokenistic' fashion.

While literature exists exploring the experiences of women and young people in affected communities in Scotland, as well as multiagency guidance issued by the Scottish government to direct statutory agency response to FGM/C, there remains a need for approaches which bring together perspectives from all the various bodies through which FGM/C is addressed in Scotland. This would bridge these institutions, approaching the situation as a 'whole entity', embracing its complexity and involving its stakeholders in a structured way, to support a more integrated response to improving the situation.

This thesis applies Soft Systems methodology (SSM), a systems approach designed for investigating complex social situations in which there are multiple, and potentially conflicting perspectives on an issue among its various stakeholders.

It used this methodology to build a contextual understanding of the situation in Scotland, and with stakeholders to find ways to improve it. Accordingly, its objectives were to clarify who was involved in addressing this issue in Scotland, what their roles, perspectives, priorities, and challenges were; then based on the foregoing, to define ways in which the situation could be improved together with the stakeholders involved.

The research recruited 23 participants, from the 3rd sector (Community groups and Non-Governmental Organisations NGOs) as well as from the statutory sector (Health care, Social work, Police, Scottish Children's Reporter Administration SCRA, and Education). The sample was based on previous Scottish government consultations on FGM/C, and participant snowballing. Data was collected using semi structured interviews and seven workshops in total. SSM models of purposeful

activity in addressing FGM/C in Scotland were created by the researcher to structure the situation, and used in workshops to co-produce with stakeholders defined ways in which the situation of addressing FGM/C in Scotland could be improved.

The study has produced a 'rich picture' of the key issues in this complex situation. Key roles included provision of education and awareness raising, wellbeing and support, health care, child protection, case investigation and legal decision making. Ten systems of purposeful activity were identified in addressing FGM/C in Scotland, including to make services more accessible to affected communities; to build knowledge and understanding of FGM/C in services; and to provide support to vulnerable women and girls affected by FGM/C. Key challenges identified included stakeholders working in their own 'silos', and a lack of knowledge and understanding of the issue in services. The key ways to improve the situation were shown to be increasing collaboration across stakeholder groups, and creating a standardised framework for community engagement and service training.

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Author's Declaration

I declare that, except where explicit reference is made to the contribution of others, this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Printed Name: Elizabeth Mayen Inyang

Signature:

1 INTRODUCTION AND BACKGROUND LITERATURE REVIEW

1.1 Introduction:

FGM/C is a harmful traditional practice which has been addressed both as a health issue and a human rights issue (UNICEF, 2013). It affects 200 million women globally (UNICEF, 2016). In communities where it is practiced it is held as a social norm, a duty of responsible parenting and necessary for the proper upbringing of a child (Mackie& LeJeune, 2009), while in cultures where it is not practiced it is seen as child abuse. Laws against the practice of FGM/C have been passed both in countries where it is traditionally practiced and in countries where it exists in communities in diaspora, such as the UK (UNICEF, 2013). In the UK, estimates of the numbers of girls at risk of FGM/C in affected communities are in the tens of thousands (House of Commons, 2014), however the great majority of newly recorded cases are historical cases of FGM/C and the numbers of actual new cases on record remain low (HSCIC, 2016). Confirmed cases however do indicate the continued existence of the practice (Hodes et al, 2016). Strong safeguarding measures are included in the strategies passed by the UK and the Scottish governments to address FGM/C, however there is now evidence that affected communities feel stigmatised and harassed by the strategies and reluctant to engage with them (Karlsen et al, 2020; Karlsen et al, 2019). Scottish Policy documents call for a greater involvement of affected communities in shaping and leading measures to prevent FGM/C (ScottishGovernment, 2016), but it is not clear how this is being achieved, with community members stating they are consulted in a 'tokenistic' fashion (O'Brien et al, 2016). It is also not clear how the Scottish policies address the sociocultural drivers of the practice, or the degree of understanding of the issue present in the statutory services.

While research has been carried out on the experiences of communities affected by FGM/C in Scotland (O'Brien et al, 2016, 2017), there is no research available which captures the perceptions and practice of stakeholders addressing FGM/C in Scotland. Broadly, the literature on FGM/C includes anthropological, epidemiological, and clinical perspectives on FGM/C, and sociological research

looking at experiences and change in practice in affected communities, however there is a dearth of literature which pulls together the experiences of communities and of stakeholders who address the practice. This gap is the more important when considering how FGM/C is addressed in diasporic contexts, where there is a culture clash and a significant difference in understanding of FGM/C.

This thesis uses a systems thinking framework, and specifically a soft systems methodological approach (Checkland, 1981; Meadows, 2008; Midgley, 2006) to explore this complex issue which involves health, law, and culture. It aims to provide a 'big picture' of the situation in Scotland, identifying what elements are present in the situation, and how these are interconnected and interdependent.

With the Soft Systems methodological approach taken (Checkland, 1981; Checkland & Poulter, 2010; Checkland & Scholes, 1990), the focus is on the purposeful actions of stakeholders in the situation, using this to clarify ways of how addressing FGM/C could be improved in Scotland. This methodology prioritises identifying what drives stakeholder actions and what goals are being sought by them; and based on this understanding, identifying how the gaps and challenges to achieving these goals can be bridged in ways that are feasible as well as acceptable to stakeholders in the situation.

The review of literature conducted found no previous study applying a systems approach to addressing the practice of FGM/C.

1.2 Definition and classification:

1.2.1 Definition:

Female Genital Mutilation FGM has been defined by the WHO as “all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons.” (WHO, 2008).

In 1990 the term Female Genital Mutilation was adopted by WHO, and then by the UN. Prior to this “female circumcision” was the commonly used term. In the 1970s, the use of this term began to be challenged in an attempt to emphasise the difference in terms of severity and consequences between FGM/C and male circumcision. However more recently, following concern that the term ‘Mutilation’

risks demonising individuals and whole cultures where the practice is a social norm, the term ‘cutting’ was proposed as less judgmental. The term FGM/C, a blend of the two has been contemporarily used as both recognising the severity of the practices and being culturally respectful (UNICEF, 2013). The terminology for the practice continues to be debated (Earp, 2016).

1.2.2 WHO and UNICEF classifications of FGM/C:

FGM/C is an umbrella term for a range of practices, varying greatly in degree and extent of effect on the anatomy and function the female genitalia, from a prick or nick which may heal leaving no scar or visible sign (Creighton et al, 2016) to infibulation where the outer labia are sewn together leaving in its most extreme form a space of as little as 3 mm to allow for flow of urine and menses (Abdulcadir et al, 2011).

The World Health Organization classified FGM/C into four types in 1996. The classification was revised in 2008 following criticisms that it was difficult to apply and use in practical settings (WHO, 2008).

The four types are defined as follows:

1) Type 1: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy);

2) Type 2: Partial or total removal of the clitoris and the labia minora, with or without excision

of the labia majora (excision);

3) Type 3: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

4) Type 4: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising and cauterisation.

When the revised classification was published, the debate regarding Type IV FGM/C, and whether it should be removed altogether due to the minimal risks to

health associated with these practices was acknowledged (WHO, 2008). The decision to retain it was to allow the recording of changes in practice of FGM/C to less invasive forms, as well as due to the concern that a practice could be changed in name only while retaining its originally invasive form. The stretching of the clitoris and labia minora were omitted in the new format (ibid.). No reason was stated for this. Its practice exists in some African countries, but the communities which practice it do not relate it to FGM/C, and its consequences are less recognised in the current discourse on FGM/C (Kaggwa et al, 2023; Wasige & Jackson, 2018).

The classification provided by the WHO is anatomically precise however not always easy to apply and results in some difficulty in data collection. Women who have undergone the procedure may not themselves be sure on what type they had (Elmusharaf et al, 2006), and clinicians may also find it difficult to categorise type of FGM appropriately based on appearance at presentation (Creighton & Hodes, 2016). UNICEF has therefore proposed an alternative classification for collecting data which is simpler to understand (UNICEF, 2013).

The UNICEF classification is as follows:

1) cut, no flesh removed,

2) cut, some flesh removed,

3) sewn closed,

4) type not determined/not sure/does not know.

However this also causes some confusion as the categories do not match those of the WHO classification. UNICEF Type 1 “Cut, no flesh removed” is equivalent to “nicking” or pricking, which is categorised as WHO Type 4, while UNICEF Type 2 “Cut, some flesh removed” is equivalent to WHO Types I and 2 (clitoridectomy) and Type II (excision) combined. UNICEF Type 3 “Sewn closed” is equivalent to WHO Type 3, Infibulation (Reisel & Creighton, 2015). The WHO definition is predominantly used in the literature and is referenced in this thesis.

FGM/C may be clitoridectomy, excision or infibulation. WHO Type 3, infibulation, is generally portrayed in Western media as the typical form of FGM/C, however it

actually amounts to about 10% of the practice globally, Type 1 (clitoridectomy) and 2 (excision) being the more common (PPAN, 2012; UNICEF, 2013). Infibulation is however a greater concern to public health because its severity gives it greater potential for complications to health (Yoder et al, 2013).

1.3 Health consequences of FGM/C:

There is a difficulty in discussing the health consequences of FGM/C as it is not a uniform practice. It has differing degrees of invasiveness, and is not carried out in uniform settings. The health consequences of FGM/C depend on multiple factors (Abdulcadir et al, 2011). This includes the type of FGM/C carried out, the level of hygiene at the time of cutting, pre-existing health status of the child, the competence and experience of the cutter as well as whether it was a traditional cutter or a medical professional, and the presence of related psychological or psychophysical complications (ibid.).

There is a scarcity of high quality studies on the clinical consequences of FGM/C, most research on FGM/C being epidemiological and anthropological to study its prevalence and context; and relying on recall and self reporting which may be imperfect (Abdulcadir et al, 2015; Obermeyer, 2005; Reisel & Creighton, 2015). While it is clear that some women suffer terribly from their FGM/C (Glover et al, 2017), others report that it has had no negative effects on their life (Obermeyer, 1999). Some women may also endure the medical or psychological consequences without relating/attributing them to their FGM/C (O'Brien, 2016, p. 37), considering them part of the normal condition of being a woman (Abdulcadir et al, 2011; Hicks, 1996; Mackie, 2003; Reisel & Creighton, 2015).

The health consequences of FGM/C can be categorised as immediate and long term.

Immediate complications may include severe pain, urinary retention, haemorrhage which could result in anaemia, shock or death depending on its severity; infections of the urinary tract, septicaemia, tetanus, or transmission of infections such as HIV or hepatitis where more than one child is cut with the same instruments without disinfection (J. Abdulcadir, 2011; Reisel & Creighton, 2015).

Long-term consequences of FGM/C could be obstetric, urogenital, and psychosexual.

Urogenital complications tend to be both more frequent and more severe with more extensive types of FGM/C (Type 2 and 3) FGM/C than in Type 1 or 4 (Amin et al, 2013). They may include severe dysmenorrhea, haematocolpos (menstrual blood retention in the vagina), and slow micturition due to the physical obstruction of the urethra and vagina as well as retention cysts (Abdulcadir et al, 2011; Amin et al., 2013). Chronic and recurrent infections as well as infertility following infections are also more prevalent in women who have undergone FGM/C, and this is again associated with the anatomical extent of the FGM/C (Almroth et al., 2005).

Negative obstetric outcomes are also associated with FGM/C. These include significant risk of prolonged labour, higher risk of instrumental delivery and Cesarean section and post partum haemorrhage, laceration and episiotomy (Berg et al., 2014; WHO, 2006). The risk of prolonged labour and haemorrhage may be reduced in a resource rich environment, however an increased risk of caesarean section and vaginal tears remains (Wuest et al., 2009). The mechanism for these problems is thought to be tissue inelasticity due to scarring following FGM/C (Reisel & Creighton, 2015). Abdulcadir (Abdulcadir et al., 2011) notes that infibulation presents specific challenges to care during labour, including monitoring of dilatation and presentation of the baby, and inserting a urinary catheter. The risk of adverse outcomes increases with the extent of the FGM/C (WHO, 2006).

Reported psychological consequences of FGM/C have included significantly higher levels of post traumatic stress disorder PTSD, anxiety, depression, and memory problems compared to uncut women (Behrendt et al., 2005; Knipscheer et al, 2015; Vloeberghs et al., 2012). Psychological trauma following FGM/C increases with degree of cutting (Kobach et al., 2018).

There are many reports of loss of sexual function following FGM/C, which is unsurprising given the removal of sexually sensitive tissue, although again there is a lack of high quality studies in this regard. A review of 15 studies by Berg and Denison (Berg & Denison, 2012) noted the variability in quality and heterogeneity

of data, however concluded that compared to uncut women, women with FGM/C had a significantly higher likelihood of painful intercourse, lack of sexual desire and reduced sexual satisfaction.

Female sexuality is psychosocially complex and many women living with FGM/C do not see themselves as sexually disadvantaged but view it positively, strongly identify with its meaning and the status it gives them and report good sexual relations (Catania et al., 2007). In FGM/C not all sexually sensitive tissue is excised, as the visible clitoris is only a portion of the entire organ (ibid.), and in infibulated women the clitoris may often be intact beneath the sealed labia (Nour et al, 2006). Defibulation and sexual therapy has therefore been helpful to women with sexual dysfunction (Catania et al., 2007).

With regard to psychosexual outcomes, it seems clear that women and girls who cope with it better are those who view it positively and strongly identify with its meaning and the status it gives them, and where any issues associated with it are normative in her surroundings (Abdulcadir et al., 2011; Catania et al., 2007). This has strong implications for girls and women living in diaspora.

In the context of a socially normative practice, any complications may not be seen as problems but as necessary steps to a desired status, and the woman or girl has the benefit of being surrounded by women whose stories, problems and life issues reflect her own.

In diaspora this is not the case. In a wider culture that does not practice or understand the practice of FGM/C, a girl cannot count on this supportive background context. What is meant to bring the girl in line with a norm for womanhood actually results in the opposite, makes her different from other women, and makes her problems unusual ones. The psychological implications are therefore much greater (Abdulcadir et al., 2011; Catania et al., 2007). A girl who has moved to or lives in a Western country will learn that not all women are cut, that she is considered mutilated and that she probably cannot function sexually the way an uncut woman can. This can result in internal conflicts regarding loyalty to her family and her culture, a sense of betrayal, as well as feelings of insufficiency resulting in sexual problems which may not reflect actual physical damage (Johnsdotter, 2018; Johnsdotter & Essen, 2004).

1.4 Prevalence and demographic markers:

While exact numbers of affected women remain unknown, 200 million women in 30 countries are said to have undergone FGM/C (UNICEF, 2016) with immigrant communities continuing the practice in other countries (UNICEF, 2013).

FGM/C is practiced in some given form by various ethnic groups the world over, most prominently in parts of Africa found in a wide belt from the Atlantic coast in the west to the Horn of Africa in the east. It is not uniformly practiced within this geographical area; Egypt, Ethiopia and Sudan account for 50% of circumcised women in Africa (Yoder et al., 2013). It is also practiced by some groups in the Middle East, Indonesia and Malaysia (UNICEF, 2016).

There has been a drop in prevalence noted in younger generations of girls, although this drop is uneven among countries of practice (UNICEF, 2016).

1.4.1 Ethnicity:

This is a major marker for the practice of FGM/C (UNICEF, 2013). Generally, countries with a very high prevalence, such as Sudan, Egypt, and Somalia, tend to be ethnically homogenous, with Sudanese Arabs, Egyptians and Somalians being the overwhelming majority in these countries for example. While minority groups in such countries are more likely to fall in line with the dominant culture, the influence of ethnicity is more easily seen in multi-ethnic countries with a lower prevalence rate. For instance Senegal has a national prevalence rate of 26%, however it is 0.9% among its Wolof people and 82% among those of Mandinka ethnicity (Yoder et al., 2013). Iraq has a national prevalence of 8%, however it is practiced only by the Kurdish Iraqis (UNICEF, 2016).

While the practice of FGM/C varies with ethnicity, ethnicity itself is not usually cited as a reason for practice. Social acceptance is the most frequently cited reason (UNICEF, 2013). It may be more likely for ethnic differentiation to be a motive for a community in diaspora or for one seeking to define itself in opposition to another. For instance foot binding among Chinese emigrants in San Francisco lasted longer there than in urban China (Mackie & LeJeune , 2009) and early

colonial attempts to outlaw FGM/C among the Kikuyu in Kenya backfired, the practice becoming for a while a symbol of anti-colonial resistance (Caldwell et al., 2000).

Some ethnic groups are to be found in multiple countries, for example the semi-nomadic Peulh or Fulani people who are found widely dispersed across the Sahel and West Africa. The prevalence of FGM/C among them varies depending on which country they are found in. In Guinea where the national prevalence is 97%, the Peulh have a prevalence of 99%; in Senegal (national prevalence 25%) the Peulh have 55%; and in Cameroon which has a very low prevalence of 1% the Peulh prevalence is 13%. Conversely the Somali people have uniformly high prevalence rates across borders, 98% in Somalia which has a national prevalence rate of 98%; 97% in Ethiopia which has a national prevalence rate of 74%; and 98% in Kenya, which has a much lower national prevalence rate of 27% (UNICEF, 2013) Ethiopia and Kenya share a border with Somalia, perhaps allowing for stronger cultural bonds and the maintenance of these customs among the Somali people.

The shared social norms which hold FGM/C in place are also broadly reflected in the contiguous ethnic groupings practicing it. In the countries around the horn of Africa it tends to symbolise strong honour and modesty codes, while in west and east Africa it tends to more often be associated with the definition of personhood and coming of age rites which confer adult status (Ahmadu, 2000; UNICEF, 2013).

Ethnicity is not however a static indicator for the practice or non-practice of FGM/C. Change occurs with migration, intermarriage, and with change in the social, economic and political environment. As well as this, ethnic groups may have sub-groups which differ regarding the practice of FGM/C (UNICEF, 2013).

1.4.2 Other sociodemographic characteristics:

In the majority of countries where it occurs the practice of FGM/C appears to be more prevalent in the rural, rather than urban environment, although the reasons for this are not clear. It is speculated that families residing in urban areas are less likely to be influenced by older relatives who may normally have authority over carrying out traditional rites (Yoder et al., 2013). With the exception of Sudan and Somalia, higher educational status of the mother has been seen to reduce the prevalence of FGM/C in their daughters, and in most countries girls in the

wealthiest households are less likely to be cut. However caution is advised in interpreting these findings, as these variables may overlap or may be confounded by other factors. For example, urban residence and educational or economic status may overlap; or the rural/urban divide may be confounded by other factors such as ethnicity (UNICEF, 2013). Nigeria for example is an exception to the rule with a greater prevalence of FGM/C found in the urban rather than the rural areas. This is explained by the fact that FGM/C is practiced within the highly urbanised Yoruba (61% prevalence) and Igbo (45% prevalence) ethnic groups in the south of the country, but not by the Hausa (0.4%) who make up the majority of the rural north (Yoder et al., 2013).

The age at which FGM/C is carried out varies with the custom of the community carrying it out. The age ranges from infancy, to pre-pubertal, to puberty, to adulthood (Yoder et al, 2004). There is also no universal motive for the practice. This, just as the type of FGM/C performed, varies with the customs and traditions of the practicing community (Yoder et al., 2004; Yoder et al., 2013).

1.5 Drivers for FGM/C:

This section reviews the known drivers for FGM/C in the communities where it is practiced, in the countries of origin and in diaspora. There is not usually a singular reason for making the decision to cut, but rather it tends to be based on a mental map incorporating multiple reasons- beliefs, values and codes of conduct important in a community (WHO, 1999).

1.5.1 Social norm, marriageability, and tradition:

While various cultures present varying primary motives for the practice, marriageability and social acceptance is the most commonly mentioned reason across cultures (Mackie & LeJeune, 2009; UNICEF, 2013).

FGM/C is not an individual practice, but rather is a community practice, and refusing it comes with some cost to the individual. There exists the mutual expectation that all members would follow the rule, and not conforming to the social norm would leave an uncut woman at a disadvantage in comparison to her

peers. There may be loss of good social standing to the whole family, with the lives of other individuals in the family being negatively impacted. There is therefore strong motivation to follow the rule, even against personal preference (Mackie & LeJeune, 2009). Therefore even where costs of the practice may be acknowledged, the benefits are seen to outweigh them. In reviewing FGM/C in Egypt, Assaad commented that “motivated by love and concern for their daughters' future, well-meaning women have perpetuated the custom and have insisted on inflicting pain on their daughters out of a firm belief in the physical and moral benefits of this operation as a guarantee of marriage and consequent economic and social security” (Assaad, 1980, p. 3).

Abdelshahid and Campbel found that attitudes to the practice may not be homogenous in practicing communities, but positive, negative, or ambivalent, weighing the social necessity of FGM/C and the costs of refraining from it against concerns about the experience of trauma and negative sexual effects of the practice (Abdelshahid & Campbell, 2015). Costs considered included the accepted (though not universal) belief that this will leave a girl without capacity for sexual self-control, and the loss of social standing both to the girl and her family.

Reviewing the range of reasons for the persistence of circumcision in Africa, Caldwell et al noted that at their heart was the fear that their children will be seen as abnormal and would be un-marriageable (Caldwell et al., 2000). They note that this was not an unfounded fear: contemporary Yoruba women in Nigeria in West Africa for example, in communities which had an over 90% prevalence rate of FGM/C, while beginning to question the need for female circumcision following anti-FGM/C campaigns (Type 1 being the normative form here), themselves hardly questioned male circumcision, only 5% of them stating they would accept sexual intercourse with an uncircumcised man, and only 1% prepared to marry such an individual (ibid.). Examining the attitudes of Somali men to FGM/C (Type 3, infibulation, being 63% prevalent in Somalia, with an overall 98% prevalence rate for FGM/C) Gel et al found that 96% preferred to marry circumcised women, although 85% preferred the milder Sunna (Type 1 or 2) form. Only 2.8% said they would chose to marry an uncircumcised woman (Gele, Bø, & Sundby, 2013).

In the West African Yoruba group, researchers questioned why the practice of FGM/C persisted despite dilution in both the justification for, and the nature of the practice over time(Caldwell et al., 2000). The traditional form among the Yoruba was Type 1 (clitoridectomy); and the primary cultural justification was the belief that in childbirth the baby would die if the clitoris touched its head. With the advent of modern medicine and decline in infant mortality people were increasingly sceptical of the reasoning that the clitoris caused infant death; and the practice was now largely carried out by off duty nurses who performed a minimalist version of the procedure, removing only the tip of the clitoris or simply making a cut just deep enough to draw blood. This practice persisted however, despite the changes in form and weakening in justification. While a handful of people supporting it still cited the survival of the child, a few in urban areas felt it controlled promiscuity and some stated that they were bowing to their own parents' preference, almost 90% cited respect for tradition and social conformity as their reason for supporting the practice (ibid.).

1.5.2 Religion:

Religious duty is an often cited reason for FGM/C (UNICEF, 2013). Many practicing communities hold the belief that it is required by Islam and one needs to have it done in order to be a good Muslim. It is however not mentioned in the Quran, and is not practiced by most Muslims the world over (ibid.). However, there is a reference to it among the *hadith*, or sayings of the prophet, which has been seen to suggest support for the practice. This saying "Do not cut too deeply as it is better for a woman and more desirable for a husband" has kept the issue controversial in some practicing communities, however it is not a normative Islamic obligation and the Quran itself prohibits bodily alteration (Caldwell et al., 2000; Gele et al., 2013). Following migration, members of practicing communities often realise that FGM/C is not a requirement of the religion following integration with Muslims who do not observe the practice (UNICEF, 2013).

FGM/C is also found among some Christian and Jewish groups, in Eritrea for example although it is not part of Christian or Jewish teaching either. In some cultures with a historical practice of FGM/C, religion and tradition may be

intertwined, and distinction between the two with regard to the practice may become blurred (Shahawy &, 2019; UNICEF, 2013). Ethnicity also confounds attempts to explain prevalence by religious practice (Yoder et al. , 2004).

1.5.3 Moral safeguard

In some, although not all, practicing societies, FGM/C is used as a social moral safeguard to ensure virginity before marriage, women bearing this responsibility through the physical barrier of infibulation, or through clitoridectomy aimed at reducing her libido (Abdelshahid & Campbell, 2015).

It has been noted that practicing communities hold the distinction between libido and sexual pleasure itself. Women are believed to have a greater natural libido or sexual desire than men and circumcision is held to decrease this sexual lust and increase self-control (Berg & Denison, 2013). The clitoris here has been misconceived as the source of sexual desire, rather than of pleasure, and circumcision is aimed at reducing their sexual appetite, not their sexual gratification (Abdelshahid & Campbell, 2015; Fahmy et al., 2010).

Infibulation is primarily found in countries around the northeast and horn of Africa such as Somalia, Sudan, Eritrea and Djibouti (Yoder & Khan, 2008). FGM/C has a very high prevalence of over 80% in these countries, with 63% of women reporting infibulation in Somalia and a third of circumcised women reporting infibulation in Eritrea and Djibouti (UNICEF, 2013). Based on her ethnographic studies in northern Sudan, Hayes commented on the strength of the symbolism of infibulation there, positing that in Sudan, 'virgins were made, not born' (Hayes, 1975). FGM/C is similarly very highly prevalent in Egypt (87%), however infibulation is uncommon (2%), with non-infibulating forms (Type 1 and 2) being practiced (UNICEF, 2013). Mackie notes that these geographical areas correspond to the ancient Nubian Empire to which he posits the practice could be traced.(Mackie & LeJeune, 2009) The practice is also associated with ritual purity in these areas. In Egypt the commonly used term for female circumcision is *tahara* (purification) (Assaad, 1980).

It has been noted that the context of the practice of FGM/C in north east Africa and in the horn of Africa, for example in Egypt, Sudan and Somalia is not that of a rite of passage. FGM/C is here a symbol establishing a girl's moral standing and the protection her family gives it (Boddy, 1982; Hayes, 1975). This is a common challenge to abandonment of FGM/C because in weighing whether or not to have their daughter cut, a family is considering their daughter's standing and future prospects in their community (Gruenbaum, 2005).

1.5.4 Rite of Passage/ Initiation into adulthood

In other FGM/C practicing cultures FGM/C is not proof of virginity but part of a rite of passage carried out for initiation into full womanhood (Ahmadou, 2000). It may be part of a coming of age ceremony, required for acceptance among peers and full adult participation in society. This is more commonly seen in parts of western Africa (where the predominant type of FGM/C is Type 1 and 2 (Yoder et al., 2008)), for example among the Mandinka in the Gambia and Senegal (Hernlund & Shell-Duncan, 2007), and among the Kono in Sierra Leone (Ahmadu, 2000). The context of female circumcision within these groups is primarily a cementing of social capital within female power hierarchies, and perpetuating the position and influence of female elders. Uncircumcised women are excluded from these networks and from acceptance as adults and peers (Ahmadu, 2000; Shell-Duncan et al., 2011). Mixed methods research by Shell-Duncan et al. found no direct association with marriage here, with 66% of women surveyed disagreeing with the statement "If a girl is circumcised, she has a better chance of finding a good husband", and 72% disagreeing with "A girl who is not circumcised will have difficulty finding a husband" (Shell-Duncan et al., 2011). It is also not uncommon for women from non-circumcising ethnic groups who have married into the Mandinka community and possibly even had children there to voluntarily request circumcision when they eventually became fed up with the condescension of their peers (Hernlund & Shell-Duncan, 2007). Hernlund and Shell-Duncan also note that in recent years while there has been some waning in the ceremonies traditionally associated with it, the circumcision itself persists. However in Senegal where the FGM/C practicing Mandinka are a minority, the grassroots Tostan initiative has had

some success in bringing about whole village renunciations of the practice (ibid.).

1.5.5 Peer pressure

FGM/C is practiced in the context of giving the girls who have undergone it a higher status than those who have not. Girls who have already been cut using derision and mockery on those who have not undergone the procedure has also been cited as a driver (Abdelshahid & Campbell, 2015), with uncut girls pleading with their reluctant mothers to arrange for them to be cut so as to end their public humiliation. Gruenbaum (Gruenbaum, 2001, 2005) recounts her observations in a Sudanese community in the 1970s which included the Arab Sudanese who practiced infibulation and the Zabarma ethnic group who did not practice FGM/C at all. Arab Sudanese girls who had already been cut mocked the uncut girls of their own ethnic background as well as the Zabarma girls by name calling 'Hey, unclean!'. Despite opposing taunts of their own, the Zabarma girls had started harassing their mothers to get them circumcised to conform to the higher status Arab practice, with questions like 'What's the matter, don't we have razor blades like the Arabs?'. By 2004, largely to stop fighting among girls, the Zabarma in that community had taken up FGM/C, although clitoridectomy rather than infibulation.

1.5.6 Aesthetics

In some cultures the circumcised vagina is explicitly the preferred appearance for the female genitalia. For example in Sudan the infibulated, closed vagina is seen as neat and clean, while its natural state is seen as gaping and undignified, and potentially wet and smelly (Gruenbaum, 2001), the wetness also being associated with ritual impurity (Gruenbaum, 2006). In the care of women undergoing de-infibulation, Abdulcadir cautions women's preferences need to be taken into account, and that it is advisable to first establish what degree of opening a woman would prefer, or be comfortable with, to reduce the potential for dissatisfaction following the procedure (Abdulcadir et al, 2011).

Furthermore some cultures view the circumcised genitalia as more properly male or female, using circumcision to remove what is seen as more feminine (the prepuce) in boys, and what is seen as more masculine (a protruding clitoris) in girls (Ahmadu, 2000; Boddy, 1982). While Boddy here describes perceptions in the horn of Africa to the east (where type 3 is commonly practiced), Ahmadu writes about her experiences in Sierra Leone on the western coast of the continent (where type 1 and 2 are prevalent). Interestingly this same element of striving for an idealised female appearance is a cultural driver in the increasing demand for female cosmetic surgery, including genital surgery, in the Western world today (Dustin, 2010).

1.5.7 Health concerns

The belief that FGM/C is of health benefit to the woman exists in some societies, for example protecting from disease (Shell-Duncan & Hernlund, 2000) or (non-infibulating types) actually easing childbirth (Hernlund & Shell-Duncan, 2007). In Yoruba society in West Africa, the traditional belief is that the clitoris is harmful to the emerging baby (Caldwell et al., 2000; Gruenbaum, 2001). Circumcision in this society is not associated with coming of age rites. It is carried out on both boys and girls in the first week of life, the reason given for the early age being that the pain of the procedure is not remembered (Caldwell et al., 2000).

1.5.8 The role of men

In infibulating societies (those which practice type 3 FGM/C), there is also the belief that the narrowed vaginal opening makes intercourse more pleasurable for men (UNICEF, 2013). This reinforces the practice for women as it is assumed to keep their husband sexually satisfied. There is evidence however that many men dislike the practice as they blame it for a lack of sexual responsiveness in their wives and resulting in painful intercourse for both partners (Gele et al., 2013; Gruenbaum, 2006).

The role of men in the perpetuation of the practice is however worth unpacking a little. Fran Hosken presented FGM/C to the international community as the mutilation of females in Africa, “a region where absolute patriarchy is the rule, where women are deprived of property and land rights, where polygamy and wife

abuse are the rule, and where male dominance is absolute both in the village as well as in national government" (Hosken, 1993, p. 69). Abusharaf (Abusharaf, 2001) notes that Hosken's writing and that of others (Esther Hicks's *Infibulation: Female Mutilation in Islamic Northeastern Africa* (Hicks, 1996), or Alice Walker and Pratibha Parmar's *Warrior Marks: Female Genital Mutilation and the Sexual Blinding of Women* (Walker & Parmar, 1993)) made FGM/C a symbol of tyrannical patriarchy and oppressive gender roles in Africa and raised an image of the African woman as subservient and passive, one whose "sexual and reproductive potential is controlled by men and whose genitals are mutilated in silence and without protest" (ibid, p113). Abusharaf however emphasizes that there was ample evidence that it was women, not men, who insisted on circumcising their daughters (Abusharaf, 2001). This notwithstanding, a closer look at gender and power dynamics in practicing communities show that women's empowerment and agency influence their decision making for the practice of FGM/C (Toubia & Sharief, 2003; Wasige & Jackson, 2018).

Women's experiences however vary, by type of FGM/C as well as by cultural context in which it is done, and there has been push back in the feminist discourse against framing of FGM/C which reduces it to patriarchal oppression. Ahmadou, an anthropologist initiated into the Bundu society in Sierra Leone (where type 1 and 2 are typically practiced) shared feminist concerns over women's physical, psychological and sexual wellbeing, but found it challenging to reconcile her personal experience of initiation into the all female Bundu with the prevailing global discourse on FGM/C. She contested the assumption that patriarchy is the culprit, with women "accepting 'mutilation' because they are victims of male political economic and social domination" (Ahmadou, 2000, p. 284).

In challenging inconsistencies in the UK response to FGM, including legal inconsistencies which fail to challenge other unnecessary genital cosmetic alterations, Dustin asks why, with regard to ascribing the practice of FGM/C to patriarchy, "violence against American and European women is not identified as cultural and is seen as an aberration on the part of individual men, while violence against African and Asian women is viewed as intrinsic to their culture and therefore their identity" (Dustin, 2010, p. 9). In her analysis of feminism and

anthropology in the global debate over FGM/C, Walley suggests that lumping together the diverse forms of the practice into one entity "obscures the diverse geographic locations, meanings, and politics in which such practices are embedded, and rhetorically constitutes a generic 'they' who conduct such practices and a generic 'we' who do not" (Walley, 1997, p. 429).

Wasige and Jackson (2018) summarise the debates within feminism, acknowledging that Western feminism played a key role in instigating international concern with FGM/C, however its tone in turn instigated a backlash from postcolonial feminists (Abusharaf,. Ed., 2006; Ahmadu, 2000; N. Toubia, 1994; Walley, 1997) regarding the terminology and conceptualisation of the practice. In this push back, the western feminist discourse was seen to be infantilising and demonising practicing communities and erasing the autonomy of African women both as practitioners and resisters, creating a false hierarchical binary between western and African women, and erasing the reality that African women were already engaged in anti-FGM/C activism (Wasige & Jackson, 2018).

The existence of the practice dates back to antiquity. Type 3 FGM/C is still sometimes called pharaonic circumcision, linking it to the time of the Egyptian Pharaohs; and more commonly, infibulation, deriving from the Latin word fibula, which was the brooch used to pin up the Roman toga as well as on the genitals of slaves to prevent sexual activity (Abdulcadir et al., 2011). Mackie (Mackie & Lejeune, 2009) compares FGM/C to the historical Chinese practice of foot binding, and speculates that what may have originated at the highest strata of society as a patriarchal fidelity-control practice may have diffused down through society as families tried to marry into higher strata, the practice transforming over time into a "universally required sign of respectable marriageability" (ibid. p.4.). He suggests that FGM/C may have for instance originated under similar circumstances in the ancient Nubian empire, an area which today is southern Egypt and Sudan, both of which countries have a high prevalence of the practice. He points out that whatever the original causes of the practice, they can be separated from what at present actually causes its perpetuation, with men and women endorsing it as a result of mutual expectation of its requirement for marriageability (Mackie & LeJeune , 2009).

As FGM/C is a range of practices in a range of contexts, Caldwell points out that universalist interpretations do not respect this range of contexts and forms of the practice (Caldwell et al., 2000), and Gruenbaum contends that public discourse in the West which stresses that FGM/C is aimed at depriving women of their sexuality and is fundamentally driven by male dominance is in itself driven by a desire for simple answers, as there is no single consistent reason or set of sociocultural determinants for FGM/C (Gruenbaum, 2005).

Patriarchal structures may support the practice of FGM in communities where it is established as a social norm, facilitating it and not permitting public challenge to it, but addressing these structures by themselves does not secure cessation of the practice, (Mackie & LeJeune, 2009).

A 2015 systematic review on the role of men in the practice of FGM/C found that level of education of men was a key factor for opposition to FGM/C, and that men acknowledged social obligation and the lack of dialogue between men and women as key barriers to abandonment (Varol et al, 2015) .

1.6 Drivers in Diaspora:

1.6.1 Drivers for practice:

Data on the practice of FGM/C in immigrant communities in Western countries is limited, but available evidence suggests that the practice exists (Berg & Denison, 2013; Elgaali et al., 2005; Hodes et al., 2016; Morison et al., 2004). Migration into a different cultural context has been shown to make it easier for individuals and communities to critically reflect on the practice (Johansen, 2006), and available evidence shows change in attitude to, prevalence, and severity of FGM/C practiced by communities in diaspora.

O'Brien at al (O'Brien, 2016, p. 11) reference an International Organisation on Migration IOM statement on communities in diaspora holding on to traditions for reasons of cultural identity, indicating that poor integration may result in withdrawal into the immigrant community where cultural markers may be strongly held onto for reasons of cultural identity rather than marriageability. However

there seems to be consistent evidence of abandonment of the practice over time in diaspora.

Berg and Denison conducted a systematic review of factors perpetuating and hindering FGM/C by members of communities practicing FGM/C residing in Western countries (Berg & Denison, 2013). They included 21 studies, both qualitative and quantitative, located in Europe, North America and New Zealand. They found that multiple factors influenced the perpetuation of the practice, which was congruent with the WHO 'mental map' of drivers of the practice (WHO, 1999).

FGM/C was a cultural tradition which was recognised as meaningful and valued, and expectations from the wider immigrant community, as well as from family and friends remained a driver for the practice. The need to maintain sexual morality and the view that FGM/C reduced sexual lust in women; FGM/C as a necessary requirement for marriage; the religious duty to preform FGM/C; and to a lesser extent, the idea that male sexual pleasure was increased by infibulation (an idea disputed by the male participants in the qualitative studies included) as well as hygiene and cleanliness as a health benefit for the woman were all seen to be factors driving the practice in diaspora (Berg & Denison, 2013). The drivers for FGM/C therefore were similar to those in the country of origin. Conversely, it was found that female peer pressure to continue all forms of FGM was no longer significant (ibid.).

1.6.2 Change in attitude and practice:

In affected diasporic communities the perspective on FGM/C is not monolithic, with some supporting the practice and others opposing it (O'Brien, 2017; Shahawy, Amanuel, & Nour, 2019; Vogt et al., 2017).

Berg and Deison found that the negative health issues associated with FGM/C, especially infibulation, and the loss of sexual pleasure as well as negative personal experiences of undergoing FGM/C were inhibitors of the practice. The fact that FGM/C was illegal in the host country was strongly appreciated by mothers as a support in the decision not to cut daughters. That it was not a religious requirement and that the husband was against the practice were also inhibitors for FGM/C (Berg & Denison, 2013).

A key finding of Berg and Denison's review was that many factors which were drivers for FGM/C were also inhibitors of the practice: religious reasons were both a cause (when seen as an obligation) and an inhibitor of the practice (once it is seen as optional, or even contrary to, Islam); health reasons were drivers while FGM/C was believed to benefit women but became inhibitors when the focus fell on the health consequences for women, including painful sexual intercourse and loss of sexual pleasure; social norms were a strong driver of the practice in the country of origin but the discourse on FGM/C in the present country of residence strongly rejected it and so facilitated self-reflection. Berg and Denison proposed that this dynamic reflected 'a migrant perspective of living in two worlds' leading to a 'cultural accommodation' and concluded that the practice of FGM/C is a 'tradition in transition' which will eventually be abandoned (Berg & Denison, 2013, p. 852).

The 1741 participants in the studies included in the systematic review by Berg and Denison were mostly from north Africa and the Horn of Africa, notably Eritrea, Ethiopia, Somalia and Sudan. These areas have a very high prevalence of FGM/C (over 85%), and Egypt, Ethiopia and Sudan account for half of the circumcised women in Africa (Yoder et al., 2013). It however means that the findings would mostly represent drivers for FGM/C found in these regions. The drivers highlighted in this review would therefore be more relevant to immigrant communities from countries in the Horn of Africa. However, the principle of 'tradition in transition' which Berg and Denison propose would most likely affect all migrant communities in diaspora whatever their ethnicity.

In their review of the literature on cultural change in the practice of FGM/C after migration, Johnsdotter and Essen note that despite portrayals of FGM/C as a 'deeply rooted' and persistent practice, their research found that both attitudes and behaviour regarding the practice could change drastically where conditions were favourable (Johnsdotter & Essen, 2016). Cultural reflection was facilitated in diaspora. For example, in her Doctoral dissertation, Johnsdotter (Johnsdotter, 2002) had found that for Somalis resident in Sweden, all the reasons for FGM/C were turned inside out. "What was once largely seen as 'normal' and 'natural' about their own cut and sewn genitalia was questioned in Sweden, when the

women were met with shocked reactions among healthcare providers in maternal care and delivery rooms. An until then strong conviction that circumcision of girls was required by religion was questioned when Somalis met Arab Muslims, who do not circumcise their daughters, in Sweden. The fear that their daughters would be rejected at marriage if uncircumcised disappeared in the light of the immense Somali diaspora in the West, where Somali men can be expected to accept and even appreciate uncircumcised wives. In addition, the risk of stigmatization and ostracism disappeared when living in an environment where most girls are not circumcised. Finally, informants were well aware of the legal ban on circumcision of girls and testified that few Swedish Somalis would dare, even though they, in principle, might approve of female circumcision, to have their daughters circumcised. While Somalia offers an environment where circumcision of girls is widely accepted, many Swedish Somalis express fear of the Swedish social authorities and their right to take custody of children by force." (Johnsdotter & Essen, 2016, p. 18).

Johnsdotter and Essen's review found that results from other studies were consistent with abandonment following migration to a non-cutting culture. They highlighted several studies.

In Denmark, physical examinations by school physicians showed that while circumcision had been noted in most Somali girls in previous years, it was absent in their younger sisters born in Denmark, despite the fact that it was still legal in Denmark for parents to have it done abroad at the time, until 2003 when this report was published (BerlingskeTidene, 2003). Studies of Ethiopian Falashi Jews confirmed by physical examinations that they had abandoned the practice upon migration to Israel (Belmaker, 2012; Grisaru et al., 1997). A 1995 study of Arab Bedouin women also migrated to Israel showed a high prevalence and strong support for FGM/C (type 4), however a follow up study in 2008 showed that the practice had been abandoned by this target group (Belmaker, 2012). A large mixed methods study in Germany with a majority of respondents from West African countries showed widespread opposition to FGM/C in both its quantitative and qualitative components (Behrendt, 2011). A survey of Somalis in Norway showed 70% preferred to abandon the practice while 30% preferred continuation - the

study did not clarify what form of FGM/C was acceptable to this 30%. This is relevant as there is evidence that in many cultures where infibulation was the norm, while the idea of a girl remaining completely uncut still remains unthinkable, there is now a shift to the milder 'sunna' form of circumcision, which does not infibulate but includes anything from only pricking to the removal of some flesh (Gele et al, 2012; S. Johnsdotter, 2002). And a qualitative study by the same Norwegian group found that that a woman's being uncut now had higher status than being cut, with most men preferring an uncut wife (Gele et al, 2012).

Other research is consistent with the findings from Johnsdotter and Essen. The attitudes to FGM/C following migration were examined in a recent Swiss study by means of Implicit Association Tests. It compared attitudes of immigrants to Switzerland from the state of Gezira in Sudan to attitudes in Gezira in Sudan itself (Vogt et al., 2017). It found that contrasting viewpoints on FGM/C were present among migrants just as they were in their country of origin. Sudanese immigrants however had systematically more positive attitudes towards uncircumcised girls than was seen in their country of origin. The authors cautioned against uncritically casting suspicion on any group of immigrants as it was likely to exaggerate tension and misunderstanding between them and their host community. It was found that programmes aiming to promote abandonment of FGM/C which ignored the heterogeneity of views among immigrants could leave them feeling misrepresented and attacked, whereas building up on the already existing diversity of views may be more effective, as this had already been shown to significantly improve attitudes towards uncircumcised girls (Vogt et al., 2016).

The influence of the age upon arrival in a non-cutting society has also been examined. In the UK, Morison et al conducted a mixed methods study on the attitudes to FGM/C in young male and female unmarried ethnic Somalis living in London based on their age upon arrival in Britain (Morison et al., 2004). They found that girls who had arrived the country younger than the usual circumcision age range (6-11 years old) were less likely (42% of respondents) to have been circumcised than their peers who had arrived in the country above that age range (91% of respondents), indicating that parents were less likely to have their daughters circumcised after arrival in the country. They also found a range of

attitudes to the practice. 70% of the female respondents had been circumcised, and two thirds of those infibulated, however the majority of both male and female respondents did not intend to circumcise their own daughters. Of those who did intend to, the vast majority preferred the 'sunna' form with one male interviewee specifying only a prick to draw blood. More males intended to have their daughters circumcised than females (42% vs 18%), with higher age at arrival in the UK being a significant factor among the men supporting it, though not among the women. Interestingly, while all the women supported the legislation against FGM/C, some indicated the intention to have 'sunna' done on any daughters they may have. The researchers speculated that the interviewees assumed the laws referred to infibulation alone, and did not consider the milder 'sunna' to be FGM/C. Those who did not intend to circumcise their daughters recognised that it was an important cultural tradition and expected that there would be family pressure to circumcise them. The drivers to practice cited by respondents and interviewees included tradition, the sexual morals of women, religious requirement, family pressure and marriageability. The inhibitors cited were the pain and suffering of the procedure and its sequelae, and it not being required by religion. Morison et al concluded that those more likely to be in support of continuing FGM/C were older generations, males, recent arrivals and those who didn't show much social assimilation. They proposed that programmes to promote abandonment of FGM/C should address assumptions about sexuality in women and the belief that it is a religious requirement. (Morison et al., 2004) Other qualitative studies have shown that many males are ignorant of the effects of female circumcision until confronted with the reality of its effects, thereafter becoming keen opponents of the practice (O'Brien, 2016; Shahawy et al., 2019).

Attitudes to FGM/C are linked to inculturation, with both residence and duration in Italy leading to a change of position on FGM/C seen among Eritrean women (Habte & Yang, 2023). Younger generations in immigrant families are aware of the harms and illegality of the practice, and generally oppose it, while acknowledging that pressure to carry out FGM/C can still be exerted by older generations (Ali, 2020).

In reviewing the outcomes of FGM/C intervention projects in the EU, Brown et al. propose that it is beneficial to combine individual and community change

approaches conclude that there isn't a one size fits all approach (Brown et al, 2013). Action research is required to explore the current belief system relevant to a community, especially in the EU setting, where the positions of diasporic communities on FGM/C cannot be assumed, and where the cultural contexts and types of FGM/C may not be immediately clear (ibid). They also suggest that the systems approach proposed by Michie et al. (Michie et al, 2011) may be beneficial to planning behaviour change interventions, as the issue is complex, involving individuals, communities, culture, migration, beliefs, religion, health and law.

1.7 Advocacy regarding FGM/C:

This section will deal with advocacy regarding FGM/C. I will start by looking at its history as this provides context for the present debates about FGM/C and the laws passed regarding it. This is important because how the issue is framed affects what laws are made and how they are applied, and is the foundation for the policies put in place to address the issue.

1.7.1 Global advocacy:

Recorded advocacy against FGM/C first appeared in the early 1900s. In Egypt, where the practice was almost universal and remains highly prevalent, the Egyptian Society of Physicians published a statement by in 1920 on the negative health effects of FGM (Berer, 2015; UNICEF, 2013). The statement was given support by the Egyptian ministry of health. A decade later a campaign against FGM in Kenya initiated by missionaries form Britain was strongly opposed by the majority Kikuyu ethnic group, and became a focus of the anti-colonial independence movement (Berer, 2015; UNICEF, 2013). The issue of the social and cultural importance of the practice for initiation into adult womanhood was raised, rejecting the possibility of separating the initiation form the cutting (ibid.). The British colonial government did pass laws against the practice, and an enquiry on FGM was held by the British parliament in 1945. Due to resistance in Kenya however, all resolutions passed on the subject were revoked by 1956 (UNICEF, 2013).

In the 1970s, women's groups and NGOs in Africa began to bring the issue into the public discourse in the context of improving the status of women. A WHO seminar on traditional practices affecting the health of women was held in Khartoum in 1979, discussing female circumcision as well as child marriage. The seminar, attended by nine African and Middle Eastern countries resulted in recommendations for health education and training programmes to be established with the aim of eradicating the Practice of FGM/C (Pazdor, 2009). Fran Hosken, an American feminist, journalist and publisher had been a temporary advisor on FGM at the seminar. She published The Hosken Report (Hosken, 1980), in which she framed the issue in strong feminist and universalist terms. It was a landmark report in that it included the first ever estimations of the prevalence of FGM on a country by country basis (UNICEF, 2013). Her work was influential in persuading the WHO to get involved in campaigning to end FGM/C, which it had resisted on the grounds that it was not a health issue but a sociocultural one (Boyle, 2002; in Pazdor, 2009).

In 1979 the UN adopted CEDAW (Convention on the Elimination of all forms of Discrimination Against Women), explicitly recognising FGM/C as a human rights violation against women.

The 1980s and 90s saw the emergence of some international bodies important to advocacy against FGM/C. The IAC (Inter African Committee on Traditional Practices Affecting the Health of Women and Children) was formed as a follow up to the Khartoum seminar of 1979 which had urged health education and training to combat FGM/C. It now has national committees in 28 African countries and 15 affiliate countries outside the continent. Rainbo (Research Action and Information for the Bodily integrity of Women) was founded in the US by Nahid Toubia, a Sudanese surgeon and women's health activist; and FORWARD was founded by Efua Dorkenoo, a Ghanaian-British nurse and anti FGM/C campaigner. Both Rainbo and FORWARD held a feminist perspective and presented FGM/C as a human rights issue.

The UN bodies were more hesitant to enter the debate on FGM/C than the NGOs. A snapshot of the tensions inherent in anti FGM/C advocacy could be seen in Copenhagen in 1980. A UN Conference for Women held in the city raised the issue

only peripherally. Conversely, the Copenhagen NGO forum which ran parallel to the conference ranked it highly on their agenda. This bolder approach however resulted in some consternation, with several African delegates walking out in protest, questioning the legitimacy of the western 'experts' discussing the issue and objecting that the focus of the proceedings should be on "clean water and food, not on their genitals" (Pazdor, 2009, p. 27).

So far the issue had been framed as a health issue in the public discourse, however in 1993 at the World Conference on Human Rights in Vienna it was re-presented as a human rights violation. Following this, many countries set up legislation outlawing the practice (UNICEF, 2013).

1.7.2 Advocacy in the UK:

Activism against FGM/C in the UK was initiated by African women following challenges with the provision of services to women from affected communities (Wasige & Jackson, 2018). The activist group FORWARD evolved in the UK from WAGFEI (Women's Action Group for Excision and Infibulation) and other concerned groups, following the Minority Group Report MGR on FGM/C published in the UK in 1980. This report was key to the passing of legislation against FGM/C in the UK in 1985 (Berer, 2015; Pazdor, 2009).

It is worth noting that not all UK anti FGM/C groups gave their support to this anti FGM legislation. BWHAFS (Black Women's Health and Family Support), an NGO established to support the health and wellbeing of immigrant families opposed the wording of the legislation on grounds that it was racist. This focused on a clause inserted following pressure from the RCOG (Royal College of Obstetricians and Gynaecologists) to ensure that female genital cosmetic surgery remained legal, which permitted surgical operations necessary for the physical or mental health of the girl/woman, but not any related to custom or ritual (Pazdor, 2009). The debate on the difference between FGM/C and female genital cosmetic surgery (FGCS) which preceded the passing of the 1985 bill (Dustin, 2010) did admit that there was "no precise anatomical definition that would accept one and not the other" hence the need for qualification by 'custom or ritual' (Lord Glenarthur, Prohibitiobn of Female Circumcision HL Bill, 23 January 1984). FORWARD, on the other hand, while recognising the double standard presented by the law chose to

accept it, prioritising the protection of children over debates on the similarities between FGM/C and FGCS. Efua Dorkenoo of FORWARD was quoted in an interview in 2004 as saying 'we don't have time to wait until white women are conscious of their own oppression [in relation to cosmetic surgery]' (Dustin, 2010, p. 19). The bill was passed into law, but the double standard remains unresolved, and debates about how best to approach FGM/C continue.

1.8 Ongoing debates:

1.8.1 Cultural tensions:

It has been argued that it is important to recognise the cultural perspective when defining FGM/C as abuse, not in order to justify it, but so as to understand its persistence and to create effective strategies to eliminate the practice (Debelle, 2016; Webb & Hartley, 1994).

There is a difficulty in cross-cultural perspectives on child maltreatment. Korbin (Korbin, 1991) argues that while cultures vary in what they define as child maltreatment each has a standard of what is seen as acceptable care, and where idiosyncratic behaviour transgresses these norms it is easy to legitimately call this abuse in a cross cultural context. The difficulty is greatest at the level where a culturally normative practice is seen as abusive by outsiders. Here, the difficulty lies in the reality that an approach of extreme cultural relativism may leave children at risk exposed to harm, while an approach that leaves no room for a cultural perspective is an ethnocentric one, presuming one's own cultural beliefs and practices as superior to all others.

FGM/C has well documented negative obstetric, gynaecological, psychological and psychosexual outcomes and as such is a public health issue. However in societies where FGM/C is practiced it is a social norm for a variety of reasons. Despite any risks, families feel obligated to do this for their daughters because of the social benefits if they do and the high social costs if they don't (WHO, 2012). Therefore in this context, FGM/C would be seen as a measure of necessary care for their daughters, not as aggression against them.

This aspect of the debate tends to be ignored in western discourse about FGM/C (Wasige & Jackson, 2018). FGM/C is different from most forms of gender based violence because while women are its victims they are also involved in carrying it out, on all the girls/women in a practicing community, because it is highly valued in the culture and socially normative (WHO, 2012). The promotion of FGM/C as something of positive value, despite any costs associated with it, underpins its persistence in practicing cultures. Girls who have not undergone the procedure are perceived to be disadvantaged or unprepared for adulthood, and families who have failed to do this for their daughters seen as negligent.

One participant in the My Voice research carried out in Scotland (O'Brien, 2017) voiced support of the practice as she felt it safeguarded the child's future: 'It's very rare to find women [in my community] who know the law and generally they don't believe it is for the protection of children. FGM is the real protection for the children as it is the way to make sure they get married' (ibid. p.30).

It has been argued that an approach which without context declares the practice to be child abuse and ordinary parents perpetrators to be prosecuted is simplistic, and such campaigns to eradicate the practice risk trying to 'engage through insult' (Ahmadou, 2000; Wasige & Jackson, 2018)

Positive engagement with practicing communities is however crucial. To achieve abandonment of FGM/C there has to be a desire within the practicing community to do so, and evidence shows that communities will resist campaigns perceived to be hostile to their culture, that laws alone are not enough to engender change, and that multi-component interventions which empower communities for change are more effective (WHO, 2012).

1.8.2 Criminalisation, a dilemma in child protection?

UK Law allows genital surgery for the mental or physical health of a girl it defines that with regard to mental health it is immaterial whether the girl or anyone else believes the procedure to be necessary due to custom or ritual. The situation is complex however, as individuals and communities who practice FGM see it as a non-abusive cultural practice (Weston, 2017) and thus may otherwise be model parents (Webb & Hartley, 1994).

The UK strategic approach to tackling FGM was put forward in the National Action Plan in 2014. It states unambiguously that "FGM is a severe form of gender based violence, and where it is carried out on a girl, it is an extreme form of child abuse. Everyone who has a responsibility for safeguarding children must view FGM in this way" (House of Commons, 2014). Child protection measures are therefore to be applied accordingly.

At the 2016 Round Table Committee on FGM meeting, the French success in securing convictions of culpable parents was lauded, however the UK anti FGM/C campaigner Hibo Warde, asked the French representatives "What happens to the kids whose mothers and fathers you have jailed?" Her questions suggesting that the children concerned were now twice a victim (to FGM and to separation from their families) was left unanswered (House of Commons, 2016).

The perception that FGM/C is an avoidable mutilation which every child has a right to be protected from is the reason using criminal law is considered appropriate and necessary, as a deterrent and to ensure punitive measures for engaging in the practice. Despite its positive value however, the criminal law can be a blunt instrument. Encouraging the reporting of parents or grandparents to the police by their children is a complex issue. Taking children into care on the basis of an accusation alone that a crime is intended (BBC, 2017b) raises questions about the burden of proof, and of ethnic and racial profiling (Berer, 2015). Taking children who have previously undergone FGM/C into care raises questions of what exactly the child is now at risk of, as unlike in cases of sexual abuse, she does not continue to be at risk of it (Berer, 2015).

Legislation against FGM/C tends to be ineffective when not accompanied by measures to influence cultural traditions and expectations, because it then fails to address the practice within its context. It should rather be one of the measures supporting a social movement towards elimination of FGM/C, challenging the practice and legitimising new behaviour (UNICEF, 2013). The UK government has passed strong criminal laws against FGM/C among its measures to combat the practice, but has been accused of offering far too little in terms of working with communities (Berer, 2015; House of Commons, 2016).

1.8.3 A double standard with respect to female genital cosmetic surgery:

A level of complexity inherent in the drive to end FGM/C is reflected in the perceived double standard in the legalities surrounding Female Genital Cosmetic Surgery (FGCS) and FGM/C.

While FGM/C is strongly opposed, FGCS is broadly seen as acceptable in UK society even though the procedures in question may have little to differentiate them (Liao & Creighton, 2007; Veale & Daniels, 2012). The legal language used to describe FGM/C and the medical language used to describe FGCS are about identical (Berer, 2015), and the procedures may be requested for similar reasons (aesthetics, pleasure of a spouse/sexual partner).

Demand for female genital cosmetic surgeries in the West is rising (BBC, 2017; Liao & Creighton, 2007). It has been argued that adverts for FGCS, both online and in women's magazines, pathologize an appearance that deviates from the presented ideal of a 'barbie doll slit'. The adverts promote a 'youthful', 'feminine', 'neat and tidy' genital look; suggest that a protruding clitoris may look and feel like a very small penis and would benefit from reduction, large labia are unhealthy or unhygienic with a potential for unpleasant odours. They also propose that sexual partners would appreciate the 'improvement' suggested (Bramwell, 2002; Chibnall, McDonald, & Kirkman, 2019; Schick et al., 2011). Ironically, these expressions mirror those used by communities which practice FGM/C to explain why they do so, as noted in the section on Aesthetics as a driver. The circumcised genitalia of both men and women reflect their idealised form in practicing communities, and in communities where infibulation is normative the closed vagina is seen as neat and tidy while its natural state perceived as gaping, wet and potentially smelly (Ahmadu, 2000; Gruenbaum, 2001). The link that FGM/C may simply be female genital cosmetic surgery which has become normalised in a society, and as a normalised practice has become expected, and even required, of women in that society has been recognised (B. D. Earp, 2016).

The language used to advertise FGCS procedures does clearly reflect the different types of FGM/C. Adverts for 'clitoral reshaping' or 'clitoral unhooding' parallel clitoridectomy or type 1 FGM/C; 'labial trimming' parallels excision (type 2); vaginal tightening or 'vaginal rejuvenation' reflect some degree of infibulation

(type 3), and piercings do not require any euphemisms (Chibnall et al., 2019; Liao & Creighton, 2007). However, these are not regarded in the same way as FGM/C. The law in the UK in fact explicitly states that vaginal surgeries are allowed for the mental health of those who wish them, but reasons of culture or ritual are not acceptable. It explicitly applies this to women as well as to girls. This double standard has been picked up on, and has come under increasing criticism (Berer, 2010; Dustin, 2010; Earp, 2016; O'Neill et al., 2020).

The position that consent is the crucial difference and cannot be given by a minor undergoing FGM/C is undermined by the fact that the law in the UK and in Scotland does not rest on issues of consent. UK law defines 'girl' as also including woman, (and Scottish law states 'person'); and as such prohibits an adult woman from consenting to and obtaining FGM/C (Berer, 2015). Refusing a woman the right to re-infibulation on her request after delivery risks infantilising her, and it has been argued that it is ironic that a law apparently introduced to protect bodily autonomy in effect proscribes it to women of particular cultures, speculations about her cultural conditioning notwithstanding (Shahvisi, 2017).

Questions of culturally determined customs then arise (Bewley, 2013). As has been noted, there has been a steady rise in the UK in demand for FGCS, with requests for alterations coming even from preteens 'as young as nine' (BBC, 2017; Liao & Creighton, 2007), the most popular requests being for labioplasty or labial 'trimming', with a preference for a prepubescent vulval appearance (Liao & Creighton, 2007), and even requests for cosmetic clitoridectomy (Veale & Daniels, 2012). What effect widespread access to and use of pornography, as well as cosmetic surgery advertising, has had on cultural expectations of genital appearance, and a perception of abnormality about their own genitalia in women, is a question open to investigation (BBC, 2017; Kelly & Foster, 2012; Liao & Creighton, 2007). But arguably, this could be seen as a newly developing cultural, or sub cultural, norm in the west.

Under the laws against FGM/C genital surgery is permitted in cases where it is required for the physical or mental wellbeing of the patient, although reasons of culture are not to be accepted. What this means in practice in relation to FGM/C is unclear. Should a psychiatrist be required to give legal advice on FGCS? In view of

the rise in demand for FGCS, are these trends new culturally determined customs and rituals? (S. Bewley, 2013) Bewley ultimately argues that this is a question to be determined by the courts not by doctors (S. Bewley, 2016).

The validity of the law against FGM as it stands has therefore been questioned, pointing out its ethnocentric and racial undertones (Shahvisi, 2017) with calls to either review the law or to extend the prohibition on the procedures described therein to all non-therapeutic surgery (Berer, 2010, 2015; Finlay, Baverstock, & Marcer, 2016); or at least for greater guidance for and regulation of FGCS (Kelly & Foster, 2012; Liao & Creighton, 2007).

1.8.4 Nomenclature/classification. Is type 4 mutilation?

Another level of complexity is brought in by the reality that FGM/C is an umbrella term for a wide variety of practices. These range in severity from those which can be physiologically and anatomically debilitating, most readily exemplified in the type 3 FGM/C, infibulation, to the type 4 which may be a vulvar nick or a prick. Type 3 FGM/C is the type which in the public perception is most closely identified with the term 'FGM', but which makes up only about 10% of what is classed as FGM/C (WHO, 2008).

The less severe types of FGM/C may actually be difficult to detect, as evidenced by findings from a London FGM/C referral clinic. Here, specialist staff examined all referred children using a colposcope for magnification and photo-documentation. Five of the eleven cases diagnosed as type 4 FGM/C had to be diagnosed on the basis of history alone as there were no physical findings, and the authors caution that without specific expertise any subtle signs present may be missed even more frequently. They conclude that "a normal examination does not exclude the possibility that FGM has taken place" (Hodes et al., 2016).

This then does beg the question of how exactly has the child been mutilated? The authors of the above study emphasised the UK guidelines that any case of FGM/C is child abuse and therefore must be investigated accordingly along the established channels.

WHO has acknowledged the difficulty created by the inclusion of type 4 in the classification of FGM/C, however has argued that it should remain as is for fear of the more severe practices taking refuge from the law under a declassified type4, by a 'change in name, not in practice' (WHO, 2008). The issue has remained contentious (Earp, 2016; Earp & Johnsdotter, 2021)

1.8.5 Medicalisation as harm minimisation:

Arora and Jakobs took up this debate in 2016. They pointed out the absence of a recognised classification system that is based on the functional effects of the range of procedures that fall under FGM/C; and that grouping all forms of FGM/C under the one umbrella assumes that the various forms carry similar risks, which is inaccurate. They proposed a new system based on the effects of the procedure on morphology or function. They then went a step further to propose that 'de minimis' procedures, such as a vulvar nick, be permitted under medicalised conditions as they may satisfy a cultural requirement and when medicalised should have no lasting functional or anatomical effect (Arora & Jacobs, 2016). They went on to argue that a punitive approach to vulvar nicks when they are used as a harm reduction measure is disproportionate and ultimately causes more harm than good (Jacobs & Arora, 2017).

Their position was strongly opposed on the grounds that condoning a lesser form of the practice undermines the work done hitherto to eradicate FGM/C, and that any harm reduction gained would be offset by legitimising and perpetuating this lesser cut on to future generations (Askew, Chaiban, Kalasa, & Sen, 2016). It was also questioned whether there was a demand from practicing communities for this 'minor' cut to replace more extensive procedures (Shahvisi, 2016).

WHO opposes medicalisation, finding that there is no guarantee that the form of FGM/C administered is less severe, and that there is no evidence that medicalization leads to decrease in practice of FGM/C (WHO, 2012). This position is supported by the high rates of both prevalence and medicalisation in Egypt (Kimani & Shell-Duncan, 2018; Refaat, 2009; UNICEF, 2013)

1.9 UK and Scottish legislation and policy development on FGM/C

1.9.1 Legislation on FGM/C:

FGM/C was criminalised in the UK under the Prohibition of Female Circumcision Act in 1985. This followed advocacy by FORWARD (Pazdor, 2009), as well as strengthened public opinion on the issue following the airing of a Sudan based documentary on female circumcision on the BBC in 1983 (Berer, 2015).

In 2003, the 1985 Act was replaced by the Female Genital Mutilation Act (UK Parliament, 2003). This law covered England and Wales. It updated the law making it an offence to assist a girl (or woman) to carry out FGM/C upon herself, also making it an offence to assist a non-UK citizen abroad to carry out FGM/C on a girl/woman normally resident in the UK. Exceptions were made for surgical operations 'necessary for her physical or mental health', explicitly stating that no regard is given for reasons of 'custom or ritual'.

In Scotland, the Prohibition of Female Genital Mutilation Act was passed in 2005, replacing the 1985 Act (Scottish Parliament, 2005). It also increased the penalty for FGM/C from 5 to 14 years and enacted extraterritorial powers making it illegal to have the procedure carried out abroad.

In 2015 the Serious Crimes Act 2015 (UK Parliament, 2015; Weston, 2017) bolstered the law against FGM/C in England and Wales by creating the offence of failing to protect a minor from FGM/C, thus allowing prosecution of those responsible for a girl under 16 who had undergone FGM/C. It also created a provision for the anonymity of an alleged victim of FGM/C. In both England and Wales and in Scotland the law was extended to cover permanent and habitual residents.

1.9.2 UK policy development on FGM/C:

The section will give an overview of landmark documents in the development of policies to address FGM/C in the UK and in Scotland and their outcomes. It will also highlight issues with the statistics on FGM/C used in these documents.

1.9.2.1 Intercollegiate Guidelines 2013:

In 2013, the Intercollegiate guidelines on FGM (RCM, 2013) were published by the Royal College of Midwives, Royal College of Nurses, Royal College of Obstetricians and Gynaecologists, Unite/Community Practitioners and Health Visitors

Association, and Equality Now. These were non statutory guidelines, however they were hailed as ground-breaking because they recognised the need for a coordinated multiagency approach if FGM/C were to be effectively addressed in the UK (RCOG, 2013).

They presented FGM/C bluntly as child abuse deeply rooted in communities which practiced it. The scale of the problem in the UK was presented as 66 000 women in the UK who had undergone FGM/C and 24 000 girls under the age of 15 at risk of it. These statistics were based on a study published by FORWARD in an attempt to provide a reliable estimate of the prevalence of FGM/C in the UK. It was based on the 2001 census figures, from which the numbers of women from countries where FGM was practiced was obtained, and the prevalence of FGM/C in these countries was applied to women resident in the UK and their daughters (Dorkenoo, 2007). Its limitation was that it assumed that prevalence rates in the UK were similar to that in country of origin. This was acknowledged in the original study, but the figures were presented at face value in the Intercollegiate guidelines.

The document gives a background of the global and UK scale of the problem, and sets it in the context of global policies to end the practice. It then reviews the UK legal response to FGM, and identifies the barriers to prevention of FGM/C in the UK and issues surrounding identifying girls and women who were victims of FGM. The barriers to prevention were listed as professional lack of awareness, concerns over stigmatising people from minority groups, concerns about overwhelming the service with referrals, unclear thresholds for referral, lack of monitoring and surveillance systems and lack of accountability (RCM, 2013, p. 14). The valued status of FGM in practicing communities and the factors which drive it were not stated as barriers to prevention. The lack of prosecutions for FGM/C was assumed to be due to underreporting, given the scale of the problem. The document proposes a top down approach to tackling FGM/C, focused on the law, prosecution and empowering professionals to identify and refer cases.

1.9.2.2 UK National Action Plan 2014:

In 2014 the UK Government hosted the first Girl Summit, co-hosted with UNICEF, aimed at mobilising efforts to end FGM/C, as well as child, early and forced

marriage (CEFM). The summit resulted in commitments to end FGM from the UK Government and other organisations.

In July of that year the report, "FGM: the case for a national action plan" (House of Commons, 2014) was released by the UK House of Commons Home Affairs Committee. It followed public consultation with advocates, professional bodies, social care representatives, police and others and gave rise to the Government response published in 2016 (UK Parliament, 2016).

The strategies of the plan centred on Prosecution of FGM/C; safeguarding of girls from affected communities; provision of services to women living with FGM/C; and training of professionals in the statutory services. Acknowledgement was given to the role of affected communities in ending FGM.

The report emphasized without nuance that FGM was a grievous form of child abuse and everybody who deals with is has a duty to see it as such (para.8.). It admitted a paucity of information on prevalence in the UK however noted that even conservative estimates suggest that it could be the most common form of severe physical child abuse in the country (para. 14), and a response commensurate in scale was suggested. There was no recognition of the decrease in risk with migration to a non-cutting country.

Potential reasons for the low level of reporting to the police were given, including not seeing it as a crime, social pressure, and the fact that in most cases FGM/C occur as a one off event in an otherwise loving and caring environment (para. 25, 39). However, prosecution was emphasized as an effective deterrent which would send a strong message to perpetrators that FGM/C is not permissible in the UK (para. 35) with the proposed strategy to support this being greater protections to those who come forward, such as anonymity (para 36).

Safeguarding was to be promoted through the health services, social workers and schools, with training to be given to professionals to help in the identification and referral of girls at risk (para. 56,57,64,71). Girls at risk are identified as the daughters of women who have had FGM or are from a country where FGM is practiced (para56.), and despite the very broad reach of such criteria it was recommended as a matter of policy that they be referred to social care (para.57).

The barriers to abandonment were recognised as ignorance of the law, ignorance of the health risks, a mistaken belief that it is a religious requirement and taboos around speaking on the subject (para.101). The key role of communities in addressing these was also recognised: "FGM will continue to be a problem in the UK until communities themselves chose to abandon the practice", with a call for funding of community based initiatives (para. 104).

1.9.2.3 Outcomes

Following the publication of the National Action Plan 2014, mandatory reporting of FGM/C by professionals in statutory services (including GPs, hospital Doctors as well as school teachers) to the police was introduced in England and Wales in 2015. This was established in order to create a more reliable dataset on FGM/C in order to allow a clearer picture of the scale of the problem, as well as to support safeguarding.

Mandatory reporting however has not been without controversy. Strong concerns about the effects of compulsory submission of sensitive, patient identifiable information about women with FGM/C who attend the NHS for whatever reason, with or without their consent, had been raised at the time it was to be implemented (Bewley, 2015). Ultimately, mandatory reporting duty to the police was limited to girls under the age of 18, however information on every woman presenting with FGM/C was to be collected to allow for the creation of the enhanced FGM/C dataset.

The potential for unintended consequences in this policy, especially a loss of confidence in the statutory health services were noticed early. The possible reluctance of families to seek pregnancy and perinatal care, or care for early or late consequences of FGM/C was recognised by doctors (Mathers & Rymer, 2015). The potential for a breakdown in the long term doctor-patient relationship was highlighted, as were concerns that many doctors may not have the requisite skill to make a definitive diagnosis of FGM/C, especially in cases of type 1 and 4. As well as these, concerns about the psychological trauma to women compelled to discuss their FGM in order for doctors to comply with mandatory reporting were also raised (Dixon, 2015).

It was pointed out that all this was likely to be counterproductive to eradication strategies. Clinicians raised the alarm that the breach in confidentiality would strain the trust between already disadvantaged women and their health care providers. Regarding mandatory data submission, it was pointed out that there was no evidence that the benefits would outweigh the potential harm of such a step. It was also pointed out that the inclusion of genital piercings (a form of Type 4 FGM/C freely practiced in the UK) undermined a meaningful evaluation of the data gathered with respect to FGM/C (Bewley et al., 2015; Gerry et al., 2016; Naftalin & Bewley, 2015).

These concerns have since proven to be well founded with affected communities reporting that they feel racially harassed and stigmatised (Dixon et al., 2018; S. Karlsen et al., 2020; Karlsen et al., 2019).

1.9.2.4 Statistical issues:

The statistics which have been used in the development of UK policies to address FGM/C are acknowledged to be problematic (Karlsen et al, 2023; Karlsen et al, 2019; A. Macfarlane, 2019).

Two sets of statistics for FGM/C in the UK are presented in the report (House of Commons, 2014). The first give the scale of the problem as 66 000 women in England and Wales who had undergone FGM/C with 24 000 girls under the age of 15 at risk of FGM/C Type 3, and 9 000 at risk of FGM/C Type 2. These statistics were based on a study published by FORWARD in 2007, in an attempt to provide a reliable estimate of the prevalence of FGM/C in the UK. It was based on the 2001 census figures, from which the numbers of women from countries where FGM was practiced was obtained, and the prevalence of FGM/C in these countries was applied to women resident in the UK and their daughters (Dorkenoo, 2007). The limitations acknowledged by the study included that it assumed that prevalence rates were similar in the country of origin and in the UK, notwithstanding qualitative evidence of downward trends in diaspora; as well as the fact that in a given country only certain regions or ethnic groups may practice FGM/C and that this ethnicity was impossible to derive from the census data. The figures were presented at their face value in the House of Commons report.

The second, more recent set of statistics given was from a study based on the 2011 census figures a decade later (Bindel, 2014). It gave a much higher estimate of 170 000 women living with FGM/C in the UK and 65 000 girls 13 and under at risk. This study used similar methodology to the 2007 Dorkenoo, Morison and Macfarlane one, however added 52 500 women to the study population estimated to have joined family members who had come in through an asylum route since the census in 2011 up till the end of 2013.

In a follow up to their 2007 study, Macfarlane and Dorkenoo (Macfarlane & Dorkenoo, 2015) updated their figures using the 2011 census. They published their findings in 2015, the year after the National action plan report was released. Their estimated was more conservative. 137 000 women and girls potentially living with FGM/C in England and Wales, with 144 000 girls under 15 years old born to mothers from FGM/C practicing countries, but only 66 000 girls in that age group born to mothers who themselves actually had FGM/C. Regarding an estimate of girls at risk resident in the country, the authors stated that "It is not possible to quantify the prevalence of FGM among girls born in England and Wales to mothers from FGM practising countries or assess the numbers of girls at risk on a population level. These are judgments which can only be made through contacts between individual women and relevant professionals and other practitioners." (Ibid. p.4) Macfarlane and Dorkenoo critiqued the Bindel study for, among other things, having added figures for all asylum seekers, not just those from FGM/C practicing countries, clarifying that when appropriately adjusted, less than 9 000 was a more accurate estimate for this group than the 52 500 assumed by the Bindel study.

The Enhanced dataset on FGM/C is a "repository for individual level data collected by health care providers in England" (HSCIC, 2016, p. 4). Its first annual report on FGM/C following the publication of the 2014 National Action Plan was released in 2016. It came with caveats that the data presented should be interpreted with caution due to completeness being low and varying by submitter. In 2016 it found 8 656 total NHS attendances where FGM/C was identified, (whether or not the attendance was FGM related) and 5 702 newly recorded cases, that is, those presenting to the NHS for the first time. Of these, 106 cases were of girls under the age of 18. Of these 106, 18 had FGM/C carried out on them in the UK (11 of

these girls were also born in the UK). 10 of these 18 cases were FGM type 4, potentially piercings. The dataset says that overall, of the cases of known type of FGM/C undertaken in the UK over 70% of cases were type 4-piercings. It also consistently advises a high degree of caution when interpreting its outputs.

The great majority of cases are historical, in adult women. Subsequent annual reports show similar numbers, with 5 391 newly recorded cases in 2017, and 4 495 in 2018. Numbers are low for cases born or undertaken in the UK, and further, the majority of these are known to be piercings (HSCIC, 2017, 2018). These numbers indicate that while FGM/C does occur in the UK, it seems to be at a rate very much lower than estimates of girls at risk suggest.

These findings are in line with those of a recent review of the statistics on which UK policies on FGM are based by Karlsen et al, which concluded that the measures currently available are not capable of giving an accurate picture of the numbers of girls at risk of FGM/C, but that available information indicated the number of girls who experienced FGM/C living in the UK was very low (Karlsen et al., 2023).

1.9.3 Scottish strategies:

Scottish law against FGM/C was passed in 2005 to replace the 1985 Act which had been replaced in 2003 for England and Wales, however anti-FGM/C campaigns specific to Scotland only commenced in 2007. This followed the UK Government asylum seekers dispersal scheme to Glasgow in 2007, a rapid increase in people of African origin living in Scotland between the 2001 and the 2011 census, and issues emerging with service provision for this population (O'Brien, 2016; Wasige & Jackson, 2018).

1.9.3.1 Scottish Refugee Council Report 2014:

The Scottish Refugee Council published a report in 2014 (Baillot et al., 2014) which was the first attempt to estimate the population of women and girls affected by FGM/C in Scotland.

The report used data from the 2011 census and other sources in order to estimate the prevalence of FGM/C in Scotland. Using the rates of prevalence in countries of origin, the number of women in Scotland potentially living with FGM was found to

be 23 979 women with 2,750 girls born to these mothers from practicing countries between 2001 and 2012. Because of the limitations of the data, this report limited itself to identifying that these numbers of women and girls from affected communities live in Scotland, and did not attempt to quantify the numbers of women/girls affected (Baillot, 2014, p. 3).

1.9.3.2 Scotland's National Action Plan to Prevent and Eradicate Female Genital Mutilation (FGM) 2016-2020:

The Scottish strategy to end FGM/C (ScottishGovernment, 2016) is situated within the wider strategy to eradicate violence against women and girls, Equally Safe. The objectives of equally safe include promoting positive gender roles, that individuals and communities recognise and challenge violent and abusive behaviour, that women and girls access relevant, effective and integrated services and that men who carry out violence against women and girls must change their behaviour and are supported to do so (ibid. p.8).

The aims are presented as twofold: Firstly, prevention of FGM through supporting change in attitudes, behaviours, practices and policy, and protection from FGM as part of the Equally safe strategy; and secondly, ensuring accessibility to the support and services required by survivors of FGM. The plan is to be implemented by 'working with potentially affected communities, statutory agencies and third sector and community organisations' (Ibid. p.6).

The three year update on the national action plan reported on projects funded to address FGM/C, and introduced a bill to create FGM protection orders, and reiterated commitment to provision of accessible services to affected women and 2019 (ScottishGovernment, 2019). The bill has since been passed however guidance relating to the use of protection orders it is not yet available.

1.9.3.2 Outcomes:

Much training has been provided regarding FGM/C to midwifery and obstetric services in Scotland since 2015, and women from affected communities have reported positive experiences of interaction with GPs, midwives and nursery support staff, with respect to education about FGM and support in resisting

pressure to have it done. Midwives were most frequently mentioned among service providers as helpful sources of information (O'Brien et al, 2017, p. 33).

The importance of community engagement and leadership in addressing FGM/C is referenced: "FGM will continue to be an issue in Scotland until communities themselves chose to abandon the practice" (ScottishGovernment, 2016, p. 21). Despite these statements however, it is not made clear how communities will be supported/ empowered to lead on this issue, and it is Police Scotland which is tasked with coordinating media campaigns and implementing prevention strategies which are to influence social attitudes (Ibid. p.23). Wasige and Jackson (Wasige & Jackson, 2018, p. 14) point out that the continued emphasis on criminalisation disregards the sociocultural factors which drive FGM, and that "the inclusion of African voices in FGM consultations is meaningless when the resultant national action plan only placates international policy drivers and support for African-led peer support groups is minimal". Two problematic outcomes therefore seem to be persisting dissatisfaction in the affected communities, and unintended consequences of the policies.

The Scottish government funded a participatory action research project with communities affected by FGM, 'MyVoice' (O'Brien, 2016). This project identified that there was frustration felt in communities , with participants suggesting that they felt they were invited to be part of consultations to 'respond to policy developments that have already been decided, but have not been invited to be proactive or supported to become empowered and lead their own commutes' (Ibid. p.16). There is also expressed frustration with the level of priority the issue is given in dealing with members of affected communities, a sense of harassment by the authorities regarding this issue, and a blanket approach which did not recognise the sacrifices some families have already made to oppose FGM/C (O'Brien et al, 2017, p.33).

Conversely, despite most participants from affected communities being opposed to FGM, the My Voice project showed that there are still people in affected communities who do not know about the law against FGM, and who did believe that it is in the best interests of the child (O'Brien et al, 2017, p.30)

The Scottish action plan places a strong emphasis on safeguarding, through all the statutory services. However in Scotland, (Scottish Parliament, 5 September 2019, p. 15) evidence shows that for the period 2013-2016, there were 52 girls referred to the police as at risk of FGM/C for evaluation, all cases dismissed as FGM/C had not taken place. This evidence would seem to support the sense of stigma and harassment expressed by affected communities.

Scottish policy documents do acknowledge that no clear estimate can be made of the prevalence of FGM/C because census data does not give details on ethnicity of people resident in Scotland who come from high prevalence countries. They do not however adequately recognise the need to respond to the socio-cultural drivers of the practice, with prevention of the practice more reliant on safeguarding by intervening to prevent attempts to carry it out. They also do not engage with the reality of the 'tradition in transition', that is, the changes in attitudes to FGM/C in diasporic communities with inculturation in non-practicing societies. Where if this process were better understood in Scotland, it could potentially be leveraged to hasten abandonment. Police Scotland is tasked with implementing strategies to change attitudes, it is not clear what degree of trust and engagement exists between the police and affected communities to allow this to happen. Tokenistic engagement with communities is likely to create a policy and practice environment with a high degree of assumptions on the types, contexts and beliefs on FGM/C present in communities. This would consequently weaken or undermine strategies to address the practice. An approach is necessary which both clarifies the situation and needs in affected communities, and the challenges and priorities in addressing these needs among the stakeholders addressing them.

1.10 Conclusion

In conclusion, there is consistent evidence that the culture surrounding and maintain the practice of FGM/C is not static but dynamic, and in diaspora tends towards abandonment. While the drivers for the practice of FGM/C are similar to those in the country of origin, inhibitors included residing in a non-cutting society, confronting the health consequences of FGM/C, improved attitudes to uncut women and realising it was not a religious requirement. Perspectives on the

practice vary in the communities which traditionally practice it, and programmes aimed at hastening abandonment are more likely to succeed if they are sensitively carried out, and not alienating to the communities they are trying to reach.

Strategies to address FGM/C in the UK have had mixed outcomes, with the law against FGM/C seen to provide an enabling environment to resist the practice, but with communities feeling harassed, stigmatised and unheard. Scottish policy documents speak of the importance of working with communities to end FGM/C, but communities have said consultation with them is tokenistic.

There is strong indication that the practice of FGM/C declines in diaspora, and that this is the case in the UK, but this seems unacknowledged and underutilised in understanding the issue and the development of strategies which leverage abandonment and minimise unintended consequences.

I have in this chapter provided a background to the issue of FGM/C, globally, in the UK and in Scotland, showing the complexity of the issue. There are many different perspectives in the situation, of its drivers, in advocacy and ongoing debates surrounding FGM/C, and on policies addressing it. There is also an absence of literature which pulls together the various stakeholder perspectives and priorities in addressing FGM/C, with most literature focusing on community or individual experiences, but not exploring the wider stakeholder context in which the practice is addressed.

This thesis aims to fill the gap by synthesising findings form a wide stakeholder base in order to find a cohesive way to improving how FGM/C is addressed. To this end this PhD will use a soft systems approach to help to understand the specific situation in Scotland and to find ways to improve it.

In the following chapters, I will introduce Systems Thinking and Soft Systems Methodology and propose their application to the issue of addressing FGM/C in Scotland.

2. THEORETICAL FRAMEWORK AND JUSTIFICATION

Chapter 1 showed how complex the issue of FGM/C is. There are different viewpoints, problems, stakeholders, and disagreements. There are multiple problems in this situation, and how to begin to improve it is neither clear, nor simple.

This chapter introduces a methodological approach that is explicitly developed to deal with complex topics, to pull together the multiple issues present and find ways to address them cohesively.

2.1 Introduction to systems thinking:

Systems thinking has been defined as "an enterprise aimed at seeing how things are connected to each other within some notion of a whole entity" (Peters, 2014, p. 1). The "whole entity" is the system, or the idea of a system. It has also been defined as 'an interconnected set of elements that is coherently organised in a way that achieves something' (Meadows, 2008, p. 11), thus including *purpose* in the definition of a system. Building on Meadows, Stroh defined systems thinking as 'the ability to understand the interconnections [in systems] in such a way as to achieve a desired purpose' (Stroh, 2015, p. 16). Stroh was interested in the potential of systems tools for catalysing social change, and thus defined it in terms of change. Checkland defines the process of systems thinking as "consciously organised thinking using systems ideas", introducing the idea of systems as conceptual tools (Checkland, 1999, p. 45).

System thinking has made a relatively late entry into the field of public health (Carey et al., 2015). The movement itself grew out of parallel developments in theoretical and applied sciences over the course of the last century; this multidisciplinary background meaning that there is a variety of methodologies, tools, and approaches which sit within the systems movement and utilise systems principles (Edson et al., 2016; Jackson, 2000; Peters, 2014)

While systems thinking as a technical discipline developed in the 20th century, holistic approaches to understanding reality are found in spiritual traditions and in

Greek philosophy, Aristotle being credited with the phrase that the whole is greater than the sum of its parts (Mingers, 2014).

Modern Systems ideas emerged as a generalisation of ideas about organisms, which were developed within biology in the 1st half of the 20th century. At the time, there was debate regarding the issue of 'vitalism', that is, what was it that conferred life. Living things, to many, were clearly more than the sum of their parts. 'Organismic biologists' argued that the degree of organisation was the key characteristic which engendered life, instead of a metaphysical spirit (Checkland, 1999). von Bertalanffy contended that these ideas about organisms could be generalised to complex wholes of any type, that is, to "systems". He formulated his ideas in his General Systems Theory (Von Bertalanffy, 1968), and is credited with being the 'father' of modern systems thinking (Edson et al., 2016).

The interest in approaching complex issues as interconnected wholes is key to systems thinking. The developments of the scientific revolution were founded on Descartes' ideas (Descartes, 1637) of reductionism. Reductionism proposed that to understand a thing, it should be divided into its smallest components which could then be studied in isolation; and that this approach would ultimately allow understanding of the most complex things. The success of science and technology in the world today speaks to the power of this approach. However, while it worked well with experimentation in the natural sciences, it was inadequate when faced with real world complex social problems (Edson et al., 2016; Jackson, 2000). In complex social and human problems, the elements are richly interconnected, and interdependent, and the nature of the connections may be more important than the nature of the elements themselves. In addition, the connection of the elements may give rise to properties which are not associated with any individual parts, but only with the interconnected whole – emergent properties (ibid). Systems thinking sees itself not as aiming to supplant analytical reductionist enquiry, but as being complementary to it in the pursuit of understanding of the world and its workings (Chapman, 2004; Checkland, 1981).

The foundational ideas of the systems movement were grounded in ideas about physically existing organisms. Thus systems were initially thought of as palpable entities; only with time establishing systems as abstract concepts to be used as a

descriptive devices for making sense of entities in the physical world (Checkland, 1999).

2.1.1: Development of systems thinking:

Midgley described the development of the systems movement as having three waves (Midgley, 2000).

The first wave being the hard systems approaches, including system dynamics (Meadows, 2008; Sterman, 2001), which an used objective view of reality and objective definition of problem. These aim to improve decision making by identifying the elements in the system and their interactions, and thus identifying leverage points for change and avoiding unintended consequences in attempts to create change. Hard systems approaches however neglected 'worldviews' and assumed a unity of purpose; they perceived systems as real world entities which could be precisely managed (P. Checkland, Poulter, 2010; Rodríguez-Ulloa, Montbrun, & Martínez-Vicente, 2011).

In the second wave, soft systems methodology (SSM) (Checkland, 1981; Checkland & Scholes, 1990) was developed due to the inadequacy of the hard systems approaches in addressing the level of complexity, increased by conflicting purposes, that can be found in human and social situations. It explicitly recognised the multiple and potentially conflicting purposes of stakeholders, aimed to build understanding of these, and through this learning process purposes, find ways to improve the situation. It required stakeholder willingness to work together for improvement. This approach is the systems approach utilised in this thesis, to examine how FGM/C is addressed in Scotland. This is a situation in which unity of purpose is not clear. While there is a broad stated aim to 'tackle' FGM/C, what this means to different stakeholders is not necessarily clear, nor that there is a shared understanding of it.

Soft Systems Methodology (SSM) developed through an action research programme which aimed to inquire into and improve ill-defined problem situations using systems ideas (Checkland, 1981; Checkland & Scholes, 1990). It is "an action oriented process of enquiry into problematical situations, in which users learn their way from finding out about a situation to taking action to improve it" (Checkland & Poulter, 2010, p. 191). It concerns itself with messy, problematical,

unclear (social) situations, which we perceive can be improved but cannot quite put our finger on how. It is an understanding building process which, through learning about the situation, seeks to find ways to improve it. The key uses of SSM are as a problem structuring method, and as a way to achieve accommodation between stakeholders of varying perspectives (Ledington & Donaldson, 1997; Mingers & Rosenhead, 2004; Mingers & Taylor, 1992). It is therefore well suited to building understanding about the situation of addressing FGM/C in Scotland, which has been shown to be highly complex with multiple stakeholders and conflicting perspectives; and to finding ways to improve this situation.

Soft Systems methodology was initially described as a seven step process (Fig 3.1) (Checkland, Scholes, 1990). It has now been condensed to four steps by merging the initial three and final two steps (Checkland, Poulter, 2010). These steps will be described below. SSM works by identifying a problem situation, and expressing it using tools such as rich pictures; then applying systems thinking to it, to identify the purposeful activity systems present in it; following which corresponding conceptual models of human activity are created. These systems models are then used in the "real world" to generate discussion in order to identify changes that are desirable and feasible, which can then be implemented to improve the situation. This is a process which can be used iteratively to new situations.

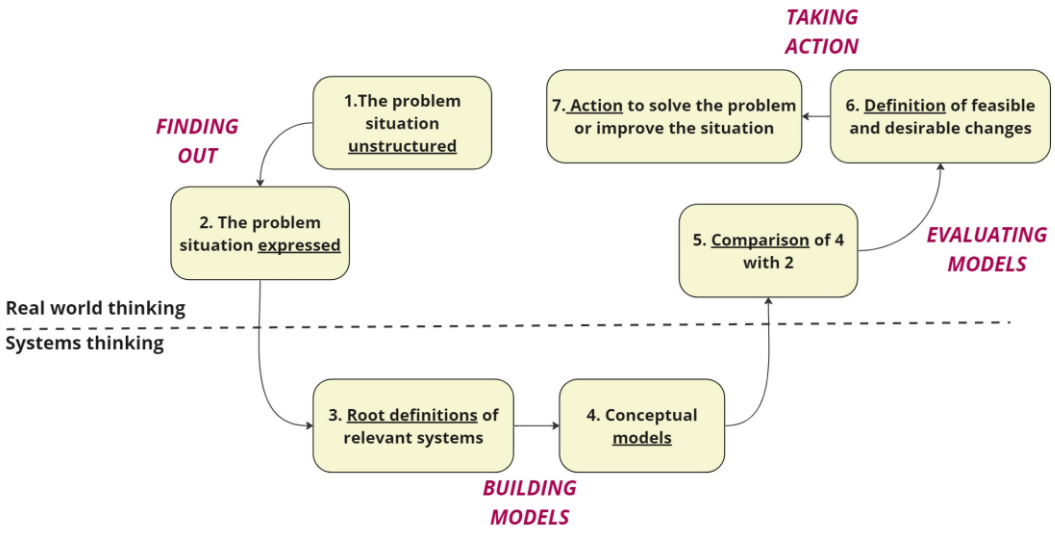

Fig. 2.1 Checkland's seven stage Soft Systems Methodology (Adapted from Bustard et al., 1999, p.2)

The process is thus potentially a continuously running learning cycle, and the decision as to whether the study ends at defining action to be taken or implementing it is not prescribed, but to be decided by the users.

Reference is usually made to “problem situations” and not “problems” because there are always multiple problems and multiple perspectives present in a complex human situation. Similarly the aim is not a “solution”, which implies a clearly defined problem about which there is consensus, but an improvement to the messy and ill structured problem situation which is acceptable and feasible to its stakeholders.

The third wave in the development of systems thinking went further, with the development of Critical System Heuristics CSH which addressed the limitations of SSM for improvement in human and social situations where power imbalance was a strong factor, so one definition of the system in question was consequently imposed on all stakeholders. It aimed to provide a reflexive framework to question what ought to be the purpose of the system, what ought to be its sources of knowledge and legitimacy, and its intended beneficiaries (Ulrich, 1996). Urlich noted that how an issue is framed, and what questions are asked, is related to the balance of power in a given situation, as power structures will influence “what is considered a problem and what can be done about it”(Ulrich & Reynolds, 2010, p. 245). However, while the CSH method aims to contribute to creating a well functioning public sphere, a limitation is that it may also require one as a precondition to enable effective use of the process (Luckett, 2006).

Considerations of boundary judgement in systems analysis also developed over time. Churchman (Churchman, 1970) pointed out that value judgements determine the placement of boundaries, that is, they determine what will be addressed and who will be included. He therefore proposed as wide as possible an extension of boundaries to include a broad range of stakeholder concerns while avoiding overinclusion, which could compromise understanding. In practice however, Ulrich (Ulrich, 1983) argued that such an approach was hampered by time and resources, and that boundary critique should include a rationally justified choice of boundaries based on dialogue and agreement with those involved in and affected by an intervention (ibid).

SSM provides a boundary framework with the concepts captured by the CATWOE (clients, actors, transformation, worldview, owners, environment) mnemonic. As detailed in the description of the SSM method (Section 3.4), this includes the desired transformation (purpose), the worldview (perspective), the actors, clients and owners (stakeholders and beneficiaries), and environmental constraints (limitations and challenges).

While there may be apparent agreement across stakeholder groups on their aim in addressing FGM/C, an imbalance of resources and power may exist. This is because affected communities in diaspora are typically minority groups for whom strategies are being designed by the government of the country within which they reside, as is the case in Scotland.

Midgley (Midgley, 2006, p. 470) argues specifically that using Urlich's 12 questions, which cover themes of motivation, knowledge, legitimacy and power in a situation, is beneficial as "they cut to the heart of many issues that are of fundamental concern to people in communities who find themselves on the receiving end of policies and initiatives that they either do not agree with or find irrelevant". He proposed that systems methodologies can be effectively mixed to for a better, more flexible response to a problem situation (Midgley, 2000, 2006).

Jackson classification of systems methodologies (Jackson, 2000), located SSM as a pluralist 'soft' systems approach to complex problems.

		Participants		
		Unitary 'Hard' systems; mechanistic metaphor	**Pluralist** 'Soft' systems; organic metaphor	**Coercive** 'Critical' systems; prison metaphor
Systems/ situations	**Simple**	**Simple unitary** (systems engineering)	**Simple pluralist** (strategic assumption surfacing and testing)	**Simple coercive** (critical system heuristics)
	Complex	**Complex unitary** (system dynamics)	**Complex pluralist** (soft systems methodology)	**Complex coercive** (Unavailable)

Fig.2.2 System of system methodologies (Adapted from Jackson, 2000, p. 359).

Systems methods are here classified using two parameters: the level of complexity on the part of the problem situation, characterised as simple or complex; and the extent to which there is a shared purpose on the part of the stakeholders involved, characterised as unitary, pluralist or coercive. This System of Systems Methodologies is therefore also useful as a tool for selecting the systems approach most appropriate to the problem situation.

Midgley has also shown that systems methodologies and tools can also be effectively mixed to for a better, more flexible response to a problem situation (Midgley, 2000, 2006).

2.1.2 Systems thinking and complex problems:

Human health and social problems sit on a continuum ranging from straightforward and easy to solve to serious and difficult to sort out. Complex problems may be distinguished from merely difficult ones by the number of elements within the problem situation, the degree of interaction of these elements, the difficulty in clearly defining what the problem is in the first place, and what a solution might be. They are characterised by the interplay of multiple factors, significant levels of uncertainty and multiple, often conflicting perspectives on the situation (Reynolds, 2010). They have been described as 'messes' (Ackoff, 1974).

The challenge posed by these messes is that attempts to intervene in order to address them have a tendency to create unforeseen and possibly unwanted side effects. Complex problems have no obvious answers, and attempts to create change often result in unintended consequences. Sterman referred to this as 'policy resistance', the "tendency of the interventions to be defeated by the response of the system to the intervention itself" (Sterman, 2001, p. 8).

Systems thinking holds the central approach that any situation of interest could be viewed as a system, itself a part of a larger system and in itself containing subsystems; and it is a framework developed to make patterns of connection clearer, for observing and understanding situations in terms of the interconnections between its multiple parts (Campbell, 1994). Systems therefore may or may not be physical or even social entities, and this difference in how systems can be viewed has been characterised as the difference between thinking about systems (for example health or legal systems) and thinking in systems; with

this difference also reflected in the traditions of systems thinking termed ‘hard’ and ‘soft’ (Reynolds, 2010). Whether real or conceptual, systems are made up of elements which are interconnected, and which over time produce a pattern of behaviour which is characteristic of that system (Meadows, 2008).

Thinking of a complex situation as a system offers an organised way to understanding the interconnections between the parts of which the complex situation is made and the behaviour of the whole, with the goal of improving the situation. Systems thinking offers “a set of synergistic analytic skills [..] to improve the capability of identifying and understanding systems, predicting their behaviours, and devising modifications to them in order to produce desired effects.” (Arnold & Wade, 2015).

2.2 Justification for a systems framework to understand FGM/C in Scotland:

This section provides a more detailed overview of systems components, as framed in systems thinking, with examples from the broader FGM/C literature. It should be apparent that a systems approach is compatible with understanding how to address FGM/C because of the complexity of the issue.

Systems thinking is founded on two ideas: emergence and hierarchy; and communications and control (Checkland, 1981). Emergence refers to the properties displayed by a system which are not characteristic of its individual parts, and hierarchy to organisation of complexity into levels of systems and sub-systems. Communication and control refers to information feedback and how they affect system behaviour.

In the sections below I describe the stratified nature of systems; the elements and interconnections present; and the emergent properties seen using illustrations from the issue of FGM/C, thereby showing how the complexity of the issue displays systemic characteristics.

2.2.1 Systems and sub-systems:

Systems exist in a hierarchical manner, where each system is comprised of other systems, which are its sub-systems, that is, systems of a ‘lower order’ level than itself, and is itself part of a greater system, which would be of a ‘higher order’

than itself (Bawden, 1998). For example, communities contain within themselves families and individuals (which can be seen as systems of a lower order to the community), and communities are themselves part of ethnic groups and countries (which can be seen as systems of a higher order relative to the community). Each subsystem is different from, and interacts with, other subsystems within the whole, such that a 'tension of difference' exists between them, and the 'environment' of a system is actually the higher order system within which it exists (Bawden, 1998).

When viewed as a system, the issue of addressing FGM/C in a given region is acted upon by the wider context of addressing FGM/C in a country, or an ethnicity, and further by the context of how FGM/C is addressed globally. Within a given region, one subsystem may be the policy makers and statutory bodies which are implementing the strategies to address the issue. Another may be the communities affected by FGM/C, which may not be a homogenous sub-system, but be further made up of those who have abandoned the practice and those who have not, and includes individual parents and daughters within both sub-groups.

2.2.2 Multiple parts/elements:

The multiple elements in a system are generally easy to identify because they are often tangible things, and these can also be divided into the sub-elements and sub-sub elements which make them up (Meadows, 2008). The actors involved in the issue of FGM/C for example are tangible elements. They would include the affected communities, which could be subdivided into families, and further into individual parents and daughters; and statutory bodies which encompass policymaking, health care, safeguarding, policing and the judiciary, which in turn incorporate the individual professionals involved in the matter.

Meadows points out that elements can also be intangible things (ibid. p13). Broadly speaking, the drivers for the practice of FGM/C can all be characterised as intangible but crucial elements. FGM/C's position as a social norm is a key intangible element, which exists in all the communities where it is practiced. Moral values, religious practice, adult social status, and aesthetic values are all

elements which although intangible, drive the practice to varying extents depending on the particular community.

2.2.3 Interconnections:

The interconnections between elements are the relationships that hold elements of a system together. They may be physical flows or may take the form of information flows (Meadows, 2008). Meadows goes on to emphasize the importance of relationships/interconnections, explaining that a system generally goes on being itself, even with complete substitution of elements, as long as its interconnections and purposes remain intact, and further, that if the interconnections change, the system may be greatly altered (ibid. p. 16).

In the following paragraphs, I will show how information flows interconnect elements in a system and influence the workings of the system, both in terms of perpetuation of the practice and ending it.

Where it is a social norm, as indeed it is in the cultures where it is practiced, an important interconnection is the parental knowledge or belief that without FGM/C their child may not be able to marry or make social progress in their community (Mackie & LeJeune, 2009). This interconnection will bolster the practice in a context where parents value the element of marriage, and value the element of social progress for their children. This position would obviously be strengthened in communities where marriage and social progress are intertwined, that is, where not being married limits social progress as may be the case in many traditional societies.

In cultures where high sexual morals are a valued element and seen as necessary to social stability certain assumptions may interconnect these elements with the practice of FGM/C. The assumption or commonly held belief that female libido is higher than men's and that circumcision in a woman helps to slake this and therefore allows her to control herself (Abdelshahid & Campbell, 2015) interconnects the practice of FGM/C with the valued element of sexual self-control, thus resulting in its emergence as a valued practice. Conversely, the acceptance that circumcision is unnecessary for a woman to exercise self-control would break this relationship and challenge the need for FGM/C. The importance

of changing interconnections as having the potential to introduce great change into the system is displayed here.

Another interesting set of relationships in the practice of FGM/C can be seen in the development of medicalisation as harm minimisation. There is recorded opposition to FGM/C by Egyptian physicians as far back as 1920, pointing out that the practice was harmful to women's health (UNICEF, 2013). This information linked the element of compromised health with the practice of FGM/C. It however did not stop FGM/C, as Egypt still has a high prevalence of the practice. Change did however occur as a result of the addition of this interconnection, in the form of medicalisation of the practice. Egypt at present still has a high prevalence rate of FGM/C, but also a high level of medicalisation of FGM/C (Refaat, 2009; UNICEF, 2013).

The interconnection with risk to health thus changed the practice but did not end it. Rather, it only created an additional link to the need for health care alongside FGM/C, thus illustrating how a system can remain itself even with complete substitution of elements (medical practitioner for traditional cutter) as long as its interconnections and purpose remain the same. Strong interconnections between the practice of FGM/C and other elements, such as social norm, rite of passage and religious practice keep it going, even where parents have concerns about the trauma and negative sexual and health effects associated with the practice (Abdelshahid & Campbell, 2015).

In terms of the influence of interconnections on ending the practice, especially in diaspora, the element of religious practice may be considered. One of the drivers for the practice of FGM/C is a perception that this is a required religious practice. This is an interconnection between the practice of FGM/C and the proper practice of religion, as two elements in the system, which declares them to be linked. On migration to non-cutting societies, this interconnection is challenged, and ruptured, by the discovery that it is not a religious requirement, which weakens the support for the practice and opens the way to its abandonment (Berg & Denison, 2013).

New interconnections made through integration with non-cutting cultures in diaspora also influence the practice of FGM/C. These interconnections may be

based on general interactions through integration with the host community, leading for example to better attitudes to uncut women. They may also be based on specific interactions pertaining to FGM/C, for example help and advice obtained from GPs regarding FGM/C related problems, leading to an increase in trust in the health service and a reinforced understanding of the link between FGM/C and harm to health. These would strengthen the links with abandonment and weaken the links with practice. On the contrary, negative experiences with statutory services may or may not affect the links with practice or abandonment directly, but they may negatively affect integration with the host community, and thus indirectly hinder abandonment.

2.2.4 Emergence:

Systems are made up of interconnected parts, but the system is greater than the sum of its parts, that is, the system as a whole has properties which do not belong to any individual element alone. Bawden described it as follows: "when the component parts of a system interact together within the boundary of that system, the process results in the emergence of properties which are different from the mere additive effect of those parts, and unique to that particular system" (Bawden, 1998, p. 2). For example, the healthy eye has multiple interconnected elements, however, vision is the property of the eye which emerges only when the eye functions as a whole, and disappears when the eye is dissected or divided. Checkland uses the example of a bicycle, which only when assembled correctly has the emergent property of being a vehicle, "the concept 'vehicle' being meaningful only in relation to the whole" (Checkland & Poulter, 2010, p. 202)

Bawden characterised 'meaning' as an emergent property of human systems, found both in individuals and in communities, and derived through the interplay of insight and experience (Bawden, 1998).

The emergent meaning of FGM/C is key to understanding the problem issue of FGM/C. The stated perspective on FGM/C of UK policy statutory bodies as reviewed in the previous chapter is that it is a grievous form of child abuse. However, it was also seen that within affected communities in diaspora, the perspective on FGM/C is not monolithic. It may be held as a valued traditional practice, or a traditional practice which is harmful and should be abandoned, or

also seen as child abuse (Shahawy et al., 2019; S. Vogt et al., 2017). These varying interpretations of the practice of FGM/C are in conflict addressing FGM/C.

This conflict in meaning is important to understanding the tension within the system, the function/purpose which the system carries out and how the system may change, and will be further discussed in the section below on purpose.

2.2.5 Purpose:

The workings of a system are directed towards some purpose or function. Checkland characterised the purposefulness of a system as an emergent property of systems (Checkland & Poulter, 2010). Generally, the word purpose is used for human systems while the word function for non-human ones (Meadows, 2008). This purpose may not be easy to spot at first glance. Meadows suggests that the best way to deduce a system's purpose is to observe its behaviour for a while (Meadows, 2008), as purposes can best be deduced from behaviour, and not necessarily from rhetoric or explicitly stated goals. Regarding the importance of purpose to a system, she states that a change in purpose would change a system profoundly, despite every element and interconnection remaining the same (ibid.).

With respect to the issue of addressing the practice of FGM/C, it seems that a key purpose of the system could be characterised as *care of the child*. However, this purpose is conceptualised differently by the various actors involved. Care of the child by protecting from FGM/C being one concept, and care of the child by practicing FGM/C being an opposing one.

This lack of unity of purpose is key to why this situation is a 'mess', and why an acceptable (to the extent possible to all parties), workable plan is necessary. The tension within the system does not exist because one group, or sub-system, wants to abuse children and another group wants to protect them, but because the duty of care is expressed in opposing ways.

Further, it may be that some in affected communities hold the concept of care for the child by protecting from FGM/C, but may not be keen to engage with the criminalisation of those who think that FGM/C is necessary care of the child, where the practice is a cultural norm. Education has been cited as a key factor instigating

change, even where the importance of the law and criminalisation in contributing to rejection of FGM/C is recognised (Shahawy et al., 2019).

This tension in purpose will exert an effect on engagement by individuals and communities with the strategies addressing FGM/C. The purpose held by an actor will influence their actions. Not engaging with strategies by not reporting a case of FGM/C one may be aware of, for example, may occur because one believes maintaining the integrity of the girl's family is more beneficial to her care than the criminalisation of her parents which would compromise it. This tension for example, was evidenced during a House of Commons round table discussion when an anti-FGM campaigner and FGM/C survivor, Hibo Wardere, pointedly queried the French representative and anti-FGM attorney Linda Weil-Curiel, who was asserting the efficacy of prosecution as the means to stop the practice of FGM/C. She asked about the psychological state of the children whose parents had been jailed, explaining that the parents would have been loving parents who did what they did out of care for their child and suggested that this approach was too aggressive and an alternative one may be taken (House of Commons, 2016).

Trust is an element linked to perceived purpose, as mistrust between actors within the system may be based on a rejection of perceived purpose held by a given group. Two extremes could be a perception of one group of actors as barbaric child abusers who must be rooted out, or the perception of another group as imperialist witch hunters from whom one's community needs shielding. This mistrust prevents genuine engagement between actors holding different points of view. Conversely, increased trust between actors, based on an understanding that all parties ultimately seek the good of the child, would allow greater engagement between the actors, thus leveraging the 'tradition in transition', the movement to abandonment of FGM/C by affected communities in the Western diaspora as described by Berg and Denison (Berg & Denison, 2013).

The choice for abandonment is a change in purpose from care by practicing FGM/C to care by protecting from FGM/C. Abandonment collapses the tension in the system that comes from conflicting purposes, as purposes regarding this issue are now aligned with one another. This bears out the emphasis made by Meadows that

purpose is so important in a system that change in purpose would cause profound change to a system.

2.2.6 Unpredictability:

Chapman (Chapman, 2004) illustrated the inherent unpredictability of complex systems with an analogy he attributes to Plsek (Plsek, 2001). He uses the analogy of throwing something to compare the behaviour of a complex adaptive system, such as a social system, with the behaviour of a more predictable (even if complicated) mechanistic system. When throwing a stone, it is possible to use the laws of physics to predict with a high degree of accuracy its trajectory and where it will land. In comparison, when throwing a live bird, it is not possible to make the same prediction, even though its path is also governed by the same laws of physics. Tying up the bird's wings and weighing it down with a stone may make its path more predictable, but would destroy the inherent capacities of the bird. He likens this to attempts to control the behaviour of a complex system by devising policies which ignore its complexity, and suggests that a more effective strategy to get the bird to the end point would be to place a bird feeder there, in this way working with the bird's natural instincts.

This inherent unpredictability of complex systems is often displayed in the unintended consequences of attempts to intervene in them. In describing this feature as 'policy resistance', Sterman opined that there are no 'side effects', only effects, and that our failure to predict these means that our mental model of the issue was too narrow, and missing relevant components and relationships (Sterman, 2001, 2006). Our 'mental model' meaning the images, assumptions and stories which make up our internal picture of the world (Senge, 1994). In the UK for instance, the mental model in which the law against FGM/C is grounded denies a relationship between FGM/C and female genital cosmetic surgery FGCS which is legal and socially broadly acceptable in UK society. The presumably unintended effect of this is that the law as it stands is accused of being racially discriminatory, even by those who would oppose FGM/C (Berer, 2015).

2.2.7 Feedback:

Meadows described feedback loops as the basic operating units of systems (Meadows, 2008, p. 5). The multiple elements of systems interact with one another

through a process of feedback, where the outputs of the process become inputs which in turn influence it. In formulating the strategies to address FGM/C in the UK (House of Commons, 2014), a concern was the lack of prosecutions on record, with the police citing few people coming forward to report. The response was, among other things, an increased emphasis on policing and criminalisation in order to ensure that a prosecution could be obtained. It is now clear that this has also resulted in communities feeling stigmatised and harassed (Karlsen et al., 2019), and less likely to engage with the Police. A lack of engagement would reduce the chances of reporting, and low reporting could once again call for further emphasis on policing and criminalisation, thus creating a negative reinforcing loop in the system.

2.2.8 Adaptation:

The feedback process gives rise to adaptation as the actors within the system act purposefully based on their worldview/ perspective. Adaptation is a key feature of many systems. It is the ability of a system to change its behaviour in order to preserve some core characteristic, thus allowing the system to maintain its integrity despite changes in its environment (Chapman, 2004). The existence of confirmed cases of FGM/C in the UK show how the practice has adapted in diaspora despite the strategies aimed against it, for example by traveling abroad to get it done (Creighton et al., 2016).

2.2.9 Non-linearity:

Complex systems also display non-linearity. Non-linearity means that there isn't a simple relationship between input and output in a system so that a given stimulus may not produce a proportional response, or simply put, it is not the case that 'if a little of some cure did a little good then a lot of it will do a lot of good' (Meadows, 2008, p. 92). In the issue at hand, the strategies to address FGM/C have had beneficial effects, such as the law providing a support to women in resisting the practice (O'Brien, 2017), however the vigorous application of these strategies has also resulted in an unwanted perception of criminalisation felt by the affected communities (Karlsen, 2019).

2.2.10 Contrasting SSM with other approaches:

The section above demonstrates how FGM/C is a complex issue which is compatible with the theoretical framework for complexity provided by systems thinking. Existing literature on FGM/C in Scotland looks at FGM/C related experiences in affected communities (O'Brien, 2016, 2017), and wider UK literature also examines experience and attitudes in affected communities (Dixon et al, 2018; Karlsen et al, 2019, 2020; Morison, 2004) or critiques the policy or statistical data on FGM/C (Dustin, 2010; Earp, 2016; Karlsen et al, 2023). This means that the perspectives and priorities of other stakeholder groups are not captured, and the implications of these in the UK context are not explored. The challenges experienced in the situation by all stakeholders are also not examined in a cohesive way limiting the capacity to effectively address the issue.

The viewpoints and priorities of other stakeholders are however an important part of the context for affected communities in diaspora. The systems thinking approach looks at the big picture of the situation because it assumes not only that all the relevant elements in an issue are important to understanding it but that the elements are interdependent and interconnected, and that these relationships impact the situation.

SSM methodology specifically uses this framework to consider how the multiple perspectives in the situation are interconnected, what their impact is, and how clarification of the various priorities driven by the various perspectives can be used to find a cohesive way to improve. It does this while assuming that consensus may not be achievable on perspectives.

SSM therefor has the capacity to capture a lot of the complexity seen in addressing FGM/C. It brings a broad view to the issue which can systematically incorporate the viewpoints of the various stakeholders addressing FGM/C. It will therefore be useful both for building understanding, and for finding ways to improve that would have buy in from the various stakeholders in this system.

2.3 Epistemological and ontological positions – Critical realism:

This thesis will use a critical realist philosophical framework, as proposed by Bhaskar (Bhaskar, 1975, 1978, 1989, 2016), which has been acknowledged as complementary to a systems thinking theoretical framework (Armstrong, 2019; Mingers, 2000a; Mingers, 2011, 2014; Smith & Johnston, 2014). It holds a realist ontology and relativist epistemology.

Bhaskar developed critical realism with an aim to reestablish the importance of ontology in the social sciences, and as a way to bridge the divide between positivism and constructivism (Denzin, 2011). Critical realism draws on methodical strains from both of these frameworks, while critiquing both for promoting 'the epistemic fallacy' - the idea that reality can be reduced to our understanding of it (Bhaskar, 1975, p. 36). He critiqued positivism for reducing reality to what can be empirically known, and forms of constructivism for viewing reality as entirely constructed by human knowledge and discourse; each in this way reducing reality to human knowledge (Fletcher, 2017). Critical realism holds that reality exists, and that we have access to it; and that our understanding of reality can be more or less congruent with it (Danermark, 2019; John Mingers, 2014). He also proposed that theories could be tested for congruence with reality (Armstrong, 2019; John Mingers, 2014) through the RRREIC process he described (Bhaskar, 2016), which ultimately asks the retroductive/abductive question 'how must the world be for the problematic situation to be so?'.

In systems literature, this idea that our understanding of reality is limited by our experience, and that reality cannot be reduced to this, has been described using the story of the blind men and the elephant, each describing the elephant based on the part of the animal he happened to be holding, and assuming that he was describing the whole (Meadows, 2008; Stroh, 2015).

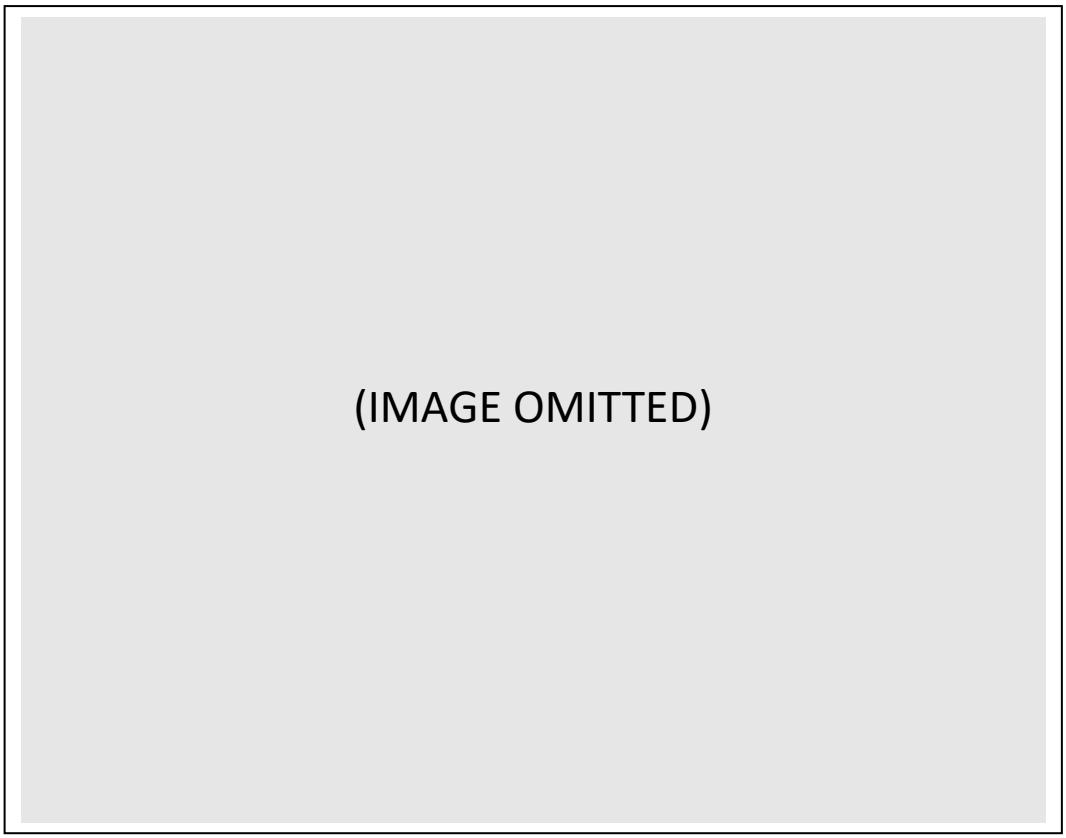

Fig. 2.3 The blind men and the elephant (Stroh, 2015, p. 33)

The parallels between critical realist philosophical framework and a systems thinking framework are recognised (Armstrong, 2019; Fletcher, 2017; Mingers, 2000a; Mingers, 2011, 2014). Mingers points out that the concepts discussed by Bhaskar mirrored those of systems thinking, and critical realism was 'deeply and fundamentally systemic in character' (Mingers, 2014, p. 3), although the main critical realist texts made little reference to systems thinking literature. Mingers draws the parallel between the 'causal mechanisms' described by Bhaskar for example and the systems generating their emergent properties of systems thinking. He proposes that both disciplines would benefit from each other, as 'systems thinking has much to offer critical realism in terms of providing clearer articulations of its concepts [and] CR can also be beneficial for systems thinking […] by providing a more rigorous philosophical underpinning that systems thinking lacks, and also by its development of particular concepts such as absence/negativity. ' (Mingers, 2014, p. 48). The concepts of absence/negativity

form part of the ontological perspective of critical realism, and will be explained below.

2.3.1 Ontological:

The systems framework assumes the ontological reality of systems as process, highlighting their organisation, interaction, and interdependence, which give rise to emergent properties (Hammond, 2017). A related key concept is that systems are hierarchically organised, with systems themselves being elements of systems of a higher level (ibid).

Critical realism as proposed by Bhaskar has a realist and stratified view of ontology. He sees reality as existing in two domains: the intransitive (which exists independently of humans); and the transitive (in which humans work to produce knowledge). He describes reality as hierarchical, existing at 3 levels. The real, the actual and the empirical (Mingers, 2004). (ibid.).

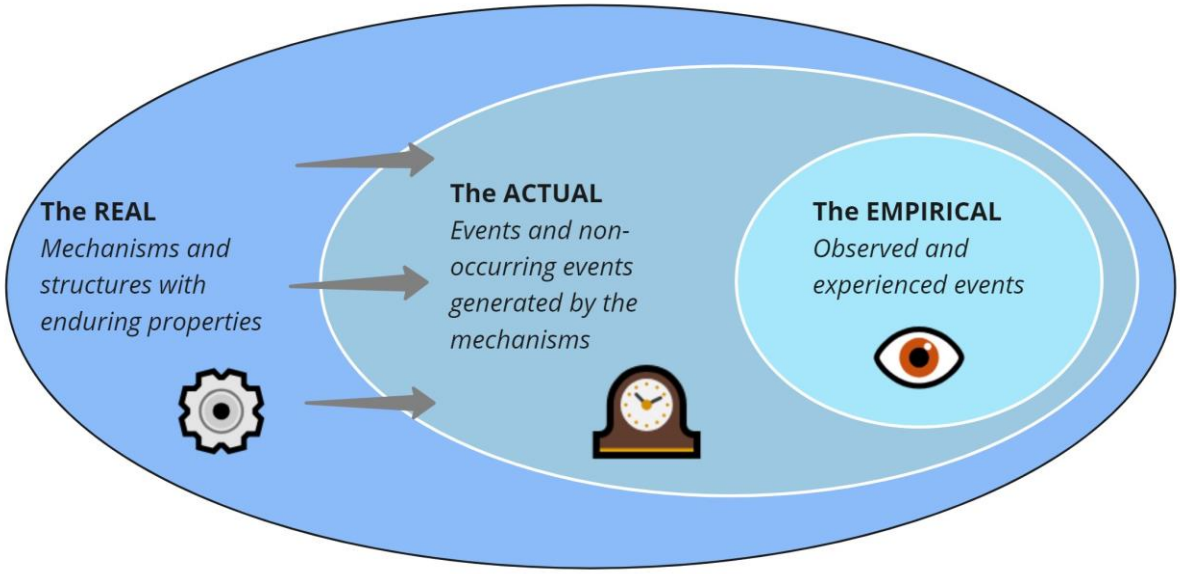

Fig. 2.4 The stratified ontology of critical realism (Adapted from Mingers 2004, p.19)

The level of the real contains all of reality. It contains the generating mechanisms, which cause effects, events and experiences. A distinction is made between the generative structures which exist at the level of the real, and the events they effect in the actual level. Critical realism recognises causal laws as different and

independent from the effects they generate, and existing even where they are not currently acting or triggering events. The level of the actual consists of events which may or may not be perceived, the perceived becoming empirical experiences. The level of the empirical includes all those events that are actually experienced (Bhaskar, 1975; Mingers, 2000b).

Crucially, this framework indicates that "we should not reduce all events to only those that are observed, and we should not reduce enduring causal mechanisms to events" (Bhaskar, 1975; Mingers, 2004, p. 9). In Bhaskar's view, the absence of a thing does not negate its existence, as "there are many absent entities or events that can have causal consequences – the appointment that is missed, the bill that is unpaid, the food that cannot be afforded" all have causal effects (Mingers, 2014, p. 71). The empirical, that is, that portion of reality actually experienced is only a subset of reality itself.

Mingers draws the parallels between critical realist and systems thinking concepts (Mingers, 2014, p. 38):
The structures, mechanisms and totalities of critical realism; and the systems of systems thinking.
The stratified ontology of critical realism; and the hierarchy or nesting of systems in systems thinking.
The powers or holistic causalities of critical realism; and the emergent properties of systems. Mechanisms generating events in critical realism; and structure generating behaviour or process in systems thinking.

The Systems view of stratified reality which shows structure generating behaviour or process has been described by Stroh using the systems iceberg model. Similarly to the stratified ontology of critical realism, it provides three levels of insight to distinguish the experienced symptoms of a problem from their underlying causes.

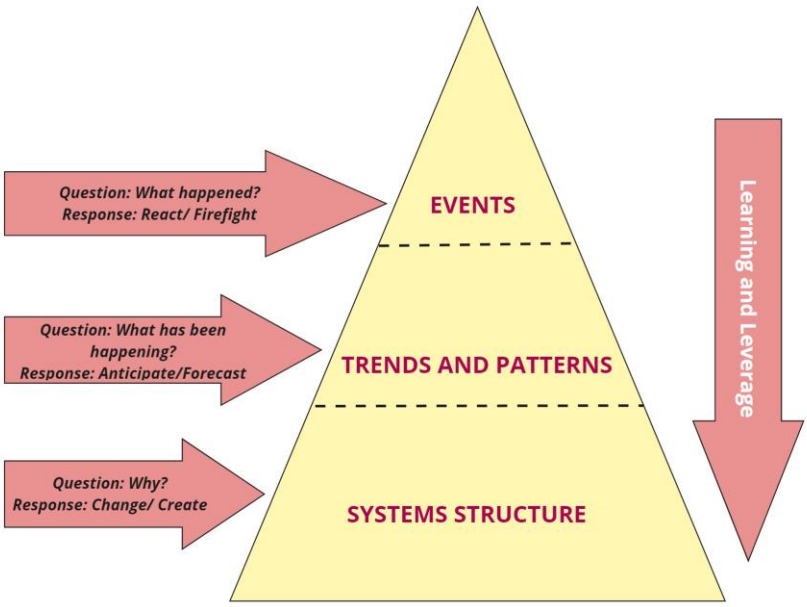

Fig. 2.5 The systems iceberg model (Adapted from Stroh, 2015, p. 37)

The events are what we perceive most easily, the things that happen which people respond to. The trends and patterns are a step back from this, the things that happen over time which anticipate the events which occur. The foundational system structure includes tangible elements such as pressures, policies and power dynamics; as well as intangible elements such as perceptions (what people believe to be true about a system) and purpose (the actual intention that drives people's behaviour)(Stroh, 2015).

The parallels between critical realism's mechanisms which generate events and systems thinking's structure generating behaviour or process has already been noted.

Soft systems methodology concerns itself with ideas or concepts (root definitions and conceptual models)(Checkland, 1981). Critical realism holds that ideas, concepts and meanings are as real as physical objects (Bhaskar, 1997). Checkland himself denied the ontological reality of systems, viewing them only as a device for thinking about the world (Checkland, 1981). He distinguished strongly between positivist and interpretivist approaches within social science and allied SSM with a phenomenological tradition. Mingers observes that Checkland took positivism as the only alternative to interpretivism, which forced him to adopt his stated position (Mingers, 2000b). He points out that this creates contradictions in dealing

with a ‘real world’ which ultimately, SSM aims to improve (ibid.), and notes that ‘the major advantage of a critical realist approach is that it maintains reality whilst still recognizing the inherent meaningfulness of social interaction’ (ibid. p.1267).

2.3.2 Epistemological

The systems position considers that in observing human systems, perception, integration, meaning, and purpose are integral to our understanding (Hammond, 2017). The epistemological implication here is that the observer does not have a neutral viewpoint from outside the system looking in, but is an integral part of the system, with assumptions, biases and motivations brought to bear on the research (ibid.).

With respect to the epistemology of soft systems methodology, Mingers points out that ‘it is strongly relativist in accepting all viewpoints as being equally valid’ (Mingers, 2014, p. 183). Bhaskar’s critical realism also utilises a relativist epistemology. It however does retain a judgemental rationalism, holding that once ideas are expressed, they cease to be wholly subjective, but become available for investigation, debate and judgement by others (Bhaskar, 1994, p. 52; Mingers, 2014, p. 183). Consequently, it can be tested for congruence with reality.

2.3.3 Implications of the Critical realist framework for this thesis:

The implication of using a critical realist philosophical framework coupled with the systems thinking iceberg model for this thesis is that the issue of addressing FGM/C can be characterised as a conceptual system which exists at three levels:

Firstly, the level of the Real/System structure, which is conceptual. At this level reside the beliefs and understanding that drives the practice of FGM/C (that it is not harmful, that it is necessary for adulthood or marriage, or for the practice of religion). Secondly the level of the Actual/Trends and patterns, which holds the social structures that drive the practice, the demand that it must be done for adult status or to enter marriage, and the social, familial, and peer pressure exerted to this end. Thirdly the Empirical/Events level, at which the cut, as well as its physical and mental sequelae is experienced by the individual.

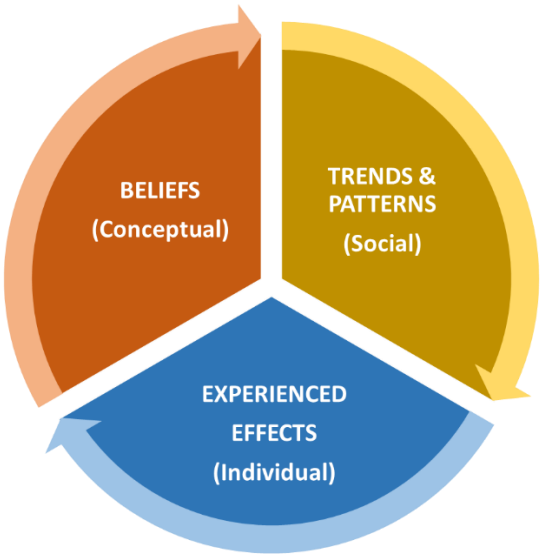

Fig. 2.6 A layered view of the practice of FGM/C based on the stratified ontology of critical realism and the systems iceberg

This layered view of the practice of FGM/C (Fig. 2.6) will be useful in examining how FGM/C is addressed by the multiple stakeholders in the situation. Stakeholder action will be clarified using SSM. This will be done by structuring the situation through identifying the SSM systems of purposeful activity for the different stakeholders. Once the situation is structured in this manner, it can be seen how, or if, and by whom, the issue is being addressed at these three levels, and where the response to the issue may be lacking.

2.4 Conclusion:

This thesis will examine how FGM/C is addressed in Scotland using a critical realist philosophical position and a systems thinking methodological framework.

Addressing FGM/C is a complex problem issue addressed through various bodies in the statutory and third sector in Scotland. This thesis will look at the 'big picture' of how FGM/C is addressed, pulling together the situation across the silos in which the issue is addressed.

Framing the issue as a conceptual/soft system allows looking at the activity on this issue across hard boundaries, integrating knowledge to better understand the situation and find ways to improve it in a way which is acceptable to the stakeholders involved.

The multiple perspectives present in the issue imply that an emphatically pluralistic systems framework is required. This is offered by soft systems methodology (SSM), which emerged as part of the second wave of systems movement.

SSM provides foundational work for promoting change in social systems by building understanding of the situation through clarifying stakeholder perspectives and the actions they engender; and by finding ways to improve the situation through identifying key parameters of interest across stakeholder groups where change could fruitfully commence.

SSM will be presented in the next chapter.

3. METHODOLOGY

3.1 Introduction

FGM/C is a complex issue with various interacting elements driving both its practice and its abandonment. The multiple, and changing, perspectives on the matter among its various stakeholders, both internally within affected communities, and in affected communities as minorities in a diaspora, make the issue a messy one. The tension present in the issue reflects the reality that there is an absence of a clear shared understanding among the stakeholders. This lack of clarity means that the problem is not well defined, and neither is it quite clear what a solution acceptable to all stakeholders would look like.

There is therefore a need in the first instance to build a contextual understanding of the situation, to clarify who is involved in addressing this issue in Scotland, what are their roles and perspectives, priorities and challenges; then based on the foregoing, to find ways in which the situation could be improved, together with the stakeholders involved .

The apparent aim of both statutory and 3rd sector bodies addressing FGM/C in Scotland is for preventing and ending the practice. There is no organised body in the public sphere promoting this practice, which exists as a part of culture for affected communities. Among the public bodies addressing this issue there may therefore be agreement in framing FGM/C as a negative practice. However, the stakeholder groups involved may have different roles and remits, which may mean different priorities and challenges. In addition, as this is not a Scottish cultural practice, there may be differing degrees of understanding of the practice and what drives it, which may affect how the practice is addressed.

Research has been carried out exploring the experiences of women, men and young people in affected communities with regards to FGM/C in Scotland (O'Brien, 2016; O'Brien, 2017), but no research pulling together the work done across stakeholder groups in the public sphere to address the issue.

SSM is an action oriented process of enquiry into problematical situations, in which users learn their way from finding out about a situation to defining ways in which it can be improved (Checkland & Poulter, 2010). It is a method designed for

investigating complex unclear human and social situations, and therefore appropriate to apply to addressing FGM/C in Scotland, where the issue itself is complex, and where unity in perspectives cannot be assumed.

This study will limit itself to building understanding and defining the action which could be taken to improve the situation, and does not aim to include a stage for their implementation, as seeing through an implementation would require time and resources beyond the capacity of this self-funded PhD project.

3.2 Purpose of study

3.2.1 Aims:

To apply systems thinking and soft systems methods to build understanding of how the issue of FGM/C is addressed in Scotland, and to co-create with stakeholders recommendations for how the situation can be improved.

3.2.2 Research questions:

Three research questions were formulated. The first focuses on the boundaries of the system addressing FGM/C in Scotland; the second on the human activity within it; and the third on ways to improve the situation.

1. What are the key elements in the system addressing FGM/C in Scotland?
   1.1. Who are the key stakeholders?
   1.2. What are the key concepts and relationships?
2. What are the roles, perspectives, priorities, and limitations of key actors in the system?
   2.1. What are the roles and perspectives of the stakeholders?
   2.2. What are the priorities and limitations of key stakeholders?
3. How can the situation in Scotland be improved?
   3.1. What are the perceived ideal situations for the stakeholders?
   3.2. What are the gaps between the ideal situation and perceived reality for key stakeholders?
   3.3. By what means could these gaps be closed?
   3.4. Which of these means are acceptable and feasible for the key stakeholders?

The term “address” FGM/C is used instead of “end” or “eradicate” because the issues of prevention, safeguarding, and provision of services to women already affected are strategically linked (ScottishGovernment, 2016, 2017, 2019).

3.3 Research Type

This research utilises both inductive (where theory is generated from data) and deductive (where theory is tested) elements.

SSM is a cyclical and iterative process (Checkland & Poulter, 2010). It uses inductive exploration to find out what is relevant to the inquiry in the situation, using this knowledge to build relevant models of the situation. It then uses these models to conduct a comparison with the situation as it stands, in a deductive way. This approach is useful to answering the research questions of this thesis because SSM seeks not only to build understanding, but also to find ways to improve the problematic situation.

The research uses a qualitative approach. Data was collected using interviews and workshops from a small purposive sample of participants and interpreted by the researcher using thematic analysis of data.

3.4 Research Strategy

This section gives a detailed explication of the soft systems methodology applied, and of the study design.

3.4.1 Four steps of the SSM learning cycle

SSM is a mature methodology of proven efficacy, with well-established core processes (Checkland, 1981; Checkland, 2000a, 2000b; Checkland & Poulter, 2010; Checkland & Scholes, 1990) The four steps of the SSM learning cycle are not necessarily sequential in practice, but are usually presented in sequence for the sake of clarity. The summary below is based on the description given by the method’s developer Peter Checkland and SSM practitioner John Poulter (Checkland & Poulter, 2010).

Step 1: Finding out about the problematical situation

Learning about the problem situation involves identifying the problem issues and expressing them. To do this SSM uses rich pictures, and three streams of analysis.

Rich pictures:

These are visual representations of the problem situation, showing the relevant elements and their connections or relationships and the key issues (Checkland & Scholes, 1990, p. 45). They are informal diagrams which aim to capture "main entities, structures and viewpoints in the situation, the processes going on, the current recognised issues and any potential ones" (Checkland & Poulter, 2010, p. 210). They provide a snapshot of the situation, displaying all the current components of the situation, and are a useful aid to thinking. Their use is primarily associated with SSM, as an aid to understanding and appreciating complex problem issues (Bell & Morse, 2010).

Analysis one (the intervention):

This considers the systems intervention itself (Ibid. p.211). It considers who is in the role of the 'client' who has caused this investigation to happen, who is conducting the investigation, the 'practitioner', and who is concerned about or affected by the outcome, the 'owner'. An individual can occupy more than one role.

As this is a self-funded PhD research project, the researcher is in the multifaced role of being both the client who has instigated the research and the practitioner who carried it out.

The person in the 'practitioner' role, identifies and lists the 'owners', those affected by the situation and the outcome of the intervention. In this case that is the researcher, working towards a PhD, and the participant stakeholders who will benefit from finding ways to improve how the address FGM/C. The practitioner also needs to ensure the ambition of the project is in line with the available resources.

Analysis two (social):

This considers the social and cultural reality of the problematic situation (Ibid. 213). SSM explores this using the roles, norms and values operating in the system.

The roles are the formal and informal social positions, the norms are the expected behaviours and the values are the standards by which behaviour in given roles is judged. This is important with respect to the multiple perspectives of the multiple stakeholders in this situation.

Analysis three (political):

This examines the disposition of power in the problematic situation (Ibid. 216). It asks how is power expressed here? How is it obtained, used, passed on, and relinquished? This is relevant as policies on FGM/C are implemented and statutory power exercised in addressing FGM/C in Scotland.

Step 2: Creation of models of purposeful activity relevant to the system.

Models of purposeful activity identified in the situation are created. These purposeful activity models (PAMs), (Augustsson et al, 2019), are conceptualisations of the system which model an "ideal" process to accomplish the goal of the system, based on the worldviews/perspectives held by the various stakeholders. They will capture the ideal transformations that participant stakeholders aim to achieve in addressing FGM/C.

Checkland's key ideas in applying systems thinking to social problems highlighted the subjective: the "Weltanschauung", meaning individual worldview or viewpoint/perspective on a situation, and human action consequently having subjective purpose. He described the element guiding purpose as the "Weltanschauung" or worldview of the stakeholder, and their purposeful action as the intentional behaviour of the actor within a system, in accordance with what their worldview was regarding a given issue. (Checkland & Poulter, 2010).

The key tools SSM uses to do this are "root definitions" (RDs) of purposeful activity systems and their corresponding conceptual models. (Checkland & Poulter, 2010). The root definitions are formulaic statements describing the system based on specific worldviews/perspectives present in the situation.

The models differ from models of the physical or social world – they are conceptual, and represent pure purposeful activity based on declared worldviews (Checkland, 1981; Checkland & Poulter, 2010; Pidd, 2001). Their aim is to

simulate, feed and structure debate about the problem situation, not to describe an actually existing process.

RDs are structured descriptions of a system comprising of three elements (the PQR formula): what(P), how(Q), why(R).

The RD is written as a statement: A system to do P, by means of Q, in order to achieve R. Where P is what the system does, Q is how it does it, and R is why it is being done.

This formula expresses the purposeful activity of the system based on the worldview of an individual or group involved in the situation – a particular view/understanding of what the system is and what it does. In any complex social situation there will be multiple root definitions of the system, because there are multiple worldviews/perspective and their associated purposeful activities.

So, P *What* is the immediate aim of the system; Q *How* is the means of achieving that aim; and R *Why* is the longer-term aim of the purposeful activity which reflects the understanding of the issue.

CATWOE is a mnemonic used in SSM to further fill out the root definition by helping to identify and categorise the people, processes and environment of the system in question (Ibid. p.221).

The purposeful activity is defined by (T), a transformation process, and (W) a world view. It will require actors (A), people to do the activities which make up T. It will affect clients (C) outside itself who are its beneficiaries or victims. It will take as given the constraints of the environment (E) outside itself eg. the law, or budgetary constraints. The process T could be stopped by the person/persons who are the owners (O).

The conceptual models may be issue based or primary task based. Primary task based models are focused on activities within existing organisation boundaries, while issue based models describe activities that cut across organisational boundaries. Checkland and Poulter note that issue based models have a greater capacity to stimulate discussion among stakeholders (Checkland & Poulter 2010, p. 223).

Step 3: Using these models to question the real situation.

Once the subjective conceptual models of the system have been made explicit, it is possible to compare them (these models of clear and ideal activity systems grounded in given perspectives) to the "real world" situation (which is messy, due to the multiple and conflicting perspectives and purposeful activities active within it, that is, the "web of problems).

The comparison is done through stakeholder discussion, structured by use of the models. The aim of the discussion will be to find what actions are needed to close the gap between the "real world" situation and the ideal models, for the various stake holders addressing FGM/C.

Multiple models of purposeful activity will be found in any complex system with multiple stakeholders and perspectives. Each model used to structure discussion should have 7 +/- 2 elements within it in order to remain workable for the purpose of the discussion (ibid. p.224).

Step 4: Defining/taking action to improve the situation.

Ultimately, all these possible actions to close the gap between reality and the ideal need to be ranked according to how (resource) feasible and (socially) acceptable they are among the stakeholders.

The SSM process does not set out to achieve consensus among the various perspectives in a complex problem issue, rather It aims to find "accommodation among a group of people with a common concern" (Checkland & Poulter, 2010, p. 229), without abandoning the possibility of consensus. This is important, as there is a likelihood of conflicting perspectives in addressing FGM/C in Scotland and achieving consensus may be challenging.

The process of defining acceptable and feasible changes may be done through detailed discussion, or through the use of a table for facilitation. A light footed approach is advised however (Checkland & Poulter, 2010, p. 228), to avoid getting bogged down in filling table matrices and rather to respond flexibly to the issues being highlighted as important by the stakeholder group.

	Activity to improve	Does it exist (Yes or No)	Who is responsible	Area of improvement
Primary tasks	1. 2. 3. 4. 5. 6.			
Consensus tasks	1. 2. 3. 4.			
Multiple perspectives	1. 2. 3.			

Table 3.1 SSM table for ways to improve

In using a table the actions to improve are ranked as follows. In the columns are tabulated: the activities, whether these activities exist in reality or not, whose responsibility they are, how there could be improvement in this area, and whether it is doable. The columns give a measure of feasibility.

In the rows are tabulated: the ranking of these activities by the degree of support for them among the participants. Activities which all participants are agreed are essential are ranked highest as 'primary tasks'; those for which there is some support but which are not considered essential by all are ranked below the primary tasks as 'consensus tasks'; activities which are supported primarily by the stakeholder/ stakeholder group which proposed them will be ranked lowest and recognised as 'multiple perspectives'. The rows give a measure of acceptability.

The SSM approach to improving a situation is an iterative one. Desirable and feasible change usually requires some change in structure, process/procedure, and in attitude (ibid. p.231). Any action taken based on this creates a new situation which could again be subjected to the SSM inquiry process.

3.4.2 Study design

The study was designed to utilise SSM tools to build understanding of the situation in addressing FGM/C, and to find recommendations for improving the situation.

A reflexive journal is included in Appendix 1.

Study Design	Purpose	Tools
Background literature review	*Build understanding of situation*	Database searches, reference list searches
Stakeholder interviews		Semi-structured interview guide
Workshop 1		Rich Picture
		Perspective exercise
		Context exercise
Workshop 2	*Find recommendations for improving the situation*	Root definitions of activity systems
		Conceptual models of the ideal activity systems
		Tabulation of actions

Table 3.2 Study design

In this thesis, the social and cultural stream of analysis included the background literature review (Appendix 3) on the drivers of the practice, in countries where it is traditionally practiced and in communities in diaspora; and the ongoing debates in the situation, while the political stream of analysis included the background literature review on advocacy, and on legislation and policy on FGM/C.

An interview guide (Appendix 9) was created by the researcher based on the aim of exploring the perspectives, purposes, priorities challenges and limitations found in the various stakeholder groups.

The 12 questions offered by Urlich's CSH (Appendix 17) were used to enrich the development of the interview schedule through inclusion of additional questions and/or prompts to ensure its themes were covered. The purpose here was to promote greater clarity and understanding of the situation both by giving participants every opportunity to speak on issues relevant to them; and to support through a review of these key themes.

The rich picture for workshop 1 was created based on data obtained from interviews.

To support the discussion of the rich picture and to build understanding, a perspective model was created (Appendix 13) (Morgan, 1993, p. 3). This is a simple visual representation of the perspectives in a situation, arranged around what the perspective was of. In addition, a context exercise was designed (Appendix 14) (Systems Workshop given at the SPHSU, University of Glasgow, Dodd, 2019). This again was a visual exercise, in which participant stakeholders located their challenges/problems on a grid indicating whether they thought they had control, or influence over addressing them, and whether the challenges were in their immediate or wider environment.

The Workshop 2 root definitions and corresponding conceptual models were based on findings in the preceding interview and workshop 1 stages.

Further details of these are presented in subsequent sections.

3.5 Sampling strategy and data collection:

To address the research questions, research participants needed to be involved in the specific issue of FGM/C which was addressed by a small population in Scotland. Non probability sampling was therefore used to identify potential participants with this characteristic.

A purposive sample of stakeholders was therefore made to support selection of participants who were involved in the research topic and could be information rich sources for the study (May, 1997; Tonkiss, 2004). Sampling was therefore aimed at recruiting participants who were in a role in which they are addressing/had addressed FGM/C in Scotland.

Participants were selected using a sampling framework (Appendix 4) designed to cover the third sector (community groups and Non-Governmental Organisations NGOs) and statutory services (Health, Social Services, Police, Education, Legal (Scottish Children's Reporter Administration), Policy and Legislation).

The framework was based in the first instance on bodies referenced in Scottish Government consultations on the issue (ScottishGovernment, 2017), and snowballed through contacts suggested by participants. The listed organisations and individuals were approached. Snowballing was done by asking participants at

the end of each interview if there was anyone else they felt it would be helpful to approach for this research, and if those suggested had not previously been contacted, they were approached.

The study did not recruit people supportive of FGM/C as there is no organised body promoting the practice, To support the literature review in building understanding of the bigger picture of 'what' is being addressed, the perspectives of this group were captured indirectly through community groups which are engaging on this issue in the public sphere, as these are part of the communities where this practice exists, and respond to the drivers of the practice in their work addressing FGM/C.

The study is not focused on exploring personal experience of the practice and was not set up to recruit or support vulnerable women. Again, the perspectives of this group were captured indirectly through the community groups, some of whose active members could themselves be survivors of FGM/C who now address the issue in the public sphere.

3.5.1 Interviews

Purpose

The interviews were semi-structured and conducted with a range of stakeholder participants. They were aimed at building an understanding of the wider picture in addressing FGM in Scotland at present.

Recruitment

The study aimed to recruit 10-18 participants, aiming for representation from both relevant third sector organisations and statutory services. The number was to ensure a representation of key perspectives while remaining feasible for the time and resource constraints of this PhD project.

Ultimately, 20 interviews were conducted.

Participants were recruited through direct contact, or self-referral after seeing publicity for the research. Direct contact was made with the groups on the initial contact list, and with contacts referred by interested participants. An initial email

was sent, followed by another email, followed by a phone call where the number was available.

Publicity:

1. Recruiting email forwarded to twenty-three third sector organisations through the Women's Support Group, a Glasgow based NGO.
2. Recruiting email forwarded through a previously known contact to relevant contacts with the Scottish Children's Reporter Administration SCRA.
3. Recruiting email forwarded to both CELCIS (www.celcis.org) and CPCScotland (www.childprotection.scot) through CP Lead Officer at Stirling Council, (this contact was made through from the Network Manager at the SHINE project (www.gla.ac.uk/shine).

Direct contact:

1. Initial contact list
2. Two NHS midwives who then provided contacts for a consultant and a general practitioner.
3. Self-referred social work contact provided contacts for five other potential participants in the service.
4. Contact in education was made through supervisor contacts.

Stakeholder type	Contacts made	Self-referred	Recruited	Excluded	Interviewed	Location
Community groups	9	2	4	5	4	Glasgow/Edinburgh
NGOs	9	2	4	5	4	Glasgow/Edinburgh
Statutory Health	9	1	4	5	4	Glasgow/Edinburgh
Stat/Social Service	7	2	5	2	5	Glasgow
Stat/Legal	1	1	1	0	1	Glasgow
Stat/Police	5	2	1	4	1	Glasgow/Edinburgh
Stat/Policy	1	0	0	1	0	Edinburgh
Stat/Education	6	0	0	6	1	Glasgow/Edinburgh/ WLothian/ELothian/ Dundee/Aberdeen
Total	47	10	19	28	20	

Table 3.3 Responses to recruitment for interviews

Additional details are in Appendix 19.

Participants were from four community groups (KWISA Kenyan Women In Scotland Association, 2gether 4better, Community Info Source, African Challenge); four NGOs (Red Cross, Just Rights, Sacro, Shakti Women's Aid); from statutory social care; health care practitioners; the Scottish Children's Reporter administration SCRA, the police and education. Seven stakeholder groups were represented.

	Stakeholder groups	Participants
	Community groups	4
	NGOs	4
	Health care	4
	Social service	5
	Legal	1
	Police	1
	Education	1
Number	7	20

Table 3.4 Interview participation summary

Settings

This research was carried out online. It had originally been planned as in person but was moved to an online setting due to the COVID-19 pandemic.

The interviews were individual and carried out almost exclusively over Microsoft Teams, except with one participant who requested Zoom. On average, the interviews lasted for about one and a half hours.

A recording of the interview was made on the University of Glasgow Teams or Zoom account.

Process

An interview guide was used. The interviews explored the roles, perspectives, challenges and limitations of participants in addressing FGM.

The interview schedule was enriched with themes (motivation, knowledge, control, legitimacy) from the CSH 12 question grid, to ensure that participants had the opportunity express all the issues important to them on this issue.

The interview aimed to build understanding of the present situation in addressing FGM/C in Scotland, giving participants room to unpack their points as well as ensuring the questions and prompts in the interview guide were covered.

The interview guide (Appendix 9, participant information sheet (Appendix 6) and consent form (Appendix 5) are presented in appendices.

At the end of each interview, the participant was asked if they have any other comments to add on the issue.

Creation of Rich picture

The interview data was used to create a rich picture to represent the situation 'addressing FGM/C in Scotland'. It is presented along with a thematic analysis of the interview data in chapter 4.

A rich picture would usually have been drawn by the participating stakeholders themselves (Barbrook-Johnson & Penn, 2022c). In this thesis, this process was altered due to the COVID 19 pandemic. The data gathering for the rich picture was done remotely, during the initial lockdown period when people were just getting to grips with zoom and teams. It was decided by the researcher that in the absence of in-person interaction, as well as with the recognised Rich picture challenge of getting people to draw even with pens and paper; a request that stakeholders draw pictures in an unfamiliar online medium, on an unfamiliar platform (a Miro board) with limited interaction and with possible attendant internet connectivity issues, was too demanding.

The rich picture was therefore created by the researcher based on data obtained through the interviews. The Miro whiteboard platform was used.

The contents and structure of a rich picture are usually left up to its creators with few constraints other than the suggestion to use images rather than text where possible (Barbrook-Johnson & Penn, 2022c).

To capture as rich a snapshot of the situation as possible, the structure of this rich picture was designed to show the problem issue being addressed at its centre, and the various stakeholders addressing it around this core. The coded data for

stakeholder roles, perspectives, priorities and challenges was synthesised by the researcher to create a representation of the situation.

Emojis were used visually express issues where possible. Text summaries of coded data also used to express the priorities and challenges of stakeholders.

The rich picture was then validated at the first set of workshops, where participants were invited to give feedback on the part of the picture which represented them. Participants from stakeholder groups absent at the workshops (education, police, SCRA) were contacted up to three times by email for feedback. Stakeholders from education and police returned responses by email. Corrections were made for clarity and more accurate representation of stakeholder input.

The picture was updated with the feedback given, and is presented in Chapter 4 in its final form.

In this thesis, the rich picture is both an output of the interviews conducted, and a discussion tool used in the workshops.

Two additional discussion tools were used with the rich picture to support building shared understanding in workshop 1, a perspective model and a context exercise:

Perspective model: a simple perspective model (Morgan, 1993, p. 3) was created (Appendix 13), based on the perspectives codes from the interview data. It captured data from the codes for participant perspectives on what FGM/C was and its drivers. These perspectives were arranged around an 'FGM/C' box in the middle. For example, 'grievous abuse', or 'harmful traditional practice'; 'driven by men', or 'driven by women'.

It served as a discussion tool to build shared understanding of the perspectives on FGM/C found among interview participants. This exercise did not aim to build a consensus among participants. It only aimed to present the various perspectives present, by so doing potentially expanding the picture of the complexity and nuance present in the situation.

Context exercise: a context exercise (Systems Workshop given at the SPHSU, University of Glasgow, Dodd, 2019) was designed for participants (Appendix 14).

This was informed primarily by the challenges code in the interview data. Stakeholder identified challenges in the situation were presented to the workshop participants, who were asked to classify these based on whether they had control, or only influence, over addressing them; and to indicate whether those challenges they had no control over addressing were in their immediate or wider environment. This exercise aimed to support understanding of stakeholder capacities and limitations.

3.5.2 Workshop 1

Purpose

Workshop 1 aimed to further build understanding of the situation, including a shared understanding of the situation among participating stakeholders; as well as to obtain validation for the rich picture created by the researcher following the interview stage.

Recruitment

Workshop participants were invited from the interview participant list. An additional participant joined from a participating community group. The response for workshop 1 recruitment was as follows:

Fifteen participants were recruited out of twenty-one invited. Fourteen of the twenty were from the interview stage and one additional participant joined from a participating community group. There were six non-uptakes (five no time available, one no response).

There were four absent on the day for their workshops. Two cancellations due to events on the day, one dropout due to tech issues, one no-show.

In all, eleven participated out of twenty-one. Four stakeholder groups were represented at the workshop, Police, Education and SCRA were absent.

Workshop	Stakeholder groups	Participant number
1a	Comm. group Comm. group Comm. group	3
1b	NGO Social care Health care Health care	4
1c	NGO NGO Social care Health care	4
Total	4	11

Table 3.5: Workshop 1 participation summary

Absent stakeholders were contacted by email for their feedback and validation of the Rich picture, and responses were obtained from the Police and Education participants. Feedback on the Rich picture was therefore obtained from 6 stakeholder groups.

Settings

Workshop 1 was carried out over Microsoft Teams, and used an online platform, Miro (www.miro.com), to present the models to be used for discussion. Participants made contributions using sticky notes on the Miro board and verbally. The workshops each lasted two hours. This workshop stage was done in three small group workshops of 3-4 people. One small group workshop for community group participants, and two small group workshops with a mix of NGO and statutory service participants as summarised in the table above.

A recording of proceedings was made in the University of Glasgow Microsoft Teams account used.

Process:

Workshop 1 covered:

- discussion of and feedback on a rich picture (P. Checkland, Scholes, J., 1990, p. 45) created based on stakeholder input at interview stage to express the issues, actors and relationships in the system

- discussion of a perspective diagram (Morgan, 1993, p. 3) created based on stakeholder input at interview stage to explore the various perspectives on the issue,

- carrying out a context exercise (Systems Workshop given at the SPHSU, University of Glasgow, Dodd, 2019) created based on stakeholder input at interview stage to explore the constraints within which the actors operate.

A workshop guide was followed. (Appendix 11)

The participants had been asked to sign into Miro prior to the workshops and have a practice with using the post its. The use of the board and the post its were explained at the workshop and was practiced during the warmup exercise. A facilitator was present at each of the workshops to provide tech support for anyone who had issues signing in or using the board. Despite this, the use of the Miro board was a challenge, especially for the community group participants. However, between the audio recording of the discussion of the Rich picture, the perspective and context exercises and the post it notes used, a lot of data was captured.

Creation of root definitions of purposeful activity systems and conceptual models

Formulaic 'Root definitions' and corresponding conceptual models (Peter Checkland & Poulter, 2010) of relevant purposeful activity systems were created by the researcher based on data obtained in Interviews and Workshop 1.

The process of creating conceptual models of purposeful activity systems and the root definitions they are based on has been described in section 3.4.

The process was followed. The detailed presentation of development of the root definitions of purposeful activity systems found in addressing FGM/C in Scotland and their corresponding conceptual models is given in Chapter 5.

Ten root definitions were developed. These were used as foundations for ten corresponding conceptual models which showed the ideal scenarios implied by the perspectives of the stakeholders addressing FGM/C in Scotland.

These root definitions and conceptual models were outputs of the SSM process as well as tools used in its conduct.

The detailed presentation of findings from the use of the models for stakeholder discussion in workshop 2 to obtain challenges and gaps in addressing FGM/C in Scotland, as well as feasible and acceptable ways to improve the situation; is presented in Chapter 6.

3.5.3 Workshop 2

Purpose

Workshop 2 aimed at defining ways in which the situation could be improved, and was structured using the conceptual diagrams of relevant purposeful activity systems identified as present in addressing FGM/C in Scotland.

Recruitment

Workshop participants were invited from the interview participant list plus the additional participant in workshop 2.
The original police participant was not available, but found a replacement who also brought in another team member.
The response for workshop 2 recruitment was as follows:
Fourteen participants were recruited out of twenty-one invited. Seven non-uptakes (two no time, five no response).
Two of the workshops at this stage had to be rescheduled to accommodate for timing difficulties over the summer, and an additional one put on to allow all those interested a chance to participate.

Workshop	Stakeholder groups	Participant number
2a	Comm. group Comm. group Comm. group	3
2b	NGO Social care Health care	3
2c	NGO	1
2d	NGO Education Police Police Social care	5
Total	6	12

Table 3.6. Workshop 2 participation summary

Settings

Workshop 2 was carried out over Microsoft Teams, with the researcher sharing their screen of the Miro board showing the Root definitions and activity models and putting down notes of participant contributions on the Miro board. This workshop stage was done in four small group workshops of 1 - 5 people. One with community group participants and three with a mix of NGO and statutory service participants, as summarised in the table above. Three workshops were originally planned, an extra workshop was put on to accommodate timing difficulties for participants.

The workshops each lasted two hours.

Workshop recordings were made in Microsoft Teams.

Process:

Workshop 2 was focused on finding ways to improve the situation. It covered:

- Choosing relevant purposeful activities: A list of root definitions of relevant purposeful activities based on the interviews and workshop 1 were presented to participants. They were asked to select those of greatest interest to them, and a final two were selected by tally. The selection of two was made due to the time available for discussion. The tally ensured that the models discussed were of greatest interest to stakeholders in the room. This unavoidably meant that not all the models were discussed, however SSM does not aim for a ‘silver bullet’ that will solve every problem, rather for iterative improvement that will take the situation

up a notch, which would create a new situation with its own capacity for improvement.

- Comparing models of purposeful activity to the "real world" situation and defining actions to improve the situation: Conceptual models Checkland & Scholes, 1990, p. 40) created by the researcher to represent the ideal situation from the perspectives of the various stakeholders, (based on the data obtained at interviews and workshop1) were used to structure the discussion. They were presented to stakeholders for comparison with their perceived situation in order to identify the gaps between the perceived situation and the ideal, and then the actions required to close the gap. Prompts from the table described above were used in discussion to define the activities which are feasible and acceptable for improving the situation.

A workshop guide was followed. (Appendix 11).

Following the challenges with the use of the Miro board in Workshop 1, to ease the process, the researcher acted as scribe, writing the comments from participants on the post its. These were visible to all, and participants were asked if the note captured what they had meant to say if the note was not verbatim. This allowed the participants focus on the discussion and avoided the technical challenges.

Formal use of the table offered by Checkland for clarifying feasibility and acceptability had been planned. However, during the workshops the researcher quickly discovered that attempts at laborious filling of the matrices hampered a free and easy flow of discussion, so this was abandoned and the researcher simply used the table headings as prompts in for discussion.

Creation of SSM table summarising ways to improve the situation:

The conceptual of purposeful activity models (PAMs), were used to structure discussion in each of the small group workshop 2 sessions. This was done in line with the SSM process indicated in section 3.3.4.1 above.

Due to time constraints the ten PAMs created could not be discussed at each workshop. Participants were presented with the ten for consideration, and asked to select their top three of interest. A tally was made (and votes cast if there was a tie) and the top two selected for discussion, with a third for if there was time

available. Two models were discussed in three of the four workshops, three models in one workshop.

Once the selection had been made, the models were discussed in turn. First the model was explained as a summary of the ideal process for pursuing the purposeful activity in question and participants asked if they found it reasonable. Then each element was taken in turn and examined for gaps between the ideal and the real life situation for participants, and what was needed for improvement in their view. Details are presented in Chapter 6.

Checkland proposes the use of a table to formally pull together the ways to improve the gaps identified by participant stakeholders, while advising flexibility in the process of doing so (Peter Checkland & Poulter, 2010, p. 228).

The process described in section 3.4.1 on defining/taking action was followed. Summaries of text extracts from workshop 2 discussion of challenges/gaps in the situation and how it could be improved, as well as of post it notes form the Miro board used were utilised. They were inserted into the table, resulting in a ranking of acceptability and feasibility.

Creation of system maps of challenges/gaps and ways to improve:

An additional output of this thesis were system maps created by the researcher to visually capture the findings from discussion using the conceptual models. These were based on the text extracts and post it notes made by stakeholders from transcripts of workshop 2 proceedings, the same which were used for construction of the table described above.

The approach taken broadly followed the building of participatory system maps (Barbrook-Johnson & Penn, 2022b), although these maps were not built by participants themselves, but by the researcher based on data provided by participants in discussion. ‘Nodes’ were created to reflect key points made and linked to reflect the causal flows and justifications given by participant stakeholders. These were also arranged in a way that reflected the stakeholder group voice reflected/affected by that node. The maps attempted to capture the different positions and concerns of participating stakeholders by showing how they

were interlinked in the big picture of challenges, or ways to improve, in addressing FGM/C in Scotland.

3.6 Data Analysis:

Qualitative analysis was carried out on the data obtained as below.

3.6.1 Transcription

Transcription of audio files was done in two ways. Manual transcription of nine of the audio files was carried out by the researcher with the assistance of the auto transcribed text in Teams and Zoom. The remaining transcripts were done by professional transcription services bound by confidentiality agreements with the Social and Public Health Sciences Unit, University of Glasgow.

Data familiarisation took place through the manual transcription process where this was done by the researcher, and by reading through the transcripts with the audio recordings to ensure accuracy of the transcripts done by the transcription service.

3.6.2 Use of NVivo

Interview transcripts were uploaded to NVivo software provided by the University of Glasgow for thematic analysis.

A coding framework (Appendix 12) was developed within NVivo. The coding framework was edited as it was iteratively applied to the transcripts and then the final framework was applied across all the transcripts.

3.6.3 Thematic analysis

Thematic analysis was carried out on the interview data obtained.

Braun and Clarke defined thematic analysis as “a method for identifying, analyzing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79). It has been characterized not as a method, but a tool to use across different methods (Boyatzis, 1998), but Braun and Clarke argue that it should be seen as a method in its own right. They present it as having six phases: familiarizing yourself with the data; generating initial codes; searching for themes; reviewing the themes; defining the themes; and producing a report. (Braun & Clarke, 2006).

It was chosen for use in this thesis for its accessibility and adaptability: it is flexible, not theoretically bound, and relatively straightforward; and its applicability, being compatible with the theoretical (SSM uses a constructivist epistemology) and philosophical (critical realist, which acknowledges the subjective position of both the researcher and participants) framework of this thesis (Braun & Clarke, 2006; Sims-Schouten, Riley, & Willig, 2007).

The process of thematic analysis applied in this thesis is laid out below.

Both deductive codes (based on the CATWOE elements), and inductive codes (built up from what participants say) and were used to develop thematic frameworks.

Development of the coding framework (Appendix 12) was an iterative process, which allowed the selection of themes and the recognition of which codes they encompassed, as it was applied through successive transcripts.

The coding was in the first instance more theory driven (Braun & Clarke, 2006): it commenced with the deductive codes suggested by the SSM framework, which was to identify the purposes and priorities (the SSM desired 'transformations') of the stakeholders; and why they were desirable (their 'worldview' on the issue). The requirements of the models and workshop exercises which were to be derived from the data also influenced the coding. For example, a high number of descriptive codes were created due to their helpfulness for designing a Rich picture of the situation.

Coding commenced with the creation of deductive category codes for roles, perspectives, priorities, and challenges and limitations of stakeholders. These specifically reflected key elements of the research questions, and were in line with the broader soft systems methodology purpose of building understanding of stakeholder worldviews and purposeful actions in this situation. These codes also mapped over their related SSM **CATWOE** elements as follows: the 'roles' code included the **C**lients, **A**ctors and **O**wners in the situation, and then included a sub-code for the 'network' of the stakeholder; the 'perspectives' code corresponded to the **W**orldview SSM element, and sub-codes eventually included 'participant view/understanding of FGM/C ' and 'perspectives driving the practice of FGM/C'; 'priorities' corresponded to the SSM **T**ransformation element, and included sub-

codes for the ‘expressed priorities’, ‘transformation worked towards’, ‘long term aim’, and ‘ideal scenario’; while ‘challenges and limitations’ corresponded to the SSM **E**nvironmental constraints.

Deductive category codes were also created to reflect the four themes of Ulrich’s 12 questions, namely ‘motivation’, ‘power’,’ knowledge’, and ‘legitimacy’.

A category ‘direct questions’, was created for specific elements raised by the interview schedule. These included: ‘scale’, the ‘role of men’, ‘language’, ‘cosmetic surgery’ and ‘sensitivities’ raised by the issue.

The data was then examined iteratively for themes to be identified.

Inductive codes were created for key issues raised by participants within the various categories listed above.

For example, the ‘role’ category was coded for key issues present for each participant (eg community group individual participant 001-COM-MB; health care individual participant 010-STAT-Health) stakeholder. These individual participant codes were reviewed for themes present.

The individual participant themes were then examined in stakeholder groupings for overarching themes in the stakeholder groups present (community group, health care, NGO etc.).

This process was similarly followed for the priorities, perspectives, and challenges categories.

Patterns in the themes found were noted. For example, a theme ‘reporting’ was found in the challenges category in multiple stakeholder groups (for example: police, NGO, community); while another theme ‘engaging with men’ was present as a priority primarily with just one community group stakeholder.

The key issue codes were iteratively reviewed examining for overlap, refined where necessary, and merged into themes. For example: the individual participant key issue codes of ‘support and advice for child protection’, ‘overseeing child protection’, and ‘reducing risk of FGM’ were merged into the theme ‘child protection’; while the theme ‘engaging with men’ aggregated ‘focus on men from

affected communities', 'engaging with men proactively', and 'engage exclusively with men'.

The themes were then reviewed again and arranged in order related to topic headings: participant stakeholder perspectives on FGM/C and the drivers of the practice; the roles in addressing the practice; priorities in addressing practice; and challenges in doing so. The themes were defined, and appropriate text extracts were selected for use in analysis of the data.

The participant coding key is given in Appendix 20.

3.6 Strategies for validating findings

Rich picture:

The rich picture was presented to stakeholders in workshop 1, with emphasis to participants on the portion of the rich picture relevant to their role. Through discussion, participants were asked for any perceived omissions or misrepresentations. Their contributions were noted and the rich picture updated based on these.

Conceptual models:

SSM models are not objective models of the "real world," and so cannot be externally validated. They are only relevant to debating about the "real world", as tools in an iterative process. They are required therefore, to only be *defensible* as models of the defined human activity system. As such, the phrases of the root definition should be linkable to activities in the model (Peter Checkland, 1995). While in a "hard" approach, the models must be shown to effectively represent the "real world", in a "soft" approach they only need to be internally valid, and useful as tools to structure and guide discussion (ibid).

The conceptual models created in this thesis for use in the workshops were validated through ensuring that the activities models were linked to the content of the root definitions of the purposeful activity systems they described (given in chapter 5), and through their usefulness in structuring and guiding discussion of gaps and ways to improve the situation in discussion with participants.

System maps:

These maps of challenges in the situation, and of ways to improve the situation, are based on text extracts and post it notes from stakeholder discussion directly focused on the gaps/challenges in addressing FGM/C in Scotland, and ways to improve it respectively. They were created by the researcher in post workshop analysis and are supported by data from individual interviews. They will be sent out to stakeholders in a final report, and their comments requested.

3.7 Limitations of SSM

In reviewing the difficulties in use of SSM (Connell, 2001; Mingers & Taylor, 1992), three main levels of difficulty have been identified: At the level of the methodology itself – it is time consuming and requires experience; at the level of intervention management - it is challenging as it requires convincing people it's worthwhile, establishing trust, and getting people involved; and at the level of the problem issue/situation where change may be hard to bring about due to politics and power imbalance. A condition for the successful application of SSM is that ownership of the problem by key stakeholders is recognised as paramount (Peter Checkland, 2000a)

Rodriguez-Ulloa et al (2011) list the criticism against SSM as threefold. First concerning the transformation process, that the proposed changes actually implemented in the "real world" may be those pertaining to the stakeholders with the greatest influence, thus maintaining the status quo rather than introducing radical change. Second, that there are few guidelines given for the creation of the rich picture in the second stage of SSM, which risks a biased characterisation of the problematic situation. Third, that while needed changes for improvement are identified, no direct guidelines on their implementation/management are proposed by the method itself (Rodríguez-Ulloa et al., 2011).

SSM also does not provide a solution and end point – it aims for iterative improvement (P. Checkland, Poulter, J., 2010), which may be unsatisfactory to clients who want a definitive solution.

Augustsson et al highlighted that there is little guidance on how to take the last SSM step (taking action to improve), that the technicalities of SSM can be initially hard to master and that those participating in the research need to be invested in it (Augustsson et al., 2019). They however concluded that the SSM requirements for participation, consideration of contextual factors and continuous evaluation remained the significant and necessary strengths. These strengths supported SSM's most common application to structuring messy problems and coming up with suggestions for improvement (Augustsson et al., 2019; Damschroder et al., 2009).

3.8 Ethical considerations

Ethical approval for this research was obtained from the College of Medical, Veterinary & Life Sciences Ethics Committee for Non-Clinical Research Involving Human Participants, University of Glasgow. Key issues considered were as follows:

Consent:

To ensure that participant consent was well informed (S. Ali, Kelly, M., 2004), a Participant Information sheet and a Privacy notice were created; as well as Consent forms for the interviews, and for the workshops (Appendix 7). Preliminary chats also took place on initial contact with some potential participants, to explain the premise and purpose of this research. For those with whom pre-interview contact was limited to email, the emails always included the invitation to contact the researcher by responding to the email with any questions or queries about the research.

Consent forms were provided to participants as word documents by email, before the interviews and before the workshops respectively, to be signed and returned by email to the researcher. The email always included an offer to answer any questions the participant may have about the research. The consent form was always accompanied by the Participant Information Sheet and the Privacy Notice for the research, to inform participants on the purpose of this research, what will be covered in the interviews/workshops, their right to discontinue without giving a reason, and what will be done with their data. They were sent at least a week

before the scheduled date to allow participants time to read the documents, and with any reminder emails where necessary.

This information was in brief verbally repeated by researcher prior to the commencement of each interview and workshop, and the participant information sheet and privacy notice referenced as sources of more detailed information available to participants. Participants were asked if they have any questions before consent was requested again verbally to commence recording.

Sensitivity

The issue of FGM/C is a sensitive one (Lee & Renzetti, 1990) which has the potential to be distressing, especially for women who have undergone it, and where disclosures of trauma are made in group settings (Coe, 2013).

This research however is not concerned with questions about personal experience of FGM/C. Rather it is concerned with the wider and less personal questions of the strategies applied by stakeholders to address FGM/C in the Scottish context, what challenges exist in this, any potential unintended consequences, and how the strategies and approaches may be improved. Because of the impersonal nature of the study which addresses the 'big picture' of the situation, the discomfort of speaking about the subject is expected to be minimised. The study does not aim to recruit survivors of FGM from affected communities to discuss their experience, but rather representatives of community organisations (who therefore are already engaging on the issue in the public sphere) to discuss how the issue is addressed.

If a participant nevertheless was to find the discussion distressing during the interview, they were to be asked if they would wish to take a break, and if they did, this was to be done. Participants were informed that they are free to end their participation at any time, prior to commencement of the interview. This was done through the participant information sheet, and again verbally at the start of proceedings of the interview or workshop, prior to commencement of recording.

During data collection none of the participants expressed distress in speaking about FGM/C directly, although one participant from the statutory services showed some mild distress when speaking of their Italian grandparents' experience of cultural discrimination on migrating to the UK, and relating it to the discrimination

experienced by immigrant families from FGM/C practicing cultures. The participant was asked if they would like a break, but they quickly dismissed the offer. In the event, no participant required a break or withdrew from the interview or workshop.

A resource list of organisations and contacts providing support for FGM/C had been created which could be offered as part of the post interview/workshop debrief as a pointer for participant to support available (Appendix 18). This list was made with some hesitation for two reasons. The first was that the participants were already publicly involved in addressing FGM/C in Scotland and as such would likely be more aware of what resources are available than the researcher. Secondly, there was a potential that tensions may exist between groups, and singling out services offered by individual groups prior to commencement of research might be perceived as bias on the part of the researcher. Because of this, the resource list included all the groups on the initial contact list, regardless of their degree of specific focus on FGM/C (some had a broader focus on minority group adult and child safety and some offered signposting but not direct services).

The resource list was ultimately not used as it seemed out of place to offer it. There was no distress in speaking on FGM/C, and any participants who had offered personal anecdotes were from some of the very groups on the list, and well aware of the others.

Upon reflection after the fieldwork had been concluded, the resource list might have been of use, however not for it's original purpose of offering support to participants. It might instead have been of use to some participants from the statutory sector who were less aware of the existence of the support groups which existed for FGM/C. This signposting could still be offered with the research reports which will go to participants at the conclusion of this research.

Anonymity:

FGM/C being a sensitive issue, maintenance of anonymity was a consideration in this research. While the transcripts of the recordings were de-identified (names, dates and places removed), and access limited to principal researcher and the supervision team, there remained a possibility of deductive disclosure of

participant identity (Lee & Renzetti, 1990). This was because the type of social or professional role played by participants is reflected in the research, thus narrowing the field of potential identity. A Data Protection Impact Assessment was done as part of the application for ethical approval due to this risk, however the risk, and the impact was thought to be low as it was mitigated by the fact that participants were already in roles which publicly address the issue.

The participant information sheet clearly stated this risk of inability to absolutely guarantee anonymity.

Power disparity:

Another issue of ethical concern was that participants in the workshops may include people of very different perspectives and power positions, for example community representatives and police representatives who may have conflicting opinions on the issues raised. This could hamper free discussion during the workshops due to a perceived possible negative impact on the community groups, or communities themselves (Lee & Renzetti, 1990). To allow participants contribute freely to discussion, the workshops with community groups were separate from the workshops with NGOs and statutory services (Smithson, 2000). This worked well in the workshops, with rich data being obtained from the community groups which may have been inhibited by a mixed workshop.

While this mitigated the issue of power disparity, it unavoidably reduced the capacity for interaction between stakeholders. To ensure that all participants could respond to the same questions and consider the same issues, the same format and models were used for all the workshops. This ensured that each group could see, and was responding to, the input from all the stakeholders from the prior research stage. This use of shared models allowed some mitigation of the separation of a stakeholder group, but could not compensate entirely for it, as direct interaction was lost. For the purposes of this research however, this loss did not hamper finding overlap in interests for finding ways to improve the situation, as the use of the conceptual models of the human activity systems provided rich prompts for discussion, and the overlap was clearly observed, even where different models were being discussed.

Conflict of opinion:

Conflict of opinion could affect proceedings in a workshop either silencing those with opinions differing from the majority, or by derailing discussion to directions of interest to dominant members of the group (Smithson, 2000). The premise of this research is that the issue of addressing FGM is a complex one, with multiple perspectives present, and that an increase in understanding is necessary in order to avoid unintended consequences in addressing it. To pre-empt conflict, the participant information sheet (see Participant Information Sheet) noted the presence of multiple perspectives on the issue of FGM/C, the impact of the difference in perspectives on the capacity to address FGM and the need for research bringing together these multiple viewpoints. The workshops were also held in small groups aiming for 4-5 people in order to allow people more freely express themselves, community groups having their own workshop, while NGOs and statutory services in mixed group workshops, as the interviews had indicated established good pre-existing collaboration between these groups (ibid).

The NGOs also had participants from a background in FGM/C affected communities, who also brought the perspective of the affected community into the conversation at key relevant points. The NGO's position 'in-between' the statutory and community groups, thus somewhat mitigated the separation of the community groups.

Potential of harm:

Another area of ethical concern was that statements might be made in a discussion of FGM/C which may have legal implications, as the practice is illegal. This would raise up a conflict between confidentiality and welfare (Baez, 2002). Again, this was mitigated by the participants already being in roles where FGM/C is addressed in the public sphere and thus have some experience of speaking on the issue.

The participant information sheet and the consent form also stated that confidentiality may be broken if a participant says something which suggests that they or another person may be at risk of immediate and serious harm. If a questionable statement were to be made, it was to be brought to the supervisors attention and a decision to be taken as a group on whether any further steps were

required. If yes, a decision was to be made on who may need to be contacted and action taken accordingly. In the event, nothing requiring such intervention was raised during field work.

Payment:

Majority of the participants were in paid roles with regard to FGM/C. Some participants (community groups) were however in voluntary roles. Participants who were in a voluntary role in addressing FGM/C were therefore offered a compensation of £20 for the interview and £30 for the workshop.

As this research moved to an online format in response to the COVID 19 pandemic, there were no travel costs to be covered.

RESULTS	AIMS OF THESIS	SSM STAGE
Chapter 4	**Build understanding**	**Finding out: expressing the unclear situation**
Chapter 5		Building models: structuring the situation using models of purposeful activity
Chapter 6	Find ways to improve	Evaluate models: compare with reality and define feasible changes

4. RESULTS – Expressing the situation

4.1 Introduction:

This chapter will present the results for the initial SSM stages (the finding out stages), where the identified unclear problematic situation becomes an expressed one. Using an SSM rich picture supported by thematic analysis of the data, the chapter will express the stakeholder roles and perspectives as well as their priorities and challenges. The rich picture will particularly enhance the understanding of what elements are present in addressing FGM/C in Scotland, and how these are relevant to the various stakeholders involved.

The Rich Picture of the situation will first be outlined. Then findings will be presented, related to its various sections. First how the drivers of FGM/C are perceived by participant stakeholders; then the stakeholder roles in addressing FGM/C. This will be followed by sections on stakeholder priorities in addressing FGM/C and the challenges in carrying out their roles. The chapter will conclude with a reflection on issues arising under the themes of “motivation”, “knowledge”, “control” and “legitimacy” (the four themes offered by the 12 questions of CSH) in addressing FGM/C in Scotland.

This chapter lays out the background picture of the situation in addressing FGM/C in Scotland. This situation will be structured into its relevant purposeful activity systems in Chapter 5.

4.2 Rich picture:

SSM uses rich pictures as a tool to express an unclear situation in the first instance, and to help build an understanding of how those involved in it see it. How this rich picture was produced is detailed in the methods chapter. As a reminder, it is built on qualitative data obtained through individual stakeholder interviews.

The rich picture (Fig. 4.1) expresses the issues present in addressing FGM/C in Scotland. Its purpose is to provide a richly detailed snapshot of the situation captured in the stakeholder interviews, as well as for use as a discussion prompt in workshop 1 to support building a shared understanding of the situation.

I will first outline the picture before subsequently presenting related findings. Details on how the issues highlighted are understood by stakeholders in Scotland are presented following the outline.

(Please zoom in)

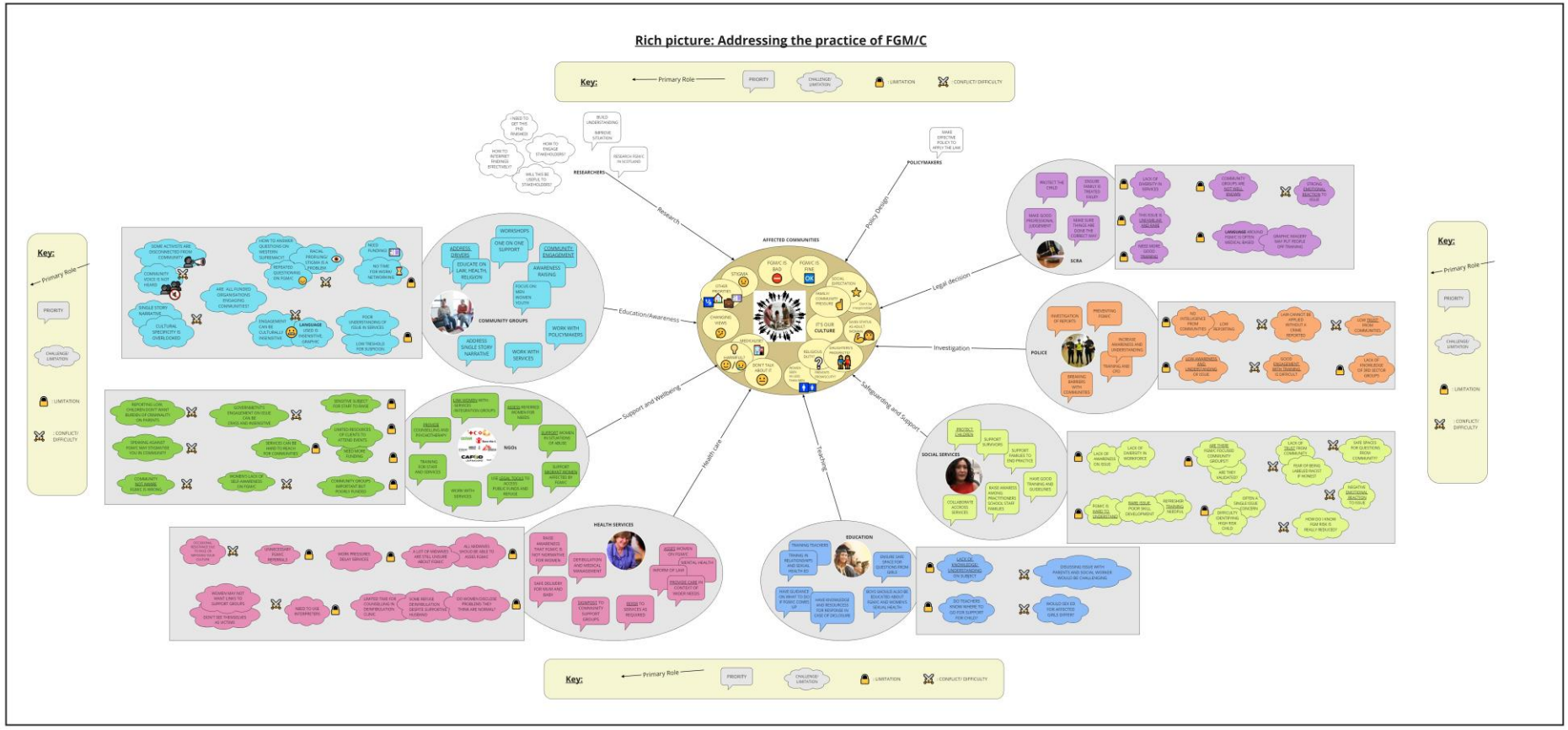

Fig.4.1 Rich Picture of addressing FGM/C in Scotland

Outline of Rich picture:

At the centre of the picture (Fig.4.1) is the issue being addressed: FGM/C in affected communities (Fig. 4.2).

At the heart of the issue in affected communities is the family within which the practice may take place, surrounded by the community, whose norms drive the practice. It is not a practice thought up by individuals, but one which is presented to them as the 'done thing' in their community. There is however a varied picture in the affected communities. Views in affected communities are not monolithic. Changes in attitudes to the practice are ongoing in countries of origin, as well as in diasporic communities, as shown by the literature review. This is reflected in affected communities in Scotland. Positions on the practice are not monolithic, with some opposed to the practice, others maintaining a positive view of it. Regardless of personal position on the practice there is pressure to do it, there is social expectation from parents/grandparents and extended family who see it as the responsible thing to be done for the child as 'this is our culture'.

The detail of what is driving the practice in communities of origin, and subsequently in diaspora varies. In some places it makes one a full/complete woman therefore is a rite of passage to achieving adulthood. This was referenced by a participant from Kenya and another from south-eastern Nigeria. In other places the concern is about the daughter's future marriage prospects; or that this may be a religious duty; or that it might prevent promiscuity. This was referenced by participants from the region of Sudan and Somalia. The drivers for the practice varied between ethnicities and regions, in a wider context where women's social status may be less than men's. However, it is a sensitive subject, so one which is discussed without reason. Many women in affected communities did not recognise the harms of the practice. For some women it was only when the issues were tabled before them that they had a "light bulb moment" and linked their FGM/C to the problems experienced. Community group participants acknowledged that in general, awareness raising about the harmfulness alone led people to consider medicalisation it to make it safer.

People's views changed over time, with exposure to challenge/questioning on the drivers, and integration with Scottish life. But all this happened in the context of

other problems and life issues, such as immigration issues, obtaining good housing, employment and income; therefore FGM/C may not be a priority. In addition, there was stigma associated with FGM/C. Opposing it could bring stigma from their community of origin; and on the other hand in Scotland people felt painted with a broad brush - being from an affected community you were seen as a risk to your daughters.

Around this centre portion of the rich picture are laid out the stakeholder groups addressing the practice in Scotland. The stakeholder groups include the participants who took part in this research. These are community groups, NGOs, and the statutory services which included health care, education, social services, police and Scottish Children's Reporter Administration SCRA. These sections present a snapshot of the details which will be presented in this chapter. In white at the top of the picture are recognised the presence of stakeholders in the situation who were not researched, that is of the researcher, as well as of policy makers, who are a relevant actor in the situation, but who were not represented in the research as in the end it was not possible to recruit a participant from this group.

The arrows linking the stakeholders to the communities in the centre indicate the roles they play. The circle around each stakeholder group highlights their priorities, and the rectangle beside them highlights their challenges in carrying these out. The padlock icons represent limitations and the crossed swords conflicts/difficulties.

The key to the image is placed along each border of the picture.

4.3 Perspectives on FGM/C and its practice in affected communities:

This research is focused on how FGM/C is addressed in Scotland. It is therefore necessary to first take a look at how FGM/C is understood by those addressing it.

First, the perspectives of participant stakeholders on FGM/C itself will be given.

4.3.1 Participant views on FGM/C:

This section considers whether participants viewed FGM/C as a negative, positive, or neutral practice.

All the participants in this research, including the grassroots community group representatives, viewed FGM/C negatively. The negative view of participants on FGM/C is described under themes: harm to health, infringement of rights, child protection, and negative emotional reaction.

4.3.1.1 Harmful to health:

Harm to health refers to negative impact (including, pain, bleeding, problems with periods and difficulty in sexual relationships) on the physical and mental health of women and girls due to FGM/C. All the stakeholder groups referenced their view that FGM/C was harmful to health. The terms used were harmful/negative practice, harmful cultural/traditional practice, practice causing mental and physical harm, mutilation. The community group participants more frequently described it in terms of being a cultural practice which was harmful to women, for example: *"It is a harmful cultural issue and it has a very complicated negative impact, and it has nothing positive" (005-COM-BB)*, while the social service participants more frequently referred to it as mutilation.

4.3.1.2 Infringement of rights:

Participants spoke of FGM/C depriving women and girls of bodily integrity and autonomy and being a form of abuse. All the stakeholder groups expressed the view that FGM/C was an infringement of rights. While community group participants spoke more in terms of this being a cultural practice that was an abuse of human rights; social service participants often referred to it in terms of intergenerational abuse. Participants across the stakeholder groups also referred to the practice as part of gender-based violence or violence against women, and an illegal practice in Scotland.

A community group participant contrasted the perspective on the issue in the affected communities and the services in Scotland, showing the difference in understanding:

> *"here it's taken as a legal issue. It's taken as a criminal issue, as a criminal act in the country. And also, it's looked at from the child protection issues, because it is a child protection issue to the country. In the community it's from the cultural point of view." (008-COM-WB)*

4.3.2.3 Child protection issue:

FGM/C was seen as being something children should be safeguarded from. Following on the view of FGM/C as harmful and a form of abuse, was the view that it was a child protection issue. This was recognised and supported by all the participating stakeholders, including the community group participants, giving it importance. The role played in safeguarding was however played out differently in the various stakeholder groups, as will be noted in the section on roles.

4.3.2.4 Negative emotional reaction:

A fourth theme in expressing views on FGM/C was that of a negative emotional reaction to the practice. This meant a feeling of revulsion towards the practice, where it was described in terms such as barbaric, horrific, abhorrent. The negative emotional reaction was referenced by many of the social service participants and by the statutory legal representative either as their view, or as the potential view of others. A social service participant encapsulated this view:

> *"when you hear accounts from young girls who have had FGM, or you hear mothers speaking about having had FGM, their description is very, sounds to me, very barbaric. That, sort of, of being held down, about no real concern around about, you know, whether what's being used is clean, so there's risk of infection […] And for me, it's even more abhorrent given that it's actually a woman's…a girl's genitals" (012-STAT-Social)*

This view was not expressed by 3rd sector nor health care participants. The statutory legal participant and one of the social service participants were reflexive about this view, considering its potential impact on practice and the risk of a lack of balance in response to the issue where it was present, but some others stated it

in an unqualified manner. This type of language was challenging for community group participants. One of them was emphatic in expressing the tension such views created for herself and other community members opposing the practice, as it was perceived as being denigrating and condescending to individuals and affected communities. This point will be revisited in looking at challenges in addressing the practice.

4.3.2 Drivers of FGM/C:

These were those factors which perpetuated or promoted the practice of FGM/C. Participant perspectives on the contexts and drivers for FGM/C in affected communities are unpacked in the sections below following the themes highlighted in the rich picture (Fig. 4.2), in a clockwise direction.

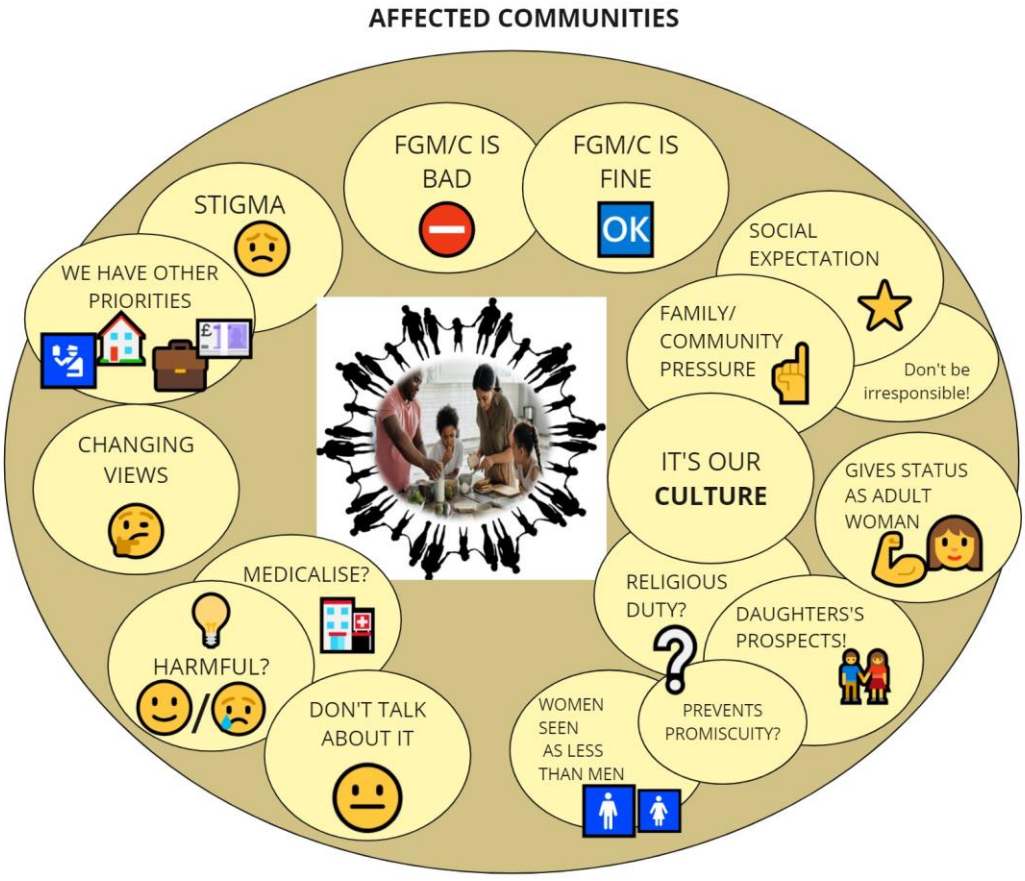

Fig. 4.2 FGM/C in affected communities.

4.3.2.1 Culture and tradition:

FGM/C was a part of the ideas, customs and expected social behaviour in societies which practice it.

Community group participants had the richest, most varied understanding of the practice, which reflected its complexity and variability, and an intimate knowledge of the communities in which this was practiced. This was related to their role, addressed in the next section, in which they raised awareness and educated on FGM/C practice in their affected communities of interest. One community group participant explained the hold of culture and tradition with respect to FGM/C:

> *"[They would say] My grandparent practiced this, my parents practiced this, I should practice this. That is our culture. Who are you to come and change that tribe, or that generation to generation? Who are you to come and change that*?" (002-COM-BB)

Because the practice was normative in the culture of affected communities, it was also often not seen as abusive or victimising, as was pointed out by a health care participant:

> *"A lot of women don't see themselves as being a victim because it's just something that they do culturally, much in the same way that men are circumcised as babies." (017-STAT-Heath)*

A community group participant highlighted that this cultural drive created a culture clash with the younger generation brought up in Scotland, and could result in family conflict, difficult for all concerned:

> *"Now, you will see someone will have maybe a culture where they come from where the FGM is accepted. Now they have their children here, where they want to force them to have that. And the children does not want to do it. Again that is another challenge, you know. And you will see in the*

house, it will be boom, boom, boom, boom, they will call police, the police will come, there will be fights, and the children will end up in the social services. So, just that again, is a mental torture, for the parents and for the children" (002-COM-BB)

The challenge within families of navigating a culture clash may mean extra parental pressure, as parents feel the need to be stricter in order to pass on their values:

"For some second generation girls and women the control is even stricter. Because, you know the parents see around them the different influences their girls are getting and they want to have that even tighter, you know, they want to make sure that they don't stray so it can be even harder for them" (003-NGO-BB)

It was also noted by a community group participant that despite strong cultural driver of FGM/C, change has been ongoing, and opinions and practice on it were not monolithic in affected communities, not just in Scotland but in the country of origin as well: "*Because still in Sudan we have some practice [FGM/C], others not".* (005-COM-BB)

Most NGO participants saw culture as the driver of the practice, with the exception of one, who viewed it more as a part of abusive practices towards women. This may have been related to their background and practice, as those NGO participants who did view it as driven by culture were from countries where FGM/C was practiced, and had roles which included engaging with both individuals and families in the context of resisting the practice; while the exception among them was a Scottish human rights lawyer working with refugee and migrant women and children affected by violence.

The health care based stakeholders generally saw the driver of FGM/C as cultural and a social expectation, which they needed to respect people's feelings about when engaging with them, even while disagreeing with the practice or also seeing it as a form of abuse. They dealt with this clash of perspectives by being respectful in how they spoke about it:

"you can't just turn around to somebody and say, well, actually you talked a load of rubbish, you're absolutely wrong, you know, blah blah blah. That's, that's just bloody cheeky. And because we are dealing with people who have been told about FGM by their parents or by their grandparents, and you know, it's a deeply held tradition within their family, within their tribe, within their village, within their area, and who am I as a white British woman to turn around and say, well, actually this is all wrong. So you do, you have to be able to be respectful of the fact that it's a tradition and it's a long held tradition. Even though it's not a good tradition. You have to be able to respect that" (009-STAT-Health)

4.3.2.2 Social expectation:

FGM/C was seen as a practice required for acceptance and participation in the life of the affected community. It was described by participants in terms of extended family pressure to have FGM/C done, and in recognising the sub-drivers discussed below.

Community participants tended to emphasise cultural drivers behind the social expectation, while social service participants tended to emphasise the family drivers.

This nuance may be relevant, as not viewing culture as the driver in the first place may alter response to the practice, and focus it at individual, and not community level.

4.3.2.3 Family pressure:

FGM/C is a practice strongly directed and influenced by (wider) family exerting pressure to live in line with social expectation.

Social service participants were generally more focused on how family dynamics drove the risk of FGM/C. This fitted in with the focus of their general statutory role of intervention in families to protect the vulnerable and support individuals and families to thrive, and their broad view of the practice as a form of intergenerational abuse. One social service participant did frame it in terms of

culture, but this understanding seemed related to the personal experience of her own grandparents as a part of an immigrant community in Glasgow.

In terms of family pressure, a social service participant noted that the pull and draw from the family back home was something they had observed, and acknowledged that:

> "*that can be really difficult because people know that if they don't do that, potentially, they're going to be cut off from their extended family.*" (012-STAT-Social)

A community group participant emphasised this pull and draw despite geographical distance: *"we are living in transnational space, and their grandparents there, brethren, for example, will ask them to do FGM"* (005-COM-BB). The same community group participant recounted an incident where a mother came to her for help with a daughter, born and living in Scotland, who was insisting FGM/C be done on her. This was as a result of grandparents and cousins calling her names when she communicated with extended family in their country of origin. The girl changed her mind when the participant explained to her and her sisters about the impact of FGM/C, what it entails, and how this effects their health now and their sexual life later.

An NGO participant pointed out the vulnerability of young couples who might generally value their extended family's advice and community support, and the consequent risk *"if they are not aware of the process in here, in terms of it being illegal, in terms of […] self-awareness about how to help themselves to be in [a] position to say no to the family members and to the communities" (*019-NGO-BB)

That FGM/C is a community driven practice is not necessarily understood by all stakeholders.

One Social service participant noted a perception in the service that women chose this for their daughters:

> *"I think, particularly perhaps for mothers, I think there's perhaps or has been, that view that women do this to their children. And they don't*

understand the women's experience and what her experience has been. Or maybe don't understand the community pressure, or the pressure from the in-laws, or you know, whoever it is that has that kind of strong role in the family" (014-STAT-Social)

The statutory legal service participant also expressed how his perspective on what drove the practice changed during a case he had worked on in which information, and support for the family involved had been provided by a community group. He moved from a position which assumed parental decision drove the practice, to one which acknowledged external family pressure pushing it:

"I hadn't really thought of it that way. I always thought it was a decision that parents wanted to take. But in actual fact, in this case it appears, they felt forced to consider, they didn't take it, but they were forced to consider it" (006-STAT-Legal)

This participant acknowledged that the involvement of a community group representative in a recent case was helpful in expanding his understanding of the practice.

The lack of understanding of the issue as being a community driven one was identified as a significant problem by one community group participant. She shared her frustration at the profiling of African women as a risk factor for FGM/C.

She pointed out that signifying African mothers as a risk for FGM/C coupled with ignorance of community drivers meant missing the fact that a white British woman would be subject to the same community pressure for FGM/C.

"If you're a white woman, married to an African man, then it's almost like oh, it's okay, just pass and go. That in itself is really not understanding the issue of FGM at all. Because on one side you're assuming because I am an African woman, therefore I'm going to allow my children to be…I'm going to be part and parcel of allowing my children to take part in the FGM of my girls. While if I'm a white woman married to an African man, then it is okay. That I'll not be able to allow my children to take part in the FGM. And that was a very narrow way of looking at it. And in actual fact almost I would say misconception, misunderstanding of the highest order.

Because FGM is a community issue. And the fact [is] that [when] this white woman would go back in this community, these children belong to the community. They don't belong to her. And therefore regardless she is a white or black woman, the children are in danger. And that is one of the things which really vex some of us. And nobody was talking about it" (008-COM-WB)

4.3.2.4 Sub-Drivers:

The practice of FGM/C is culture specific. This means that different types of FGM/C are practiced in association with the cultural practice of a given region/ethnicity.

The community group participants and some of the NGO participants had the most nuanced view of the practice which reflected difference in types, contexts and specific drivers in affected communities, that is, the cultural specificity of the practice. These themes are detailed below.

Theme1: Rite of passage:

FGM/C was seen as an event that marks transition into adulthood in some cultures.

One community group participant, from a culture which traditionally had FGM (Type1) as part of a rite of passage for girls talked about this, as a requirement/ social expectation for gaining adult status, or 'being a woman'. She mentioned the need for alternative rites of passage (that is, without 'the cut') in her community of origin, because going through this rite of passage into social recognition of adulthood and completeness of womanhood was so valued: *"it's the issue of being a woman, being this…this 'woman' which is so important. The concept of a woman in an African sense, depending whichever place you come from, is so, so important*" (008-COM-WB)

An NGO participant used stronger language to describe this driver:

"some women have been so brainwashed that they have to do this to be real women. And that brain washing is very difficult to undo […] And that is why the thing keeps repeating from generation to generation. Because it's really, really, difficult to undo that brainwashing. So even though they

went through a lot, they cannot see how their daughters cannot go through it, because they've been brainwashed that it has to be done for one reason or another" (004-NGO-WB)

Theme 2: Marriage prospects:

The assumption that FGM/C was a necessary condition for marriage and hence with securing a daughters future prospects drove the practice in certain communities. It was mentioned by community group participants who worked with Sudanese and Somali communities, where Type 3 FGM/C was practiced. One noted the perception in her community of origin that *"girls who have not gone through the process, they are unmarriageable. Nobody wants to marry them"*. She also recounted a situation where a groom-to-be's mother found out her future daughter-in-law had not had FGM/C and insisting on it as a condition for the marriage. It was not clear whether this incident had occurred in Scotland. However this driver was still strong enough in diasporic communities that even where it was not done during childhood because of the law prohibiting FGM/C, it could still be done in adulthood before marriage:

> *"even here, even for people who lived here in Europe, not necessarily in the UK, they do not do it in childhood but before marriage we find some people do it." (*005-COM-BB)

Another community group participant who worked with men from these communities on this issue said that the social expectation of FGM/C as requirement for marriage drove reluctant acquiescence even where there were doubts about the practice:

> *"Most men would say we will do it because they are afraid of social exclusion. Because in villages, the villagers will know which girl is cut and which is not cut. So people would be starting talking, oh that girl is not cut so you should not marry her. So even some men who are not pro FGM, they will do that practice just to guarantee that their daughters will be married." (001-COM-MB)*

Theme 3: Perceived religious duty:

In some cultures, the tradition of FGM/C has become entwined with the practice of religion, resulting in the perception that not doing it would be failing in religious duty. This was strongly referenced by two of the community group participants who worked with the Sudanese and Somali communities. They described how their community groups took a systematic approach to demonstrating that FGM/C was purely a cultural practice, which predated their religion, did not arise from it and was not actually required by it. They went into much detail in addressing and challenging this perception in workshops and information sessions for communities. One community group participant noted that this was the more challenging part of her education and awareness raising work because many people strongly believed the practice was part of religious practice.

Theme 4: Fear of promiscuity:

The assumption that FGM/C reduces a girl's libido and so prevents promiscuity was a perception supporting the practice of FGM/C in affected communities. A community group participant who recalled having to address the perception that *"if women are not cut then they will be kind of roaming around or they will not be satisfied with one man, and they will [be] considered promiscuous, or something like that" (001-COM-MB).*

This meant that a decision not to do FGM/C could be viewed as neglectful in the community, as *"you're leaving your daughter to become a slut, or she's going to sleep around" (003-NGO-BB)*

Theme 5: Benefit of child:

This referred to FGM/C being done for the perceived welfare of a child. The views on this were varied, and voiced explicitly by two social service participants in the context of trying to understand what drove the practice. One participant from social services spoke of her struggle to understand why people might carry out FGM/C, eventually concluding it was done because it was seen positively:

> *"I had to take myself to a place of 'So why is this happening'? Because, it can only be because people think it's a good thing." (007-STAT-Soc)*

> *"I think hearing people's stories... talking to mothers who have facilitated FGM being done on their children out of love, you know, not out of abuse or anything like that. And talking to girls who don't want it to happen. And then talking to mothers who will make sure that it doesn't happen has been really powerful."* (011-STAT-Soc)

However, this view was not a dominant one and was voiced only by those social service participants who had been involved in an open day with communities a few years prior. Another social service participant was clear that it was unambiguously intentional mutilation, and people's awareness of its illegality made them hide the practice:

> *"They're taking their children abroad to be mutilated, so that's a big barrier, you know, in this and that's a across the child protection board, you know, not very many people [say] I'm going to help my kid, you know, I'm going to expose my kid to sexual abuse. But I suppose by definition if people are going to be doing something, expose their children to something that they know is wrong, they're not going to disclose it to people who are going to take action." (016-STAT-Social)*

This difference in view on what drives FGM/C has implications, because as one NGO participant pointed out, understanding why the thing is done determines the appropriate response to it.

4.3.3 Contextual factors:

4.3.3.1 Women seen as 'less than' men:

One of the community group participants noted that FGM/C took place in the context of patriarchal perceptions of women, explaining that she meant *"where women's status was always less than men's status" (021-COM-WB)* in public life which was male dominated. This view was implicitly supported by other community group participants when they spoke of addressing issues such as coercive control or violence against women in their work on FGM/C.

An NGO participant echoed this view of inequality and need to control as a contextual driver for FGM/C, saying:

“Why are girls and women subjected to FGM? Because they're seen as less important than men, because they are seen as something that needs to be controlled, because their sexuality is seen as dangerous, because women's genitals are seen as having those mystical powers, you know that have control over women.” (003-NGO-BB)

Some of the statutory service participants were more pointed in this view, seeing it as direct oppression by men:

“for me, I think it sounds like it’s an oppression by men against women. The idea that, you know, a woman would be subjected to that, and I’m saying subjected because I feel that’s what’s happening, and that in some way makes a woman more acceptable for a man, for a husband, you know” (012-STAT-Social)

“It was historically used, I think, to subjugate women and I suspect it's still a tool to subjugate women, and women have…there are so many ways of subjugating women, it's just yet another way” (017-STAT-Health)

However, when community group participants and some NGO participants zoomed in on the concrete/tangible role of men in the situation, a more nuanced picture emerged:

“men are often seen as the drivers behind a lot of abusive cultural practices against women, but um, what I also find is sometimes men also have no bloody clue what's happening. And it's almost like the fear of men or of what men might think, what men might do, then becomes the driving catalyst for women to continue to perpetuate the practice. And that's how, you know without realizing it, there is a rift you know. We see men as the reason that we're doing all these things, and then you go and talk to men and its like ‘what's FGM’? You know, they have no idea” (003-NGO-BB)

In line with this point, some community group participants noted that men often felt that FGM/C had nothing to do with them, that it was a women’s affair, done by the mothers and the elderly women in their community, and that they were not consulted when it was carried out.

One NGO participant voiced her contrary view to the narrative of oppression by men with regards to FGM/C, and was not willing to minimise the role of women, suggesting that the situation may be different in different cultures:

> *"You know, I'm looking back to this FGM. Looking back in our culture, who were the people doing the FGM? They were women. They were not men. The men were not there. So when they keep saying men, I say maybe for some countries, but really who are the people doing this? It's women." (004-NGO-WB)*

4.3.3.2 Taboo subject:

FGM/C was a sensitive subject, one not casually spoken about. This was raised by the community groups participants, and most of the NGO participants in terms of the reluctance of people to speak about the issue and the necessity of an appropriate and culturally sensitive approach in doing so. A community group participant noted speaking about the issue could make women relive the trauma, but in the appropriate context, speaking about it could be a release, as it may have never been discussed previously:

> "*and even the trauma experiences, when they talk about it, they feel they are released, when they talk openly with other people. Because they said since our childhood we have not discussed this issue" (005-COM-BB)*

However the subject was not sensitive only in the affected communities. This was also mentioned by a health care participant, suggesting that FGM/C was still an unfamiliar and 'taboo' subject to many midwives; and by some NGO participants who emphasised that some health practitioners and some NGO staff were not willing to broach the topic; as well as the police participant, who noted that there was a real reluctance and wariness within the force to broach the issue. The racial tensions in the situation were also acknowledged by social service participants, one noting that *"I think social workers are afraid to be honest sometimes because they don't want to be seen to be racist" (011-STAT-Social).*

4.3.3.3 Ignorance of harm

A recurrent point made by community group participants and some NGO participants, was that women commonly did not link the problems they may currently be experiencing to the FGM/C they'd had, only connecting the dots once the issue was tabled. One community group participant noted that most women in her community of interest did not know what normal adult female genitalia looked like, and recalled how in education sessions on the health impact of FGM/C women became aware that they experienced the symptoms discussed, which they had never before linked to FGM/C. She confirmed that a lot of women will say they don't have any negative effects from their FGM, but that a lot of them may not connect the problems are experiencing to the FGM they had. An NGO participant echoed this point saying that *"a lot of the time, um, women won't actually identify any challenges because FGM has been part of their life for so long that it's kind of it's normal […] because you know this has been happening throughout the community or through different generations of the family, a lot of women just assume, that well, such is life" (003-NGO-BB).*

Another community group participant noted the emotional impact it had on a woman over 50 years old at one of their meetings, when it dawned on her that her own type of FGM/C, which was elongation, was responsible for the breakdown of her three marriages, *"And it was very, very emotional just for her to come to that realisation […] and the worst [was] when she realised she had been encouraging her daughters to take part in this practice, because […] the aunties are the ones who show you […] what to do, how to do it. But it has its own effect as opposed to the cutting"* (008-COM-WB)

Accordingly, a community group participant noted that in her awareness and education raising work, *"the most positive [is] also when I have a medical doctor, talking about the health background, or the health impact physically and mentally. I think this is very positive because a lot of women [come to] understand their situation" (005-COM-BB).* A community group participant whose work was with men spoke of the shock expressed when he discussed the medical implications of FGM/C with them, observing that *"medical implication is one of the main convincing arguments for refraining from this practice" (001-COM-MB).*

The health care participants also noted the lack of awareness of harm, observing that the practice of FGM/C was so normative in the communities of practice that they were concerned that women were living with symptoms of FGM/C they did not report, as they were seen as being normal for women.

4.3.3.4 Medicalisation:

FGM/C being performed in a medicalised setting for harm minimisation was raised by some of the community group participants as an outcome of awareness raising efforts on FGM/C highlighted the health risks, without addressing the factors which drove the practice:

> *"But we forgot to tell people that there are other issues and therefore the rise in medicalisation of FGM, that we still have to maintain our culture. Oh, so it's only because you're going to get an infection and you're going to bleed if it is done in the village. Hence let's recruit some medical personnel into this […] But we keep our practice." (008-COM-WB)*

This was a driver where the harm minimisation approach justified the continuation of the practice. This was important as it meant that education and awareness raising efforts could not be limited to education on harms.

4.3.3.5 Changing views:

Perspectives on FGM/C change. Community group participants reported changes in position of community members, following the drivers being challenged. This sometimes had immediate impact, as in the case of one young man who called his family back home after a workshop to prohibit them from carrying out FGM/C on his daughter; or another one who started engaging with his friends back home on social media on FGM/C and initially got push back, but where after a couple of months those friends came back to say they have investigated the thing and now agree with his opposition to the practice. The impact of this change in perspective had an impact on those back home, and community group participants spoke of deliberately engaging in awareness raising to change perceptions not just in local communities, but by extension in communities of origin.

All this change however takes place in the midst of other priorities and life stresses, with community and NGO participant pointing out that women in communities could not always attend educational events because of limitations such as transport costs and child care. FGM/C and the issues it could cause would be part of the wallpaper of life for affected communities and women, so it was often not a priority for the women who lived with it.

4.3.3.6 Stigma:

The experience of being negatively viewed in relation to the practice of FGM/C was an issue raised. It was experienced in communities both for not practicing and for being perceived to practice FGM/C.

A community group participant noted that stigma was experienced by girls who had not undergone the practice, where extended family were in support of it, for example in recounting the story mentioned above of the girl who demanded to have FGM/C following the name calling she experienced from her extended family in their country of origin. Stigma was also experienced by parents who resisted the practice, with parents or grandparents asking why they lived in *"a country that does not respect our culture?* "(005-COM-BB).

Speaking out against the practice was challenging because "*you might become like a bad person in the community" 004-NGO-WB,* and could cause fraught relations between families who continue to practice FGM/C and those who do not.

> *"I think we underestimate, when somebody chooses to abandon a practice that's been going on for 5000 years, it's not just a simple on off switch, you know. You don't just go hey, I'm just not gonna do that today. It's not smoking, you don't just give it up. We're talking about a huge shift in mindset, with massive implications and complications for individuals, families, children." (003-NGO-BB)*

So much so that: *"I know women who have been attacked on the street for their decision not to cut their daughters. And I mean attacked verbally chased down the road. You know, like really, really bad stuff. Um, 'who are you to tell us we need to do things different'?" (003-NGO-BB)*

Stigma was also experienced by affected community members from the Scottish context. A community group participant spoke of the stigma felt by women when in hospital people would be called to see their FGM/C, and in the repeated questioning on FGM/C from the statutory services:

> *"the most challenging for them is repeated questions about FGM when they are pregnant. And the midwife, social worker or health visitors, they talk a lot about FGM, even if they have not [had it]. The most challenging is the talk, and it is the stigma. For them, the stigma comes from contact. And mainly when they want to travel to Sudan, and they have a young daughter […] the police come, the social worker…So yeah, this is a big problem for them, because many of them contacted me for help […] Yeah, it's a headache" (005-COM-BB)*

Another community group participant shared how African women felt this stigma through profiling as potential abusers:

> *"The way women were being presented, specifically the African women. The way we were being treated, especially if you had to travel and you had children. For example, I'll say if you're an African mother with an African man, with your children, going on holiday, you will get stopped, you'll be questioned, you'll be… Let me use the word harassment, for lack of a better word. And it's almost like you've already…people had assumed you were going to make your children have FGM when you go out of the country [while] If you're a white woman, married to an African man, then it's almost like oh, it's okay, just pass and go." (008-COM-WB)*

Stigma was therefore experienced by individuals both from their communities, for opposing FGM/C ; and from wider Scottish society for being a member of a community associated with the practice.

4.4 Roles in addressing FGM/C in Scotland:

The roles describe the function assumed or part played by stakeholders in addressing FGM/C.

In expressing this unclear situation it is important to clarify the roles played by stakeholders, as these indicate the purposes present and at work in it. Nine roles will be discussed below.

4.4.1 Education and awareness raising:

Education and awareness raising by providing information and knowledge on the issue of FGM/C in Scotland primarily to affected communities was a theme most talked about by community group participants. They were founders or members of grassroots groups, who had become involved in work on FGM/C. Some of them had engaged in this work in their community of origin.

> *"I grew up in a family that campaign against FGM in my home country, originally from Sudan. And our work [was] to raise awareness. Because […] we think law is not the way to fight the cultural issue. Educating people is the right one. So my family is starting this by educating women and men. So I grew up in this family and participated in that work." (005-COM-BB)*

The community group participants detailed their efforts in engaging community members to challenge the beliefs that drove the practice, as well as supporting community members under pressure to have it carried out. Education and awareness raising in communities was therefore meant to challenge the drivers, raise awareness on its health impacts and inform on its illegality, and legal consequences. For participants working with predominantly Sudanese and Somali communities in Scotland, this role included a component on debunking the idea that the practice was mandated by religion.

This role was also carried out by some community group participants in a wider context of challenging violence against women. This sub text was present in the work of most of the community group and NGO participants, sometimes quite explicitly:

> *"My role is project manager in challenging violence against women. So in challenging [violence] against women we talk about all the harmful practice, the violence in all its context, whether it is female genital mutilation, gender based violence or honour based violence". (001-COM-MB)*

Another community participant worked on FGM/C in the context of supporting African families from a wide range of countries and cultures to integrate and adapt to the culture and life in Scotland. The emphasis by his group in educating and awareness raising on FGM/C was that if FGM/C had been legal and culturally acceptable in one's country of origin, it was illegal and culturally unacceptable in Scotland. Therefore carrying on the practice would destroy aspiration to a successful life in Scotland:

> *"But because we live in a different country with a different system with different law[s], we need to adapt, as I said earlier… we need to make sure that families who live in Scotland, they understand what are the law[s] in Scotland, because that will help them to be a good citizen. And that will help them also to have a good track record of their behaviour, because everything, including their behaviour, impacts their life in Scotland." (002-COM-BB)*

Community group participants engaged with the broadest cross section of people in affected communities, including women, men and youth, in their work of education and awareness raising.

Education and awareness raising was also done by other stakeholder groups, but its context varied widely and was related to how the primary role of those stakeholders engaged with affected communities. NGO participants carried out education and awareness raising in engaging with women who were vulnerable and seeking help. Depending on their primary role, they educated women about the health impacts of FGM/C, and the support available to them. The breadth of this role for NGO participants was very much dependent on the focus of their work, wider with those who offered emotional and practical support, and much narrower where the focus was on, for example, legal intervention on behalf of migrant women.

Participants from health care engaged in education and awareness raising mostly with pregnant women. They engaged with this group because women were asked about any history of FGM/C when registering for antenatal care and where there was one, referred to specialist midwives. Health care participants had the highest footfall with respect to FGM/C among the statutory services. They educated on the

health impact as of the practice, and on its legal status as part of safeguarding where the child was a girl.

Participants from social services, the police and the legal statutory service SCRA were limited to dealing with reported cases, where a risk to FGM/C had been flagged up. They had a low footfall of cases and identified this rarity as a challenge to them, which will be unpacked later. Where they did educate, this was focused mainly on educating parents and families on the child protection implications and the illegality of the practice in Scotland.

The teaching professional highlighted an educative and awareness building role within schools as part of the curriculum for Relationships, sexual health and parenthood (RSHP) education, (also known as RSE).

4.4.2 Exclusive work with men:

A role discussed only by community participants was engaging specifically with men from affected communities on the issue of FGM/C.

One community group participant focused on working exclusively with men from affected communities in Scotland to engage on the issue of FGM/C. He noted how most FGM/C initiatives focused on the women, and how the choice to work with men was considered and deliberate:

> *"There were so many reports coming on this subject, and mostly they were focusing on women […] So when this came to our organization […] we discuss[ed] it then said let us go ahead with that […] we knew how good it is to work on that [FGM/C], especially from the man's perspective. So it was an opportunity came and we grabbed it. And that's how I was involved" (001-COM-MB)*

He also saw their role as reaching out beyond Scotland:

> *"We inform people, raise awareness on this harmful practice not only here in Scotland. We are meant to work in Scotland, but in extension we ask the people who attend our workshops or [with] whom we do the outreach*

sessions to relay the message back at home so that we will tackle it from its base or from where it is coming." (001-COM-MB)

The other community group participants also engaged with men on FGM/C in the course of their work, but not exclusively and deliberately like the participant above. FGM/C was not addressed in isolation when engaging with men. The participants also ran workshops on violence against women and coercive control, to fully inform the men about the impact on women and on their relationships.

4.4.3 Representing African women:

One community group participant emphasised she was carrying on the role African women have played in challenging FGM/C, both in driving for policies against the practice here in the UK and in resisting the practice in their country of origin. A role she felt needed highlighting, as successful opposition to FGM/C had already existed in affected communities, but that this was not recognised in the discourse in Scotland. She spoke of the courage and determination of her own grandmother to protect her daughters and granddaughters from FGM, saying: *"I stand on her shoulders." (008-COM-WB).* She felt that an approach in Scotland which did not recognise the work in communities to end the practice was condescending:

"So that's the other [thing] which is very annoying, because in this country people talk and think FGM is a new phenomenon, so let's teach these communities and talk down upon them, that they need to understand" (008-COM-WB)

She saw her role as helping to raise the community voice to be counted in Scottish policy discourse, which was important as both representation and adequate understanding of the issues was necessary for any policy on FGM/C to be effective.

While the other community group participants also spoke of the need for representation, it was not necessarily as explicitly prioritised.

4.4.4 Support and wellbeing:

The role of building capacity to thrive and mitigating the impact of FGM/C for affected individuals was talked about strongly by NGO participants. They spoke of their engagement with survivors of the practice and supporting them in their needs. These were usually adult survivors of FGM/C, and on occasion girls deemed at risk of it. They engaged with affected women on FGM/C directly through their role in support provision to those in need, including practical support providing for material needs, and psychological support through counselling. Also by signposting or referral to other services the women needed, and linking her community support groups local to her where possible.

> *"I have been with [NGO] for more than ten years now […] a majority of my work during this ten years' experience as a professional was with women, and FGM was part of their casework we were dealing with, either for practical support and emotional support." (019-NGO-BB)*

> *"I was initially a counselling student on placement and I was supporting basically women who had experienced any form of domestic abuse, culture based abuse, […] FGM started to become more and more mentioned…so I am managing mostly domestic abuse services, but there's one service that specializes in supporting women from Black, Asian and minority ethnic backgrounds" (003-NGO-BB)*

One NGO participant provided support on FGM/C specifically to migrant women and young people as a human rights lawyer.

> *"I am a human rights lawyer…My particular specialism is in working with refugee and migrant children, young people, and migrant women who are affected by violence […] So my contact and the contact of my colleagues with individuals who have either experienced or are at risk of FGM is predominantly through issues that are arising relating to their immigration status. (015-NGO-BB)*

Support for women affected by FGM/C was addressed by some NGO participants explicitly in the wider context of challenging violence against women:

"[we are] one of the organisations that work with the violence against women, and that is how we got involved. Because FGM is one of the violence against women… My current role now is a team leader for visiting support" (004-NGO-WB)

And some of the health care participants from health care addressed FGM/C as part of a caseload including trafficked women, or gender-based violence.

4.4.5 Health care provision:

The health care provider role focused on the diagnosis, treatment, and amelioration of injury or other health impacts of FGM/C. Participants fulfilling this included role senior midwives who took referrals of women with FGM/C, and a consultant responsible for surgical procedures to open up women with Type 3 FGM/C. The focus here was assessment and health care provision to women with FGM/C.

"I also get all of the referrals from mainstream community midwives or antenatal clinic midwives when they come across a patient at antenatal booking that discloses they've had FGM. Then they will automatically refer to me" (010-STAT-Health)

"I set up a weekly clinic on a Friday afternoon so that if women had said that they had had any type of circumcision at all or weren't sure then they would be referred to my clinic on a Friday afternoon. And I would speak to them about it, and invariably it would involve an examination down below." (017-STAT-Health)

This role provided the clinical care women needed to allow a safe delivery, and addressed other clinical needs the woman had. The participants in this role also had a role education and awareness raising for the women in their care, informing them about their FGM/C; as well as the role of support since they signposted and referred women to other relevant services. They also played a role in safeguarding, by assessing risk of FGM/C to child through establishing whether pregnant women had intention to protect their daughter from FGM/C.

4.4.6 Teaching at school:

Teaching pupils about FGM/C in the context of providing relationships, sexual health and parenthood (RSHP) education was relevant to the participant from education. She had previously taught school pupils and was now involved in training teachers to address FGM/C as part of delivering relationships, sexual health and parenthood (RSHP) education to pupils. The participant felt that preparing teachers with regards to FGM/C was important as Scottish schools were increasingly diverse. It was important therefore to understand practices from various cultural backgrounds, so as to be able to understand challenges that a pupil may be experiencing and offer appropriate support.

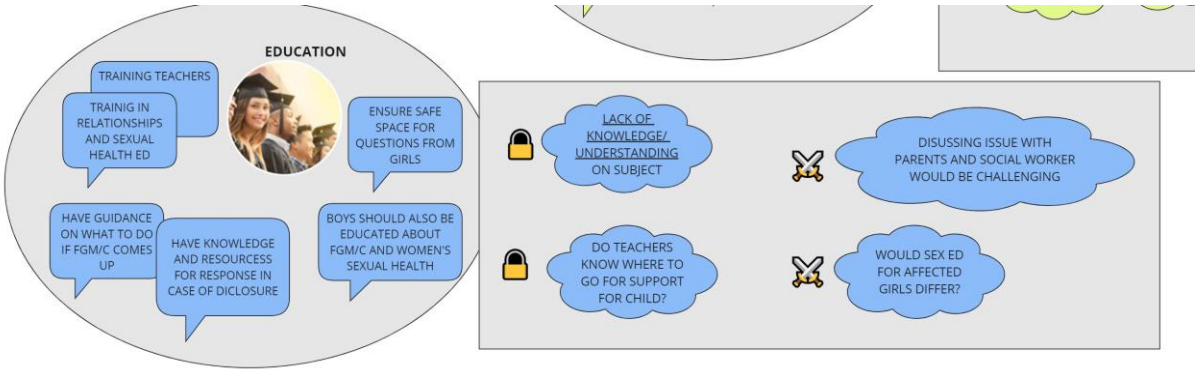

Fig. 4.3 Rich picture highlights of Education priorities and challenges.

Participants from community groups and some NGOs also had been involved in speaking about FGM/C in schools, as part of raising awareness about the practice. This was different form the role played by the teacher as the groups only went in for a defined workshop or information session. The education participant noted that teachers formed good relationships with the children in their care, and could be trusted figures that children could tun to for help or information.

4.4.7 Safeguarding and support:

This meant ensuring protection of children from FGM/C and supporting families to reject the practice. It was an explicit role for the social services:

> *"a lot of what social workers will do will be around about welfare and childcare concerns so they are things that we are worried about, that there*

are things that perhaps we'll provide support and advice." (012-STAT-Social)

Health care participants spoke of having to make a judgement during antenatal care on whether a mother had protective views, that is, whether she intended to protect her child from FGM/C, when they were assessing women who had experienced FGM/C.

Community group and NGO participants also played a role, in linking safeguarding concerns to the social services, or supporting an investigation with their knowledge and understanding of the issue.

For teachers, it meant raising a red flag if they were concerned about a child. For NGOs and community group participants it meant reporting a child known to be at risk to the social services, and working with the services on the case.

Safeguarding overlapped with crime investigation for the police where a case of FGM/C was being investigated, and legal decision making for SCRA if a minor was involved. Reports of children at risk of FGM/C were infrequent and not from the communities.

4.4.8 Investigation of crime:

The investigation of reports of criminal activity on FGM/C, to prevent the practice or prosecute those involved was the role of the police participant. It meant investigating reports related to FGM/C, either to establish a criminal case for prosecution, or to prevent FGM/C from happening. It required reports of illegal activity to have been made and the availability of leads/intelligence that could be followed up on. The police participant emphasised that carrying out this role depended on links with the services which interfaced with affected communities directly, such as education and health care; and possible links with affected communities, which were very difficult to forge.

4.4.9 Legal decision making:

Making a legal decision with respect to child protection in a case involving FGM/C was a role held by the participant from the Scottish Children's Reporter Administration SCRA. The role was very specific:

> *"my role and my organization's role is to determine which children require to go before the children's hearing. So that decisions can be made about them as to whether the state should become involved in a statutory way" (006-STAT-Legal)*

In Scotland, the role of SCRA is to review any criminal cases involving a minor, as part of a process to determine if the case merits protection orders, that is, whether compulsory orders to take the child into the custody of the state are required. The reporter identifies that a child may need protection orders, and the case then goes before a children's hearing panel which will make the final decision.

This decision is relevant in a case involving FGM/C as it is a serious crime in Scotland. It is be aimed at safeguarding the child in question. The participant emphasised that such cases were very rarely seen in his organisation, the one he had been involved in being the first he was aware of.

4.5 Priorities in addressing FGM/C in Scotland:

All the participant stakeholders worked towards ending/mitigating the effects of FGM/C. However, they had very different priorities in addressing it. Stakeholder priorities in the situation were based on the role they played as well as their understanding of the drivers and perspective on the situation. The role described the type of work they did in addressing FGM/C, while the priority describes the things they did to fulfil the role.

This means that there was some variability in the priorities of stakeholders within stakeholder roles as well. The greatest variability was shown in the priorities of the community group participants. Two focused on challenging drivers in the communities, one of whom focused exclusively on work with men; another focused on supporting integration in Scottish society, for men, women and youth; and

another focused on raising the voice of affected communities in the discourse on FGM/C.

The NGO prioritised support provision to vulnerable women, with some variation in the target groups they served. These were women facing domestic or culture linked abuse; or migrant women, either refugee or asylum seekers. Their priorities ranged from practical or emotional, to legal support.

The priorities of the statutory service participants were strongly related to the role of service in question and there was less variation within these groups.

Priorities found in the situation are unpacked below.

4.5.1 Community engagement:

Community engagement meant initiating and establishing dialogue on the issue of FGM/C in/with affected communities. It was the primary priority for the community group participants. It was also held by NGO, health, and education participants.

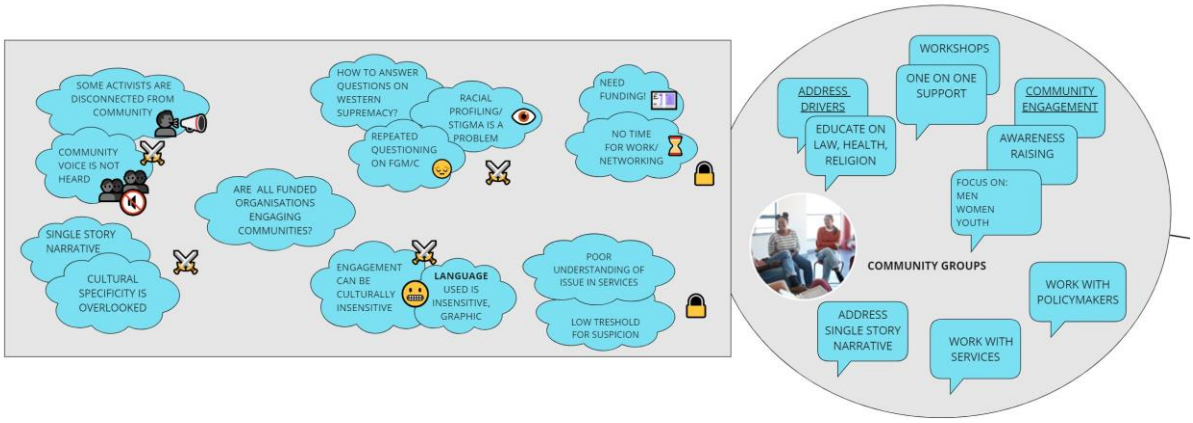

Fig. 4.4 Rich picture highlights of Community group priorities and challenges.

For community group participants, this work was done in the context of workshops and one-on one sessions with members of affected communities. It included raising awareness on the existence of the practice in affected countries. This basic awareness was not a given– some of their workshop participants argued that it did not occur, until faced with statistics on the practice published from their own countries. One community group, and one NGO participant confessed their own

lack of awareness of the extent of the practice in their home countries until they got involved in this work.

For community group participants, community engagement involved education on the medical impact of the practice; challenge to the drivers of the practice in the community of interest (for example demonstrating that the practice was not mandated by religion); education on the law against the practice in Scotland, as well as the penalties attached to the practice.

One community group participant emphasised the illegality of FGM/C in Scotland in his community engagement work, which was geared towards helping families new to Scotland integrate fully in Scottish society. He avoided debates about culture, *"because a culture is a culture"*, but focused on pointing out that *"in Scotland [FGM/C] is not acceptable. They [Scotland] don't accept that. So because they don't accept that, therefore, you shouldn't do it. That [culture] does not apply here in the UK." (002-COM-BB)*. He emphasised good citizenship, and the potential consequences of breaking the law, which would scupper the aspirations of community members in moving here.

Another community group participant emphasised the importance of engagement to educate about the drivers and the impact of FGM/C in her community of interest. She noted the limitations of law alone in eliminating a deeply rooted practice viewed as necessary, and that education was required:

> *"[The law is] not enough by itself. Yeah, not enough. Because people [will] practice it in one way or another. But education is essential. But law Is good in prohibiting the practice until people are educated, and when people are educated the following generation, they don't need the law." (005-COM-BB)*

They worked with women, men and youth separately, as this was more effective and better able to serve the specific needs of the different groups. Two of the community groups had also been involved in awareness raising activities in schools.

Most NGO participants engaged communities through the women and families they supported, through events they offered, or by speaking at schools. They aimed to empower them clients to resist the practice. One NGO participant explained how

her approach in addressing FGM hinged on first finding out why it was seen as desirable, and offering alternative options for protecting the girl or ensuring her status in the community. This was because engaging in this way yielded better results.

> *"people respond a lot better if you say, how about I give you a different option? You know, why do you want to perform FGM? Because you think otherwise your daughter is going to be unfaithful? That she's going to have extramarital relationships? […] How about, you know, we invest in your daughter's education, so that she learns how to keep herself safe. She knows how to how important consent is in relationships. She understands how to keep herself safe from wandering boys or whatever. Um, she's a very desirable bride. Because she has invested time and energy educating herself. And also that raises your own status in the community because you have a daughter that you have thrown money and energy behind to actually educate her and make her a good professional. So it's all about kind of offering those alternatives, and making sure that people see that there's different ways to arrive at the same result" (003-NGO-BB)*

This type of approach created a safe space where people could unpack their questions. The idea of such a safe space was brought up by a social service participant, but she admitted that it was probably not doable for a social service participant without launching child protection measures.

This statutory concern was noted by the NGO participant:

> *"I understand why this might bring a bit of a panic for a lot of professionals. But we need to have a softer approach. And we need to recognize that removing a child may not always be the answer" (003-NGO-BB).*

Community engagement was focused on educating and informing affected communities about FGM/C with the purpose of empowering or facilitating rejection of the practice. Community group participants emphasised the importance of a culturally informed and sensitive approach for successful engagement.

4.5.2 Engaging men:

Initiating and establishing dialogue with men on FGM/C is highlighted here separately from general community engagement because there were specific issues in engaging men. It was difficult to engage on the issue because they tended to see it as a women's issue:

> *"When I work with men, I have not talked about this much, recruiting men to attend the other courses was a big challenge, because men [say], if it is woman issue, it is not related to us. But when they attend the courses, they find it is the men's issue and not woman's only. Woman do it to please the man, not for themselves" (005-COM-BB)*

Engaging men was the explicit priority of one community group participant. His community group actively sought out and engaged with men, including asylum seekers and refugees from affected communities. This required building up trust and relationships with them through supportive services like help with online forms and employability, and worked with other groups on events to boost engagement with the host community, Scotland. When the men were open to it they were invited to workshops they offered, including on FGM/C.

He prioritised engagement with men on the issue because he noted that most interventions on FGM/C were aimed at women, and he felt engagement with men as well was crucial role to hastening the end of FGM:

> *"men have the role because, you know if men were involved from the beginning, actually this practice could have, the age of this practice would have been now almost at the dying age." (001-COM-MB)*

He noted that *"men should be involved because they have a role to play. They have, you know, in the communities that they come from, men hold the power. So if men are educated they can change this practice […] If men will say they are not going to marry women who are cut then this is, I think the last straw which will finish this practice, so men have great role play in that".*

This was the only participant who with his group prioritised exclusive engagement with men on FGM/C.

4.5.3 Support provision:

Providing material, emotional, or legal assistance to women affected by FGM/C was the key priority for all the NGO participants. They offered women direct support through for example, counselling services, or material support, of through provision of legal support, depending on the specialization of the NGO, and collaborated with the statutory services to do so: *"once the women speak about it, there is support. Once they are brave to come and speak about it, there is support, and working with social work, the health service and everything, we are able to support a lot of those victims" (004-NGO-WB).* in the case of another NGO participant, this support included the application of legal tools to obtain access to public funds and refuge for affected women.

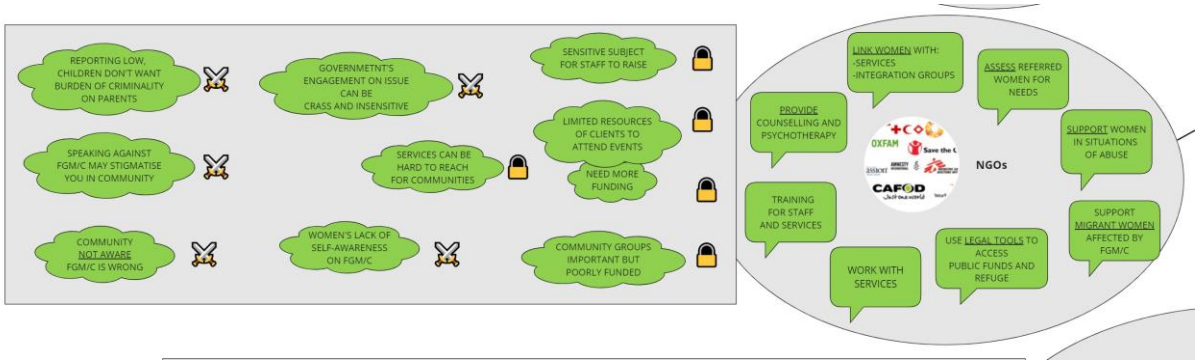

Fig. 4.5 Rich picture highlights of NGO priorities and challenges.

Another NGO participant detailed how they were able to refer women to doctors or nurses who specialised in supporting women who had experienced FGM/C, or for reconstructive surgery in order to provide needed support. Another explained how she ensured women were linked with community support groups local to her where possible, to support ensure they could feasibly and benefically access them within a limited budget: *"we will choose based on the postcode area based on their needs, in terms of improving English, improving wellbeing and friendship". (019-NGO-BB)*

Support provision was also prioritised by community group participants, who did this through accompaniment and personal support, help and signposting with accessing services and education, and ensuring women do not feel isolated. One community group participant detailed the need to support women by making sure that *they "have a proper integration, and they have everything that they need available" (002-COM-BB)*

Health care practitioners also provided support by taking a holistic approach not limited to clinical assessment/care, but also signposting or referring to other services, including financial support services and community support organisations they were aware of.

> *"It's about the whole support system round about FGM and not just about assessing their genitalia. I mean that's a tiny wee part of it and as midwives we should be supporting our women fully" (010-STAT-Health)*

Participants for the social service also described working to support women to protect themselves and their children: "*it was about making sure that she had all those…so maybe not even directly to do with FGM. It was just, actually, making sure that she had all those supports that would actually help her and the children. Just to get the best…to have the best life that they could actually have" (012-STAT-Social)*

Support provision was focused on improving the wellbeing of women and their families.

4.5.4 Service delivery:

This primarily refers to clinical assessment of women with FGM/C; provision of treatment; and mitigation of harm due to FGM/C. The key work done by the other service providers on FGM/C is unpacked in the other sections.

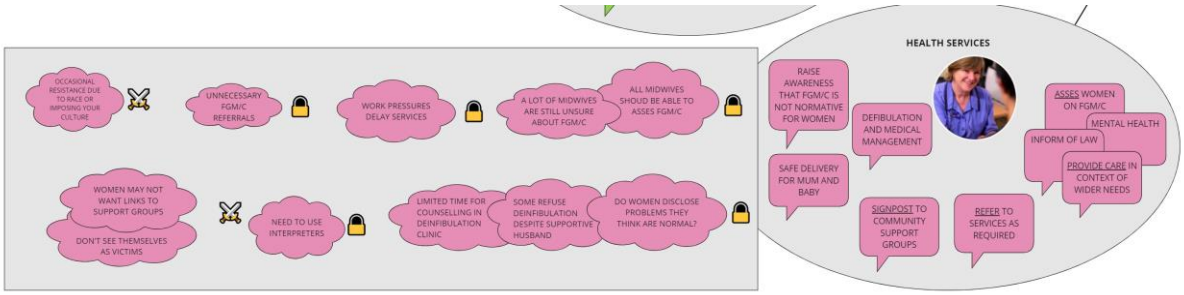

Fig. 4.6 Rich picture highlights of Health care priorities and challenges.

Service delivery for the benefit of women was the priority for the health care participants. They detailed their aims in maternity service:

> *"to have a good outcome for woman and baby in delivery with respect to FGM would be a good outcome [..]from an FGM point of view to ensure that they women get better care in labour." (009-STAT-Health)*

> *"We offer de-infibulation antenatally so that everything is nice and straightforward at delivery". (010-STAT-Health)*

Some women refused service offered them, for example deinfibulation surgery to open up their type 3 FGM/C, despite their husband's being supportive of that:

> *"The husband was quite supportive […] he was supporting her, and was trying to …not only persuade but basically counselling her also to get this procedure done….And she totally refused that"(013-STAT-Health)*

And these women were seen as needing extra support and counselling, or being seen earlier on in their pregnancy.

The service also covered provision of mental health care: *"if women were upset the other option would be I could offer them clinical psychology in-house because one of the criteria for in-house clinical psychology is where labour or birth might be potentially traumatic" (017-STAT- Health)*

Health care participants noted that women often did not see themselves as victims and were not interested in engaging with support services.

The health service saw the greatest footfall of cases of FGM/C seen among all the statutory services, as all pregnant women from affected communities went through this service. They also had specialist service providers, as opposed to the other statutory services, where any practitioner who received report of a case had to deal with it.

Service delivery was focused on improving the health and wellbeing of affected women, as well as being an interface for the statutory service with affected communities.

4.5.5 Training:

Professional development to ensure that those who addressed FGM/C in their professional roles were adequately trained to do so was mentioned by several participants from various stakeholder groups.

All but one of the NGO participants were involved in providing training, either to interagency professionals or to their own staff, in order to improve service provision.

All the health care participants trained, or were planning to offer training, to other health care providers, on assessment and treatment of women with FGM/C, in order to improve availability of care. The training available had been created by the participants or by their predecessor in their role: *"This was X's teaching that she did to the students and to other staff, […] and there will be tweaks and things that we can do to it now to update it obviously, but that is where we would start from there and take that through". (010-STAT-Health)* The health care participants were largely satisfied with the training they'd had as they felt I'd held them in good stead in their work.

Most of the social service participants had not had formal training sessions, and due to the rarity of cases they saw, were clear that they lacked the confidence thy did have in addressing more familiar issue. They depended on available guidelines, and oversight in their processes:

"we've got Glasgow City Council's best practice guidelines for it, and to be honest, because it's infrequent, as I said to you earlier in the interview, I refer to that each time" (016-STAT-Social)

The one participant from the social service who spoke of attending training on FGM/C had a role in creation of service guidelines and described how one good training session she'd made a big difference in her understanding of FGM/C. Prior information sessions had given: *"types of FGM, here's why it's practiced, and here are the prevalence numbers, although we don't really know, that kind of thing",* but this training gave her a global and cultural context for the practice which was impactful*:*

> *"it might be in a country where it's outlawed. And that might be a South Asian country, not necessarily an African country, or you know, and actually well here it's happening in Sweden or whatever, you know, so it was really quite helpful. But also to see again that it's, I think it's a cultural thing, under the cultural competence part of it, of understanding that" (014-STAT-Social)*

However, the quality of training was hit-and-miss, and sometimes non-existent. The participant from the NGO legal service admitted that while he had training on gender based violence, *"We have not had somebody come in and train us on this is what FGM/C is…The skills and knowledge that we have around that are based on our experience of working in it" (015-NGO-Legal)*

Many of the statutory service participants indicated that their knowledge of FGM/C was based on personal research. One health care participant described:

> *"I was self-taught. My predecessor had retired. I had seen it as a midwife […] But I was self-taught. I just…I watched DVDs, I read books […] I also spoke to a lot midwives in England, but I did that off my own bat […] So, I suppose the job was…I made the job" (017-STAT-Health)*

The statutory legal participant said that it was by chance that he'd had training in FGM/C in the past, before having to recently deal with a case involving the practice, and that it'd been poor:

> *"the training I undertook a decade ago was pretty much someone reading from a text putting a PowerPoint together. There was no real um, knowledge there, that was just reiterating studies. We need actual real people to come and talk to us about why this happens, what the pressures are, how families feel about what pressures are they under. Um, I think that would make it feel more real, and people would be more aware of it, and it would retain in their minds for longer" (006-STAT-Legal).*

This input from affected communities, from people with lived experience of engaging with FGM/C in communities, and from affected women was seen by most participants as very valuable in gaining understanding of the issue.

Good training was therefore identified as a need, especially in view of the rarity of cases seen. One social service participant suggested that regular updates would be helpful, as *"by the time you need that information, three and a half months down the line, you've maybe forgotten it a bit"*:

> *"some kind of rolling agenda, I don't know, maybe even three times a year or something, that you go to, with updated information and, you know, more knowledge we're getting from different organisations. Presentations from a relevant third sector who are FGM specific, that kind of thing would be really helpful" (016-STAT-Social)*

The need for training was emphasised *"because it is so rare has simply to fall back to training." (006-Legal*), as building skill from frequent practice was unlikely.

Good training supported stakeholders in effectively carrying out their role in addressing FGM/C.

4.5.6 Collaboration

Stakeholders worked with one-another to address FGM/C to various degrees. Each participant did have a network of groups they collaborated with in addressing FGM/C. However while links between statutory services were established and maintained as necessary, links between statutory and community groups were much more variable.

The community group participants tended to mention other third sector groups they networked with, but also mentioned the NHS where they had links with a GP, or working with the services on issues of child protection. They found this important because of a general lack of understanding of the issue in the services.

One community group participant in particular, spoke of prioritising work with policymakers as well as communities. They engaged in government consultations to raise the community voice in the policy arena:

> *"Beating the drums and saying we're here, this is what is happening, this is what we think, [so] the policymakers can say oh, actually, they're saying something, we can ask them a question. Or we can invite them for this meeting" (008-COM-WB)*

She noted that it had been a fight to secure a space for the community voice:

> *"The involvement of the community, we had to fight for that space where the community voice needed, not only the so-called experts, and not only the service providers, because you needed to understand the whole complexity, you've got to understand why it's done, who is doing it, and how it's done." (008-COM-WB)*

Collaboration of the communities with stakeholders was a crucial priority for her, in order to support creating an effective approach to end the practice, one which avoided unintended effects based a on lack of understanding of the issue.

NGO participants liaised broadly with both community groups and statutory service providers in supporting affected women, and in child protection matters. Health participants had established links with the third sector. Among the health care participants, all the midwives knew of, and regularly signposted women to community support groups which dealt with FGM/C, in order to ensure they had ongoing support.

The police participant spoke of liaising with health care and social work, and could mention several community groups she had previously had links with before she'd been assigned to a different post in the force. It was clear in the interview that she had prioritised breaking barriers with communities, and had deliberately worked to establish this links. She had since left that post and it was not clear if

her successor had maintained this. She was however clear on the need for breaking barriers and collaborating with communities, as with respect to FGM/C, there was no intelligence coming to the police from communities, as is detailed in the section on reporting (under challenges).

The social services were at the centre of the multi-agency network for child protection and liaised with education, and health care. Their relationships with third sector support groups were very variable however, with regards to FGM/C. Some social work participants could name third sector FGM/C support groups they had previously worked with, and the benefit it brought to social work interventions:

> *"both of those agencies, I found very helpful in terms of maybe bridging some of that relationship gap. You know, and certainly a better communication and better communication about FGM within the context of why social work are involved" (012-STAT-Social)*

She reflected on how collaboration with community groups could be beneficial to their social work practice in addressing FGM/C:

> *"I think as well it's probably about involving more third sector and community groups who would have more knowledge of FGM, and I don't mean in terms of advising us where FGM is a risk. I mean in terms of helping us to understand what FGM means, not what we think it means, but what it actually means and, you know, what ways we, as an organisation, could do better in terms with working with families around about FGM" (012-STAT-Social)*

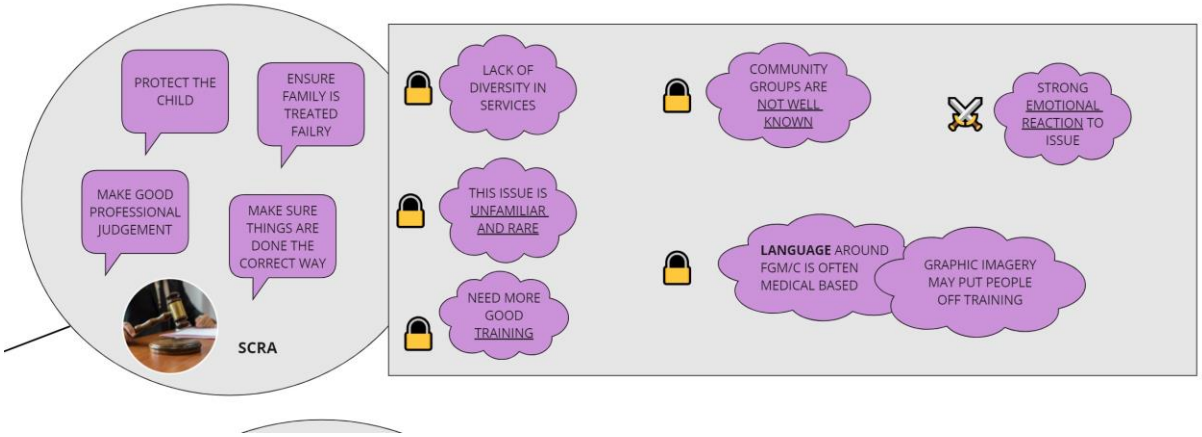

Fig. 4.7 Rich picture highlight of statutory legal priorities and challenges.

The impact of collaboration with community groups was emphatically described as beneficial by the statutory legal participant:

> *"that support service was invaluable. They provided interpreting support. They understood the law, they supported the family face to face, in their own home. Uh, without that service, I think, uh, the route this referral would have taken would have been very different. And I don't think that would've been in anyone's best interest, potentially." (006-STAT-Legal)*

Other social service participants had little knowledge of community groups working on FGM/C, although they did work with third sector support groups such as Barnardo's or Quarriers on other issues:

> *"I honestly don't know of any, and certainly not in the north east. So we would use our, kind of, standard third sector agencies, the ones I've mentioned already. But, yeah, absolutely […] we do collaborate with other professionals, we do collaborate with third sector"(016-STAT-Social)*

This lack of knowledge of community resources on FGM/C was echoed by the participant from the statutory legal service who noted that while a community group's input had been very beneficial in a recent case, and had helped him expand his understanding of FGM/C, he'd had no prior knowledge of them:

> *"it would be good if they would make themselves known to state agencies. It's also our responsibility o go out and find out about them, but I hadn't heard of them before, I've never seen a leaflet of theirs, I've never seen anything. So within the building I work in there are leaflets and information about domestic violence, about Crime Stoppers, about a whole range of issues that impact children and families. There is no poster or leaflet or signpost in relation to FGM." (006-STAT-Legal)*

Collaboration between stakeholders, or its improvement, was always seen as a positive thing by all participant stakeholders. However, with the exception of the

health services, collaboration between statutory service participants and communities was aspired to, but not well established.

4.5.7 Child protection:

Safeguarding of children from FGM/C was the key priority of the social service participants. It was also a priority held by all other participants.

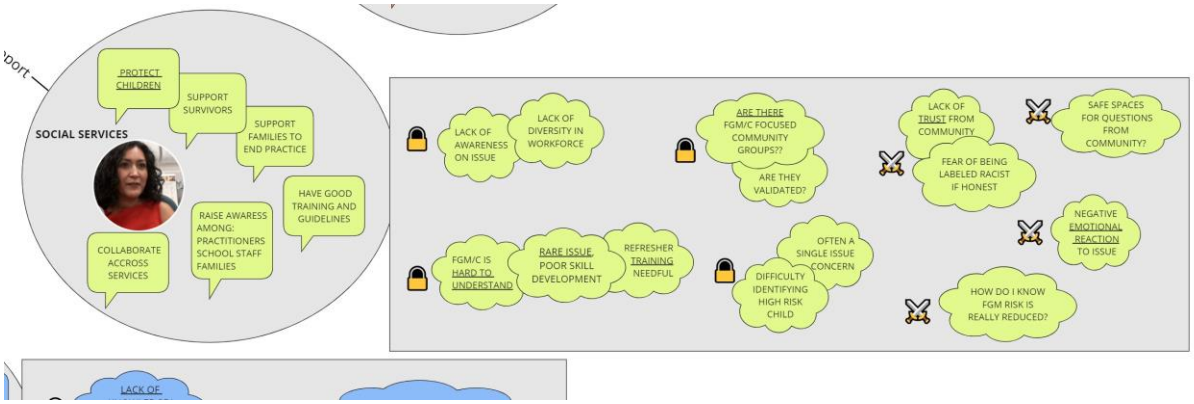

Fig. 4.8 Rich picture highlights of social service priorities and challenges.

Safeguarding meant that where a child was reported to the service as being at risk of FGM/C, social services intervened to assess the risk to the child, monitor the family and then decide if the risk has been reasonably removed.

Safeguarding was a priority for the police participant, in trying to prevent crime; and for the statutory legal participant, in working to make a right judgement on whether protection orders for state custody may be required for the safety of the child.

It was a priority for the education participant in the context of potential disclosure by a pupil. She focused on the necessity to be aware of how to respond and who to contact in such a case.

NGO participants worked with the statutory services to support safeguarding. However their approach, depending on the body, was more nuanced. For example, one NGO participant focused on the legal loopholes for protection of girls aged 16-18, where young people were classed as adults by the child protection systems,

but did not fall under adult protection systems until they were 18, creating the need for special protection orders in the interim. While another NGO participant detailed how important it was for her to find out and address the possible reasons FGM/C might be a risk; in order to better distinguish between a baseline risk due to being from an affected community from an actual heightened risk of FGM/C:

> *"I think, there comes a point where, let's say, when a statutory response is required […] That is not necessarily always good. You know if you're taking a child out of an environment where they're being beaten, abused, starved, you know, yeah, of course you need to get them to safety. But the risk of FGM doesn't always come with child abuse. It doesn't always come with sexual abuse. Most of the time, you know all the, not all, but the majority of the women I know who are survivors said I had the childhood of a Princess. I was loved. I was cared for. It was just this one thing, you know." (003-NGO-BB).*

A social service participant also noted that FGM was often a single issue of concern:

> *"quite often with FGM it's a single concern, so we're not, I'm not saying not always, but we're not often then talking about neglect and a child being sexually abused and the child's been physically abused. Often with FGM it's the one issue that we're in to discuss so, you know, the house can be perfectly presented, the kids are going to school every day, they've got great attendance. You know, parents are very focussed, education's really important, and then we have this one concern."(016-STAT-Social)*

This is a challenge to assessing actual level of risk of FGM/C to child, and also means that children at risk may have no red flag raised about them, unless they report it.

A community group participant addressed hesitation towards reporting in communities by reframing it as safeguarding of both child and family:

> *"we show them when you report a case or the potential case, you protect the child from going through the process and you protect the parent from going to jail. Because when you report the case, they will not do it and*

they will not go to jail. But if you let them do it, they will be discovered, and will be finished." (005-COM-BB)

Safeguarding was dependent on identifying children at risk and reporting.

4.6 Challenges in addressing FGM/C:

This section will explore the difficulties experienced by stakeholders in addressing FGM/C in Scotland.

4.6.1 Lack of understanding of FGM/C in services:

The absence of a good understanding of FGM/C, its practice and contexts, and how to effectively address it was a recurrent challenge. It was experienced by participants in all stakeholder groups. In the statutory services by the lack of knowledge and understanding in the service they were part of, and in the community groups because they experienced its effects. The health care participants were confident in addressing the issue, but they were specialists receiving all case referrals, and said that this confidence is not reflected across the service. The other statutory services did not have FGM/C specialists, and any cases would be taken by whoever got them.

An NGO legal practitioner encapsulated the disorientation in dealing with the issue in Scotland:

"We don't have a sense of where it is practised, how it is practised. We don't have a sense of a particularly cohesive approach to how to tackle it. But, nonetheless, we know it is happening or we understand it to be happening…" (015-NGO-Legal)

Social service participants in general referenced the lack of understanding of FGM/C in the service, and linked it to the rarity of cases they saw:

"it's not…my experience is, it's not prevalent in the northeast of Glasgow that we would…that all social workers would have a really robust knowledge and understanding of it" (012-STAT-Social)

The issue was unfamiliar, and training was limited: *"FGM has been discussed, but maybe for an hour over the course of a day" (016-STAT-Social),* and the rarity of the issue meant that there was not much chance to develop skill and confidence in dealing with the issue:

> *"If you've never dealt with this before then you're not going to have the confidence, you're not going to be thinking outside the box, you're not going to be working with people necessarily that are used to dealing with that, because it's unusual." (011-STAT-Social)*

So lack of understanding was seen to limit both confidence and effectiveness in the social services. And the police participant also spoke about how lack of understanding made an already fraught situation worse:

> *"You had all of those hurdles in terms of every barrier you can think of. The lack of trust, difficulty in communication, the language barrier, lack of understanding on the part of my social work colleagues. It's really, really, that whole area is really, really difficult to navigate."018-STAT-Police)*

The statutory legal participant spoke of how lack of familiarity with the issue meant that agencies' response to FGM/C could be disproportionate:

> *"I would classify as, eh, ah, it was a very disproportionate response to the issue at hand. You do not need 4 police officers in a house dealing with that issue. You need one, potentially two. You need officers who are aware of the cultural issues involved with FGM." (006-STAT-Legal)*

> *"social workers and police officers are often very familiar with dealing with abuse, neglect. But when these agencies had come into contact with something like FGM, it's quite rare, and how they respond, can sometimes perhaps not help the situation. I'm trying to pick my words carefully here. Um. People panic. The state agencies, uh, can almost jump in with two feet. And they overreact." (006-STAT-Legal)*

A community group participant pointed out that the lack of knowledge and understanding led to a default position of suspicion among social workers:

> *"they [social workers] have no idea about what is going on in the community. Yeah, and also they suspect always" (005-COM-BB)*

This was raised as a problem for communities, as poor understanding limiting the capacity of service providers to evaluate the situation and accurately assess risk, came with cost to the families, one participant recounting the financial and emotional impact on a family prevented from traveling a day before their trip, without the social worker having properly evaluated the family position on FGM/C in the first instance.

The problem of lack of familiarity with FGM/C was also noted with the health services, one health care participant acknowledging:

> *"in my experience an awful lot of midwives are very scared of it. It's something that every midwife should know about and be able to assess and be able to give the right information"(010-STAT-Health)*

And this lack of understanding led to unnecessary referrals of women from other health staff to the specialist midwives, or women who'd had FGM/C but needed no intervention before delivery. Lack of necessary skill among health staff also necessitated defibulation surgeries before labour (for women with Type 3 FGM/C), not during labour as was usual in their home countries.

> "*we don't get so many patients, and there are not so many people who are trained, so our worry is that if she'll come in labour in the middle of the night, and if there is no one in the labour ward who can do the procedure, then ultimately she will end up in a [caesarean] section." (013-STAT-Health)*

Lack of understanding and skill therefore risked a greater burden on the affected women.

The participant from education was very clear about her lack of knowledge and understanding on the issue. This meant that in delivering the relationships, sexual health and parenthood (RSHP) curriculum she was unsure of how to approach the

issue in an inclusive way for the potentially affected pupils concerned. It also meant engaging with families on the issue would be challenging.

Lack of understanding of how to address the issue effectively among policymakers was highlighted as a challenge by a community group participant:

> *"sitting in parliament looking at those people, discussing the FGM motion, they were saying they were discussing it because they were protecting me and they were very emotional. However, the way it was being done and spoken was really going to make people run away and hide. And actually, put the practice underground" (008-COM-WB)*

Activism was identified by a community group participant as a double-edged sword in terms of its effect on public understanding of FGM/C. As activists could only speak from their own experience, it created a "single story narrative" on the issue, overshadowing very different experiences and contexts of FGM/C. This meant that lived experience which did not fit the high profile narratives risked being disregarded.

The single story narrative on FGM was a challenge, because it prevented the issue being seen in its full complexity, which was necessary to give a good grasp of the situation. One community group participant pointed out that this grasp was lacking in the statutory services, *"because you needed to understand the whole complexity, you've got to understand why it's done, who is doing it, and how it's done." (008-COM-WB)*. This lack was acknowledged by the participant from the legal NGO stating the problem at the beginning of this section: *"We don't have a sense of where it is practised, how it is practised. We don't have a sense of a particularly cohesive approach to how to tackle it. But, nonetheless, we know it is happening or we understand it to be happening…" (015-NGO-Legal)*

4.6.2 Low reporting:

Reporting refers to informing statutory authorities or 3rd sector groups about risk/event of FGM/C regarding a minor. All participants saw themselves as sharing

in a safeguarding role, but it was especially talked about by the NGO and police participant. Case referrals to social services tended to come from school teachers or the health service including GPs and midwives. These referrals were rare.

Reporting was necessary to initiate intervention, however an NGO participant pointed out that the criminalisation of parents was a strong deterrent for reporting:

> *"because this…I mean it is a crime, is a crime done by parents. And what we've noticed is that a lot of children are apprehensive to come against their parents. So even if some of the children are at risk of having FGM, some of them might not disclose it. Because of the bill criminalising FGM. So a lot of them don't want their parents to have a criminal record. So for some children, especially the second generation, they don't want to put that burden on their parents, because we have the same thing with forced marriages, because they have to come against their parents. So it's very, very difficult. It's a very difficult thing for children. They love their parents but they don't like what they are going to do." (004-NGO-WB)*

And consequent on this, it was difficult to prosecute cases, as this was dependent on reporting in the first place because *"if the child does not say it, there's nothing the authorities can do." 004-NGO-WB*

The law was noted as a support in opposing the practice by community group participants, justifying the efforts to oppose the practice. One said:

> *"it is a support because you are not just pressuring people to say oh its wrong, don't do it. […] Like I said to you if here there was no law for that, then who are you to stop people from doing what they want? You know, because of the law, the law said you can't do that here" (002-COM-BB)*

However the impact of the law criminalising the practice was weighed against the benefit of having the law by an NGO participant:

> *"the law is necessary. But how do we balance up so that more people can come out and report it? … I don't know, because …I don't think anybody has been convicted in Scotland. And it doesn't mean that it doesn't happen."(004-NGO-WB)*

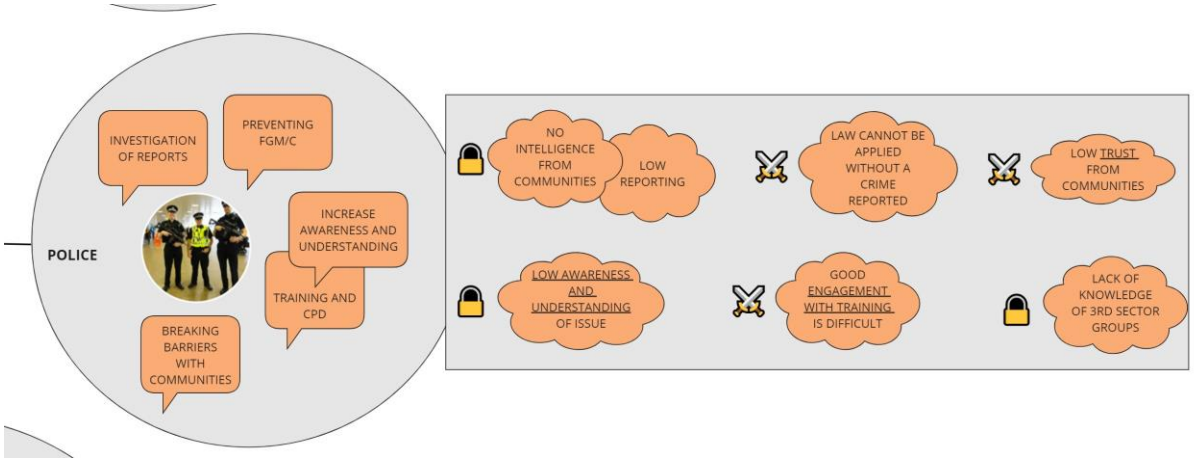

Fig. 4.9 Rich picture highlights of police priorities and challenges.

In the police participant's experience, any reports that did come in were never from the community:

> *"I had never had anything reported that I worked on that was reported merely by the family themselves or by a survivor or anything like that. It was very much third party reporting, I suppose. Whether that was from social work or from a school. That was quite often the route that the reporting took […] I never, ever had a report even say from another community member or an extended family member say, or anything like that."(018-STAT-Police)*

The lack of reporting limited the possibility of intervention to prevent FGM/C, or prosecution for it.

The low levels of reporting raise the question of whether the practice is taking place at all. NGO participants recounted cases of elevated risk they had dealt with. One recounted working with a family where she suspected girls could be cut, and the whole family vanishing without a trace during the course of the investigation. Another spoke of a young mother knocking on her office door and trying to hand over her baby girl in a desperate bid to protect her, as her husband and in-laws were insisting FGM/C be done.

Community reluctance to reporting does exist. A participant in a Zero tolerance for FGM day forum attended by this researcher emphasized the need for a community

led response to ending FGM/C, because, as she openly stated to other attendees, including the police representatives there, she would not report anyone to the police regarding this matter (FGM/C).

4.6.3 Access to service:

The ease and confidence of access to needed FGM/C related services by affected women/communities was a challenge raised by participants who interfaced with the communities. NGO participants especially spoke of the limitations affected women had in accessing their service for various reasons, including unfamiliarity with the UK system and not knowing where to turn for help. Some women had found help by circumstance:

> *"she had heard from a friend of a friend of a friend of a friend that she had come to our service, and we had helped her with FGM. And that's how she came to the door.*
> *Now, even though that story does have a happy ending eventually… this is one woman, just one. How many others are there that don't make it to the office" (003-NGO-BB)*

Another barrier to the accessibility of services was the limited resources of clients, meaning that attending events or engaging with services conflicted with time available for work:

> *"A lot of them do not come out to receive this education, because most of the migrants, especially African migrants, are poor […] So going to ask them come and sit down here and be educated, you're not going to get people to come out. […] you are taking them away from earning their little money… a lot of them have no recourse to public funds … they can't have child benefit, they can't have tax credits, they can't have all these things" (004-NGO-WB)*

Some women were in vulnerable social positions and may be afraid of reaching out at all due to an insecure status in the country:

> *"'a lot of the people experiencing FGM are migrants. And some of them do not have the right papers to stay in this country, and they have no recourse*

to public funds. And a lot of them even get scared that if they go to the police and report anything they are going to be deported."(004-NGO-WB)

The challenge of a language barrier, especially with clients going through the asylum process was potentially severe:

> *"I feel that problems around language are not really understood. Google Translate is not a suitable tool to use to communicate with women and children at risk of this, yet it is most commonly used. Either shouting in English or using Google Translate, neither of them are very good tools at all for communication." (015-NGO-Legal)*

Health care participants noted that the need to use interpreters sometimes made creating appointments difficult, but beyond that the language barrier left a worry that the women did not have time to process the information. Very importantly, the quality of communication and engagement was dependent on the interpreter:

> *"you're only as good as your interpreter. And so I suppose you have to guarantee that the interpreter's giving the women the right information. […] if it was a particularly niche language like Oromo, you know, you then end up getting a male interpreter. It's just…I mean that's just horrific. Why would any woman want to talk through a male interpreter" (017-STAT-Health)*

These challenges meant that women may not access the help that actually is available to them at present and hence lose out on the potential benefit to their welbeing or safety.

4.6.4 Barriers to effective engagement:

Several barriers to effective engagement on FGM/C between affected communities and services addressing the issue were identified, as below.

4.6.4.1 Speaking about FGM/C:

A difficulty in opening and maintaining conversations on FGM/C was experienced both by affected women and by some service providers.

The difficulty women faced in opening up about the issue was described by one NGO participant:

> *"it's not easy sometimes for them to tell you straightforward they have undergone this process. They feel shame. They think, we are in 2020/2021, they shouldn't talk about FGM, but this has happened to them so that's why our first advice is to encourage them. This is not something done by themselves for themselves so they shouldn't feel shame or embarrassed to talk about it." (019-NGO-BB)*

However, a converse challenge identified by NGO participants was the reluctance of staff to broach the issue. One mentioned that health care staff needed to be less "prissy" about broaching the issue and address it directly. Another focused on the volunteers working at her NGO giving training and insistence to ensure they asked a direct question on FGM/C:

> *"most challenging wasn't from the client's side, to be honest, [but] from sometimes volunteers I have worked with. I mean workers, sometimes they were a bit like […] sound angry with me when I have advised them, please ask a direct question about FGM. This was challenging, [but] to make things simpler for themselves and accept that this is an issue here, we have to be knowledgeable how to ask our vulnerable people."* (019-NGO-BB)

The police participant also noted this challenge in the force:

> *"the difficulty that we would always have, is not always just around having those conversations amongst yourselves and getting the issue understood, […] But there's a real, real reluctance, and maybe fear as well about having those conversations. What can be said, what can't be said. Are there things that shouldn't be said? What's, you know, am I going to offend people by saying certain things"' (018-STAT-Police)*

This difficulty on both sides in speaking about the issue meant it could go unmentioned when it could be relevant in a given situation.

4.6.4.2 Use of Language:

Many participants noted a difficulty in finding appropriate language/expressions for talking about FGM/C, and the potential for unintended consequence was pointed out.

In the context of parliamentary discussions on FGM, community participants involved in the event felt the language was so stigmatising that even they who strongly opposed FGM/C in their communities were put off by it to the point of feeling the need to defend their communities:

> *"I can tell you for sure, I think…not I think, I'm an open person. I'm highly educated, highly travelled across…including all the other women we were with there. But when we left that place, I can tell you we were ready to defend FGM. Much as we didn't want to be part of it and we have fought against this practice for many years [...] our stomach was churning. Why? The language which was being used, we were being portrayed as simply barbaric actually. One of the MPs mentioned that" (008-COM-WB)*

The terminology for FGM/C was itself problematic. One participant pointed out that even among community organisations dealing with it there was division on whether the term 'cutting' minimised the practice while 'mutilation' was demeaning and indicating that some cultures were barbarian.

An NGO participant pointed out a that a practical issue in talking about FGM is that is commonly referred to as circumcision in affected communities, and as such would be immediately understood, as opposed to having to explain what FGM is; and secondly that condescending language scuppered effective engagement:

> *" the people use the language circumcision. Female circumcision…The language you use with the people, you have to be tactful because for you to achieve…to be successful, you have to mind your language. Come down to those people's level and then be able to tell them these things are not right. But if you are not ready, if you are standing high up and then put the people down, in what way are you going to manage to get through to them? It's going to be almost impossible"(004-NGO-WB)*

Health care participants also spoke of struggling with the language for FGM/C:

"I sometimes feel that I have to think two or three times before telling them, first of all the word 'FGM' … what does she understand about that word?…So I have to tell them, like in simple words, that you have [had] this procedure as a child …what they have done, what [are] the consequences of that. So, typically the word 'FGM', I cannot use for them. It is not for the patient, it shouldn't be because it becomes, I just feel that it is not right… maybe, it can be mentally upsetting for them"(013-STAT-Health)

"you've got to be careful how you say it to people, what you say to people. I would never use the word 'mutilation' to a woman that I'm talking to. I would use 'cutting' rather than 'mutilation', um, because that's just, you know, 'mutilation' is a very, um, emotive word. So, and some women can find it quite offensive, so, you have to be careful, and you have to be respectful" (009-STAT-Health)

Language and terminology therefore had the potential to worsen engagement, and participants depended on tact and experience to figure out the best way to speak to women on FGM/C.

4.6.4.3 Graphic imagery:

The use of explicit imagery on FGM/C in its discussion was problematic.

Community group participants acknowledged that an appropriate context was as for example a clinical one, or in an education exercise, which if involving communities should respect cultural sensitivities such as single sex settings.

Doing otherwise risked making a spectacle of affected women and was not in accord with the way other sensitive and intimate issues were treated.

The inappropriateness of graphic imagery in public engagement contexts was highlighted by a community group participant, in describing in this reaction of a trained nurse from South Africa who was familiar with FGM/C, to a Scottish government FGM/C event, and pointing out that the impact was likely negative on the community targeted:

"what she told me is she felt like the training was saying when you meet any African woman on the street, open her and look at her and see what it looks like. And why did she say that? Because the whole anatomy was being

discussed there. The whole issue of how an African woman looks. What does a janitor have to do with all those things? The graphics-, […]

But this person who is telling me that is a professional nurse, and she's trained back at home, so she understands the concepts and everything. But if she came out feeling like that, how about the woman on the street? The woman who you want, or the man who you want to stop this practice. Are they really going to stop it? I don't know. I think you are just going to make things worse. People are just going to build some walls […] we needed some dignity, we need some dignity" (008-COM-WB)

She spoke of a Scandinavian artist who created an anti-FGM art installation attended by government representatives, where an audio of screams was played when a cake of a black woman's body was cut and noted the discrepancy in how other sensitive issues were handled, and how FGM/C was handled:

"what would I say? In this country, when there is a crime, when there is an accident, you don't show the gross images of what is going on. Yet, [at] such a function which had ambassadors, had the ministers, it was seen as art. An African woman's body is okay to display it, and that is seen as that. People are cutting cake and you could hear their screams, and that was very traumatic for people who have undergone FGM, and even for some of us who were watching it. It's like whoa…I can't remember the name you use for such…it's gross."(008-COM-WB)

This participant was used to engaging on FGM/C with women, and men, and in public contexts as a campaigner, yet the negative impact of this insensitive approach was palpable in her words.

In the context of clinical care, a health care participant described how using anatomically detailed images was helpful in her work, in explaining to women what type of FGM/C they had and how it may affect them. This engagement, though graphic, was seen positively by the health care participant, and acknowledged as appropriate by community group participants.

But not all statutory service participants found anatomical drawings helpful. The statutory legal participant spoke about the clinical content of guidance documents as being a challenge in his work:

> *"I think the language round about FGM is often very medical based, but uh, obviously needs to be. But how do we then discuss that with the family face to face? When you're talking about cutting a child. There's a kind of, a lot of the workers and police officers and reporters and children's panel members, they're not medically trained. They're using very medical language to discuss a very sensitive topic with laypeople. And we ourselves are laypeople in that process, and finding that kind of more suitable language to discuss this topic, I think, would make it easier. Perhaps more comfortable to discuss" (006-STAT-Legal)*

Graphic language and imagery was therefore a challenge for engagement in this situation. The same participant speculated on the negative impact this may have on service engagement with training:

> *"I remember the training I had […] had images involved in it that uh, I will never forget. Uhm, that were extremely graphic. And I think that potentially puts people off because that information then disseminates [and] people who haven't been on the training, will think oh God, I'm not going on that" (006-STAT-Legal)*

This was a challenge because *"that might be the very person that then gets the referral about FGM"*. This difficulty in engagement with training was also noted by the police participant.

The statutory legal participant compared the situation with training for child sexual abuse:

> *"The training that surrounds that is extensive, research driven, and it takes place throughout the year for all workers. People engage with that process. Now that's no less a horrific topic than FGM, but for some reason that, the way that we engage with that topic, they have found a way to make it uh, accessible that they seem not to have done with FGM" (006-STAT-Legal)*

The impact of graphic training/awareness raising materials was shown in an anecdote shared by a social service participant:

> *"so one of my friends is a teacher and last summer holidays he was speaking to me because, as part of their...before the kids came back after summer holidays they saw two videos about FGM, very explicit videos about females being cut, and he was very distressed by it and things, you know" (016-STAT-Soc)*

Conversely, the participant from education had seen a TV drama on FGM/C which presented it in a nuanced way, with various perspectives on the issue presented. She was appreciative of the approach taken there:

> *"it wasn't just a case of, this is FGM. It's really bad. It's awful. It's child abuse That's the, that's what the character came in, the whoever the doctor was. … They looked at it from the parent's side as well. They brought, I think it was a teenager… saying I don't look the same as everybody else. And so therefore she wanted sort of reconstructive surgery, … I mean in as much as you can in a 45 minute television drama, …, it discussed the subject from a range of different perspectives, so it wasn't black and white." (020-STAT-*Edu)

It did not prevent her from seeing FGM/C as harmful, and a safeguarding issue, but gave her enough nuance and context to suggest that the issue was generally 'wildly misunderstood' in Scotland.

The use of graphic imagery and clinical language was therefore a potential barrier to effective engagement on FGM/C for both communities and service providers when thought was not given to context and impact.

4.6.4.4 Negative emotional reaction:

Some participants described a feeling of revulsion which threatened objectivity in dealing with FGM/C.

Parallel to community sensitivity in discussing the issue was the strong emotional reaction acknowledged by the social service, and legal participants, and the consequent potential negative impact this had for the fair treatment of families.

"if you consider it to be particularly barbaric, for example, your response will be punitive, harsh, not understanding. So I think that's, that's the challenge for me." (007-STAT-Social)

"They should be treated in the same way, but I feel that sometimes that may not be the case because it's such a real thing, is people's gut reaction is one of revulsion to this type of practice. And trying to balance those two things of responding well and dealing with how you feel about the nature of what's being alleged are sometimes hard for people to balance." (006-STAT-Legal)

The negative emotional reaction in service was therefore a challenge to due process in the exercise of power in addressing FGM/C.

4.6.4.5 Cultural sensitivity:

Skills/competence necessary for culturally appropriate and effective engagement on FGM/C with affected communities and individuals was important.

These social demands were often not considered, and this was a challenge if people in communities were actually to be engaged. This was frequently noted by the community group and NGO participants. One community group participant emphasised the very negative impact of a Government engagement exercise where the facilitator was a 25 year old white man. It went down very badly with the women he was addressing:

"it doesn't go well for a 60 year old African woman sitting in the same class and being taught by a 25 year old young white man. And you're talking FGM. I think you've lost the plot. You absolutely have no idea what you are doing and how you are doing it" (008-COM-WB)

An NGO participant echoed this:

"There was a government person that came to talk to us about FGM, and this was a man. I said really? How do you want these women to start talking about those personal things with a man? And some of the women could not open up. Some of the clients could not open up. So these are some of the things that the government has to understand" (004-NGO-WB)

Another NGO participant linked this lack of sensitivity to a conflict in priorities:

> *"The balance between a victim centred approach and a law enforcement approach is often challenging to take, it is a challenging balance to meet…I attended an event before the pandemic where a member of... the Border Force was there giving a talk. It was the most extraordinary crass, blunt, insensitive talk that I have come across in a very long time, with case studies that were just extraordinary the way she was describing them[…]The whole event was on FGM/C. It was a Scottish Government run event. It made me wonder whether we were even talking about the same thing. I think that bridging those priorities is a challenge and difficult"(015-NGO-Legal)*

On the other hand, cultural insensitivity was also noted from activists ostensibly from affected communities, who were apparently culturally distant/ or not integrated with these communities. This also resulted in insensitive and counterproductive engagement and was particularly challenging when it came from activists of African background, because then communities had to contend with "*isn't this your person who is doing it anyway?. Why are you complaining?" (008-COM-WB)* An example was given of an activist who had created vagina cupcakes to raise awareness about FGM/C in an African community. The negative impact that would have had in the community was clear to this community group participant and other community representatives present she was with, despite being lauded by a Western audience:

> *"were all like ah, hey. It's good it never arrived where it was going…because I can imagine what would have gone through that community. If us, in a big conference in London, we are sitting there and we saying oh!... But she was being cheered on by the rest of the world. But I don't know how far she had communicated her idea [to the community]. The connect or disconnect she has within the community… Yes, creativity is good. But me eating my own vagina, that one now is another story." (008-COM-WB)*

A lack of cultural sensitivity was therefore experience by communities both in engagement with statutory bodies, and in insensitive activism.

4.6.4.6 Cultural specificity:

An understanding of the types and contexts of FGM/C being peculiar to particular communities was a relevant challenge to engagement. FGM/C is practiced in different ways, for different reasons in different contexts, and women would gravitate to support groups which could understand their own experience and where they felt comfortable. This was spoken about by community group participants.

> *"Somali people, they know how it is practiced in Somalia […] Similarly in Sudan we know the motivation of people, why the people do it and the language they use, and the meaning of the things. I think it is important" (005-COM-BB)*

Health care participants also mentioned this issue. One health care participant would offer all the women she saw for FGM/C a link to a particular community support group in the area. She noticed the difference in uptake among her clients:

> *"women that I referred that were Sudanese and Somali, I think they…you know, they found it very beneficial. They tended to be the groups that were much more open to it. I found that other women were not so keen" (017-STAT-Health)*

She did not speculate on whether cultural relevance may have played a role in this, but did say that *"giving somebody a support group leaflet is also saying that you think that perhaps they might be a victim A lot of women don't see themselves as being a victim because it's just something that they do culturally, much in the same way that men are circumcised as babies". However* she did express surprise that child protection concerns she had were more often had with women with type 1 FGM/C:

> *"the only women really that I felt would maybe do it were bizarrely women who had had the Type 1, so the…you know, the least invasive, if you can say that. You know, any FGM is invasive. But a couple of Nigerian women I came across, very educated, were over here studying and married to men*

who were studying, just felt that it was cultural. And that by me trying to ask them not to do something was not… it was me being ethnocentric, it was me saying, well my culture's better than your culture… But in the main most women who have had it wouldn't want to inflict that on a female child, interestingly. And the ones that did were very adamant it was cultural". (017-STAT-Health)

She did not elaborate, but this was an interesting point, and showed that an approach which worked for some women, did not work for women who had experienced a different type of FGM/C, in a different context (FGM/C as practiced in Sudan and Somalia was commonly type3 which was the most invasive type, and also was associated with marriageability and religion, which was not the case in Nigeria).

One community group participant noted that while the 'black ethnic minority' label was supposed to bring people together, it also ended up disadvantaging African women through a 'single-story narrative' on the issue, which affected engagement and service delivery to the affected women.

4.6.4.7 Racial issues:

Limitations, friction or tensions in engaging on FGM/C based on race were raised. Awareness of racial difference was acknowledged by some of the statutory service participants, less so in health and more so in the social services.

One health care participant did acknowledge racial tensions her engagement with women:

"And I think there's also an element of, I don't really want to talk about this, I particularly don't want to talk about this with you because you are white and you don't probably understand. I think they didn't necessarily say it in those…see it in those terms but I think I definitely got that vibe […] I think they accepted that they probably had to come and see me because they were told that they had to because it might affect their delivery. And [that] there would be child protection issues if they wanted to, you know, perpetrate it" (017-STAT-Health)

She said this experience was not uncommon for her, however it was not shared by the other health participants, most saying they felt they had a good relationship with the women they dealt with. The one other midwife who did say she'd been challenged on race said it came from an activist, not one of her clients.

The racial tensions in engaging on FGM/C were also acknowledged by social service participants, one noting that *"I think social workers are afraid to be honest sometimes because they don't want to be seen to be racist" (011-STAT-Social).*

Another social service participant spoke about misinformation in communities on racial bias in the activities of social workers. There was a perception in the communities about "*disproportionate numbers of black African children coming into care in comparison to white Scottish children. That social workers were on commission. You would you know, get more money for example, for black African children" (007-STAT-Social)*

This fed the lack of trust for the good will of social services, which was already a challenge for them with communities in general.

Another element racial issues played was in a lack of diversity in the Scottish workforce. This was noted by both social service and statutory legal participants as a limitation. They generally noted that while the population of Scotland was increasingly diverse, there wasn't a corresponding diversity in the services. This affected both the capacity for cultural competence in the service, and the ability of community members to engage with them. One social service participant said she thought the service was:

> *"a long way from where we'd want to be, I think the intention is there, but I think the diversity in Glasgow, which is a wonderful thing, is not then replicated by a diverse workforce […] Cultural diversity I think is important in your workforce, [to be], representative, I think of the range of the communities that you support, but also [to have] a cultural sensitivity that comes with that as well." (007-STAT-Social)*

Racial issues therefore, in inhibiting discourse, or development of competence, were a barrier to effective engagement on FGM/C.

4.6.4.8 Trust:

Confidence in the reliability and trustworthiness of other stakeholders in addressing FGM/C was a challenge to engagement highlighted explicitly or implicitly in multiple ways by Community group, NGO, social service, and police participants. There was lack of trust in communities for social service and police, and vice versa, lack of trust from social workers for communities, as well as between community groups.

One NGO participant explained why trust for social services and police was low in communities:

> *"if in your homeland the police are the people who beat you up and throw you in jail for nothing, that's what you're going to assume for Scottish police as well. If social workers are the people who take your kids away, that's what you're going to assume for social workers here as well." (003-NGO-BB)*

And summarised the implications of this lack of trust for community relations with services: *"I think it's very rare that we'll see a woman or a whole family, you know, accessing support from police or social work […] I would say health, brilliant. Other services, not so brilliant"*

A community group participant spoke about the aversion community members felt for involvement with the police: *"For people, just saying police, it is a big issue for them."(005-COM-BB)*

Social service participants acknowledged that there was a lack of trust in society in general, and affected communities in particular for social workers due to fears about losing children:

> *"trust is probably huge. Respect is huge. Understanding is huge. Openness. So I think certainly for a lot of our families, white and black, are really mistrustful of social work. The power imbalance, the fear that people have about losing their children or being judged inappropriately or not understood. I think those are giant things for people" (011-STAT-Social)*

Lack of trust for the police was also big challenge acknowledged by the police participant and was related to the lack of reporting. It was however a barrier very hard to breach.

> *"more than anything, I think what I would really have loved to have been able to establish, […] some form of, some way of being able to just get information from the communities. You know, a little bit of intelligence. And, you know, not talking about massive pieces of information, but just, it would have been lovely to get to the point where there was enough trust that information could start to filter in, that would actually help us" (018-STAT-Police)*

This had not happened during her time in that post. Communities remained reluctant to engage with social work and police.

Conversely, there was also a lack of trust voiced by many of the social service participants in the transparency of the families involved when dealing with child protection concerns related to FGM/C:

> *"we know it's not something that's…it's not overt. You know, we know that somebody's not going to say to us, oh, we're going away back to have FGM on our daughter, they're not going to tell us that" (012-STAT-Social)*

> *" I've never worked with a family where their starting position is, yeah, we are going to take our children to be mutilated, so it's a difficult starting point […] just more because of the lack of honesty at the starting point. And that sounds disrespectful, doesn't it? I don't mean that to be disrespectful to people, I just mean that I've not worked with a family yet that say, yeah, we are plan on taking our girls to be mutilated because it's cultural and we're going to do it in three month's time, we've never had that" (012-STAT-Social)*

This lack of trust was also an issue in discussing collaboration with community groups. It was considered good in principle, but one social service participant conditioned it on the group being validated:

> *"If there was a validated, and that's my words that's not words that I'm told to say by the council or anything. If there was a validated third sector*

organisation, FGM specific, then every single time I would say a referral to that FGM service for this family" (016-STAT-Social)

And by validated he meant: *"an organisation that is using trusted methods of intervention, they've got very clear reasons why, and are auditing their interventions, they're looking at outcomes and measuring success by whatever they define success to be and it's very transparent" (016-STAT-Social)* This need for assurance that the community groups were 'on the same page' with the service with respect to FGM/C was a concern also voiced by another social service participant as a condition for successful collaboration.

This lack of trust was not voiced by the health care participants who had working relationships with the groups.

In terms of trust between community groups, a community group participant also raised the question of validity. He questioned whether all the community groups involved and funded had an authentic and genuine connection with community, or simply printing flyers which may be neither received nor understood in their community of interest:

"my question is, does this [educational programme] reach the community in the right channel? That is the question. Because there are so many organizations out there who have said, are we are dealing with FGM. We are highlighting it, we are doing that. They put in application forms to the Scottish Government, they are getting the funding. But my question is are these organization really reaching the community who are in it?" (002-COM-BB)

His point was that all funded groups should be honest and transparent about their reach. In addressing FGM/C in Scotland, community groups competed over the small pot of funding that went to them, which may explain tension between groups, but does not invalidate his point.

Trust was therefore a multi directional barrier in engagement with communities on FGM/C.

4.6.4.9 Discrimination in the law on FGM/C:

The law on FGM/C was reported as problematic due to a perception of cultural imposition, and discrimination on genital alterations.

One community group participant had met with arguments that the law against FGM/C was a cultural imposition, a form of "western supremacy". He recounted the challenge of debating those opposed to the FGMC law, despite being against FGMC themselves, on the grounds that it was racially discriminatory to those from affected communities:

> *"from an intellectual point of view, we had a very challenging issue with some educated person who is against FGM, and thinks that this [the law], is racially profiling people when it comes to FGM. So, targeting certain people […] because, they know that this is practiced by some people in Africa and some parts of Asia. Which means this is a law particularly for these people. So this is a racially profiling issue" (001-COM-MB)*

Some saw it as cultural imposition:

> *"some people are saying this is our culture so we have to preserve our culture […] the westerners want to impose their own culture on us, […] they are interfering in our culture, which they should not do." (001-COM-MB)*

He noted that even the terminology was seen by some as a form of "western supremacy":

> *"the mutilation, they say this is a kind of western supremacy, you know, imposing on us to show that we are Barbarians or something like that" (001-COM-MB)*

There is double standard in the law against FGM/C which allows anatomically similar alterations for reasons of mental or physical health, while prohibiting them for reason of custom or ritual. This was also noted by some participants to be discriminatory.

A health care participant noted that:

> *"we're in a situation in the UK where women can go and get genital, um, cosmetic surgery. You know, they can go and get labiaplasty, they can go and get this done, they can go and get that done, and none of that, um, is prosecuted under the current legislation, and you could argue that perhaps it should be[..] people from FGM affected communities could say, well, hang on a minute, you do this in this country, and yet you're telling us that we can't do this, and how is it different? And I think that the problem is, I think they're absolutely right" (009-STAT-Health)*

An NGO participant examined the motives, those behind FGM/C and those behind other cosmetic surgeries, to show that they are often not very different:

> *"What is the ultimate goal? Is it actually going to improve their quality of life or are they being victimized by a partner or a culture or a family? You know, these are the questions we should be asking. And when we do start asking those questions, I think we'll find out that a lot of the time, motivations are not all that different, and a lot of the time, we need to take a long hard look at ourselves and question our practice"(003-NGO-BB)*

Participants were generally opposed to cosmetic genital surgery alternatives for FGM/C, health participants mainly not supporting removal of healthy tissue without clinical reason, and social services emphasising that no such surgeries should be done to children. The issue was not spontaneously brought up by participants, and was discussed in response to a prompt.

The discriminatory element in the law was a barrier to engaging with anti-FGM/C work for some in affected communities.

4.6.4.10 Funding:

Funding, that is, available resources to carry out work in addressing FGM/C, and time constraints were cited by community group and some NGO participants as limitations in effective engagement on FGM/C. Their capacity to do offer the service they would like to. Lack of funding meant few staff, and few staff meant less time for networking.

" I'm always in stress too, because I have shortage of staff, and I could not participate in all events, yeah, all survey for this issues while dealing with other things. So improving and growing the capacity of my organization, it [would] help us also to improve our participation. Now I devote my time to the community to raise their awareness. This is a priority for me, but to participate in event and other things, networking with peer organizations, I have no enough time to do that" (005-COM-BB)

One community group participant described how a previous community initiative on FGM with African women had to be disbanded for lack of resources to maintain it:

"some people fell by the wayside, because remember, this is a free job, you're not being paid. You're just using your time, it's a passion, it's a reason, you're just… So a lot of people fell on the wayside for various reasons. One, funding, volunteer time, childcare, work, study, and all that"' (008-COM-WB)

Among the health care participants, the resource issues were of time and staffing, work pressures causing time delays to needed interventions.

Funding constraints affected community group participants the most among the stakeholder groups. It was also mentioned as a constraint by some NGO participants. It prevented effective engagement of FGM/C by incapacitation their work.

4.7 Reflections on the four themes from Critical Systems Heuristics:

As a reminder,12 questions from critical systems heuristic were used to enrich the interview questions, in order to support capture of issues relevant to stakeholders in this situation.

This thesis does not set out to conduct a Critical Systems Heuristics (CSH) inquiry. However, the four themes of motivation, knowledge, control/power and legitimacy highlighted by the 12 questions of CSH are ones of key relevance to any

stakeholder inquiry, and will be reflected upon here to build relevant understanding in addressing FGM/C in Scotland. These themes are reflected on below.

4.7.1 Motivation:

The motivation of stakeholders in addressing FGM/C was given by all participant stakeholder groups as being for the benefit of girls, women, families, and communities, as FGM/C is in the first place harmful. This seems straightforward enough, however there is also some tension in the situation, where objection to FGM/C in the UK is perceived by some in potentially affected communities as motivated by imposition of cultural values and/or western supremacy. The solution to this tension would be to make the justification for opposition to FGM/C clear. As one community group participant pointed out, it should be opposed on the basis of harmfulness, not profiling by culture (as appears to be in the law at present). This basis (of the harmful nature of FGM/C) for opposition to FGM/C is implicitly and broadly assumed as self-evident in the services, hence the harmfulness of FGM was frequently cited as the reason FGM/C was viewed negatively.

However, the permissiveness of the UK and Scottish law toward cosmetic surgery weakens this position. As noted in the literature review, the law does not rest on consent – it prohibits FGM/C in adult women as well as in minors. Neither does the law rest on intrinsic harmfulness, as it permits anatomically similar cosmetic alterations for reasons of mental health (but not culture or rite). As has been covered by the work of Earp and others (Dustin, 2010; Earp, 2016; Earp & Johnsdotter, 2021; O'Neill et al., 2020) demand for female genital cosmetic surgery has been on the rise in the UK, even in young girls, and has been linked to widespread exposure to pornography. This could arguably then be classed as a cultural driver justifying FGCS; however cultural drivers are not allowed to justify FGM/C under law.

While awareness of this conflict has been growing in the literature and academia (O'Neill et al., 2020), the FGM/C law had been noted by community groups from the beginning as having racialised basis (Dustin, 2010), as seen in the literature review.

This research has highlighted that in current practice, some community groups have a challenge in dealing with accusations of western supremacy in approaches to end FGM/C, even from those personally opposed to it. This issue could be dealt with by legal opposition to the practice on the basis of harm caused, not of cultural profiling as seems to be the case. This links back to the start of this section, and the fact that the law weakens opposition on the basis of harm in its permissiveness to anatomically similar procedures in FGCS.

The matter is open, and is unlikely to be closed, until the overlap between FGM/C and the socially acceptable cosmetic genital alterations in the UK is acknowledged in policy; and the basis of laws regarding FGM/C are clarified accordingly. If the impact of certain alterations is such that medicalisation is not justifiable because of their long term effects on a woman's bodily capacities, then it this rule ought be generally applied to cosmetic genital surgeries as well. On the other hand, if the procedures are not harmful/debilitating/incapacitating, the question needs to be answered as to why medicalisation of FGM/C is not to be permitted (Berer, 2010; Earp, 2016). These questions are yet to be answered.

Of course, part of the complexity of this issue is that FGM/C is a range of practices, some of which (clitoridectomy, infibulation) may have long term impact; and some of which (piercing, nicking) seem not to. Perhaps this distinction will need further clarification as well.

4.7.2 Knowledge:

Knowledge considered by stakeholder participants to be relevant was twofold. That of lived personal or community experience of FGM/C, and that of government guidelines to guide practice. People with lived experience of the issue are recognised as a valid and genuine source of knowledge, as opposed to someone who 'just put together a PowerPoint' without deep understanding of the issue. There is a recognition that this is a cultural practice, and it is those with intimate familiarity with that culture who can give useful knowledge on the matter.

However, this also comes with a limitation. FGM/C is not a single practice in a single context. It is a range of practices, with a range of impacts which happen

across widely different cultural and geographical contexts. Therefore while lived experience is legitimately seen as key, the limitation is that of a "single story" gaining dominance. For example the literature review pointed out that FGM/C type 3 (which has its own primary cultural context and health impacts) is the most widely known, but constitutes just 10% of global practice (PPAN, 2012; UNICEF, 2013; WHO, 2008). This was the limitation pointed out by a community group participant highlighting that the platform given individual activists can be a double-edged sword. While their work raises awareness on FGM/C and brings to light needs for addressing the issue; it may mainstream one narrative, and consequently legitimise only those narratives that match, causing the cultural specificity of the practice to become obscured, and the statutory responses to FGM/C to become blunted.

An example of this may perhaps be seen in the surprise of one health participant, that the women who were less likely hold protective positions were 'bizarrely' those with type 1, a 'milder' form of FGM/C.

In her surprise, there was here a lack of appreciation that this lack of protective position may be linked precisely to the less extensive form of FGM/C in question. FGM/C type 1 means total or partial clitoridectomy. This means that depending on the degree of the cut, and bearing in mind that most of the clitoris as an organ is situated subcutaneously, the consequences of the cut are relatively more subjective than they would be for a woman who has undergone type 3 (infibulation) (Abdulcadir et al., 2016; Catania et al., 2007). Depending on individual experience, especially if done in infancy, and degree of cut, the harmfulness of the FGM/C type1 may be much less clear to the woman, and demands to refrain from it be perceived the more easily as a cultural imposition. Especially bearing in mind that even women who have had the most invasive type 3 do not automatically connect the dots between the cut and negative experiences they may have.

In a discussion outside the context of this study, a health provider said to this researcher that in her view, FGM/C type 1 was more strongly linked to domestic abuse than type 3, as this is what she saw with the women who accessed her service. An alternative explanation would be that all women with type 3 FGM may

objectively need health care intervention, either to give birth or to allow intercourse, and therefore a fuller cross section of this group would be seen in health settings. This is not necessarily the case with FGM/C type 1, where a woman may have a less disrupted sexual experience and would have unobstructed childbirth. She would therefore be less likely to seek help unless there were extraneous reasons, such as a presence of domestic/other abuse; this introducing a sample bias in the women seen with type 1 by services.

This hypothesis could potentially be backed up by the observation made by health care participants, of these women not wanting to engage with support groups because they did not see themselves as victims; whereas those with type 3 FGM/C seemed readier to engage.

All this is to say that awareness of cultural specificity needs to be a component of knowledge and understanding of the issue in order to properly contextualise the cases of FGM/C seen by the services, and that the 'single story narrative' pointed out by community groups, hinders this by suggesting a one fits all approach which does not actually fit all.

4.7.3 Control/power:

The power to apply the law with regards to FGM/C was held by legal and police services, as well as with social workers, whose opinion was weighty in decision making on matters of safeguarding.

In terms of eliminating the practice of FGM/C, imposition of the law, despite being necessary for efforts to delegitimise the practice, was seen as inadequate to end a long standing, accepted and 'hidden' cultural practice on its own. Mackie (Mackie & LeJeune, 2009), had compared FGM/C with the practice of foot binding in ancient China. That practice was ended by the imposition of law in a relatively short period of time (Mackie, 1996). The difference with FGM/C is that it is indeed 'hidden'. It involves genitalia, which are intimate and so not publicly visible, therefore cannot be monitored the way foot binding could be. It is also (where cutting is involved), done in a moment, while foot binding took months/years to achieve, so could be interrupted. As such, the most obvious and potentially

effective way to tackle FGM/C is by challenging it's drivers – the beliefs which perpetuate the practice. The community groups which engaged in doing this have demonstrated its effectiveness by giving accounts of changed minds and changed practice.

On the other hand, the variation in knowledge and understanding across the services meant that it was possible that a statutory practitioner who has had no training on FGM/C and no previous experience in dealing with it, could be tasked with making decisions with legal implications for families and individuals.

In describing ideal scenarios of how FGM/C should be approached, participants agreed that collaboration was beneficial, because of the knowledge and understanding of the issue present in communities which was lacking in the services. However, communities also described that it was a fight to get their voice heard on the issue.

The situation therefore was that the community groups, which were rich in knowledge in addressing the practice, had little funding and no statutory power. Whereas conversely, services where knowledge and understanding of the issue was admitted to be low had the power and statutory duty of safeguarding.

This creates a situation where broadly, knowledge seems inversely proportional to power.

The aspirations to collaboration could, if put into practice, allow knowledge and understanding to inform policy and legal decision, but this hinged on trust, and acceptance of the legitimacy of all stakeholder parties.

4.7.4 Legitimacy:

Who is seen as a legitimate stakeholder in this situation? For the participant groups in this study, it was clear that legitimate stakeholders, that is those who could acceptably be collaborated with, were those who opposed the practice of FGM/C.

The reciprocal issue of trust is relevant here.

On the side of the services, it was seen as important that community groups were in agreement on opposition to FGM/C. Acceptance to be seen as legitimate was

proposed through ‘validation’ meaning approval based on transparency about what they are doing and how. This validation would underpin trust that these groups were indeed working to stop FGM/C.

On the part of communities, trust for the services was a challenge, and was seen to be better with the health services. The fact that the relationship of trust was better between health care providers and communities than between social services/police and communities can be explained as a consequence of the difference in role. By default, health services are familiar as supporters of wellbeing who can be trusted. Doctors and nurses are globally known, and their service provides necessary help for childbirth and wellbeing. Social services on the other hand may be unknown in the county of origin, and feared as having capacity to take away children, while the police may be very negatively viewed in the country of origin. The lack of understanding and insensitive engagement on FGM/C experienced by communities also did not build trust, despite a mutually acknowledged need by community groups to collaborate with statutory bodies to effectively tackle FGM/C.

To build trust in communities for statutory intervention, barriers to be overcome were stigmatisation, profiling, and cultural sensitivity in approach. This also links back to the question of discrimination, expressed by communities in questioning the motivation of statutory opposition to FGM/C, as the law against FGM/C was seen by some to be discriminatory.

The discriminatory wording in the law had been noted early on by community groups when the UK law was initially passed (Dustin, 2010), and this has clearly remained a nagging question. It however did not prevent openness to collaboration, as community group participants were willing to work with other stakeholders to end FGM/C and appreciated the enabling support provided by the law (O’Brien, 2017; Shahawy et al., 2019). Issues of profiling and stigmatisation in engagement however remained an ongoing challenge. Legitimacy therefore was related to trust, and trust was guarded.

4.8 Summary and Conclusion:

The chapter expressed the complex issue of addressing FGM/C in Scotland. Through the use of the rich picture the stakeholder roles, perspectives, priorities,

and challenges were captured in one impactful image. It was complemented by a thematic analysis which explained the contents of the picture in detail.

Multiple challenges were unveiled in the situation. Despite Scottish policy documents emphasising the need for community involvement in addressing FGM/C, community groups have expressed that it is a challenge to be heard or taken seriously. The many barriers to effective engagement with communities on FGM/C are shown to be ongoing, including cultural sensitivity and an understanding of cultural specificty. There is an admitted lack of knowledge and understanding of the issue in the statutory services with variable quality and uptake of training. There is a mutual lack of trust or links between communities and social services. The issue of insensitive language and graphic imagery was an ongoing challenge both for communities and for non-clinical service providers.

Multiple perspectives and priorities have been shown to operate within addressing FGM/C. An NGO participant summarised the complexity inherent in the issue pithily:

> *"it is an issue that cross-cuts migration, it cross-cuts child protection, it cross-cuts adult protection, the criminal justice system, the civil system. It cross-cuts...in thinking about how we tackle it there are sensitivities around race and racialised communities within Scotland. I know there are disagreements in approach there. You are not going to get somebody who is an expert in all those kinds of things. I don't know if there is such a thing as an FGM/C expert because you can't be an expert in all of those things or practise your daily life in all of those things." (015-NGO-Legal)*

In taking a systems approach to examining this issue this thesis not attempt to be 'expert in all of those things', but to look at how the issues 'cross-cut' one another.

All participant stakeholder views of FGM/C were negative. This is unsurprising considering that stakeholders were those in positions of addressing FGM/C in the public sphere. The key finding here was the nuances between stakeholders in how

FGM/C was addressed. The greatest internal stakeholders group variation was found within the community groups. Here the various community groups addressed FGM/C in a way which focused on a specific gap they had identified. Some groups focused primarily on education and awareness raising because they held that people practice FGM/C due to beliefs they hold, for instance because they believe it a religious requirement for the practice of Islam, and if they were educated to know that this was not the case they would reconsider the practice. Another group focused on engaging men because while women are usually the focus of engagement efforts, FGM/C as a social norm is a society wide issue, therefore to hasten its end men must be involved, and their position was that had men been involved from the beginning, the practice would now be in its dying days. Another group focused on engagement with policy makers, because they had felt that in initial community engagement by the Scottish government the language and approach used was off putting and denigrating. So much so that even women who were anti FGM/C activists in their communities left the sessions feeling pushed to defend their culture. Consequently they felt that the approach of the government would not effectively address the issue, but rather undermine efforts to engage communities on the issue. They therefore prioritised engagement with policymakers to support creation of good policy for a better informed approach.

Among statutory stakeholders, the nuances between them were related to the role with not much variation within the stakeholder group. For example, health care dealt primarily with mitigating physical and where necessary mental impacts of FGM/C, because doing so would improve the health and quality of life of the women. The police focused on breaking barriers to facilitate reporting, because if they had reports, they could apply the law and protect women and girls. Social services focused on safeguarding, their position being that FGM/C would have harmful lifelong negative consequences on any girls at risk. Safeguarding was actually a priority which was held by all stakeholders across the board, but it was of primary importance for the social service participants.

Existing consideration of the different ways FGM/C is addressed in Scotland did not consider the conceptual understanding of their role which stakeholders brought

into the situation. It could only be described as ‘multi sectoral’, for example as reflected in multi-agency guidance on child protection.

This thesis identifies the nuances of the different ways FGM/C is addressed, and shows differences and similarities in stakeholder positions. This will help to clarify and build understanding of the situation. The initially messy, unclear situation, will be structured, showing explicitly the multiple ways in which FGM/C is being addressed by stakeholders in Scotland at present.

Structuring it using an SSM framework will be described in Chapter 5. This will subsequently allow synthesising issues in these various approaches to define a cohesive way to improve the situation which will be described in Chapter 6. It will also ultimately allow an analysis of the situation through the lens of the critical realist framework in Chapter 7, looking at how FGM/C is addressed at the three ontological levels in which it exists.

In the next chapter, the SSM process will be used to structure this complex situation, as the perspectives, priorities and challenges present will be used to identify the purposeful activity systems present within it.

RESULTS	AIMS OF THESIS	SSM STAGE
Chapter 4	**Build understanding**	Finding out: expressing the unclear situation
Chapter 5		**Building models: structuring the situation using models of purposeful activity**
Chapter 6	Find ways to improve	Evaluate models: compare with reality and define feasible changes

5. RESULTS 2 – Structuring the situation

This chapter describes how SSM was used to structure the issue of addressing FGM/C in Scotland.

The chapter presents the models of purposeful human activity systems present in the situation, and their corresponding conceptual models.

The chapter also sets up chapter 6, which will present ways to improve how FGM/C is addressed in Scotland based on stakeholder discussion of these models.

5.1 Introduction:

The first step in SSM analysis was to express the unstructured, messy situation. This expressed situation shows that although there are shared interests and themes, the problem is different for different actors in the situation. The messy situation is not a single system, but a 'web' of systems, which is what makes the situation ill-defined and messy in the first instance.

SSM is an action oriented process of enquiry into problematical situations, in which users learn their way from finding out about a situation to taking action to improve it.

(Checkland & Poulter, 2010).

In the SSM process of enquiry (described in the methodology chapter), the situation is clarified by structuring this 'web' into various systems of

purposeful human activity present within it. This is in line with a key assumption of SSM which is that human activity is purposeful, based on an actor's perspective on the situation and the course of action the perspective justifies (Checkland & Poulter, 2010).

This structuring therefore uses the various transformations sought by stakeholders in the situation and their justifying worldviews to clarify the purposeful activity systems at play in the situation. The system definitions are hence 'soft', that is, malleable, depending on which understanding of the system is represented.

The multiple purposeful activity systems present in a situation are described using the 'root definitions' (RDs) of these systems; and elements relevant to the system are captured by the CATWOE (Clients, Actors, Transformation, Worldview, Owner, Environment) mnemonic (see Chapter 3, section 3.4).

The root definitions of purposeful activity systems are described using purposeful activity models (PAMs). These PAMs are models of the 'ideal' for the stated worldview in the root definition, not models of an actual process in the real world. They are devices which therefore cannot be externally validated as they do not exist in the real world. They need to be defensible, to fulfil their purpose. Their purpose is in structuring and guiding stakeholder discussion on ways to improve the situation. The process of their derivation and their defence is laid out below (Checkland &Poulter, 2010; Checkland & Scholes, 1990).

5.1 Building Root definitions of Purposeful Activity Systems:

Root definitions of purposeful activity systems in the situation addressing FGM/C in Scotland were created using the PQR formula (see below). This was aided by the CATWOE mnemonic to highlight elements relevant to each system (ibid).

Each root definition encompassed **a transformation process and a worldview (a desired T and the W which justifies it; see box).**

The formulaic PQR form of the RD is:

A system to do P, by means of Q, in order to achieve R.

P is what the system does: the Transformation T sought
Q is how it does it: the processes it involves, the actions taken
R is why it is being done: the worldview W which justifies P, the transformation sought

The desired transformations T and the worldviews justifying them were synthesised from data obtained from the interviews and the discussions in Workshop 1 and presented in Chapter 4.

The desired Transformations were derived from the priorities and the challenges found in the situation.

The worldviews W were derived from the reasons given by stakeholders to support their priorities, and what they hoped to achieve in addressing the challenges. The worldviews were what justified the transformations aimed for.

C: Clients – beneficiaries/victims of T

A: Actor – those carrying out T

T: Transformation – desired change

W: Worldview – perspective driving T

O: Owner – those who drive T

E: Environmental constraints taken as a given in doing T

The CATWOE mnemonic aided the development of the root definitions. The T and W elements are key to the expression of the root definition and are presented in table 5.1 showing the construction of the root definitions. The other CATWOE elements relevant for each RD are presented in the description of the models built from each root definition.

<u>Primary task vs. Issue based root definitions:</u>

Root definitions of purposeful activity systems may be “primary task”, which means focused on a process in line with organisational boundaries, in this case those of the stakeholder groups; or “issue based”, which means focused on an issue which cuts across organisational boundaries (Checkland, Poulter, 2010; Checkland & Scholes, 1990)

While primary task definitions will reflect transformation processes of primary interest to one group, issue based models have the advantage of crossing boundaries of interest between stakeholder groups, and hence easily stimulating the thinking of all stakeholders present at a workshop. The suggested approach for

SSM is to use a mix of primary task and issue based models in discussion with stakeholders (ibid).

This has been the format followed by this thesis. Ten root definitions of purposeful activity systems were created, describing activity in addressing FGM/C in Scotland, six primary task and four issue based. These ten were ultimately presented to stakeholders over the course of four workshops. Due to time constraints two or three preferred ones were selected for discussion at each workshop.

5.3 Purposeful activity systems addressing FGM/C in Scotland:

Ten root definitions for purposeful activity systems present in addressing FGM/C in Scotland were developed, presented in Table 5.1 and unpacked in more detail in section 5.4.

The components for building up the root definitions are presented in the columns. They were synthesised from the data presented in Chapter 4.

The first column indicates whether the root definition is issue based or primary tasks based. This column sets up the structuring of the purposeful activity systems by prefacing the Transformations sought with the priorities they fulfilled or challenges they addressed which were presented in Chapter 4. The next two columns show the desired Transformation, and the Worldview which justifies it respectively. The fourth column summarizes the transformation process of the purposeful activity system, showing its input and output. The fifth column gives the root definition, using the PQR format, of the purposeful activity system in question.

Is root definition Issue based/ Primary task?	Transformation	Worldview (What Is the justification of doing what this system does?)	Transformation process: Input → Output	PQR Root Definition
<u>Issue based</u>: this was of interest to NGO's and health care, as well as community groups. It addressed the challenge that women affected by FGM/C could not easily access available services.	Make service accessible	Services are hard to reach, and affected community has poor links with them. Creating good links will increase likelihood that women, youth, men will make contact when necessary.	Community with poor links to services → community with good links to services	1.A system to make services more accessible to affected communities, by outreach and awareness raising, in order to increase likelihood that those affected by FGM/C reach out for help and support.
<u>Primary task</u>: this was the primary interest of community groups. Tt fulfilled the priority of community engagement for education and awareness raising to challenge drivers of FGM/C.	Hasten abandonment of FGM/C	FGM/C is a harmful traditional practice, existing as a social norm with a low awareness of the harm to wellbeing of women and girls, therefore education and awareness raising will	Community practicing FGM/C → Community abandoned FGM/C	2.A system to hasten the abandonment of FGM/C in affected communities, by education and awareness raising on the practice in order to protect the wellbeing women and girls.

		hasten the end of the practice.		
<u>Issue based</u>: this was an interest for all stakeholder groups. It fulfilled the priority of collaboration expressed by stakeholders.	Improve collaboration between stakeholders	A unified approach makes use of various stakeholder strengths to more effectively address the issue	Stakeholders not working in collaboration → stakeholders working in collaboration	3.A system to improve collaboration between stakeholders, by creating and maintaining good working relationships, in order to more effectively address FGM/C
<u>Issue based</u>: this was of interest to all statutory groups, and supported by third sector groups. it addressed the challenge of lack of understanding of FGM/C in services.	Improve knowledge and understanding of FGM/C in services	More education/training is necessary to prepare for dealing with an issue that is uncommon, as skills unlikely to be picked up elsewhere	Practitioners under skilled in dealing with FGM/C → practitioners better prepared to deal with FGM/C	4.A system to improve knowledge and understanding of FGM/C in services, by providing good training in order to build confidence in addressing issue
<u>Primary task</u>: this was of primary interest to the social care stakeholders. It fulfilled the priority of child protection which was key for the social services.	Improve child protection	Child protection intervention safeguards the health and wellbeing of children	Children at high risk of FGM/C → children at low risk of FGM/C	5.A system to improve the protection of children at risk of FGM/C, by improving identification and intervention, in order to

				safeguard their health and wellbeing
<u>Issue based</u>: this was of interest to NGOs and health care, potentially social service. It fulfilled the priority of delivery of relevant services to women in need of them.	Improve service delivered to affected women	Improved service means better outcomes for women	Present service to affected women → improved service to affected women	6.A system to improve the effectiveness of service delivery on FGM/C to women by re-evaluating gaps in service provision and uptake, in order to support the wellbeing of women, girls and families in affected communities
<u>Primary task</u>: this was a primary interest of one community group. It fulfilled the priority of engaging with men for education and awareness raising on FGM/C.	Engage with men on FGM/C	Men lack awareness on FGM/C but have leadership roles in families and communities which can be used to hasten the end of FGM/C	Men not engaged on FGM/C → men engaged on FGM/C	7.A system to engage men on FGM/C, by education and awareness raising, in order to hasten the end of FGM/C by men's opposition to it
<u>Issue based</u>: this was of interest to an NGO, and the legal statutory body SCRA, police. It fulfilled the priority of support provision.	Protect vulnerable women	Vulnerable women should be legally protected from harm	Vulnerable Women affected by FGM/C → protected women affected by FGM/C	8.A system to support service to vulnerable women affected by FGM/C, by effective use of legal tools,

				in order to give them protection and support
<u>Issue based</u>: this was of interest to NGO, social services, police. It addressed the challenge of low reporting on FGM/C.	Facilitate reporting of FGM/C	There is low reporting due to barriers that can be removed	Individuals aware of FGM/C risk but not reporting → individuals aware of FGM/C risk reporting	9.A system to facilitate reporting of FGM/C, by breaking barriers to reporting in communities
<u>Primary task</u>: this was of primary interest to a community group. It addressed the specific priority of collaboration with policymakers to support well informed policy on FGM/C	Support creation of good policy on FGM/C	Existence of well informed policy would hasten the end of FGM/C with fewer unintended consequences	Policy with unintended consequences in addressing FGM/C in Scotland → policy without unintended consequences in addressing FGM/C in Scotland	10.A system to support the creation of good policy regarding FGM/C in Scotland by working with policymakers in order to hasten the end of FGM and protect the wellbeing of affected communities

Table 5.1: Root definitions describing the purposeful activity systems in addressing FGM/C in Scotland, with their associated priorities, worldviews and transformations.

This table summarises the formation of the relevant purposeful activity systems. More detail on each lies below.

5.4 Description of purposeful activity systems using CATWOE:

Each purposeful activity system root definition is explained below using the elements of CATWOE.

5.4.1 System to make services more accessible to affected communities through outreach and awareness raising because accessing services by individuals affected by FGM/C will improve their wellbeing.

The desired transformation here was based on the challenge of access to services not being easily accessible to affected women and communities for various reasons (section 4.6.3). The justifying worldview was that addressing this challenge meant that necessary help was obtained when needed if communities were better linked with services. The client here was the affected community. The actors with a role to play in this transformation would include the NGOs and the statutory bodies offering a service to link into (health, social) as well as communities themselves who would need to be open to strengthening and utilising the links. The owners driving this transformation were the NGOs and service providers. The environmental constraints included time, resource, and language constraints in the communities, as well as cultural barriers, and the existing policy framework within which all stakeholders worked.

CATWOE components:

T -Make Service accessible

W- Services are hard to reach, and affected community has poor links with them. Creating good links will increase likelihood that women, youth, men will make contact when necessary.

Process- improve links

C- community

A- community, NGOs, Services

O- NGO's, Statutory services

E- time, funding, existing policy, language and cultural barrier

5.4.2 System to hasten abandonment of the practice in affected communities, by education and awareness raising, in order to protect the wellbeing of women and girls.

The transformation here was to hasten abandonment/end of FGM/C. It was based on the community group priority of engaging with their communities of interest for education and awareness raising, to challenge on the drivers of FGM/C and inform on the law in Scotland (section 4.5.1). The justifying worldview for this was that education on the harms and illegality of the practice, as well as (where relevant) absence of religious requirement for it empowers people to abandon the practice and so protect to women and girls. The client beneficiaries were women, girls and their communities. The owners who drove this transformation were the community groups who engaged to challenge drivers of FGM/C. The actors involved were the community groups as well as the NGOs and services who provided support through direct or indirect involvement. The environmental constrains were the limited resources of community groups and the policy frameworks which support funding and within which FGM/C is addressed in Scotland.

CATWOE components:

T -Hasten abandonment
W- FGM/C is a harmful traditional practice, existing as a social norm with a low awareness of the harm to wellbeing of women, therefore education and awareness raising will hasten the end of the practice
Process- Education and awareness raising
C- community, women and girls at risk
A- community groups, NGOs, Statutory services
O- Community groups
E- Funding, time, existing policies

5.4.3 System to improve collaboration between stakeholders, by creating and maintaining good working relationships, in order to more effectively address FGM/C.

The desired transformation of improved collaboration was one of the stakeholder priorities (section 4.5.6). It was desired because each stakeholder role had its own strengths and capacities, so collaboration would improve the response to FGM/C. All stakeholders were clients/beneficiaries here, all stakeholders had a role to play, and all stakeholders owned this transformation process creating and maintaining good working relationships. The enviromental constraints included funding, time and the need to work within existing policy guidance.

CATWOE components:

T – improve collaboration
W- A unified approach makes use of various stakeholder strengths to more effectively address the issue
Process- creating and maintaining good working relationships
C- all stakeholders
A- all stakeholders
O- All stakeholders
E- Funding, time, existing policies

5.4.4 System to build knowledge and understanding of FGM/C in services, by providing good training, in order to build confidence for addressing the issue.

This desired transformation was derived from the challenge of lack of knowledge and understanding of the issue in the services (Section 4.6.1) as well as the priority of training (section 4.5.5), with the justifying worldview that this was the way to build capacity for addressing something that was rarely seen and poorly understood. The clients would be the statutory service providers; and the actors would be all stakeholders, either in giving or in receiving training. The owners are the statutory service providers. Environmental constraints remain resources and existing policy frameworks.

T – Improve knowledge and understanding of FGM/C in services
W- More education/training is necessary to prepare for dealing with an issue that is uncommon, as skills unlikely to be picked up elsewhere
Process- Providing good training

C- statutory services

A- all stakeholders

O- statutory services

E- Funding, time, existing policies

5.4.5 System to improve protection of children at risk of FGM/C, by improving identification and intervention in order to safeguard their safety and wellbeing.

The transformation desired here is based on the priority of child protection (section 4.5.7). The justification for it is that safeguarding of girls at risk would be improved if they could be more easily identified, and if social workers built their competence in intervening. The owner of this purposeful activity system are the social services, the clients are minors at risk. All stakeholders are actors as all have safeguarding roles. the environmental constraints are resources and existing policies.

T – Improve child protection

W- Child protection intervention safeguards the health and wellbeing of children

Process- improving identification and intervention

C- child at risk

A- all stakeholders

O- social services

E- Funding, time, existing policies

5.4.6 System to improve service delivered to women affected by FGM/C, by re-evaluating gaps in service provision and uptake, in order to improve outcomes and experience for affected women.

The transformation for this purposeful activity system was the improvement of service delivered to women. It was based on the priority of delivery of relevant services to women in need of them (section 4.5.4). The worldview justifying this transformation was that it improves the outcomes for women, and their experience engaging with the service. The clients are the affected women and girls. The owners of this system are the health service, social services, and NGOs

which provide service to women. These are also the actors in the situation, constrained by their resource, including time, availability.

T – Improve service delivery to affected women

W- Improved service means better outcomes for women

Process- Re-evaluating gaps in service provision and uptake

C- affected women and girls

A- NGO, Health, Soc work

O- health care, NGO, social services

E- Funding, time, existing policies

5.4.7 System to engage men on FGM/C, through education and awareness raising, in order to hasten end of the practice by men's opposition to it.

This transformation was based on the priority of engaging with men (section 4.5.2). the world view justifying this was the belief that men could play a very strong role in resisting FGM/C if they were educated on the harms and challenged on the drivers. The clients were men, by extension women and girls benefited here. The owners of this process were a community group dedicated to engagement with men, and the actors were community groups. The environmental constraints were available resources, and policy frameworks supporting community engagement and funding of initiatives.

T – Engage men on FGM/C

W- Men have leadership roles in families and communities which can be used to hasten the end of FGM/C

Process- Education and awareness raising

C- men, women, girls

A- community group

O- community group

E- Funding, time, existing policies

5.4.8 System to provide support to vulnerable women and girls affected by FGM/C, by effective use of legal tools, to give them protection and/or refuge.

This purposeful activity system transformation was derived from the priority of support provision (section4.5.3). The worldview was that legal tools should be available and used to protect vulnerable women and girls. The owners of this purposeful activity system, as well as the actors in it were NGOs, police and SCRA. The clients here are vulnerable women and girls. The constraints are resources and legal frameworks and tools available.

T – Support vulnerable women and girls
W- Vulnerable women should be legally protected from harm
Process- effective use of legal tools
C- vulnerable women, girls
A- NGO, police and SCRA
O- NGO, SCRA, Police
E- Funding, time, existing policies

5.4.9 System to facilitate reporting of FGM/C, by breaking barriers to reporting, in order to improve safeguarding.

This transformation was based on the challenge of low reporting of potential cases of FGM/C (section 4.6.2). The justifying worldview was that if barriers to reporting are removed, reports would come from the communities. This would support child protection. The clients here were anyone aware of heightened risk of FGM/C to a girl. The actors would be any stakeholders with a role in safeguarding. The owners of this purposeful activity system were the police, social work, and NGO participants who focused on legal aid and safeguarding. Environmental constraints were stakeholder funds, time, and existing policy frameworks.

T – Facilitate reporting of FGM/C
W- There is low reporting due to barriers that can be removed
Process- breaking barriers to reporting
C- those aware of risk of FGM/C to self or others
A- NGO, Police, Social service, Education, community group, health care

O- NGO, social service, Police

E- Funding, time, existing policies

5.4.10 System to support creation of good policy on FGM/C, by working with policymakers, in order to improve the effectiveness in addressing FGM/C.

The transformation here was the support and creation of good policy on FGM/C in Scotland, and the process was working/engagement with policymakers. The owners of this purposeful activity system were a community group with a specific priority to raise the voice of African women on FGM/C in the policy sphere through collaboration with policy makers (section 4.5.6). The justification for this is that well informed policy would limit the pitfalls and unintended consequences that would come from a poorly informed policy. The beneficiaries of good policy on FGM/C would be all stakeholders, and all stakeholders would be actors, as their roles would be defined/affected by policy.

T – Support creation of good policy on FGM/C

W- Existence of good policy would hasten the end of FGM/C with fewer unintended consequences

Process- working with policymakers

C- Community, women and girls affected, NGOs, statutory services

A- all stakeholders

O- policymakers, community group

E- Funding, time, existing policies

5.5 Building models of purposeful activity systems:

Having identified the 10 key root definitions, the next step was to develop models of the purposeful activity they described. These purposeful activity models (PSMs) provide a key methodological stepping stone for structuring discussion about the real world situation. The model for the first PAM is presented here as an example; the remaining models are in Appendix 15. The models were used in workshop 2 to guide the discussion on gaps between the ideal and the real world, and of ways to improve the situation.

Each model illustrates the transformation process indicated in the root definition of the PAM. The model process follows the system format:

INPUT→TRANSFORMATION → OUTPUT

Where an input is an entity in focus prior to the transformation and the output is same entity following the desired transformation. (Table 5.1)

The transformation process was modelled in a logical sequence of steps. This is presented in the blue section of the models below.

Input and output indicate the transformation being sought in the purposeful activity, and define the purpose contained in the model. The red boxes in the models show the input and output.

Checkland suggests that the process in a model have 7 +/- 2 activities for ease of use. The format followed for developing the models was that the first one or two elements were related to the input, the last one or two were related to the output, and the rest deal with the process itself. The models propose an ideal process, and their purpose is to help structure discussion about the issue in question (P. Checkland, Poulter, J., 2010).

Each model also included a section on monitoring activities, to support evaluation of the system in terms of efficacy, efficiency and effectiveness. This is presented in the green boxes in the model below. In the event however, the workshop time was focused on discussing the transformation process aspect of the model due to time constraints.

Example model:

An example conceptual model is presented here for understanding, illustrating the first PAM (section 5.4.1)

(please zoom in for detail).

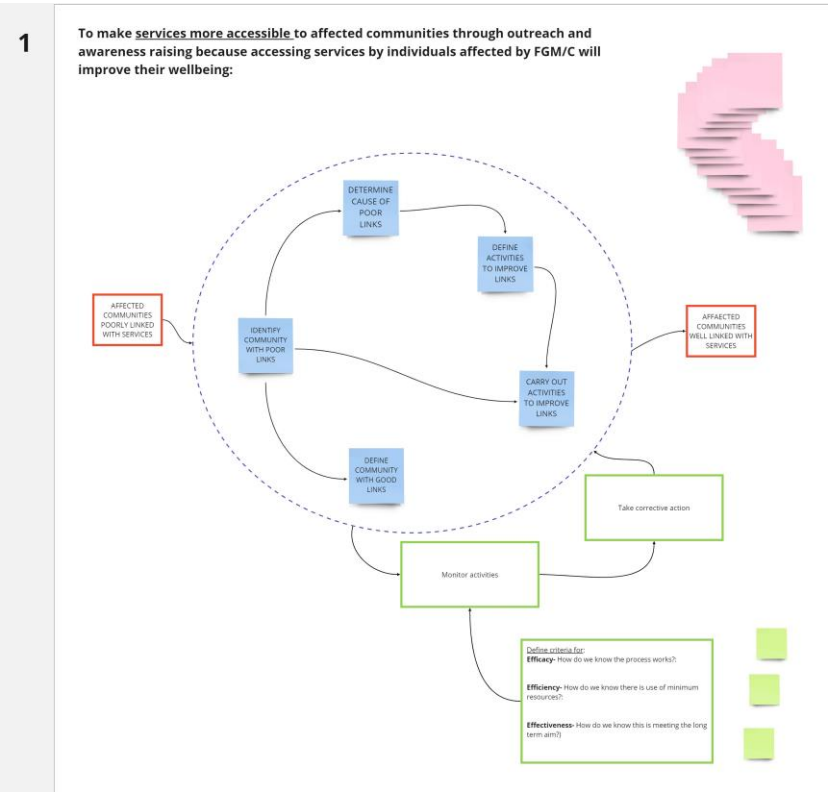

Fig. 5.1 Model of system (1) to make services more accessible

It has five elements describing an ideal process for making services more accessible. The first step is to identify communities with poor links to services. This is related to the input (affected communities poorly linked with services). The last step is to define communities which are well linked with services, in order to make clear what is being aimed for, which is the output (communities well linked with services). The remaining steps concern the process – determine cause of poor links, define actions to improve links, and then carry out the actions. How the models were used to structure discussion is presented in section 3.4.1 .

The remaining models follow a similar format and are included in Appendix 15.

5.6 Reflection and Conclusion:

The use of CATWOE provided a foundation for the development of the root definitions of purposeful activity systems in addressing FGM/C in Scotland, clarifying what needed be elicited from data. The roles, perspectives, priorities,

challenges in the situation were reflected by the elements of CATWOE, and used for developing the root definitions and their PAMs.

The most common benefit of using SSM is provision of structure in complex and messy situations (John Mingers & Taylor, 1992), and the purposeful activity systems structured the unclear situation in addressing FGM/C in Scotland.

The structuring is important for clarity. SSM holds that the perspectives/worldviews in the situation are key to understanding purposes in a ‘messy’ human and social situation. However, these are not always clear.

In the process of developing the root definitions, the initial idea was to look for perspectives (CATWOE worldviews) on FGM/C and how they vary across stakeholder groups. The perspectives found were all broadly against FGM/C. Some viewed it more as a harmful traditional practice, and some viewed it more as grievous abuse, so there was some nuance. However, none of this really added knowledge or helped with justifying the varied system transformations these groups were working on. It turned out that this approach, while not in itself ‘wrong’, was too superficial and simply did not go deep enough to uncover the specific link between the worldview and the transformations in question. To apply the methodology more precisely, the perspective needed was the worldview to the particular way each stakeholder addressed FGM/C, not broadly to FGM/C itself. The data was then coded again, more closely searching for this, with a key word turning out to be 'because'. “I do this 'because' this is the situation as I see it”.

This brought up a picture of dramatic difference, both between groups and within groups, as shown above. It also with great clarity justified the work each stakeholder was doing, their specific approach to addressing FGM/C. This was the “worldview” and “transformation” relationship presented by the SSM methodology, where, as Checkland emphasised (Checkland, 2010), the worldview was the more important because it drove workings of the input-transformation-output activity of the (conceptual) system.

This chapter structured the expressed situation in addressing FGM/C in Scotland into ten purposeful activity systems present in the situation. These are ten ways in which the system ‘addressing FGM/C’ was framed by participants, based on their

understanding of what was necessary and why it was necessary to address the issue in this way. It then described how purposeful activity models were created for these systems.

This provides clarity in a previously unclear situation. Where it had not been clear which questions need be asked to improve the situation in a way that integrates the perspectives and priorities of the various stakeholders, PAMs will provide structure for exploring the situation and defining ways to improve it in a way that is cohesive across stakeholder groups.

The findings on the gaps highlighted and the ways to improve defined through the use of the purposeful activity models will be presented in chapter 6.

RESULTS	AIMS OF THESIS	SSM STAGE
Chapter 4	Build understanding	Finding out: expressing the unclear situation
Chapter 5		Building models: structuring the situation using models of purposeful activity
Chapter 6	**Find ways to improve**	**Evaluate models: compare with reality and define feasible changes**

6. RESULTS 3 – Defining ways to improve

Chapter 4 and 5 were aimed at building understanding of the situation in addressing FGM/C in Scotland, chapter 4 providing a rich picture of the situation, and chapter 5 showing how the situation was structured using root definitions and conceptual models of purposeful activity.

Chapter 6 will present the ways to improve the situation defined through stakeholder discussion which was guided by the purposeful activity models PAMs and supported by the interview data.

The chapter includes a table of ways to improve addressing FGM/C in Scotland as well as two system maps visualising the challenges/gaps in the situation and the ways to improve it respectively.

6.1 Introduction:

The PAMs were used to guide and structure discussion on the activity systems of interest in stakeholder workshops, serving as devices to help clarify the gap

between the existing situation and the ideal, and to identify ways to close this gap.

This approach allowed stakeholders to identify the specific activities needed to improve elements of interest to them, and further, allowed a synthesis to be made of the activities to improve which were of interest to multiple stakeholders in the situation, across four workshops carried out.

One workshop (2a) was held with community groups alone. This was in line with the ethical considerations made for this thesis (section 3.8) which noted that due to power disparity and potential conflict of opinion, community groups would have a separate workshop in order to allow participants express themselves freely. The other three (2b,c,d) were multi agency, with a mix of NGO and statutory service participants. (Stakeholder group representation across workshops has been presented in section 3.5.3).

In this way, structuring the previously unclear situation into the multiple purposeful human activity systems operating within it ultimately allowed a derivation of ways to improve the situation that cuts across the boundaries of these systems, hence defining ways to improve the situation for stakeholders with disparate priorities.

In their function as a discussion guide, purposeful activity models (PAMs) presented the ideal steps for the process of achieving the aim of the purposeful activity. These ideal process steps were picked up usually in sequence, or occasionally going with the steps which caught the attention of the participants. The steps were used to question whether there were gaps or challenges between the ideal situation and the currently existing situation at the various steps. For example, using Model 1 on "making services more accessible" the first step was identifying communities with poor links. The question was asked if these communities were clearly and easily identified/identifiable. If not, what were the challenges there? And then, what could be done to address those challenges?

The challenges identified often mapped across multiple steps and models and were highlighted by various stakeholder groups in different workshops. Findings therefore are presented as related to specific steps in the models of the ideal, but

as aggregated findings of challenges/gaps highlighted. The same approach is taken to present the ways to improve, generated by discussion of the models.

A summary table of which models were chosen, in which workshop, with which participants present is given in Appendix 16.

6.2 Challenges/gaps in addressing FGM/C:

Discussion of the models led to gaps and challenges being identified by stakeholders in the four small group workshops. It immediately became apparent that similar issues were being raised from different perspectives across the workshops.

For example, in discussing model 1 on making services more accessible, community group participants in workshop 2a spoke of the difficulty for individuals in immigrant communities accessing services, due to lack of understanding of how the system works as well as inadequate language skills. Discussing this model in workshop 2b, a health care participant noted that in her experience, some women may not want to be integrated into Scottish society, as they return for multiple births without having made any progress in English language; and may not be interested in the services offered.

This issue was also raised when discussing a different model. In discussing model 3 on collaboration in workshop 2c, an NGO participant pointed out the importance of communication between the individual, the community, and the services (both statutory and 3rd sector), as she had found that affected individuals needed much support to speak about their problems due to shame, embarrassment and not knowing who to talk to. All these points converged on women not accessing available services.

This issue was therefore linked across stakeholder groups, and across issues of concern in different PAMs. As these interlinkages between stakeholder concerns on various issues emerged in post workshop analysis, a map was constructed by the researcher to capture this.

The map aims to show how the challenges in the situation are interconnected and interdependent; how challenges in one area of the system have effect in other

areas; and how challenges affecting individuals, communities, and services overlap. The map aggregated findings from discussion of the conceptual models across all the small groups in workshop 2, supported by the interview data. Causal flows for listed elements were captured as given by stakeholders.

The map did not attempt to resolve differences of perspective, but rather aimed to include them. For example, some participants indicated women may not access services because of shame, or language barrier, while another indicated that they may not actually want to. These perspectives are not necessarily mutually exclusive (as affected communities are made up of diverse individuals), but they do differ. Both views were captured in the map. Discrepancies between stakeholder positions also had room for reflection in the feasibility columns of the table of ways to improve (section 6.3.1).

6.2.1 Map of challenges in addressing FGM/C in Scotland:

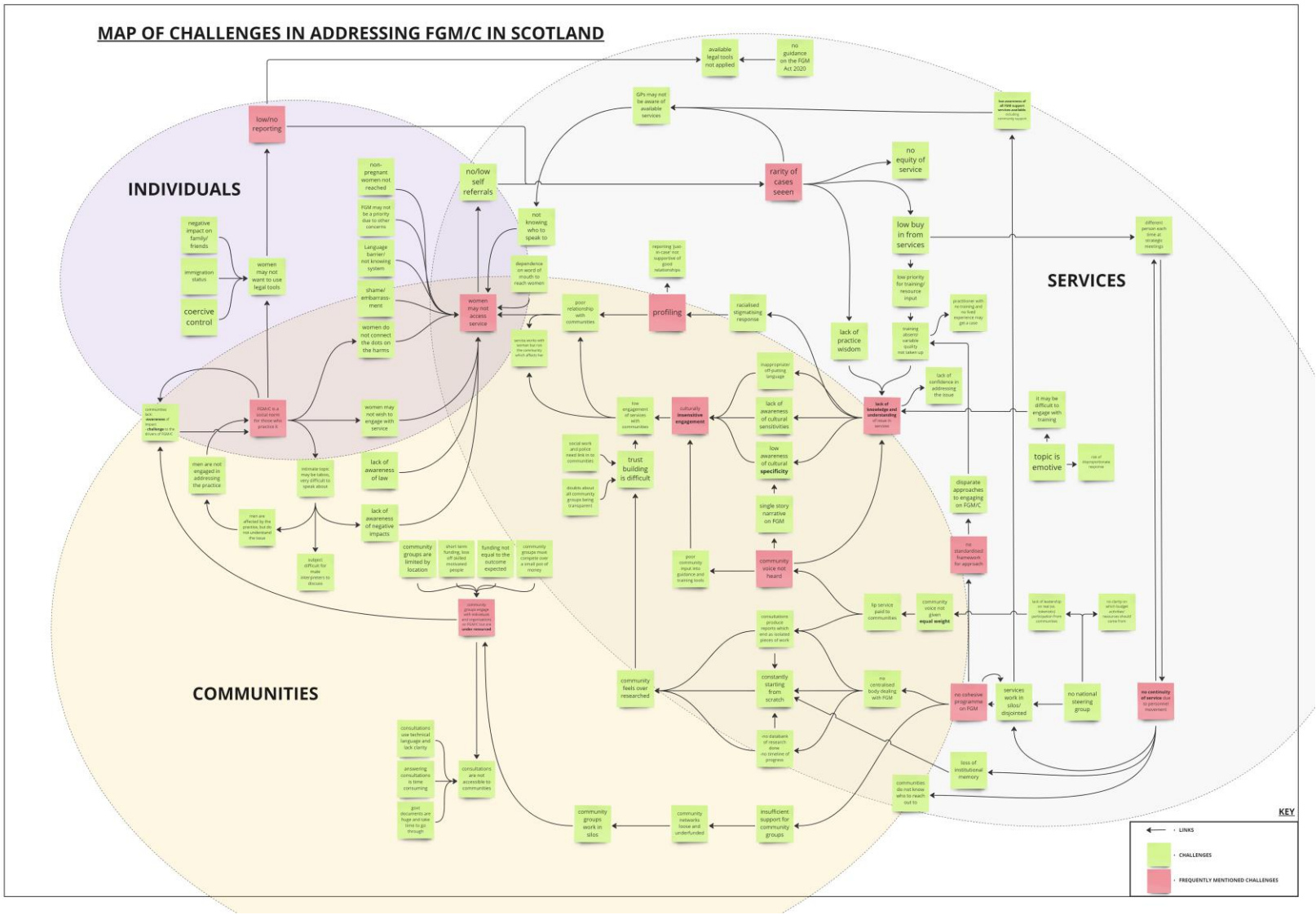

Fig 6.1. System map of challenges in addressing FGM/C in Scotland (Please zoom in for detail)

6.2.2 Description of map:

The map is laid out on overlapping background theme areas of “individuals”, “communities”, and “services”. This was done to associate issues with the group/s to whom they were most relevant. The idea came from a participant who characterised the response to FGM/C as involving individuals, their communities, and the services, “like a chain” (019-NGO-BB), while suggesting that there was a need for individuals to communicate with their communities, communities to communicate with both individuals and services, and services to respond to both.

The map depicts all the interconnections and interdependencies found, and some of the main pathways the map captures are described below in a series of loops. Please zoom in for detail on the images.

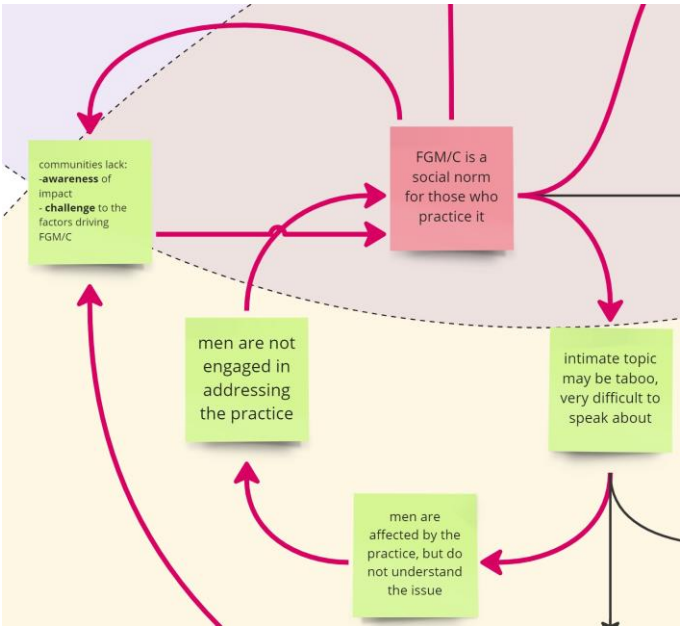

Fig 6.2. Loops 1 and 2 - A normative and self-perpetuating practice.

Loop 1 (Normative and self-perpetuating) and 2 (engagement of men) describe how the practice being socially normative is self perpetuating (Figure 6.2).

Loop 1: Normative and self-perpetuating

In the overlap between individuals and communities lies a focal problem in addressing FGM/C, namely that it is a social norm for those who practice it, one

with a perceived positive social/cultural value (unpacked in detail in chapter 4). This is captured above in Figure 6.2. Due to its normative status, there is lack of awareness of the negative health impacts of the practice, as whatever impacts are experienced will often be seen as a normal part of a woman's life without explicitly being linked to the FGM/C (this is detailed in the section on ignorance of harm, Chapter 4). FGM/C being nominally harmless, culturally normative, and socially beneficial, there is a consequent lack of challenge to the drivers of the practice to help people re-evaluate their position on the practice. This supports the maintenance of the social norm, creating a self-reinforcing loop in communities which practice FGM/C (Loop 1).

Loop 2: Engagement of men

Loop 2 looks at the gap of men not being engaged in resisting the practice. By definition, a normative practice is not usually challenged or questioned, but accepted. This normative practice is sensitive and may be very taboo to talk about, meaning that while men are also affected by the practice in their relationships, they often do not understand the issue and are not engaged in challenging it (Figure 6.2), which again supports the perpetuation of the practice (Loop 2.) The fact that men are also affected by FGM/C, physically and mentally in their intimate relationships, was raised by community group participants and an NGO participant, the NGO participant explicitly stating that men feel the more shame and embarrassment to talk about it in their communities, and that *"they are not in a position to talk to their own families about their own feeling [and] even they can't understand the issues"* (019-NGO-BB). There was a lack of knowledge and understanding among men, and reluctance to discuss it, even with professionals in the NHS. This lack of engagement of men also feeds into the self-perpetuation of the practice (Figure 6.2.).

Loop 3 – Rarity and lack of understanding:

The third loop centres on the rarity of the practice as seen by service providers, which leads to both a lack of buy in from them, and a lack of "practice wisdom" in addressing the issue, which results in insensitive engagement with communities. Insensitive engagement is a barrier to engaging with services (Section 4.6.4),

feeding into the rarity of cases seen by services, forming a reinforcing loop. This is a large loop through the map (Figure 6.1) and will be discussed via a series of shorter arcs through the loop.

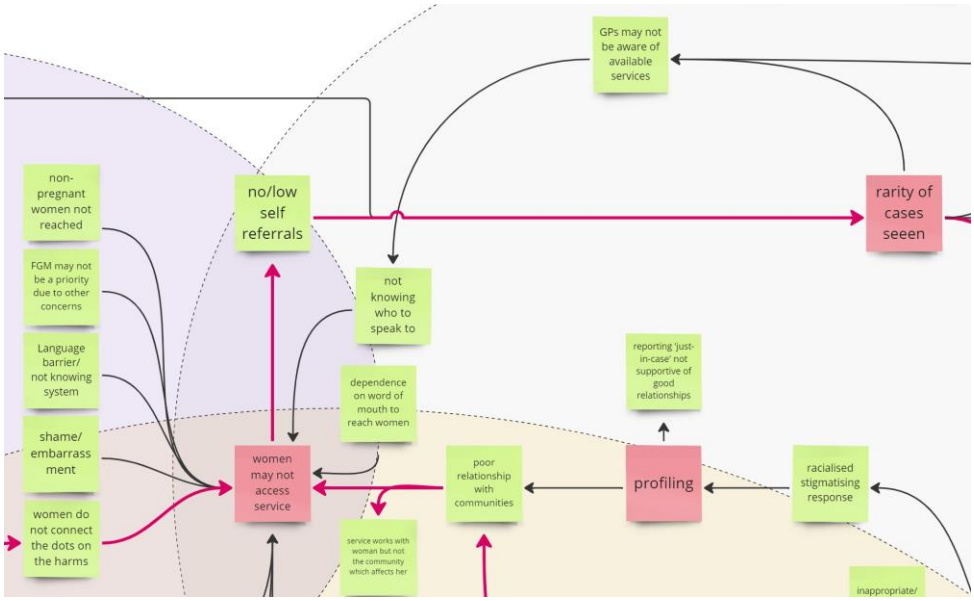

Fig 6.3. Loop 3 Rarity and lack of understanding, Arc 3a.

Arc 3a

Figure 6.3 shows that women may not access services for a variety of reasons. The fact that FGM/C is normative in a community means that women may not readily "connect the dots" on the harms until they are tabled, as their symptoms are seen as a normal part of female life. They may therefore not access services which could improve their quality of life because they accept an issue as a fact of life. This was detailed in section 4.3.3 under ignorance of harm.

There are other reasons women may not access service. Immigrant communities not being familiar with how the health care system works coupled with language difficulties are barriers. Ante-natal services routinely ask women about history of FGM/C and refer all cases to a specialist midwife who can assess them for their needs. However, a health care participant pointed out that non-pregnant women with FGM/C are not seen by default in this way and need to make themselves known, for example, to their GP. This may not happen if women don't prioritise the issues they are dealing with, either because they accept them as normal, or because *"FGM is the least of their worries"*, (009-STAT-Health) and other vulnerabilities or life priorities may take precedence. Community group

participants pointed out that language barriers mean that even leaflets through a letter box may not be understood, and not knowing how the health system works in the UK means services may not be accessed. An NGO participant working with the Kurdish community emphasised the shame and embarrassment felt by women which made it very difficult to for them to open up about their FGM/C, necessitating direct questioning on the issue. A social services participant pointed out that some community members may not wish to access the services because they are not in agreement with opposing FGM/C : "I suppose by definition it's underground, isn't it […] So, by definition it's…some members of a community don't want to be linked to professional services or third sector services that will refer in to other agencies." (016-STAT-Social).

All this contributed to low/no self-referrals to services, which means that there is a rarity of cases seen by the services. A health participant noted that due to rarity, GPs themselves may not be aware of all the available services on FGM/C or who to refer to, and consequently, the women may still not access the service they need: *"every woman that I see, information gets sent to the GP […] and I've never had a reply from a GP yet. You know, there's…it's not…they don't see it as a priority […]so if they don't know we exist or they don't want to know that we exist, then if they have a woman that walks in to the surgery that needs a referral, they won't necessarily know where [to refer them]."* (009-STAT-Health)

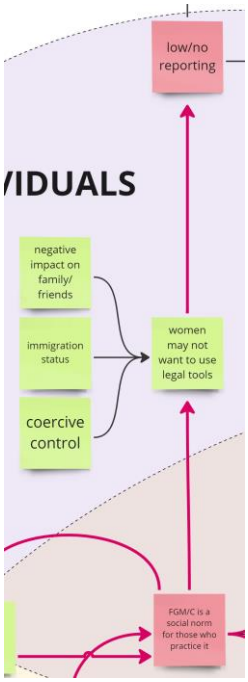

Fig 6.4: Loop 3 Rarity and lack of understanding, Arc 3b.

Arc 3b

FGM/C being a social norm also meant a reluctance to use legal tools to deal with it (Figure 6.4). Due to fear of negative impact on family and friendship ties, children would not want to report parents, and people did not want to get in trouble with their neighbours. This was discussed in section 4.5.7 and section 4.6.2.

An NGO legal participant noted how low self-reporting was: *"as a legal service provider, we rely on referrals and self-referrals, so referrals from [social and health services], but self-referrals as well. Self-referrals for this issue are zero, to legal services anyway"* (015-NGO-Legal). Reasons he noted for this in his experience included broader issues of domestic abuse or coercive control, where immigration status of vulnerable women could be dependent on an abusive partner.

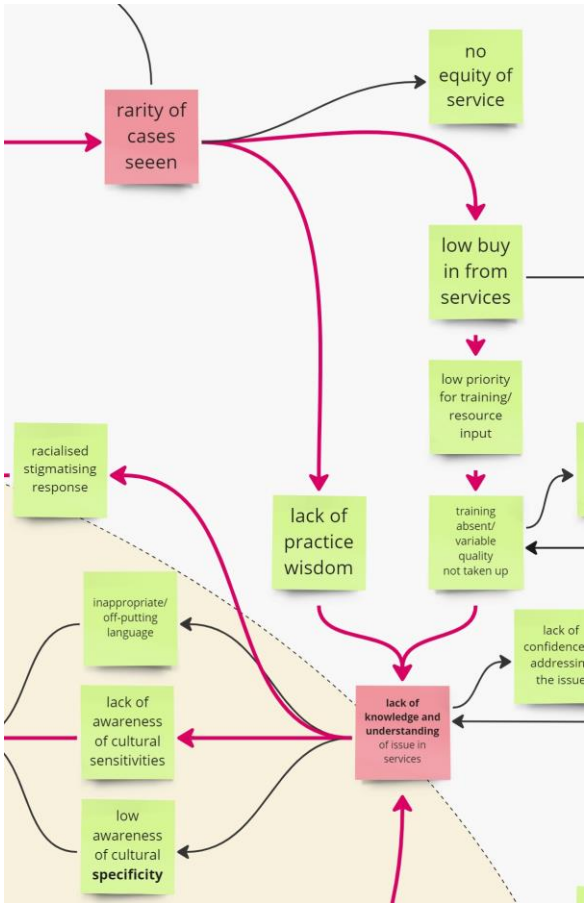

Fig 6.5: Loop 3 Rarity and lack of understanding, Arc 3c

Arc 3c

The rarity of cases seen had a double effect – on the one hand lack of practice wisdom; on the other a lack of buy in from services and a variable quality/presence of training. Both led to a lack of understanding of the issue in the services (Figure 6.5.).

A social service participant noted that few FGM/C cases dealt with resulted in a lack of knowledge/understanding of the issue the service and the need to link to those who saw more: *"we don't have any practice wisdom just now to be honest [..] So I suppose it would be learning from other places[..] maybe England or London or whatever, that deal with this much more regularly than we do, and sharing the knowledge that other professionals have, and third sectors."* (016-STAT-Social).

Regarding buy in, a health service participant noted that *"buy-in from GPs has been really difficult. And I think that's critical, is…you know, you could […] just*

have information up on the surgery wall so that the women would see the information and then actually don't need to see the GP, they could do a self-referral. But that's just been difficult. And it takes money."; and that *"When we were developing the guidelines for Lothian, the…I have to say, the buy-in from education wasn't very good. It was a different person that came to the meeting every time and that was a real, kind of…bit of a pain really. There wasn't the buy-in from education. Because, you know, health is fairly robust, our guidelines are working and…but the buy-in from education was not great at all."* (009-STAT-Health)

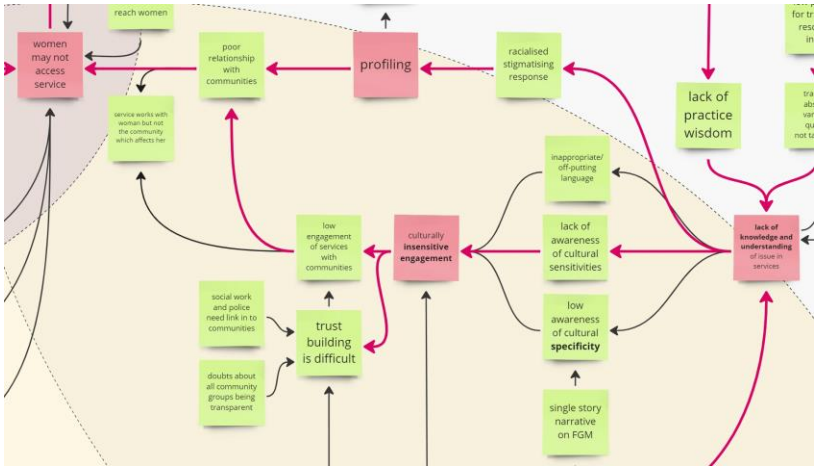

Fig 6.6: Loop 3 Rarity and lack of understanding, Arc 3d

Arc 3d

The lack of understanding of the issue in services led to insensitive engagement and profiling in dealing with affected communities (Figure 6.6).

The link between lack of knowledge and a stigmatising response was made by the legal NGO participant: *"our knowledge and understanding around this issue is almost purely anecdotal […] we don't actually know what's happening, how it's happening or who's doing it. Like, we have guesses from our anecdotal experiences but that's about it. And therefore, with our lack of knowledge, any response to it is likely to be dipped in, you know, racialisation and stigmatisation"* (015-NGO-Legal).

Another NGO participant pointed out that profiling was based on an educated approach that a child was at greater risk of FGM/C than the general population due to risk due to being from a particular country or community, however that the problem was that it wasn't clear how well trained the services were in *"identifying general risks to a child versus [an actual] heightened risk of FGM"* (003-NGO-BB). Community group participants opposed profiling on the grounds that it both pointed a finger at potentially innocent families and was blind to potential cases that did not fit the profile.

Lack of understanding also resulted in insensitive engagement through poor use of language, and ignorance of cultural sensitivity and specificity (section 4.6.4), and was linked to a 'single story' narrative on FGM/C (section 4.6.1).

Insensitive engagement and profiling resulted in a poor relationship of services with affected communities. Social services and police participants said that they were dependent on other services for a link in to communities, and trust building was difficult. The lack of trust inherent in the situation was unpacked in section 4.6.4.

All this was detrimental to engagement, and ultimately to women accessing services; as one health care participant pointed out, services depend on word of mouth to reach individual women. A social service participant also noted that the services work with the woman but not with the community which affects her; this is a particular challenge as FGM/C is community driven.

No cohesive programme

Another factor feeding into the challenges in addressing FGM/C was that there is no cohesive programme on FGM/C (Figure 6.7).

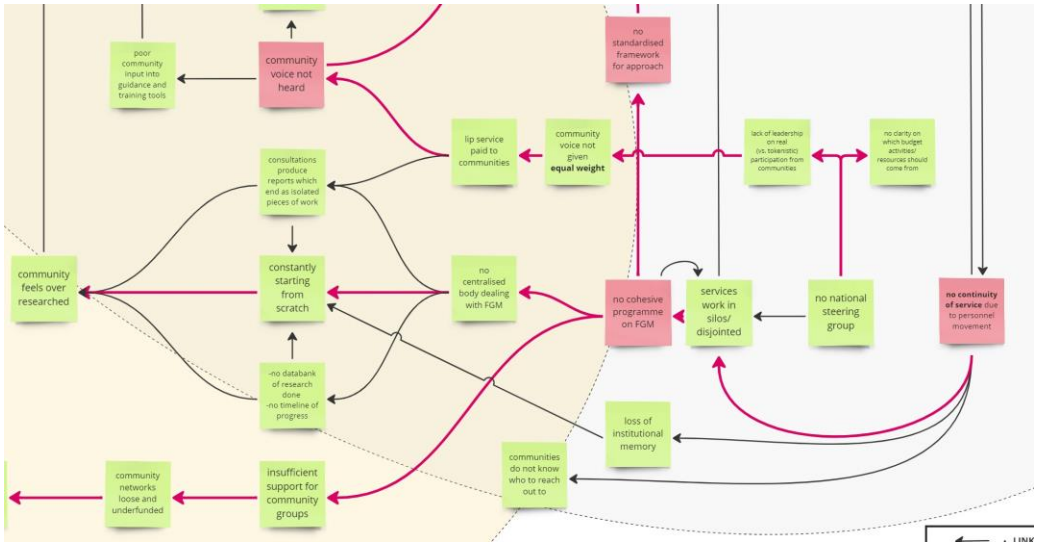

Fig 6.7: Lack cohesive programme and community voice.

A police participant pointed out that while services worked together on a specific issue like a child protection intervention, on the broader issue of FGM/C "*we're, kind of, working in silo, we're not joined up, there's no national steer*" (022-STAT-Police). Part of the problem was a lack of continuity in services – people who had been in their roles long enough to acquire some understanding of the issues surrounding FGM/C moved on from jobs, and their replacement would start over from the beginning. This was pointed out by community group, NGO and statutory service participants, with one noting, "*we're on our third round of Scottish government civil service dealing with this […] in the space of about two and a half years*" (015-NGO-Legal).

Community group participants noted that it seemed they had to start from scratch when a new person came into a role, losing progress or momentum on projects that were then no longer funded, or forgotten. One pointed out the need for active maintenance of national archives with a timeline of research and projects done, otherwise there was a risk of losing institutional memory:

"there have been other researches which have been done, both at policy level in various government agencies, in charity, in schools, and churches, whatever, where are all these recommendations and answers? Where are they? Where is all this information? So that we are not really repeating ourselves or maybe we have missed something as people come and go because charities work short-term cycles, you know? There is need to have all that information" (008-COM-WB)

Another noted that *"we are talking about this topic [since] 2005, now we are in 2022 and we are talking about the same topics, you know? Many people have given their time, their knowledge but again we are in the same…it looks like these are 'new' topics"(*002-COM-BB). Community group participants questioned why archives are not consulted and why decisions had not been implemented or implemented piecemeal.

The problem of lack of continuity in service also affected this present research. Attempts to recruit a policy maker had yielded initial interest, but later no response. it was later discovered that the loss of contact had been due to the person moving on from the office.

Community group participants said they didn't feel their voice was given equal weight by policy makers, compared with the voices of statutory services. The legal NGO participant stated that *"historically it's been lip service that's been paid to [community voices]. And the networks are loose. They're not funded from…by anyone. And…so the promotion of that side of this work has historically been poor, despite it being, I think - from a common sense perspective - the best way to address this question"*. (015-STAT-Legal)

Community voices not being heard, or being heard in a tokenistic way contributed to the lack of understanding of the situation among the statutory services.

The lack of a cohesive approach also meant that there was no standardised framework for training and community engagement on the issue, which means that training on FGM/C is of variable quality, or absent/not taken up whereby in was insufficient. A community group participant pointed out that different organisations were providing teaching for the police, for schools, or for engagement with communities, without a consistent framework or necessarily an appropriate approach to the issue. Lack of a standardised approach in training/teaching also contributed to lack of adequate understanding of the issue, and subsequently to ineffective/insensitive engagement with communities and individuals.

Loose community networks

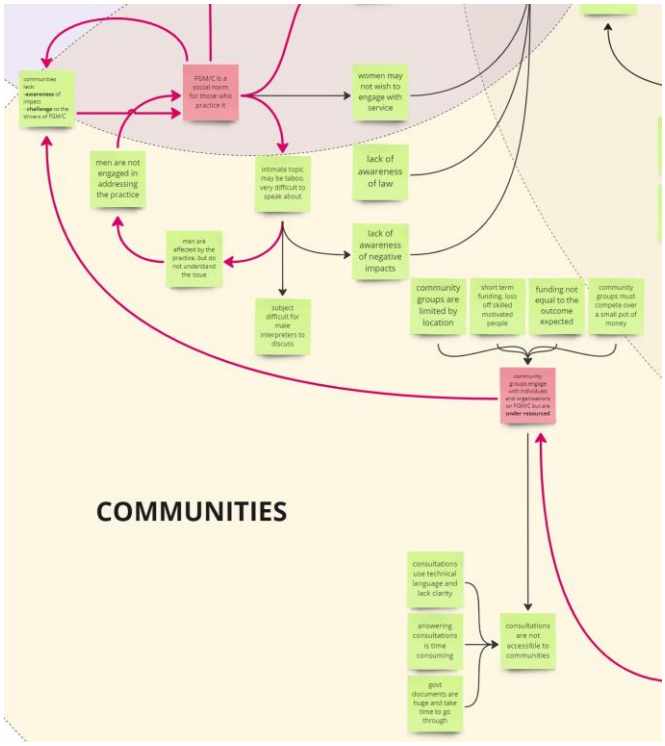

Fig 6.8. Loose community networks

The absence of a cohesive approach to addressing FGM/C meant that the grassroots community were poorly supported. Their networks were poorly connected, which resulted in duplicated work and lack of shared skills and resources. Their work was also limited by funding, availability of time, and geographical location (Figure 6.8). Statutory service participants recognised these limitations of community groups, noting for example how a community group which was active in engaging with men was based in Glasgow but had no counterpart in Edinburgh.

Grassroots community groups play a key role in addressing FGM/C. It is a community driven practice, and they engage directly with communities to raise awareness on FGM/C, including on its legal status, challenge the drivers of the practice and provide support for integration into Scottish society. Their being under supported and loosely inked with one another and with the services meant that this key was underdeveloped and underutilised.

Summary:

A large reinforcing loop can be drawn through the map of gaps and challenges in addressing FGM/C in Scotland (Figure 6.1), showing how the challenges

experienced by the multiple stakeholders in addressing FGM/C in Scotland are interconnected and interdependent.

The practice is normative due to several drivers in affected communities, but women affected by FGM/C may not access available services for a variety of reasons.

Outside specialist antenatal services, service providers say they see cases rarely, and there is little or no reporting from communities. The rarity of cases seen leads to a low understanding of the issue and available resources in the services, as well as a lack of buy in for resource input and training. Lack of a cohesive programme for addressing FGM/C in Scotland means that there is no standardised approach to training or engagement on the issue. Community groups which raise awareness and challenge the drivers of the practice are under resourced and do not feel their voice is taken seriously. They are an existing but underutilised resource in promoting abandonment of the practice in affected communities.

The challenges for individuals, communities and services in addressing FGM/C form a complex system; and the ways to improve the situation are similarly interrelated and interdependent, and will be detailed below.

6.3 Ways to improve addressing FGM/C

SSM proposes the use of a table for presenting the ways to improve the situation, and for clarifying feasibility and acceptability. The planned use of the table suggested by Checkland (Checkland & Poulter, 2010) had to be adapted, as attempts at laborious filling of the matrices did not allow a free and easy flow of discussion during the workshops. The headings from the table regarding feasibility were simply used to provide prompts during the discussion. Based on the recordings of the workshops, their transcripts, as well as the annotations made with stakeholders on post it notes placed on the models during the workshops, the researcher subsequently extracted the ways to improve identified by stakeholders.

These are summarised in Table 6.1 below.

6.3.1 Table of ways to improve addressing FGM/C in Scotland:

The table presents the ways to improve addressing FGM/C in Scotland. These were actions which stakeholders thought would improve the situation, by closing the gaps or addressing the challenges they had identified in the situation. It also ranks these 'activities to improve' by their acceptability and feasibility.

The actions to improve the situation are ranked by degree of consensus regarding their **acceptability** in the rows of the table.

Ways proposed and agreed on by stakeholders in all the community and multiagency participant workshops ranked as primary tasks. Ways proposed and agreed on in at least two workshops were ranked as consensus tasks. Ways proposed by just one stakeholder/group where there wasn't consensus were ranked as multiple perspectives.

Primary tasks are those **accepted** by all stakeholders as important in addressing FGM/C; consensus tasks are those which not all stakeholders found relevant, but on which there is some agreement. Multiple perspective tasks are those which are raised by one or two stakeholders in the situation. This does not mean that these are not important, but that they are prioritised by only a minority (ibid).

The **feasibility** of the ways to improve was reflected in the columns of the table, which asked: whether the proposed way to improve existed, who was responsible, what improvement was needed, and if it was doable. The 'does it exist' column reflected on if, or to what degree, such an action already existed. The 'who is responsible' column captured stakeholder reflection on which actors were involved in this way to improve. The 'is it doable' column captured relevant nuances or differences of opinion, and a question mark (?) was used where the answer was not clear.

The use of the table allows a presentation of findings which does not depend on consensus between all participating stakeholders but captures nuance and proposes which interventions would be most pragmatic to start with.

	ACTIVITY TO IMPROVE	DOES IT EXIST YES/NO	WHO IS RESPONSIBLE	AREA OF IMPROVEMENT	IS IT DOABLE
Primary task	Establish standard-ised framework for FGM/C for all agencies	No	Government / policymakers need to take lead, all stakeholders to be involved	-Develop a standardised national training product and materials. -This basic framework should be adaptable by all services/agencies for different tiers of specialization. -To cover engagement on FGM/C and training	Yes, but requires leadership from government
	Collabo-ration	Poor, as agencies and community groups work in silos	All stakeholders, with leadership from government	-Stronger links are needed between community groups and between community groups and services -Collaboration, not competition, should be supported between community groups -Government should work closely with community groups -Community groups should share lived experience and knowledge of what works in addressing FGM/C	Yes. -Must take into account possible negative dynamics between groups -Purpose of the networking must

				-Equal weight should be given to community voice, not lip service -Communities should provide input on not just issue, but on how to design service -Yearly event, or 'open day' on FGM/C where all stakeholders, including community groups are invited would be helpful	be clear; all should be on the same page with respect to opposing FGM/C
	Training on FGM/C	Yes, but is variable in quality, availability, and uptake	Policymakers, service providers, communities	-Expanded, mandatory, repeated, to keep it current. -For health visitors, not just midwives. GPs, mental health services, 3rd sector, education, social service police. -Should differentiate between baseline risk due to demographic, and actual heightened risk. -Should be supported by lived experience and community input. -Should cover context, not just practice of FGM/C -Should be designed in a way that recognises the sensitive/emotive nature of the topic, for services as well. -Should include input on what works in addressing FGM/C from the communities	Yes. Low reported numbers mean FGM/C is given low priority; however, lack of experience/practice wisdom coupled with seriousness of issue makes training crucial.

				-Should offer support to vulnerable women who are taking part	
Consensus tasks	Capacity building for community groups	Yes, but existing funding is not equal to the outcome expected; and community networks are loose and so lack one voice	Policy, all agencies can provide support, community groups	-Create formalised network which is community led, this shared platform to allow for one voice from communities on FGM/C -Representatives from services to work with community resources already there to build relationships. -Agencies should support training/information sessions with community groups on how to access services, the legal status of FGM/C, the role of the social worker, wider education on child protection -Organisations which are well resourced should pass it on for defined activities/events -Validation of community groups for transparency of leadership and purpose would build trust for working relationships	Yes -Government has oversight and funds -Trust between community groups and services is necessary
	Improve agency engage-	Yes, but may be culturally	All stakeholders	-Engagement on FGM/C should be harm based, not profiling based	Yes, but this requires training based on

	ment and response to FGM/C	insensitive or an over-response	to work together	-Agencies should understand the problem issue and the process of engagement for good impact -Graphic images should be limited to appropriate context, for example, clinical, to avoid making a spectacle of women - Services should be joined up on broader approach to FGM/C, not just on Child protection -Response should be measured, proportionate to risk - Cause of risk should be determined, as that determines the appropriate response - there should be greater collaboration with services which work more closely with family. Social care and police need a link in to communities.	collaborative input from services and communities
	Cohesive approach to research and practice	No	Policymakers	-Disconnect between research done and policy should be closed -Maintain databank of summaries on research done, timeline of progress, and current goals on FGM/C - Community consultations should not end as stand alone pieces of work, but should be integrated into practice	? Yes This had consensus form participant stakeholder groups but did not receive input from a

				-Consultation documents should be easy to understand, condensed and clear -Genuine participation should be sought - Continuity of service should be improved over frequent personnel moves.	policymaker perspective
	Engage with men	Yes, One community group focused on men, but there is need for more of this work.	Services Community groups	-Workshops focused on men are necessary, as their needs are different -For good engagement, FGM/C should be broached indirectly, for example in the context of wider support -Training, shadowing, and workshops are needed for male staff, including interpreters, as it may be difficult for them to talk about this issue	Yes, but there are few organisations working with men on FGM/C
	Raise awareness of services available	Services for support exist, but engagemen	Policymakers, services	-Posters on GP walls to raise awareness of services available -Leaflets on community resources for FGM/C should be made available to services	Yes, but there is a lack of clarity on which budget should cover posters

		t could be better		-School registration could include a question on FGM/C in questionnaire, so information can be provided to women if they have any concerns	-Consensus on school questionnaire question is unclear
Multiple perspectives	Support reporting	Yes, but people may hesitate for fear of profiling None, or very low reporting from communities	All services which can note risk to child Individuals	-Services should be empowered to raise a red flag when concerned - Women could be supported to use legal tools	-Yes, but training needed to distinguish baseline from heightened risk. Reporting 'just in case' is not helpful for building relationships. -? It is very challenging to address the complex reasons

					women may not wish to report.
	Build relationships with families	Yes, especially in primary schools	Education	-Better awareness and understanding in education sector, to support families not to practice.	Yes, usually with women and children, less so with men.
	Change terminology	Yes, but can be improved	? unclear	-Female circumcision is the term used and understood in communities, not FGM/C. Cutting does not include forms of FGM which do not involve cutting such as elongation. -Use term 'potentially affected communities', not affected communities, to avoid profiling	- Would require more discussion for consensus among stakeholders -Distinction of communities at risk as 'affected' needs to be maintained to clarify target community for

					funded interventions
	Raise awareness of legal tools	Yes, but not across all services	Services	-Awareness that legal tools for support of women affected by FGM are not dependent on their qualifying for recourse to public funds	Yes, can be part of training
	Holistic approach to funding for FGM/C issues	? unclear	Policymakers, services	-Funding for FGM/C may be linked to funding for Violence Against Women interventions	? Policymaker input required

Table 6.1. Ways to improve addressing FGM/C in Scotland

Multiple ways to improve the situation coming from the multiple stakeholder perspectives present are suggested by Table 6.1. The pragmatic approach to intervention in addressing FGM/C in Scotland provided by the SSM approach indicates that the primary task activities are most acceptable across the multiple stakeholder groups.

Implementing changes that are acceptable across the board would change the situation. It would also affect other elements which are not directly addressed but which would follow on the changes implemented, because in the broader situation the elements are interconnected and interdependent. Consequently, a new situation would result, with new challenges and new potential ways to improve. SSM is an iterative process, and this new situation could be evaluated in the next iteration. In this way, it is possible that actions that are at present seen as "multiple perspectives", could in future gain buy in and become "primary tasks".

For example, the primary tasks agreed upon by all were for collaboration, standardisation, and training, while a change in terminology was a "multiple perspective". Change in terminology from 'FGM' to 'Female circumcision' was raised in the workshops by one community group participant, and by one NGO participant who was also from an affected community group. The reasoning for it was that circumcision was the term familiar and understandable to communities, as opposed to 'FGM', which is an unfamiliar acronym and a loaded term. There wasn't a consensus for this among the community group participants, as another one had said he was fine with the term 'FGM' because the practice was harmful, and we should be able to 'call a spade a spade'. The issue of terminology was not mentioned by any other NGO participant. This suggestion was therefore placed in multiple perspectives as there was no consensus for it at this stage and among these stakeholders. Stakeholder perspectives on use of language, including this conflict, were discussed in Chapter 4, section 4.6.4. Interestingly, while the health participants did not use the term 'FGM' with patients, preferring 'cutting' or 'procedure' as more sensitive, one explicitly said she would not want to use 'circumcision' because she felt it supported a continued normalisation of the practice, as the idea of circumcision was unremarkable to the patients she saw.

Collaboration and working on standardisation have implications here. If the primary task of collaboration is implemented, this process, and the related process of creating a standardised approach with genuine community input, will have effects beyond the primary task category. It could put the issue of terminology on the radar for other stakeholders, and eventually create greater consensus for change.

The SSM process does not require consensus across the board, or for all proposed ways to improve, rather it aims to identify what feasible and acceptable steps can be taken at present to iteratively move the situation in a beneficial direction.

Core ways to improve the situation have emerged through this process, and across the purposeful activity models used for discussion. These core ways of collaboration and standardisation identified would provide a platform for deeper discussion and reflection on issues relevant to stakeholders, including issues not discussed here.

It should be noted that the table is not exhaustive. At this iteration, while all the purposeful activity models presented at the workshops were acknowledged as relevant, some were not discussed due to time constraints despite being requested, as they did not make final selection for discussion. This means that some issues may not have been raised, despite being relevant.

For example, the model on improving service delivery was not selected. However, relevant to delivery of services was the fact that repeated questioning on FGM/C was a problem which community group participants had noted as stigmatising (section 4.3.3, Stigma). However, the need for direct questions on the issue has also been noted by service providers, as women may lack awareness or not "connect the dots" on the impact of FGM/C (section 4.3.3, Ignorance of harm), and may find the issue difficult to raise (section 4.6.4, Speaking about FGM/C). That being the case, the question of how to improve the sensitivity and delivery of service in this area would need discussion which was not covered in this research as that PAM was not discussed. Therefore, the list in the table above cannot be taken as comprehensive, rather as a foundation and a direction for work to be done. This is in line with SSM being an iterative process.

The findings at this iteration are that the implementation of these primary tasks of collaboration and standardisation would be a definitive step in improving how FGM/C is addressed in Scotland.

6.3.2 Map of key ways to improve the situation in addressing FGM/C in Scotland:

A map (Figure 6.9) was created to visualise the ways to improve, and to show the interdependence and interconnectedness of the ways identified for improving the situation. This map is not a mirror image of the challenges map. It does not attempt to provide a linear point for point solution to the challenges identified. It is best understood in relation to the table of ways to improve (Table 6.1.).

It starts with two key primary task ways identified to improve the situation: standardisation and collaboration. It shows how these reinforce each other, and loop out to include improvement in training, the third primary task. It shows how effective collaboration would have an impact on consensus tasks: it would link to a cohesive approach to practice, and capacity building for community groups. Ultimately, it shows how these primary tasks of collaboration and standardisation would eventually support rejection of the practice as a social norm and openness to engagement with services, thus empowering individuals to resist the practice.

The map therefore shows how starting with the ways for which there is most consensus sets in motion changes further from the core of the map for which there is less consensus, which ultimately trickle down into addressing the challenges for which there is no single/simple acceptable solution. It shows that the interconnected and interdependent nature of the system means that where core areas of leverage are identified, such as the primary tasks which here form reinforcing cycles for improving the situation, change set in motion would have impact even in the parts of the system not directly engaged at the start.

The ways to improve are not silver bullets that will end the practice, but feasible and acceptable ways that, taken together, could iteratively improve the situation.

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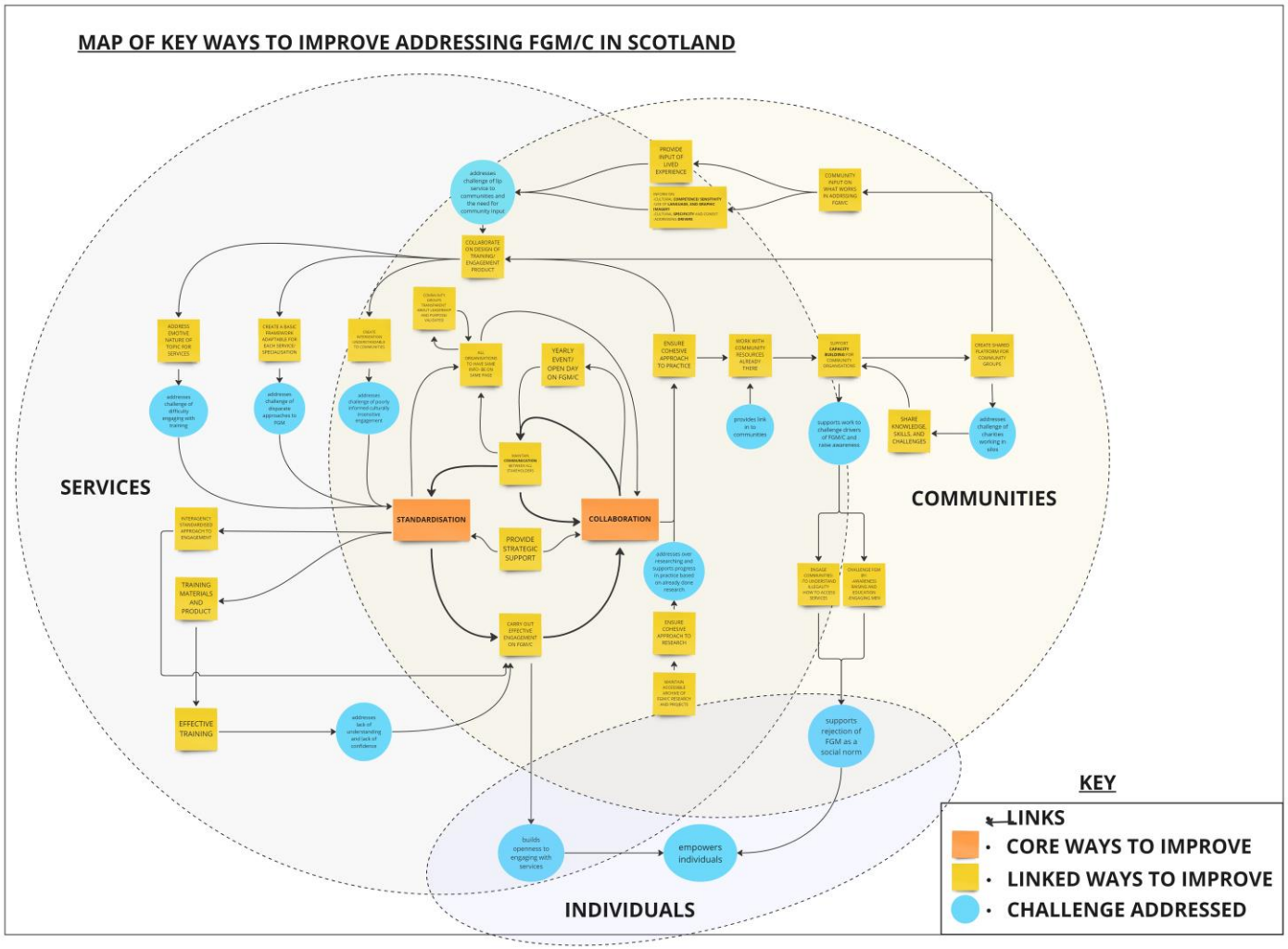


Fig 6.9. Key ways to improve the situation in addressing FGM/C in Scotland

The core and interlinked ways to improve the situation visualised by the map are unpacked below.

The map is again laid out against a background of communities, services and individuals, indicating relevance of the ways proposed to communities and services, and the ultimate impact on individuals respectively.

The two identified core ways to improve, standardisation and collaboration, reinforced each other and are presented as reinforcing loops (Figure 6.10).

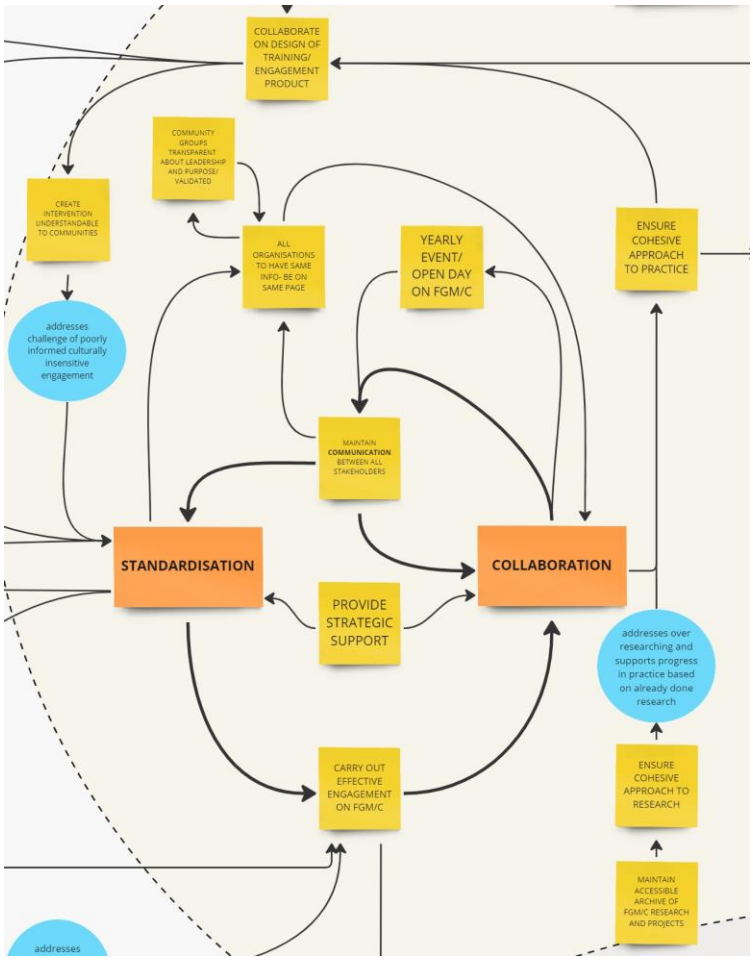


Fig 6.10. Collaboration and standardisation loops.

Collaboration:

Collaboration between stakeholder groups came up as a way to improve the situation in all the small group workshops, even though the PAM on collaboration (section 5.4.3) was selected for discussion in only two of the small group workshops.

Collaboration was raised by community group participants in two contexts. One was the need for collaboration between community groups to make use of one another's strengths and experience. The other was the need for a collaborative body, which included all stakeholders and gave equal voice to community organisations, to create a standardised training framework for FGM/C. The need for government leadership and facilitation in this was also emphasised:

"It's good to have a collaborative body but on top of that we need to have the main body that will facilitate all the sessions or workshops […] the body should be the government or the policy maker because these are the people who have to keep recorded all this information […] of our input as a community organisation or community leaders." (002-COM-BB), as well as the need for communities to have access to the outcomes of these proceeding so they can be aware of what has been done and what still needs to be done. This participant noted the need for sustainable communication flow, so that all organisations could "be on the same page".

The police participant also noted the importance of government strategic leadership and support on collaboration:

"there's a national level, local level, and they need to be intertwined […] you need to get the national part right and that's for Scottish government at the top and then the statutory agencies to agree on the strategic aims so that we can then form relevant stakeholder groups which of course would include communities and our third sector agencies and support services who are pivotal in all of this. But I think you need to get the hierarchy all agreeing in the strategic objectives first for anything to work […] we all need to agree on a joined up approach." (022-STAT-Police)

This need for government strategic support is indicated on the map between the collaboration and standardisation loops (Figure 6.10). This would address the problem that *"we're, kind working in silos, we're not joined up, there's no national steer"* (022-STAT-Police).

Collaboration meant between all stakeholder groups, avoiding lip service to communities. In this regard, an NGO participant detailed the example of how his

organisation engaged with another minority group on a different issue, in order to improve their service to them:

"[They] are constantly on a time loop with other parts of our organisation, telling us not just what their views are on certain substantive issues but how to design our services. So not just the what, but the how. And that's an example of where I think the direction needs to go in" (015-NGO-Legal)

He explained that this approach avoided the pitfall of lip service where there was *"no input at all from folk with lived experience or folk with lived experience are brought in for some academic research projects and then discarded and there's no loop […].An organisation like ours will consult with them for something or other, produce the consultation and then not do any further work. It's an isolated piece of work"* noting that *"What we're trying to do now is to be more looped in."* (015-NGO-Legal)

Greater collaboration was also called for between the statutory services. A participant from the social services pointed out the need to work closely and maintain good relationships with other services to help in better assessing risk and providing additional support.

Community group participants suggested that that collaboration can be both expressed and concretised through *"yearly events, for example, where the community should be invited. We have, for example, the Zero Tolerance Day which most organisations or most community organisations could not do properly because there is lack of funding."* (001-COM-MB) The International Day of Zero Tolerance for female genital mutilation is observed annually on the 6th of February. The 16 days of activism against Gender-Based Violence which runs annually 25th November- 10th December, was also suggested as good timing for such an event. Health and social service participants also spoke of the benefit of open day type events they had previously attended.

Standardisation:

Standardisation meant developing a National training framework which provides the input of community, supports cultural competence and understanding of the

issue including the use of language and graphic imagery, and also addresses the emotive challenges of the issue for services.

The consensus was for a framework which has a basic structure but is flexibly adaptable for various specialisations.

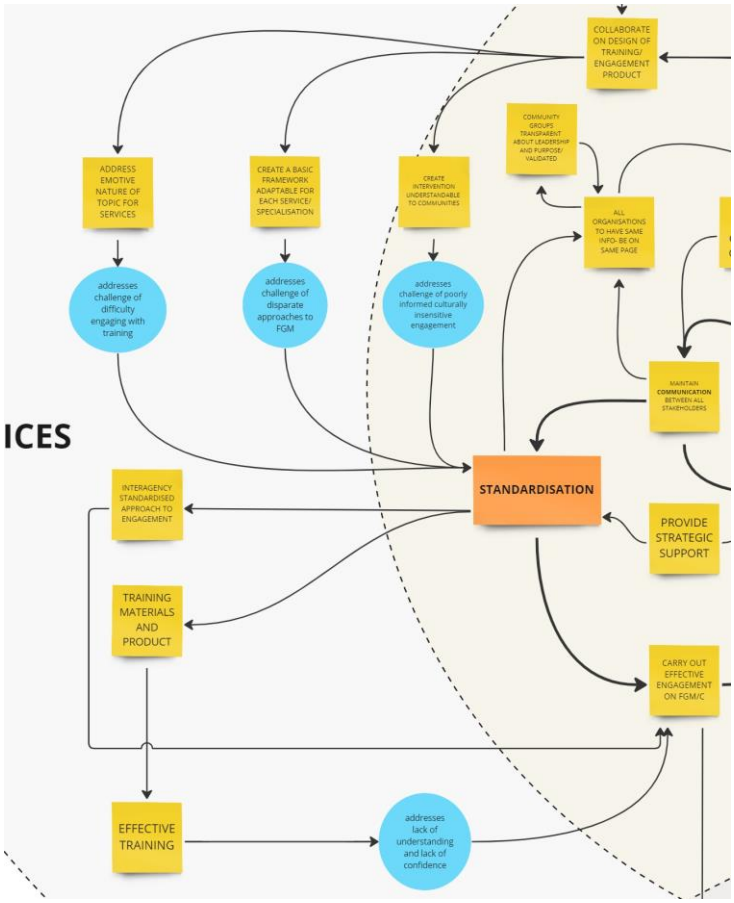


Fig 6.11. Collaboration for a standardised training and community engagement product

The need for a standardised approach was voiced by community group participants who noted that there were discrepancies in how different organisations approached the issue, and that there needed to be a clear framework available. The differences in stakeholder roles or priorities was recognised, but the need for a basic framework was emphasised:

"I'm not saying that we need to say the same things but […] there is a standard, a basic standard which we [should have] a framework which all of us can adopt and improve on and personalise on it. And that will mean […] that everybody has that framework in mind when they are teaching, giving information." (008-COM-WB)

The police participant echoed this idea: *"I think a national multiagency product that's accessible to all agencies is required[…] in some form, whether it has to have different tiers for your level of specialism, but a national training product or materials are definitely required."* (022-STAT-Police), noting that it needed to capture the views of the third sector.

She noted succinctly that without the input from communities, any guidance issued on addressing FGM/C is "pointless" going on to explain the need for guidance on what works: *"are people [who oppose FGM/C] in communities affected actually listened to, can they help prevent it, are they helping prevent it? And if they are, they need to tell us. Because that is…that would inform strategy because that would effectively tell us how we could do it."* (022-STAT-Police)

Community input would cover the issues of cultural sensitivity and lack of knowledge in services, consistently raised by the community groups, and acknowledged as a challenge by the services.

The importance of "lived experience" informing training was expressed by many participants, one justified it by explaining that *"they're the ones who've experienced the risk or [have] some tangential knowledge and understanding of the perpetration of it, and in effect that allows them to be answering all of these questions […] question better than us."* (015-NGO-Legal) However, another NGO participant pointed out the need to provide support for individuals speaking at such events as it could have negative repercussions.

A caveat to be noted on this issue is that as discussed in Section 4.6.4, FGM/C is culturally specific, and a survivor or activist can only speak from their own context and experience. This risks creating a "single story narrative" (section 4.6.1), which leaves people unaware of the full complexity of the issue. However, standardisation supported by genuine collaboration would support awareness of other contexts and highlight the dangers of the 'single story'.

Another important point to be noted is that a negative emotional reaction to the issue (section 4.6.4, negative emotional reaction) could both undermine a fair approach to a case, and engagement with the training in the services. The statutory legal participant had noted the more effective approach utilised in his organisation's training on child sexual abuse would be beneficial for FGM/C (4.6.4, Graphic imagery).

Creating a standardised training product with community input would support effective engagement with communities and in turn feed into improvement in collaboration.

Cohesion and community empowerment:

Improving the situation will include effectively utilising already done research on FGM/C in Scotland to support a cohesive approach to practice, which includes relationship and capacity building with existing community resources.

A cohesive approach to addressing FGM/C supports development in practice based on previously completed research. This addresses the over researching of affected communities and makes use of knowledge already available.

Several participants noted the need for capacity building for communities to enable effective collaboration. Community group participants spoke about capacity building including funding, but also support for good networks. The education participant emphasised that if there are people who *"are on the ground, have got the lived, on the ground experience, they have worked with this, those should be the people leading the discussion – not some random member of government that's been picked at random to lead it. It should be led by the people on the ground, working with communities where FGM's a concern. And by the communities themselves as well. But again, that takes time, money, you know, and opportunity to do that."* (020-STAT-Edu)

One NGO participant explained how his organisation engaged in capacity building for a panel of migrants they worked with:

"We, sort of, help coordinate what they're doing […] we provide them the space and the time. We pay for their time. And we help coordinate and set things up for them and they set the agendas and they decide the activities and they execute

the activities with our resource. So it's about organisations and services that are well resourced passing that resource down." (015-NGO-Legal)

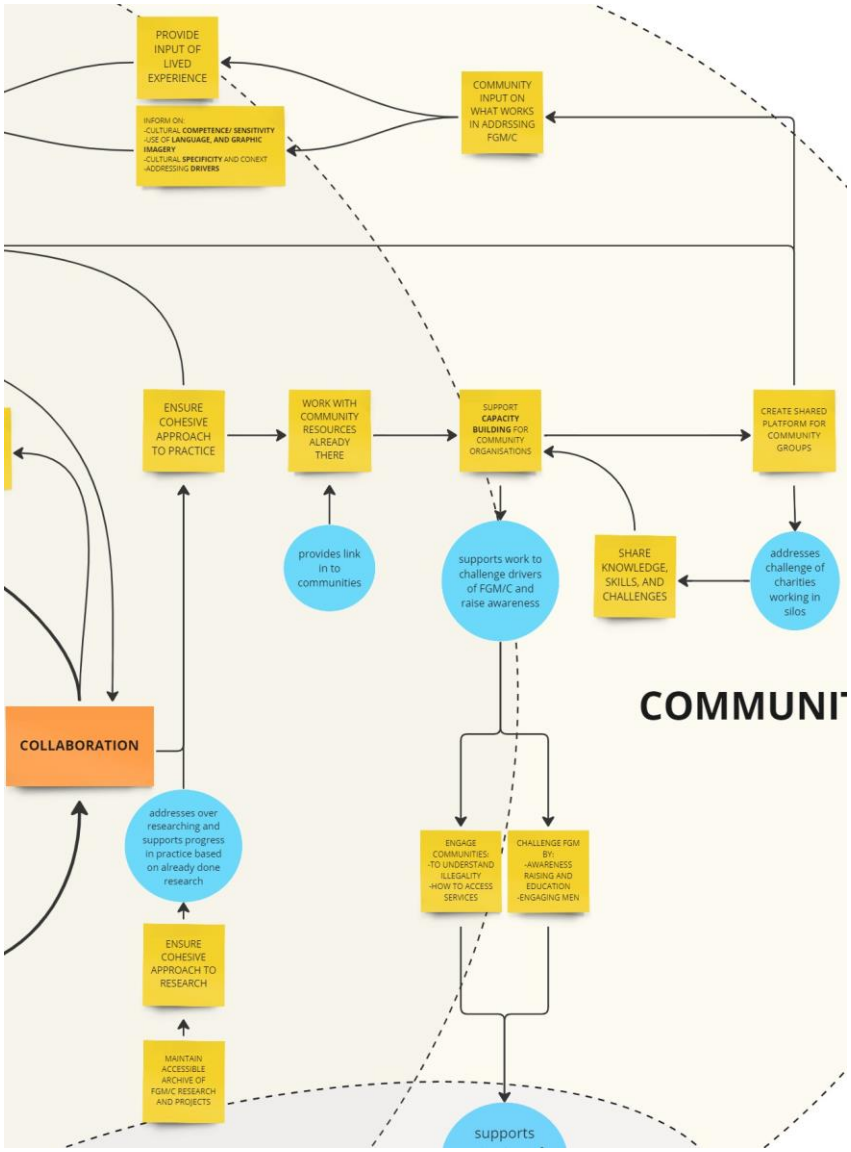


Figure 6.12. Capacity building for community groups

Another NGO participant spoke about the fact that while training for professionals was given much consideration, communities also needed support, recalling at a workshop: *"a woman who was a survivor of FGM saying, you know, there's all this training for professionals, how to speak to communities, but when I arrived in Scotland, nobody told me how to approach and speak to professionals and what they would want to hear".* (003-NGO-BB)

It should be noted that the Scottish government National action plan on FGM (ScottishGovernment, 2019) already indicates many of the suggestions made here, including on collaboration with communities. This suggests that there is a gap between the aspirations of policy and their implementation as it currently stands. It also does bolster the perception of some participants that 'lip service' is given to communities on this issue, and that despite a lot of work already done, things seem to be starting from the beginning each time as consultations are held but findings are filed away and do not continue to inform practice. This thesis did not succeed in recruiting a policy maker for their input, however as SSM is an iterative process, there is scope to include input from this group in a future exercise.

6.4 Conclusion

This chapter presented the ways in which addressing FGM/C in Scotland could be improved. These ways to improve were based on discussion of the gaps and challenges identified by stakeholders, and how best they could be closed. The discussions were guided by the conceptual models of purposeful activity systems present in addressing FGM/C in Scotland.

The challenges and proposed ways to improve the situation are numerous, and play out at level of the individual, communities, and the services. Multiple ways to improve the situation were proposed by stakeholders.

Tabulation of these ways using the SSM table captured the emergent key priorities of stakeholders in improving how FGM/C is addressed in Scotland across stakeholder groups. It allowed a grouping which indicated not only the ways in which the situation could be improved, but also showing which of these ways were most acceptable across the body of participant stakeholders and which were less so. It also provided a clear ranking which qualified the ways to improve by their feasibility.

The key ways, to improve the situation which had the greatest consensus were identified as a greater collaboration between stakeholders, which would address

the challenge of stakeholders working in silos; a standardisation of approach to community engagement and to training programmes on FGM/C, which should include community input; and improvement to quality and uptake of training on FGM/C which would address the challenge of lack of understanding of the issue in services.

Tabulation by acceptability and feasibility indicated which of ways proposed for improvement were the most feasible and acceptable, and therefore the most pragmatic to start with.

In the maps created presented the dynamic relationships of the challenges in addressing FGM/C in Scotland, and those of the ways to improve it. These provided an understanding of the situation missing in the rich picture, as rich picture expresses the complexity of a situation but does not present its dynamics.

Mapping of the gaps and challenges and the ways to improve this complex situation showed that they are interconnected and interdependent, meaning that changes in one area of concern will ultimately result in changes in other areas of concern. Addressing the key ways to improve the situation therefore has the potential to ultimately also affect issues for which there is less consensus at present.

This chapter presented both the ways the situation could be improved identified by stakeholders, and where among them to start for optimal impact in improving how FGMC is addressed in Scotland.

7. DISCUSSION

7.1 Introduction:

Addressing FGM/C in Scotland is a complex situation. In approaching it, what questions needed to be asked was not clear in the first place.

This thesis took a soft systems approach to the issue, looking at the big picture to see what elements are relevant and how they are interconnected. It utilised a critical realist philosophical framework to situate the conceptual approach of soft systems within a reality with which it interacted and which it sought to influence. The thesis considered the roles, perspectives, priorities, and challenges of stakeholders in addressing FGM/C in Scotland. It identified ten purposeful activity systems present in the situation, and using conceptual models of these, identified gaps in addressing the practice and ways to improve the situation. It showed how both the gaps and the ways to improve were interlinked and interdependent.

This chapter reviews the aims and objectives of this thesis and summarises the findings. It discusses them using the critical realist ontological framework. It then lays out the methodological contribution of the thesis and its limitations, before concluding with implications for policy, practice and research.

7.2 Summary of Research findings

7.2.1 Review of aims and objectives:

The aim of this thesis was to apply systems thinking and soft systems methods to build understanding of how the issue of FGM/C is addressed in Scotland, and to co-create with stakeholders recommendations for how the situation can be improved.

The research questions were:

1. What are the key elements in the system addressing FGM/C in Scotland?
    1.1. Who are the key stakeholders?
    1.2. What are the key concepts and relationships?

2. What are the roles, perspectives, priorities, and limitations of key actors in the system?

2.1. What are the roles and perspectives of the stakeholders?

2.2. What are the priorities and limitations of key stakeholders?

3. How can the situation in Scotland be improved?

3.1. What are the perceived ideal situations for the stakeholders?

3.2. What are the gaps between the ideal situation and perceived reality for key stakeholders?

3.3. By what means could these gaps be closed?

3.4. Which of these means are acceptable and feasible for the key stakeholders?

The broad term 'address' FGM/C has been used to encompass the issues of prevention, safeguarding, and provision of services to women already affected, which are strategically linked (ScottishGovernment, 2016, 2017, 2019).

The thesis study design incorporated three stages: a first round of semi structured interviews; and two rounds of workshops. The interviews and first set of workshops aimed to build understanding of the situation, and the second set of workshops aimed to find ways to improve the situation.

7.2.2 Summary of findings:

Participant stakeholders in addressing FGM/C in Scotland were recruited from across the 3rd sector (grassroots community groups, and NGOs) and the statutory sector (health care, social service, police, Scottish Children's Reporter Administration SCRA, and education). Twenty-three participants were recruited across the seven stakeholder groups.

Visual expression of the situation was created with a rich picture describing the issue of addressing FGM/C in Scotland. It captured views on the situation in affected communities with respect to the divergence of positions on FGM/C, the drivers of the practice, which mirrored that of the countries of origin, contextual issues including lack of awareness of harms and the fact that it may not be easy to discuss, as well as the challenges of stigmatisation in the context of changing views on the practice.

Key stakeholders:

The key stakeholders identified by this research were actors in the third and statutory sectors recruited for the study, as described above. In line with its systems approach the thesis took a 'big picture' view of addressing FGM/C and aimed to recruit stakeholders from all the sectors where the issue is of relevance. The key stakeholders identified who could not be recruited were the policymakers. Research outcomes show that this was a relevant gap, as the findings for the ways to improve the situation involve the buy in and support of policymakers for their implementation. The systems approach ensured that a wide sample of stakeholders in this diasporic context, looking not only at the affected communities, but at the third, and statutory service participants who addressed it.

Concepts and relationships:

The key conceptual findings of this thesis were methodological, the systems of purposeful activity present in the situation. These were the 'purposeful actions' to address FGM/C taking place across stakeholder groupings. They are specific to the SSM process. They aggregated the desired, justified, actions of the stakeholders.

The key relationship found in these was between the 'worldview' or perspective of the stakeholder on addressing FGM/C, and the 'transformation' they wished to achieve, that is, their priority in the situation, or the challenge they wished to address. This provided a cohesive, structured way to evaluating how the situation could best be addressed, and pulled together concerns in addressing FGM/C across the stakeholder groups.

Ten purposeful activity systems in addressing FGM/C in Scotland were identified.

They focused on making services more accessible so that those affected can reach out for support; promoting abandonment of the practice through education and awareness raising; collaboration between stakeholders to improve effectiveness; improve understanding of FGM/C in services in order to build confidence in addressing the issue; improve child protection for better safeguarding; improve service delivered to women for their wellbeing; engaging men to secure their opposition to FGM/C; protect vulnerable women by effective use of legal tools; facilitate reporting on FGM/C; and engaging with policymakers to support creation of good policy on FGM/C.

Roles:

A wide range of stakeholder roles was identified.

The primary role played by community groups was of education and awareness raising on FGM/C in communities. NGO participants focused on the support and wellbeing of vulnerable women, migrants, or victims of gender based violence. The health services provided health care to mitigate the impact of FGM/C, while the social services addressed FGM/C primarily through safeguarding of children at risk. The police investigated reports related to risk of FGM/C, and the statutory legal body SCRA made legal decisions regarding the need for FGM/C cases involving minors to proceed to a children's panel. Teachers addressed FGM/C as part of teaching the RSHE curriculum and teacher training.

While these were their primary roles, most stakeholders also saw themselves as having a part to play in educating about the law, signposting to support services, and safeguarding.

Perspectives:

Participant perspectives on the practice were negative. This was unsurprising, as all participants belonged to organisations addressing FGM/C with a view to ending or preventing it. It was seen as harmful to health, an infringement of rights and as a child protection issue. Some statutory service participants described a negative emotional reaction to the practice. Key drivers of FGM/C were seen to be culture and tradition, social expectation and family pressure.

While views of the practice were negative, understanding of the drivers and their contexts varied across stakeholder groups. Community group and some NGO participants were confident in their knowledge and understanding of the issue, with much greater variance across the statutory services. Among the statutory services the specialist health care participants were most confident in their knowledge and in how they addressed the issue.

Priorities:

Stakeholder priorities in addressing FGM/C varied across stakeholder groups. Community engagement, and engagement with men were key for community groups. This was a key priority for them because they worked for change in views

on FGM/C at community level, as opposed to providing a service or intervention to an individual. NGO priorities were to provide material, emotional and legal support for vulnerable or affected women. Service delivery to mitigate the health impact if FGM/C was the priority for the health care participants, and child protection the key focus of the social services, and SCRA. Appropriate training on FGM/C and how to address it, as well as collaboration in doing so were priorities acknowledged across stakeholder groups.

Challenges:

Challenges in addressing FGM/C in Scotland included a lack of understanding of the issue in services, insensitive engagement with communities, no standardised framework for approach, variable quality of training, lack of a cohesive programme on FGM/C, community voice not being heard, low reporting on FGM/C, services not being accessible, and multiple barriers to community engagement.

The challenges in the situation were interconnected and interdependent, and played out in reinforcing loops across issues concerning individuals, communities and services.

Ways to improve:

Participants identified collaboration and standardisation as key ways to improve the situation. To improve how FGM/C is addressed, study participants identified that collaboration between stakeholders, including with communities and community organisations needs to improve. Standardisation meant developing a standardised national training product on FGM/C. This standardised product was to be developed in collaboration with affected communities.

The perceived ways in which addressing FGM/C could be improved varied among stakeholder groups. However, Collaboration and standardisation of approach to FGM/C were identified as having the greatest acceptability and feasibility across stakeholder groups.

Reflection:

FGM/C is addressed in Scotland in various ways and by diff organisations. All participating 3rd sector and statutory sector organisations explicitly want FGM/C to end. However, several problem issues exist.

One is that the different organisations approach the issue in different ways and with different priorities. This in itself is not a problem, rather a strength, because FGM/C has to be addressed at different levels and in different ways if the response is to be optimal. The problem lies in the fact that the response is not co-ordinated, and organisations work in separate silos. This means that their various strengths are not shared, but their weaknesses nevertheless impact everyone. This is shown by the map of challenges which demonstrates how all the challenges are interconnected. Collaboration is needed to solve this problem.

Another issue of concern is that broadly knowledge seems inversely proportional to power in addressing FGM/C in Scotland. Community groups understand the complexities of the issue and its specific nature, contexts and drivers in their various affected communities of interest. These groups raise awareness, educate, and the challenge drivers of FGM/C in communities. They are however loosely bound, poorly resourced and have no civil authority. Statutory services on the other hand are clear that this issue is poorly understood in the services. Training is of variable quality, with varying degree of engagement. This means that a practitioner with no previous training and very poor understanding of the issue may be tasked with the duty of making decisions on it with legal implications for individuals and families. Collaboration to produce a standardised framework for training and engagement, which is adaptable for use by various agencies would be necessary to solve this problem.

A third issue is that trust is a scarce commodity between community and statutory organisations, especially where the issue of child protection is concerned. This research has shown that community organisations also prioritise and work towards child protection from FGM/C. However, while statutory organisations are linked up with one another on child protection, they generally have poor links with community organisations. Communities feel marginalised, that engagement with them is tokenistic, and that they are not given an equal voice at the table in strategizing to address FGM/C. On the other hand, services lack trust that individuals in affected communities are honest with them where child protection is concerned. This divide unfortunately creates a situation where services are trying to address a problem which they do not understand well, in communities to which

they have very limited access. Building relationships to foster and support collaboration may be a challenging task, however is the only way to build trust and improve the situation. Validation of community groups which services can work with has been suggested as a start, but this needs engagement with the groups in the first instance. A suggestion that the groups should 'make themselves known' has also been made. However, as has been pointed out, the groups are under resourced and have limited capacities, and hence would need to be supported in this.

Scale of practice.

The scale of the practice of FGM/C in Scotland is not known (ScottishGovernment, 2016).This thesis did not set out to answer that question. It is however a relevant question in the situation. From the findings in this study the need for care and support of affected women is clear, but the number of new cases taking place is not. Support of survivors and prevention of new cases of FGM/C is strategically linked, and the scale of the practice has implications for political interest in the issue and consequent funding of measures to address it.

It is not clear if the rarity of reported cases of FGM/C is due low levels of the practice or low levels of reporting, or both. The practice being a criminal offence was shown to impact reporting. Finding a way to sensitively indicate risk or scale of the practice in Scotland is an open question for investigation (Karlsen et al., 2023).

The participant stakeholders in this research cited rarity of the FGM/C cases seen as a challenge to competence and buy-in in addressing FGM/C. Not knowing the scale of the practice was not identified as a theme in participant responses. Rather, the discussion was framed around how they in practice addressed it in their role. Had the questions been framed differently, the impact of not knowing the scale of the practice might have been explored.

Downward trends in the practice in diasporic communities are recognised in the literature(Berg & Denison, 2013) findings from this research indicated that the driving forces for the practice are still present in the beliefs challenged by community group participants, and in the extended family pressures for the practice.

7.3 Discussion of findings:

This discussion will be first be framed using the critical realist ontological framework, and then look more broadly at the relevance of the findings of this research to the broader literature on addressing FGM/C.

7.3.1 Discussion of findings using a critical realist framework:

The layered critical realist ontological framework (Figure 2.2) stratifies reality into the domains of Real, Actual, and Empirical. The Real including structures/mechanisms that can generate events; the Actual including the events generated by the real whether or not they are observed; and the Empirical including observed and experienced events (Bhaskar, 1975, 1997; Mingers, 2000a; Mingers, 2014). The discussion will be enriched with the corresponding systems iceberg model (Figure 2.3) in which systems structure generates trends and patterns which produce events (Stroh, 2015).

The SSM approach taken in this thesis has helped to understand the different stakeholder perspectives on how FGM/C should be addressed, and these were aggregated in the ten purposeful activity systems found in the situation. The findings showed that purposes aligned across stakeholder groups to prioritise collaboration and standardisation as a way to improve the situation.

The findings can be understood through the critical realist framework, showing that change needs to happen at all three ontological levels to address FGM/C effectively.

Establishing the layers:

The domain of the Real encompasses the mechanisms, including conceptual mechanisms, that generate reality. In the context of FGM/C, the conceptual mechanisms/system structure in which the practice is rooted is belief (Bhaskar, 1975, 1997); these beliefs are mental modes which characterise FGM/C as necessary, desirable, and socially beneficial (Mackie & LeJeune, 2009) Furthermore, depending on context, these belief may include the understanding that FGM/C is required for marriage, or by religion; or for adult status; that it is not harmful; and that it should be done because it is tradition, (Mackie &LeJeune, 2009; UNICEF, 2013).

The belief present in the domain of 'Real' is expressed in the Actual. It creates patterns, for example, a **requirement** of FGM/C for marriage or for a rite of passage into adulthood. These social patterns mean that an absence of FGM/C causes social problems experienced at the Empirical/event level. This reflects the importance of absence highlighted in critical realist ontology, which says that the absence of a thing can also have impact, for example the meal that cannot be afforded. (Mingers, 2014).

Adult status or marriage do not in themselves need FGM/C, except where there is a belief that they do. Neither does the practice of the relevant religion, as this is practiced elsewhere without FGM/C. FGM/C has persisted for so long however because it was hitched onto these enduring social structures as a requirement.

The domain of the Empirical is the level at which FGM/C is experienced and observed (Mingers, 2014). This will include the experienced event of the cut, as well as its physical, mental and emotional impacts. It will also include the experience of respect or status given, or of shunning experienced in its absence or in opposition to the practice.

Collectively, the beliefs, patterns, and experienced costs of refraining from FGM/C drive the practice.

Addressing FGM/C in the real, actual, and empirical domains:

Drivers for the practice FGM/C therefore exist at all three ontological levels. These drivers are challenged by stakeholder groups in their various roles, with their accompanying varied priorities.

The purposeful activity systems which capture the actions of stakeholders and how they are justified, can also be seen in the light of the ontological levels.

Challenging the drivers in the domain of the Real, means challenging the meaning of the practice. Education and awareness programmes or engagement efforts target this level.

Where the key driver for FGM/C is recognised as meaning, the response is targeted to that domain. This was clearly the understanding of the community groups and

reflected in their challenge of drivers of the issue in the pursuit of abandonment. They targeted purpose and meaning of the practice in their work. Their key role was education and awareness raising on the practice, and their priority was community engagement on the issue. This was captured in **purposeful activity system 2** which focused on hastening the abandonment of FGM/C by education and awareness raising.

In creating an enabling environment, the law challenges the social structures and **patterns** in the Actual domain that support FGM/C, for example, by intercepting family/social pressure; or parental capacity to carry out FGM/C. Where social services intervene, informing about the law and consequences for it, they may empower women/parents against family pressure on those grounds. However, on its own, this does not actually remove the pressure, and leaves social care workers with concerns about ongoing risk.

Education challenging the positive meaning of FGM/C defuses the drivers in the domain of the Real, changes the meaning of the practice, and consequently removes the pressure on actors in the domain of the Actual. The priority of using legal tools to protect vulnerable women and children was reflected in **purposeful activity system 8.**

Health care intervenes in the domain of the Empirical. It intervenes to improve the experienced physical and mental wellbeing of the woman. This focus was reflected in **purposeful activity system 6.** Deinfibulating a woman to allow for birth of a child or for sexual intercourse, or providing counselling to help with the mental or emotional impacts of FGM/C can help concretise the harm caused by FGM/C. Recognition of the harmfulness of the practice was shown in this research and others as a key factor in changing position on the practice (Johansen et al., 2013) thus having an effect in the domain of the Real.

The complexity of the situation is reduced where the practice is recognised as harmful, including when medicalised, in affected communities. The intercultural challenge of difference in perceptions is removed, because all parties now perceive it as harmful. Where FGM/C is recognised as harmful **and** becomes socially unnecessary due to a community shift to abandonment, there has been change in both the domains of Real and Actual. It then becomes easier to address

it as unqualified abuse, and reporting loses some of its challenge, as FGM/C will no longer be done by ordinary, well meaning parents. This is in line with the social convention theory proposed by Mackie (Mackie & LeJeune, 2009). As pointed out by NGO participants in this research, this does not remove all barriers, as the reporting of parents by children has challenges beyond the issue of FGM/C. The stakeholder concern with breaking barriers to facilitate reporting is reflected in **purposeful activity system 9.**

However, the complexity in the situation increases again with lack of trust, stigmatisation, and profiling experienced by individuals in communities, despite an aligned position and practice on FGM/C with the law. These are both experienced events (stigma) in the Empirical domain, and patterns existing at the Actual (profiling). Profiling and stigma were repeated concerns raised by community group participants in this research. This is in line with findings elsewhere in the UK which concluded that government priorities to address FGM/C are undermined by their own safeguarding approaches (Karlsen et al., 2020).

Effectiveness in engagement was found to be linked to a respectful and informed approach. This concern is reflected in **purposeful activity system 4,** which is focused on knowledge and understanding of the issue in services. Patterns of insensitive engagement talked about by the community group participants were linked to lack of knowledge and understanding on the issue. A gap in knowledge of both cultural sensitivity and specificity were also linked to a "single story narrative" on the issue. These were the gaps targeted in **purposeful activity system 10**, which reflects the focus of a community group on working with policymakers to support formation of good policy to address FGM/C. Knowledge and understanding are perceptions of the issue. This means they are conceptual system structures residing in the domain of the Real. A lack of understanding results not only in insensitive engagement, it is also linked to patterns of profiling in the Actual domain. An understanding in the domain of the real of FGM/C as barbaric child abuse generated patterns and trends of a negative emotional response which was a challenge to dealing with cases fairly/objectively. There is literature on gaps in the technical knowledge of service providers, and its impact on service provision and on the stigma felt by women (Evans et al., 2019; Ugarte-

Gurrutxaga et al., 2023), but there seems to be less exploration of the impact of this emotional factor of revulsion on service providers.

The challenge of sensitivity in engagement was also demonstrated with the difficulty in using the right terminology. This is in dialogue at an empirical level, where health care providers intuitively avoided calling the practice FGM, because of the connotations of the word mutilation, but where calling it circumcision was also seen to lack emphasis of the harmfulness of the practice. There was also some resistance reported based on a perception of cultural imposition. These conflicts are at the level of meaning. Refusing the term female circumcision (FC) and calling it female genital mutilation (FGM) may indeed be making the jump ahead to cultural imposition.

As one participant noted, calling it female circumcision left her with the task of having to explain why the practice is wrong, and how it is not normative. However, this precisely meant engaging with the Real domain of meaning. And in practice, this was precisely the approach taken by participants interfacing with women when they refused to call it FGM with them, but resorted to understandable language and worked their way up from there, using neutral words like 'procedure'. The term ‘FGM’ is shorthand for announcing harmfulness of the practice and justifying opposition. This may cut out some advocacy work, but it creates more work in the area of engagement. This double-sided effect is likely why there is lack of consensus on the issue.

Improved collaboration on addressing FGM/C was found to be desirable to all participating stakeholders. This concern is reflected in **purposeful activity system 3.** It targets the pattern of behaviour between stakeholders which is in the domain of Actual, but impacts the Real because collaboration expands knowledge and understanding and challenges mental models and meanings. Its absence addressing FGM/C at the empirical level, for example through insensitive engagement on the matter.

Standardisation of approach also plays out in the actual domain as it creates patterns in approach to the issue, however it is rooted in the real. Standardisation makes up for differences in meaning at the level of the real – meanings, because it allows a framework that fills in gaps. It is important because this research found

that there is a big variation in knowledge about the issue among stakeholder groups, with the risk that a practitioner with no training on FGM/C and no prior experience in dealing with it could be faced with the duty of making decisions that impacted families.

Collaboration and standardisation could address shared challenges. For example, the use of language in documents and graphic imagery was cited as a problem by both community group participants and by Scottish statutory legal participants. These are challenges at the experienced, Empirical level. On the one hand, community group participants described the lack of sensitivity and loss of dignity they felt when graphic images were used in public. On the other hand the statutory legal participant spoke of the unhelpfulness of the clinical language in guidance documents to non-clinicians working with families, and the negative emotional impact of graphic imagery in training materials which could put people off training. With collaboration, a standardised approach with a basic framework adaptable to each service's needs could be designed,.

Limitations of acting at only one level:

The drivers for the practice exist at every ontological level, and the responses to it are also interconnected and feedback on one another across domain levels. Therefore, to optimally address FGM/C, responses in all three ontological domains are required. For example, challenging drivers at the real; putting up a legal barrier at the actual; and ameliorating morbidities at the empirical.

Intervention limited to the real domain, for example education and awareness raising, is important, but takes time and requires a "critical mass" (Mackie & LeJeune, 2009) of people to abandon the practice in order to achieve abandonment. While it may cause change in belief, change in behaviour is still limited by social pressure exerted at actual level on people (Johansen et al., 2013; McChesney, 2015). This can explain why despite awareness of the impacts of FGM/C, women may still chose to engage in it (Johansen & Ahmed, 2021a)

Intervention only at the actual, for example relief of social pressure for FGM/C through settling in a non cutting country is insufficient on its own, as people will travel to get it done if they still believe in it's importance, or possibly adapt the practice to a less invasive one (Johansen & Ahmed, 2021a).

Where intervention is only at the empirical level, for example medicalisation of the practice, social pressure and beliefs will continue to drive it (Kimani & Shell-Duncan, 2018).

Intervention with legal tools, for example protection orders, or child protection interventions, is completely constrained by the extent of reporting, which is low where cultural drivers for it remain strong. They will therefore only be helpful in reported cases, and completely miss the affected children in a community about whom no red flag is raised.

Use of the critical realist framework for policy evaluation:

The critical realist framework, for example as adapted to the issue of FGM/C in figure 2.6, may also be useful in evaluating current policies and action on FGM/C. As has been shown in the discussion above, a robust response to FGM/C needs to address the practice at all three ontological levels. This tool can therefore be used by stakeholders to evaluate their own position in addressing FGM/C, and can clarify to them what their limitations are in this response, and who they may need stronger collaboration within order to strengthen this response. For example, social workers may acknowledge that they act at the social level of trends and patterns, where they work to interrupt the familial and social pressure to carry out FGM/C. The framework may help them see that they may have a lower level of influence at the conceptual level of Beliefs which drive the practice, and that they may benefit from working with a community organisation which does address and challenge these driving beliefs. The framework can clarify for a health worker that their primary area is in addressing the Experienced Effects of FGM/C at the individual level, and that other groups will support the woman at the social or conceptual level.

Similarly, a government policy to address FGM/C can be evaluated for how comprehensively or robustly it does so by examining how well its strategies address all three levels. This framework makes clear that given the differing strengths of stakeholder groups, only a genuine collaboration could produce a comprehensive response or design an effective standardised approach to addressing FGM/C. The use of this framework can clearly show where a policy or strategy to address FGM/C is incomplete. For example if community engagement is lacking, the policy

or strategy is likely weak in terms of addressing FGM/C at the level of driving beliefs.

The above section provided a philosophical underpinning to the need for a collaborative response to FGM/C in Scotland. A broader exploration of the literature in relation to findings in this thesis follows below.

7.3.2 Relevance of research findings:

Reviews of approaches to ending the practice of FGM/C have shown that interventions must be multifactorial to be effective and produce lasting results (Barrett et al., 2020; Johansen et al, 2013; McChesney, 2015).

McChesney's review summarised key elements of a successful approach as being community led, generating change at community level, and empowering women. Chesney also points out the failure of various attempts to address FGM/C by cultural imposition, that is by interventions which attempt to impose values and beliefs on practicing communities; or by cultural relativism, which informs about the practice, but accepts it as a different cultural practice and does not end it. On their own, health education, or legislative change, or rights based interventions, were also all found to be unsuccessful. McChesney's findings corroborated those of a previous review (Johansen et al., 2013). Both reviews found that community engagement to be key for intervention success.

The European REPLACE project to transform social norms is also grounded in community engagement (Barrett et al., 2020) and utilises Mackie's social convention theory (Mackie & LeJeune , 2009) which proposes that as FGM/C is community driven, it requires a shift in practice at community level to allow individuals to freely act on a change in attitude to FGM/C. The project was found to increase community readiness to abandon FGM/C over time.

In line with the above, the findings of this research have emphasised the importance of community engagement. Without it, what is being addressed cannot be understood, neither can the present needs of the affected communities. In the absence of community engagement, the potential for unintended consequences in intervention is high (McChesney, 2015). Community complaints about profiling,

stigmatisation, and the lack of understanding in the services found in this thiesis corroborate this.

The practice is difficult to understand for those outside affected communities, or even those from affected ethnicities who are culturally dissociated from it. However, the target audience for intervention initiatives are precisely those who do see it as normative and necessary. This thesis shows that interventions have to be such as to make headway with practicing groups, not with those dissociated from the practice.

Research evaluating interventions to address FGM/C tends to be focused on affected communities in their countries of origin (Johansen et al., 2013; McChesney, 2015; B. Shell-Duncan et al., 2011) or on these communities in diaspora (Barrett et al, 2020; Vogt et al., 2017). It does not usually take a collective view of the other stakeholders involved in the situation. This is a gap that the scoping review by Baillot et al, as well as this thesis, have begun to address. Literature available on service provision to affected diasporic communities tends to focus on health care provision (Evans et al., 2019; Leye, Powell, Nienhuis, Claeys, & Temmerman, 2006) but not on the role of other stakeholders.

In the western diaspora, affected communities live in a wider context where norms and values do not support FGM/C, with established laws and statutory responses against it. This context is a relevant one in addressing FGM/C, no less than the internal context of the affected communities themselves (Berg & Denison, 2013; Johnsdotter & Essen, 2016). In line with a scoping review of approaches to participation, prevention, protection, and provision of services in addressing FGM/C in Europe (Baillot et al., 2018), this thesis found that key stakeholders were community groups, NGOs and statutory sector practitioners who address FGM/C in their roles.

While the Baillot review had a Europe and UK wide focus, this research is situated in Scotland. In line with Baillot et al, this research has found a lack of adequate engagement with communities, and the importance of collaboration across stakeholder groups, each of which had a role to play in the situation.

This thesis showed that community leadership for change on FGM/C is compromised when in practice the community voice is given lip service. This is also reflected in the literature (Connelly et al., 2018; O'Brien, 2016).

Community level change is supported by inculturation, and the practice of FGM/C declines in diaspora (Berg & Denison, 2013; Habte & Yang, 2023; Johansen & Ahmed, 2021b). Personal change of mind can result from exposure to education and awareness raising, as corroborated by this thesis. However, literature also shows that abandonment of FGM/C in diaspora is limited by social pressure for the practice in affected communities (Habte & Yang, 2023; Johansen & Ahmed, 2021b). Women in diasporic communities could reject the practice, be on the fence about it, or remain supporters still, for complex reasons (Johansen & Ahmed, 2021a). This research found that social pressures for the practice do exist in affected communities in Scotland.

Literature shows that change in practice is supported by a multipronged response (Barrett et al, 2020; Johansen et al, 2013; McChesney, 2015). This research shows that a multi pronged approach to addressing FGM/C does exist in Scotland, involving communities, NGOs, Health care, and Legal support; social care and policing. The purposeful activity systems identified by this research show the activities of stakeholders in addressing FGM/C.

What weakens the approach is that while it is multifaceted it is not co-ordinated. Therefore, the situation is addressed ‘in silos’; and some silos generate unintended consequences. Sterman’s statement that there are no side effects, only effects, and effects which surprise us (unintended consequences) (Sterman, 2001) are a result of our not understanding the system are pertinent here. Negative outcomes of strategies, such as profiling and stigma (Karlsen et al., 2020; Karlsen et al, 2019), have been shown by this thesis to be linked to lack of knowledge and understanding of FGM/C. This problem can be addressed by collaboration with affected communities, in order to build understanding of the issue and the context.

Such a collaborative approach implemented in a deliberate way can hasten what has been seen to happen without intervention over time, with changing practice in diaspora (Berg & Denison, 2013; S. Johnsdotter & Essen, 2016)

Collaboration within a multi-level response has been identified in this thesis as key to addressing FGM/C in Scotland effectively. This is in line with what has been found in research in European contexts (Baillot et al., 2018; Barrett et al., 2020)

The review (Barrett et al., 2020) of the European programme REPLACE further noted that in intervening, it is necessary to explore the current belief systems in a community, as these cannot be assumed in the European setting, and neither can the relevant types or contexts of FGM/C. The findings of this PhD on the changing views in communities, and the importance of cultural specificity corroborate that.

7.4 Methodological contribution: strengths and limitations

7.4.1 Systems thinking:

To the knowledge of the researcher, this is the first research study using a soft systems approach to research on FGM/C. The thesis in its findings identified the relevant roles, perspectives, priorities, and challenges present in the situation. It identified ten purposeful activity systems of stakeholders addressing FGM/C in Scotland. It then showed how these interconnected and interdependent relationships were relevant to how the situation could be improved.

7.4.2 Soft Systems Methodology:

The SSM was used to work with diverse stakeholders addressing FGM/C in Scotland. This approach brought together participants who had differing, and sometimes conflicting views of the situation and how it could be improved in a way that facilitated collaboration through the use of the models of purposeful activity.

SSM further contributed a table of ways to improve the situation which captured both the diversity of the ways proposed and the level of agreement across stakeholder groups about them.

This research contributes to the body of research applying SSM in public health, which is still in development (Augustsson, Churruca, & Braithwaite, 2020).

Use of online platform:

1. The outbreak of the COVID 19 pandemic made the switch from an in person to an online platform mandatory when ethical approval for the study was sought. An online platform was used for interviews and SSM workshops.

The online platform was convenient, eliminating the need for travel, and very helpful for scheduling time with participants who were very busy. One health care participant did the interview from a side office during her shift, another from her car on her lunch break, and yet another participant joined a workshop remotely while on a journey to England. This flexibility would have been difficult with in-person participation.

2 Creation of an SSM workshop interface on the online Miro platform: A rich picture is usually hand drawn by stakeholders. In this research the rich picture was created by the researcher in an online participatory medium (Miro) and SSM workshops were carried out in the online workshop boards created by the researcher for the purpose. This was an innovation made necessary due to Covid 19.

Rich picture:

Innovation in the use of the rich picture in this research was threefold.

The first was the researchers use of interview data to create it, as it is usually done by stakeholders themselves (Barbrook-Johnson & Penn, 2022c).

The second is the use of a concurrent thematic analysis of interview data, which provides transparency in its creation, and made it intelligible and accessible to readers. This resolved a limitation of rich pictures which is that their meaning is known to those who created it and may not be easy to share with others (Barbrook-Johnson & Penn, 2022a)

Thirdly, rich pictures present a static snapshot of a complex situation but cannot demonstrate the dynamic flows present. This thesis accompanied the rich picture with system maps which captured the dynamic causal flows of challenges and ways to improve in the situation.

Use of 12 Questions of Critical Systems Heuristics.:

In line with Midgley's recommendation for the use of multimethodology in systems inquiry (Midgley, 2006), the SSM approach in this thesis was combined with the 12

questions of critical systems heuristics (CSH) (Ulrich, 1996; Ulrich & Reynolds, 2010) to aid boundary judgement. Its themes were used to explicitly address themes of motivation, knowledge, control/power, and legitimacy in addressing FGM/C in Scotland. This justified the boundaries of this SSM inquiry in a way that SSM alone could not do. SSM uses CATWOE to gather the relevant elements, but inclusion of themes from the 12 question tool ensured that that system elements relevant to the participants were not omitted due to the constraints of her own perspective on the issue.

Critical realist framework for analysis:

This thesis used a critical realist philosophical framework. The contribution of this was twofold.

Thesis findings were analysed using a critical realist framework, thus contributing to the still developing body of work demonstrating the compatibility of critical realism with systems thinking in applied settings (Armstrong, 2019; Lawani, 2020; Mingers, 2014)

Secondly, the freedom of the ontological realism provided by the critical realist framework permitted the creation of the whole system maps. This framed the challenges and ways to improve the situation as systems present in the 'real world' which SSM seeks to improve, as opposed to the SSM conceptual maps which are only "devices used to think about the system" (P. Checkland, Poulter, J., 2010).

7.5 Limitations

7.5.1 Of methodological approach

As noted in section 3.7, a recognised limitation of SSM is that while it produces a list of desired changes to improve a situation, it does not say how this should be achieved (Augustsson et al., 2020; Rodriguez-Ulloa & Paucar-Caceres, 2005). This holds true here. The thesis does not detail how greater collaboration or standardisation of practice should be achieved, or how training should be organised. It leaves this in the hands of stakeholders. However, collaboration being a key proposed task is helpful in two ways. One, networks between stakeholders do exist already, therefore this needs not be organised from scratch, rather, be

developed and strengthened. Two, collaboration is in itself the prerequisite platform for effective standardisation, which includes that of training programmes. Application of the ways to improve proposed by the thesis is therefore doable, if there is the political will to support it.

Successful implementation of SSM requires that the relevance of all stakeholder positions are given necessary recognition. Where there is significant power disparity, there is a risk that the changed implemented are those of interest to the more powerful stakeholders, thus maintaining status quo instead of introducing change (Rodriguez-Ulloa & Paucar-Caceres, 2005). This again is relevant here. There is a power disparity, as well as a cultural disparity, between the Scottish government and its statutory bodies, and the diasporic minority affected communities. Scottish policy documents state the need for collaboration, including with affected community groups, however, this is clearly not optimised at present.

7.5.2 Of SSM methods

1. The rich picture was created by researcher instead of by the participant stakeholders themselves as would usually be the case in a participatory process (Barbrook-Johnson & Penn, 2022c).
It was originally intended to be made by participants in an in person context using paper sheets and markers. This in itself can often be daunting to participants, hence with the move to an online format, and the challenges of learning to use and online collaborative platform, it was felt that using online tools draw would be a double barrier/ undue burden on the participants, especially within a two hour time frame. So the researcher created the rich picture based on the individual interviews, and presented it to participants for feedback and validation at workshop 1.

2. Use of the perspective diagram: The initial approach taken to perspectives, which sought perspectives on what FGM/C is, led to the formation of the perspective model used in workshop 1. However it was the subsequent approach, which focused on the perspective directly justifying stakeholder action in the situation, which formed the basis of the purposeful activity systems and their conceptual models used in workshop 2.

In hindsight, it would have been very interesting to have had a diagram of the perspectives on addressing FGM/C for use in workshop 1. It would likely have generated discussion which would have better supported building of a shared understanding of the situation in the applied world, as the specific practical worldviews supporting the priorities of stakeholders would more immediately clarify why people did what they did and why things were the way they were. The perspectives relevant in the application of SSM are those which justify the transformation sought by stakeholders. This delay in uncovering the specific link between the SSM worldview and transformation in addressing FGM/C is reflective of the difficulty in mastering SSM described in the literature (Augustsson et al, 2019; Connell, 2001; Mingers & Taylor, 1992). The methodology is known to be time consuming and require experience, and this was demonstrated in the learning curve in writing this thesis.

3. Online platform: The use of the online platform (Miro) in workshop 1, required participants to input on the Miro board directly in addition to discussion. This was a barrier especially to the community group participants due to lack of skill with Miro, as well as their broadband quality (one participant dropped out due to loss of connectivity). Accordingly, Workshop 2 was adjusted to only require discussion from participants, with the facilitator making notes on the board.

Broadband was less of an issue in the interviews – where one participant lost connectivity near the end of her interview, she called back on the phone to complete it, and the recording was captured on the back up Olympus recorder which was still running.

Time constraints: The online workshops were limited to two hours each. This meant for instance that only two or three PAM models could be discussed in the workshop 2 small groups. in all, 7 were discussed, 2 of these across multiple stakeholder groups. Despite this, recurrent themes of gaps and ways to improve were captured.

7.5.1 Of study sample:

The study was not designed to recruit vulnerable women. It was designed to recruit those addressing FGM/C in the public sphere to answer the research questions. The study did not recruit those promoting FGM/C – there is no such public organisation, it is a cultural practice existing in affected communities.. Their views are indirectly represented through the grassroots community group participants who were themselves members of the affected communities and engaging with the drivers for FGM/C in their efforts for education and awareness raising on FGM/C. A capacity for loss of richness of that perspective remains as it is indirectly obtained.

No policymaker was successfully recruited. This reflected a problem identified in the study, which was lack of continuity in service provision due to moving jobs. The policy maker who initially indicated interest lost contact, apparently due to a job move. During the course of study, a participant moved from an NGO into a policymaking role, however, she continued to contribute from the perspective of her years of experience in NGO work on FGM/C.

The participant from education was a teacher and teacher trainer with no direct experience of addressing FGM/C. This lack of experience however likely reflects the majority of teachers in Scotland and provided a good addition to creating a picture of the situation at present. It would however have been helpful to have a participant with experience in schools which served affected communities to better understand how the issue was addressed there.

Health care participants were experienced specialists who took referrals. This degree of experience/understanding is not representative of the health sector as a whole, and these participants were not the first point of contact with the service. Community midwives and GPs would be, and would likely have less knowledge/understanding and be more representative of the situation in the service. However affected women were referred to these specialists therefore their role was key though not exclusive.

7.6 Implications:

7.6.1 For policy and practice

The key areas of leverage identified by this research for improvement in addressing FGM/C in Scotland are a greater collaboration between stakeholder groups, and creation of a standardised approach to training and engagement on the issue. In line with these findings, the following recommendations are made for policy and practice:

Strategic support for these ways to improved addressing FGM/C in Scotland should be provided by the Scottish government.

1. Collaboration should be strengthened across all stakeholder groups: Collaboration should be strengthened and maintained. At present organisations work in silos and stakeholder networks are loose in addressing FGM/C. This hampers a cohesive, informed approach to the issue.

Collaboration should be concretised in a joint yearly open day or event on FGM/C in which all stakeholder organisations participate. This could take place during the 12 days of action on against gender based violence in November, or the day of Zero tolerance for FGM/C in February.

2. Community organisations should be supported to provide participation and input in collaboration. Community input should inform delivery of service and training on FGM/C.

3. A standardised framework should be developed to training on FGM/C in Scotland. It should have a basic framework and materials, and should be adaptable for use by various specialties. This framework should be developed in collaboration between services and communities.

4. Training and engagement materials should consider the sensitive use of language in discussing FGM/C, as well as the appropriateness/necessity or otherwise of graphic imagery. Graphic imagery and videos may make a spectacle of affected women and dehumanise affected communities. Training materials for community engagement should recognise cultural sensitivities and cultural specificities

relevant to FGM/C, and what implications these might have for relevant affected communities.

5. Training materials should also consider how to engage those receiving the training in accessible way. FGM/C is a practice unfamiliar to most in the Scottish context and can generate a strong negative reaction. Graphic videos and images imply the need for safeguarding, but do not give an informed understanding of the human and social context of the practice, nor of the complexities of its types and drivers. They may be emotive and signpost the issue as grievous abuse which must be prevented, but do not empower for effective engagement to end the practice. Training approaches on other sensitive serious issues, for example child sexual abuse, which have been developed in such a way as to help people engage with the training may be helpful in this regard.

6. Prior findings from engagement projects with communities need to be recognised and implemented. Accessible archives of research and engagement on FGM/C should be maintained for a cohesive approach to research and practice.

7.6.2 For research

1. Validation of the system maps produced by this thesis. As the system maps of challenges in the situation and ways to improve it have not yet been validated, it needs to be taken back to stakeholders addressing FGM/C in Scotland, to ensure validity. This would also provide an opportunity to bring stakeholders together in a collaborative exercise which could strengthen links between stakeholder groups. A policy brief will be prepared for policy makers.

2. An investigation of knowledge, attitudes, and practice of FGM/C in affected communities in Scotland, to include impact of length of residence. The risks for the practice remain in affected communities, however the scale of the practice is not clear, and tools are lacking for a sensitive estimate (Karlsen et al., 2023). Perspectives on FGM/C are diverse in affected communities, and duration away from communities of origin is known to impact position on FGM/C in diaspora. A demonstration of the “tradition in transition” (Berg & Denison, 2013) and what

facilitates this would be helpful in addressing the lack of certainty about the scale of the practice and for informing policy and practice.

3. An investigation of the emotional impact of FGM/C on service providers across the services, and its impact on service provision. FGM/C was shown to generate a negative emotional response among some service providers, with acknowledgement that this had a potential negative impact on the quality of the response to the issue. The scale, nature, and impact of this is unexplored, as well as how it may be addressed in training.

7.7 Conclusion:

This thesis took a soft systems approach to build understanding of how FGM/C is addressed in Scotland, and with stakeholders to finding ways to improve this.

It analysed the issue using systems concepts as well as a critical realist ontological framework. Addressing FGM/C in Scotland is a complex situation, a "web" of problems being addressed by multiple stakeholders in various ways.

The research identified the purposeful activity systems addressing FGM/C in Scotland. It used models of these to guide stakeholder discussion which defined ways to improve the situation which were acceptable across the wide range of stakeholders and their varied perspectives. In this way, this research synthesised findings from across the range of stakeholders and defined a cohesive way forward.

There is no simple single solution to this problem issue. It needs to be addressed at multiple levels with collaborative work between stakeholders. Collaboration will allow a sensitive response both in providing services to individuals and in engaging with communities, and thus aid the process of abandonment of the practice.

Standardisation in approach to engagement and in training must respect sensitivities and needs both among communities and among service providers. It should also respect the reality of diverse views on the practice in communities. Prior findings from engagement projects with communities also need to be recognised and implemented.

The thesis demonstrates that greater collaboration among stakeholders addressing FGM/C in Scotland, and a standardisation of approaches to training and engagement on the issue are the key areas of leverage for improving the situation in addressing FGM/C.

LIST OF REFERENCES

Abdelshahid, A., & Campbell, C. (2015). 'Should i circumcise my Daughter?' Exploring diversity and ambivalence in Egyptian parents' Social representations of female circumcision. *Journal of Community and Applied Social Psychology, 25*(1), 49-65. doi:10.1002/casp.2195

Abdulcadir, J., Botsikas, D., Bolmont, M., Bilancioni, A., Djema, D. A., Bianchi Demicheli, F., . . . Petignat, P. (2016). Sexual Anatomy and Function in Women With and Without Genital Mutilation: A Cross-Sectional Study. *Journal of Sexual Medicine, 13*(2), 226-237. doi:10.1016/j.jsxm.2015.12.023

Abdulcadir, J., Margairaz,C., Boulvaina,M., Iriona, O. (2011). Care of women with female genital mutilation/cutting. *Swiss Med Wkly, 140*(w13137). doi: https://doi.org/10.4414/smw.2011.13137

Abdulcadir, J., Rodriguez, M. I., & Say, L. (2015). Research gaps in the care of women with female genital mutilation: an analysis. *Bjog, 122*(3), 294-303. doi:10.1111/1471-0528.13217

Abusharaf, R., M,. Ed. (2006). *Female Circumcision: Multicultural Perspectives*: University of Pennsylvania Press.

Abusharaf, R. M. (2001). Virtuous Cuts: Female Genital Circumcision in an African Ontology. *differences, 12*(1), 112-140. doi:10.1215/10407391-12-1-112

Ackoff, R. (1974). *Redesigning the Future: A Systems Approach to Societal Problems*. New York: Wiley.

Ahmadou, F. (2000). Rites and Wrongs: An Insider/Outsider Reflects on Power and Excision. In B. shell-Duncan, Hernlund, Y. (Ed.), *Female Circumcision in Africa: Culture, Controversy and Change*. (pp. pp. 283-312). Lynne Rienner Publishers.

Ahmadu, F. (2000). Rites and Wrongs: An Insider/Outsider Reflects on Power and Excision. In B. Shell-Duncan & Y. Hernlund (Eds.), *Female "circumcision" in Africa: culture, controversy, and change* (Vol. Directions in applied anthropology, pp. 283-312). Boulder, USA: Lynne Rienner Publishers.

Ali, S., de Viggiani, N., Abzhaparova, A., Salmon, D., & Gray, S. (2020). Exploring young people's interpretations of female genital mutilation in the UK using a

community-based participatory research approach. *BMC public health, 20*(1), 1132. doi:10.1186/s12889-020-09183-6

Ali, S., Kelly, M. (2004). Ethics and social research. In C. F. Seale (Ed.), *Researching Society and Culture* (2nd ed.). London: Sage.

Almroth, L., Elmusharaf, S., El Hadi, N., Obeid, A., El Sheikh, M. A. A., Elfadil, S. M., & Bergström, S. (2005). Primary infertility after genital mutilation in girlhood in Sudan: a case-control study. *The Lancet, 366*(9483), 385-391. doi:https://doi.org/10.1016/S0140-6736(05)67023-7

Amin, M. M., Rasheed, S., & Salem, E. (2013). Lower urinary tract symptoms following female genital mutilation. *International Journal of Gynecology & Obstetrics, 123*(1), 21-23. doi:10.1016/j.ijgo.2013.06.010

Armstrong, R. (2019). Elaborating a Critical Realist Approach to Soft Systems Methodology. *Systemic Practice and Action Research, 32*, 463-480. doi:10.1007/s11213-018-9466-7

Arnold, R. D., & Wade, J. P. (2015). A Definition of Systems Thinking: A Systems Approach. *Procedia Computer Science, 44*, 669-678. doi:https://doi.org/10.1016/j.procs.2015.03.050

Arora, K. S., & Jacobs, A. J. (2016). Female genital alteration: a compromise solution. *Journal of Medical Ethics, 42*(3), 148-154. doi:10.1136/medethics-2014-102375

Askew, I., Chaiban, T., Kalasa, B., & Sen, P. (2016). A repeat call for complete abandonment of FGM. *Journal of Medical Ethics, 42*(9), 619-620. doi:10.1136/medethics-2016-103553

Assaad, M. B. (1980). Female Circumcision in Egypt: Social Implications, Current Research, and Prospects for Change. *Studies in Family Planning, 11*(1), 3-16. doi:10.2307/1965892

Augustsson, H., Churruca, K., & Braithwaite, J. (2019). Re-energising the way we manage change in healthcare: the case for soft systems methodology and its application to evidence-based practice. *BMC health services research, 19*(1), 666. doi:10.1186/s12913-019-4508-0

Augustsson, H., Churruca, K., & Braithwaite, J. (2020). Change and improvement 50 years in the making: a scoping review of the use of soft systems

methodology in healthcare. *BMC health services research, 20*(1), 1063. doi:10.1186/s12913-020-05929-5

Baez, B. (2002). Confidentiality in qualitative research: reflections on secrets, power and agency. *Qualitative Research, 2*(1), 35-58. doi:10.1177/1468794102002001638

Baillot, H., Murray, N., Connelly, E., & Howard, N. (2018). Addressing female genital mutilation in Europe: A scoping review of approaches to participation, prevention, protection, and provision of services. *International Journal for Equity in Health, 17*(1). doi:10.1186/s12939-017-0713-9

Baillot, H., Murray, N., Connelly, E., Howard, N. (2014). *Tackling Female Genital Mutilation in Scotland. A Scottish model of intervention*. Retrieved from http://www.scottishrefugeecouncil.org.uk/assets/0000/9061/FGM_Report_FINAL_A4portrait.pdf

Barbrook-Johnson, P., & Penn, A. S. (2022a). Comparing, Choosing, and Combining Systems Mapping Methods. In P. Barbrook-Johnson & A. S. Penn (Eds.), *Systems Mapping: How to build and use causal models of systems* (pp. 161-177). Cham: Springer International Publishing.

Barbrook-Johnson, P., & Penn, A. S. (2022b). Participatory Systems Mapping. In P. Barbrook-Johnson & A. S. Penn (Eds.), *Systems Mapping: How to build and use causal models of systems* (pp. 61-78). Cham: Springer International Publishing.

Barbrook-Johnson, P., & Penn, A. S. (2022c). Rich Pictures. In P. Barbrook-Johnson & A. S. Penn (Eds.), *Systems Mapping: How to build and use causal models of systems* (pp. 21-32). Cham: Springer International Publishing.

Barrett, H. R., Brown, K., Alhassan, Y., & Leye, E. (2020). Transforming social norms to end FGM in the EU: An evaluation of the REPLACE Approach. *Reproductive Health, 17*(1). doi:10.1186/s12978-020-0879-2

Barrett, H. R., Brown, K., Alhassan, Y., & Leye, E. (2020). Transforming social norms to end FGM in the EU: an evaluation of the REPLACE Approach. *Reproductive Health, 17*(1), 40. doi:10.1186/s12978-020-0879-2

Bawden, R. (1998). The community challenge: the learning response.[Invited plenary paper at the Community Development Society. International

Meeting (29th: 1997: Athens, Ga. USA)]. *New Horizons in Education: The Journal of the New Education Fellowship*(99), 40.

BBC (Producer). (2017, 5-12-2018). Vagina surgery 'sought by girls as young as nine'. Retrieved from https://www.bbc.co.uk/news/health-40410459

BBC (Producer). (2017b, 5-12-18). Families left devastated by false claims of FGM in girls. Retrieved from https://www.bbc.co.uk/news/uk-41150621

Behrendt, A. (2011). Listening to African Voices: Female Genital Mutilation/cutting Among Immigrants in Hamburg-Knowledge, Attitudes and Practice. Retrieved from https://eige.europa.eu/gender-based-violence/resources/germany/listening-african-voices-female-genital-mutilation-cutting-among-immigrants-hamburg-knowledge-attitudes-and-practice

Behrendt, A., Moritz, A. (2005). Posttraumatic Stress Disorder and Memory Problems After Female Genital Mutilation. *American Journal of Psychiatry, 162*(5), 1000-1002. doi:10.1176/appi.ajp.162.5.1000

Bell, S., & Morse, S. (2010). *Rich Pictures: a means to explore the 'Sustainable Group Mind'?*

Belmaker, R. H. (2012). Successful cultural change: The example of female circumcision among Israeli Bedouins and Israeli Jews from Ethiopia. *Israel Journal of Psychiatry and Related Sciences, 49*(3), 178-183. Retrieved from https://www.scopus.com/inward/record.uri?eid=2-s2.0-84870917571&partnerID=40&md5=353a60d84cd7b6ff1ed8698524e28695

Berer, M. (2010). Labia reduction for non-therapeutic reasons vs. female genital mutilation: contradictions in law and practice in Britain. *Reproductive Health Matters, 18*(35), 106-110. doi:10.1016/S0968-8080(10)35506-6

Berer, M. (2015). The history and role of the criminal law in anti-FGM campaigns: Is the criminal law what is needed, at least in countries like Great Britain? *Reproductive Health Matters, 23*(46), 145-157. doi:http://dx.doi.org/10.1016/j.rhm.2015.10.001

Berg, R., Denison, E. (2012). Does Female Genital Mutilation/Cutting (FGM/C) Affect Women's Sexual Functioning? A Systematic Review of the Sexual Consequences of FGM/C

Sexuality Research and Social Policy, 9(1), 41-56. Retrieved from http://accaf.uonbi.ac.ke/sites/default/files/chs/accaf/Berg_2011_Does%20female%20genital%20mutilation%20affect%20womens%20sexual.pdf

Berg, R. C., & Denison, E. (2013). A tradition in transition: factors perpetuating and hindering the continuance of female genital mutilation/cutting (FGM/C) summarized in a systematic review. *Health care for women international, 34*(10), 837-859. doi:10.1080/07399332.2012.721417

Berg, R. C., Odgaard-Jensen, J., Fretheim, A., Underland, V., & Vist, G. (2014). An Updated Systematic Review and Meta-Analysis of the Obstetric Consequences of Female Genital Mutilation/Cutting. *Obstet Gynecol Int, 2014*, 8. doi:10.1155/2014/542859

BerlingskeTidene. (2003). *Ingen omskæring af piger i Danmark [No circumcision of girls in Denmark]*. Retrieved from http://www.bt.dk/nyheder/ingen-omskaering-af-piger-i-danmark

Bewley, S. (2013). Should a psychiatrist give legal advice on cosmetic genital surgery? *Archives of sexual behavior, 42*(3), 323. doi:http://dx.doi.org/10.1007/s10508-012-0044-2

Bewley, S. (2016). Misinformed debates on FGM can harm understanding. *BMJ (Clinical research ed.), 354*. doi:http://dx.doi.org/10.1136/bmj.i4804

Bewley, S., Kelly, B., Darke, K., Erskine, K., Gerada, C., Lohr, P., De Zulueta, P. (2015). Mandatory submission of patient identifiable information to third parties: FGM now, what next? *BMJ (Online), 351*, h5146. doi:http://dx.doi.org/10.1136/bmj.h5146

Bhaskar, R. (1975). *A Realist Theory of Science*. Leeds UK: Leeds Books.

Bhaskar, R. (1978). *The Possibility of Naturalism*. Sussex UK: Harvester Press.

Bhaskar, R. (1989). *Reclaiming Reality*. London: Verso.

Bhaskar, R. (1994). *Plato etc.: the problems of philosophy and their resolution*: Verso.

Bhaskar, R. (1997). On the Ontological Status of Ideas. *Journal for the Theory of Social Behaviour, 27*(2-3), 139-147. doi:https://doi.org/10.1111/1468-5914.00031

Bhaskar, R. (2016). *Enlightened Common Sense; The Philosophy of Critical Realism*. London: Routlege.

Bindel, J. (2014). *An Unpunished Crime: The Lack of Prosecutions for Female Genital Mutilation in the UK*. Retrieved from London: http://www.justiceforfgmvictims.co.uk/the-report/

Boddy, J. (1982). womb as oasis: the symbolic context of Pharaonic circumcision in rural Northern Sudan. *American Ethnologist, 9*(4), 682-698. doi:10.1525/ae.1982.9.4.02a00040

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*: Sage.

Boyle, E. H. (2002). *Female Genital Cutting: Cultural Conflict in the Global Community*. Baltimore: The Johns Hopkins University Press.

Bramwell, R. (2002). Invisible labia: The representation of female external genitals in women's magazines. *Sexual and Relationship Therapy, 17*(2), 187-190. doi:10.1080/14681990220121293

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Brown, K., Beecham, D., & Barrett, H. (2013). The Applicability of Behaviour Change in Intervention Programmes Targeted at Ending Female Genital Mutilation in the EU: Integrating Social Cognitive and Community Level Approaches. *Obstet Gynecol Int, 2013*, 324362. doi:10.1155/2013/324362

Bustard, D. W., He, Z., & Wilkie, F. G. (1999, 5-8 Jan. 1999). *Soft systems and use-case modelling: mutually supportive or mutually exclusive?* Paper presented at the Proceedings of the 32nd Annual Hawaii International Conference on Systems Sciences. 1999. HICSS-32. Abstracts and CD-ROM of Full Papers.

Caldwell, J. C., Orubuloye, I. O., & Caldwell, P. (2000). Female genital mutilation: Conditions of decline. *Population Research and Policy Review, 19*(3), 233-254. doi:10.1023/a:1026511611930

Campbell, D., Coldicott, T., Kinsella, K. . (1994). *Systemic Work with Organizations*. London: Routlege.

Carey, G., Malbon, E., Carey, N., Joyce, A., Crammond, B., & Carey, A. (2015). Systems science and systems thinking for public health: a systematic review of the field. *BMJ Open, 5*(12), e009002. doi:10.1136/bmjopen-2015-009002

Catania, L., Abdulcadir, O., Puppo, V., Verde, J. B., Abdulcadir, J., & Abdulcadir, D. (2007). Pleasure and Orgasm in Women with Female Genital

Mutilation/Cutting (FGM/C). *J Sex Med, 4*(6), 1666-1678. doi:10.1111/j.1743-6109.2007.00620.x

Chapman, J. (2004). *System Failure: Why Governments Must Learn to Think Differently*. London: Demos.

Checkland, P. (1981). *Systems Thinking, Systems Practice*. Chichester John Wiley & Sons.

Checkland, P. (1995). Model Validation in Soft Systems Practice. *Systems Research, 12*, 47-54. doi:10.1002/sres.3850120108

Checkland, P. (1999). Systems Thinking. In B. G. Wendy Currie (Ed.), *Rethinking Management Information Systems: An Interdisciplinary Perspective*. Oxford: Oxford University Press.

Checkland, P. (2000a). The Emergent Properties of SSM in Use: A Symposium by Reflective Practitioners. *Systemic Practice and Action Research, 13*(6), 799-823. doi:10.1023/a:1026431613200

Checkland, P. (2000b). Soft systems methodology: a thirty year retrospective. *Systems Research and Behavioral Science, 17*(S1), S11-S58. doi:doi:10.1002/1099-1743(200011)17:1+<::AID-SRES374>3.0.CO;2-O

Checkland, P., & Poulter, J. (2010). Soft Systems Methodology. In (pp. 191-242).

Checkland, P., Poulter, J. (2010). Soft Systems Methodology. In M. Reynolds, Howell, S. (Ed.), *Systems Approaches to Managing Change: a practical guide* (pp. 191-242). London: Springer Verlag.

Checkland, P., Scholes, J. (1990). *Soft Systems Methodology in Action*. West Sussex, England: John Wiley & Sons.

Chibnall, K., McDonald, K., & Kirkman, M. (2019). Pathologising diversity: medical websites offering female genital cosmetic surgery in Australia. *Culture, health & sexuality*, 1-17. doi:10.1080/13691058.2019.1574029

Churchman, C. W. (1970). *Operations Research as a Profession* (Vol. 17): INFORMS.

Coe, N. L. (2013). Announcers and confessors: How people self-disclose depression in health panels. *Health, Vol.05No.01*, 10. doi:10.4236/health.2013.51011

Connell, N. A. D. (2001). Evaluating soft OR: some reflections on an apparently 'unsuccessful' implementation using a Soft Systems Methodology (SSM) based approach. *Journal of the Operational Research Society, 52*(2), 150-160. doi:10.1057/palgrave.jors.2601054

Connelly, E., Murray, N., Baillot, H., & Howard, N. (2018). Missing from the debate? A qualitative study exploring the role of communities within interventions to address female genital mutilation in Europe. *BMJ Open, 8*(6). doi:10.1136/bmjopen-2017-021430

Creighton, S. M., Dear, J., De Campos, C., Williams, L., & Hodes, D. (2016). Multidisciplinary approach to the management of children with female genital mutilation (FGM) or suspected FGM: Service description and case series. *BMJ Open, 6*(2). doi:10.1136/bmjopen-2015-010311

Creighton, S. M., & Hodes, D. (2016). Female genital mutilation: What every paediatrician should know. *Archives of Disease in Childhood, 101*(3), 267-271. doi:http://dx.doi.org/10.1136/archdischild-2014-307234

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science, 4*(1), 50. doi:10.1186/1748-5908-4-50

Danermark, B., Ekström, M., Karlsson, J. (2019). *Explaining Society: Critical Realism in the Social Sciences*. London: Routlege.

Debelle, G. (2016). Female genital mutilation: Making the case for good practice. *Archives of Disease in Childhood, 101*(3), 207-209. doi:10.1136/archdischild-2015-308644

Denzin, K. a. L., Y. (2011). *The SAGE handbook of qualitative research*: Fourth edition. Thousand Oaks : SAGE, [2011] ©2011.

Descartes, R. (1637). *Discourse on Method and Meditations* (D. A. Cress, Trans. 4th ed.). Indianapolis, Indiana: Hackett Publishing Company, Inc.

Dixon, S. (2015). The FGM enhanced dataset: How are we going to discuss this with our patients? *British Journal of General Practice, 65*(641), 629. doi:10.3399/bjgp15X687781

Dixon, S., Agha, K., Ali, F., El-Hindi, L., Kelly, B., Locock, L., . . . Hinton, L. (2018). Female genital mutilation in the UK- where are we, where do we go next? Involving communities in setting the research agenda. *Res Involv Engagem, 4*, 29. doi:10.1186/s40900-018-0103-5

Dodd, L., Hilton, J. (2019). *Introduction to Systems Thinking in Practice*. Cranfield University.

Dorkenoo, E., Morison, L., Macfarlane, A. (2007). *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales*. Retrieved from file:///N:/References%20for%20endnote/PREVALENCE-STUDY_FINAL.pdf

Dustin, M. (2010). Female Genital Mutilation/Cutting in the UK:Challenging the Inconsistencies. *European Journal of Women's Studies, 17*(1), 7-23. doi:10.1177/1350506809350857

Earp, B. D. (2016). Between moral relativism and moral hypocrisy: Reframing the debate on "FGM". *Kennedy Institute of Ethics Journal, 26*(2), 105-144. doi:10.1353/ken.2016.0009

Earp, B. D., & Johnsdotter, S. (2021). Current critiques of the WHO policy on female genital mutilation. *Int J Impot Res, 33*(2), 196-209. doi:10.1038/s41443-020-0302-0

Edson, M. C., Henning, P. B., & Sankaran, S. (2016). *A guide to systems research: Philosophy, processes and practice* (Vol. 10): Springer.

Elgaali, M., Strevens, H., & Mårdh, P.-A. (2005). Female genital mutilation – an exported medical hazard. *The European Journal of Contraception & Reproductive Health Care, 10*(2), 93-97. doi:10.1080/13625180400020945

Elmusharaf, S., Elhadi, N., & Almroth, L. (2006). Reliability of self reported form of female genital mutilation and WHO classification: cross sectional study. *BMJ, 333*(7559), 124. doi:10.1136/bmj.38873.649074.55

Evans, C., Tweheyo, R., McGarry, J., Eldridge, J., Albert, J., Nkoyo, V., & Higginbottom, G. (2019). Crossing cultural divides: A qualitative systematic review of factors influencing the provision of healthcare related to female genital mutilation from the perspective of health professionals. *PLOS ONE, 14*(3), e0211829. doi:10.1371/journal.pone.0211829

Fahmy, A., El-Mouelhy, M. T., & Ragab, A. R. (2010). Female genital mutilation/cutting and issues of sexuality in Egypt. *Reproductive Health Matters, 18*(36), 181-190. doi:10.1016/S0968-8080(10)36535-9

Finlay, F., Baverstock, A., & Marcer, H. (2016). A debate on female genital mutilation, cosmetic genital surgery and genital piercings. *Archives of*

Disease in Childhood, 101(Supplement 1), A72. doi:http://dx.doi.org/10.1136/archdischild-2016-310863.127

Fletcher, A. J. (2017). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology: Theory & Practice, 20*(2), 181-194. doi:10.1080/13645579.2016.1144401

Gele, A. A., Bo, B. P., & Sundby, J. (2013). Attitudes toward Female Circumcision among Men and Women in Two Districts in Somalia: Is It Time to Rethink Our Eradication Strategy in Somalia? *Obstet Gynecol Int, 2013*, 312734. doi:10.1155/2013/312734

Gele, A. A., Bø, B. P., & Sundby, J. (2013). Have we made progress in Somalia after 30 years of interventions? Attitudes toward female circumcision among people in the Hargeisa district. *BMC Research Notes, 6*(1), 122. doi:10.1186/1756-0500-6-122

Gele, A. A., Johansen, E. B., & Sundby, J. (2012). When female circumcision comes to the West: Attitudes toward the practice among Somali Immigrants in Oslo. *BMC public health, 12*(1), 697. doi:10.1186/1471-2458-12-697

Gele, A. A., Kumar, B., Hjelde, K. H., & Sundby, J. (2012). Attitudes toward female circumcision among somali immigrants in Oslo: A qualitative study. *International Journal of Women's Health, 4*(1), 7-17. doi:10.2147/IJWH.S27577

Gerry, F., Rowland, A., Fowles, S., Smith, S., Hodes, D., & Creighton, S. (2016). Failure to evaluate introduction of female genital mutilation mandatory reporting. *Archives of Disease in Childhood, 101*(8), 778-779. doi:10.1136/archdischild-2016-311000

Glover, J., Liebling, H., Barrett, H., & Goodman, S. (2017). The psychological and social impact of female genital mutilation: A holistic conceptual framework. *Journal of International Studies, 10*(2), 219-238. doi:10.14254/2071-8330.2017/10-2/16

Grisaru, N., Lezer, S., & Belmaker, R. H. (1997). Ritual Female Genital Surgery Among Ethiopian Jews. *Archives of sexual behavior, 26*(2), 211-215. doi:10.1023/a:1024562512475

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

Gruenbaum, E. (2005). Socio-cultural dynamics of female genital cutting: Research findings, gaps, and directions. *Culture, health & sexuality, 7*(5), 429-441. doi:10.1080/13691050500262953

Gruenbaum, E. (2006). Sexuality Issues in the Movement to Abolish Female Genital Cutting in Sudan. *Medical Anthropology Quarterly, 20*(1), 121-138. doi:doi:10.1525/maq.2006.20.1.121

Habte, M., & Yang, Y. (2023). A qualitative inquiry into changing attitudes towards female genital mutilation following migration: the case of Eritrean women in Italy. *Journal of Gender-Based Violence*, 1-15. doi:10.1332/239868021X16908069733856

Hammond, D. (2017). Philosophical Foundations of Systems Research. In M. C. Edson, P. Buckle Henning, & S. Sankaran (Eds.), *A Guide to Systems Research: Philosophy, Processes and Practice* (pp. 1-19). Singapore: Springer Singapore.

Hayes, R. O. (1975). Female Genital Mutilation, Fertility Control, Women's Roles, and the Patrilineage in Modern Sudan: A Functional Analysis. *American Ethnologist, 2*(4), 617-633. Retrieved from http://www.jstor.org/stable/643328

Hernlund, Y., & Shell-Duncan, B. (2007). Contingency, Context, and Change: Negotiating Female Genital Cutting in The Gambia and Senegal. *Africa Today, 53*(4), 43-57. Retrieved from http://www.jstor.org/stable/4187809

Hicks, E. (1996). *Infibulation: Female Mutilation in Islamic Northeastern Africa* (Revised and Expanded ed. ed.). New Burnswick, NJ: Transaction Publishers.

Hodes, D., Armitage, A., Robinson, K., & Creighton, S. M. (2016). Female genital mutilation in children presenting to a London safeguarding clinic: A case series. *Archives of Disease in Childhood, 101*(3), 212-216. doi:10.1136/archdischild-2015-308243

Hosken, F. (1980). *The Hosken Report: Genital and Sexual Mutilation of Females*. Retrieved from Lexington, MA:

Hosken, F. (1993). The Hosken report: Genital and sexual mutilation of females. Lexington, Mass. *Women's International Network News*.

House of Commons, H. A. C. (2014). *Female genital mutilation: the case for a national action plan*. Retrieved from https://publications.parliament.uk/pa/cm201415/cmselect/cmhaff/201/201.pdf

House of Commons, H. A. C. (2016). *Roundtable Discussion on Female Genital Mutilation*. Retrieved from https://www.parliament.uk/documents/commons-committees/home-affairs/160706-FGM-Roundtable-Transcript.pdf

HSCIC. (2016). Female Genital Mutilation (FGM) - April 2015 to March 2016, Experimental Statistics. Retrieved from https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/female-genital-mutilation-fgm-april-2015-to-march-2016-experimental-statistics. Retrieved 21 July, from NHS Digital https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/female-genital-mutilation-fgm-april-2015-to-march-2016-experimental-statistics

HSCIC. (2017). Female Genital Mutilation (FGM) Annual Report 2016/17 [PAS]. Retrieved from https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/female-genital-mutilation-fgm-annual-report-2016-17-pas. Retrieved 4 July, from NHS Digital https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/female-genital-mutilation-fgm-annual-report-2016-17-pas

HSCIC. (2018). Female Genital Mutilation (FGM) - April 2017 to March 2018, Annual Report, Experimental Statistics Report. Retrieved from https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/female-genital-mutilation-fgm---annual-report-2017-18. Retrieved 5 July, from NHS Digital https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/female-genital-mutilation-fgm---annual-report-2017-18

Jackson, M. C. (2000). Systems Approaches to Management. Retrieved from https://doi.org/10.1007/b100327

Jacobs, A. J., & Arora, K. S. (2017). Punishment of Minor Female Genital Ritual Procedures: Is the Perfect the Enemy of the Good? *Developing World Bioethics, 17*(2), 134-140. doi:10.1111/dewb.12135

Johansen, R. E. (2006). *Experiences and perceptions of pain, sexuality, and childbirth: A study of female genital cutting among Somalis in Norwegian exile, and their health providers.* (Ph.D. dissertation). University of Oslo, Norway,

Johansen, R. E., Diop, N. J., Laverack, G., & Leye, E. (2013). What works and what does not: a discussion of popular approaches for the abandonment of female genital mutilation. *Obstet Gynecol Int, 2013*, 348248. doi:10.1155/2013/348248

Johansen, R. E. B., & Ahmed, S. A. E. (2021a). Negotiating Female Genital Cutting in a Transnational Context. *Qualitative Health Research, 31*(3), 458-471. doi:10.1177/1049732320979183

Johansen, R. E. B., & Ahmed, S. A. E. (2021b). Negotiating Female Genital Cutting in a Transnational Context. *Qual Health Res, 31*(3), 458-471. doi:10.1177/1049732320979183

Johansen, R. E. B., Diop, N. J., Laverack, G., & Leye, E. (2013). What Works and What Does Not: A Discussion of Popular Approaches for the Abandonment of Female Genital Mutilation. *Obstet Gynecol Int, 2013*, 348248. doi:10.1155/2013/348248

Johnsdotter, S. (2002). *Created by God: how Somalis in Swedish exile reassess the practice of female of female circumcision.* (Dctoral dissertation). Lund University, Lund.

Johnsdotter, S. (2018). The Impact of Migration on Attitudes to Female Genital Cutting and Experiences of Sexual Dysfunction Among Migrant Women with FGC. *Curr Sex Health Rep, 10*(1), 18-24. doi:10.1007/s11930-018-0139-4

Johnsdotter, S., & Essen, B. (2016). Cultural change after migration: Circumcision of girls in Western migrant communities. *Best Practice and Research: Clinical Obstetrics and Gynaecology, 32*, 15-25. doi:http://dx.doi.org/10.1016/j.bpobgyn.2015.10.012

Johnsdotter, S., Essen, B. (2004). *Sexual Health among Young Somali Women in Sweden: Living with Conflicting Culturally Determined Sexual Ideologies.*

Paper presented at the Advancing Knowledge on Psycho-Sexual Effects of FGM/C: Assessing the Evidence, Alexandria, Egypt. http://lup.lub.lu.se/record/528293

Kaggwa, M. M., Chaimowitz, G. A., & Olagunju, A. T. (2023). Labia minora elongation: a neglected form of genital mutilation with mental and sexual health concerns. *eClinicalMedicine, 58*, 101879. doi:https://doi.org/10.1016/j.eclinm.2023.101879

Karlsen, S., Carver, N., Mogilnicka, M., & Pantazis, C. (2020). 'Putting salt on the wound': a qualitative study of the impact of FGM-safeguarding in healthcare settings on people with a British Somali heritage living in Bristol, UK. *BMJ Open, 10*(6), e035039. doi:10.1136/bmjopen-2019-035039

Karlsen, S., Carver, N., Mogilnicka, M., Pantazis, C. (2019). *When safeguarding becomes stigmatising: A report on the impact of FGM-safeguarding procedures on people with a Somali heritage living in Bristol*. Retrieved from Bristol: https://research-information.bristol.ac.uk/files/187177083/Karlsen_et_al_2019_When_Safeguarding_become_Stigmatising_Final_Report.pdf

Karlsen, S., Howard, J., Carver, N., Mogilnicka, M., & Pantazis, C. (2023). Available evidence suggests that prevalence and risk of female genital cutting/mutilation in the UK is much lower than widely presumed - policies based on exaggerated estimates are harmful to girls and women from affected communities. *Int J Impot Res, 35*(3), 212-215. doi:10.1038/s41443-021-00526-4

Karlsen, S., Mogilnicka, M., Carver, N., & Pantazis, C. (2019). Female genital mutilation: empirical evidence supports concerns about statistics and safeguarding. *BMJ, 364*, l915. doi:10.1136/bmj.l915

Kelly, B., & Foster, C. (2012). Should female genital cosmetic surgery and genital piercing be regarded ethically and legally as female genital mutilation? *BJOG: An International Journal of Obstetrics & Gynaecology, 119*(4), 389-392. doi:doi:10.1111/j.1471-0528.2011.03260.x

Kimani, S., & Shell-Duncan, B. (2018). Medicalized Female Genital Mutilation/Cutting: Contentious Practices and Persistent Debates. *Curr Sex Health Rep, 10*(1), 25-34. doi:10.1007/s11930-018-0140-y

Knipscheer, J., Vloeberghs, E., van der Kwaak, A., & van den Muijsenbergh, M. (2015). Mental health problems associated with female genital mutilation. *BJPsych Bull, 39*(6), 273-277. doi:10.1192/pb.bp.114.047944

Kobach, A., Ruf-Leuschner, M., & Elbert, T. (2018). Psychopathological sequelae of female genital mutilation and their neuroendocrinological associations. *BMC Psychiatry, 18*(1), 187. doi:10.1186/s12888-018-1757-0

Korbin, J. E. (1991). Cross-cultural perspectives and research directions for the 21st century. *Child Abuse Negl, 15*(Suppl 1), 67-77. doi:10.1016/0145-2134(91)90010-B

Lawani, A. (2020). Critical realism: what you should know and how to apply it. *Qualitative Research Journal*.

Ledington, P., & Donaldson, J. (1997). Soft OR and Management Practice: A Study of the Adoption and Use of Soft Systems Methodology. *The Journal of the Operational Research Society, 48*(3), 229-240. doi:10.2307/3010421

Lee, R. M., & Renzetti, C. M. (1990). The Problems of Researching Sensitive Topics: An Overview and Introduction. *American Behavioral Scientist, 33*(5), 510-528. doi:10.1177/0002764290033005002

Leye, E., Powell, R. A., Nienhuis, G., Claeys, P., & Temmerman, M. (2006). Health care in Europe for women with genital mutilation. *Health Care Women Int, 27*(4), 362-378. doi:10.1080/07399330500511717

Liao, L. M., & Creighton, S. M. (2007). Requests for cosmetic genitoplasty: how should healthcare providers respond? *BMJ, 334*(7603), 1090-1092. doi:10.1136/bmj.39206.422269.BE

Luckett, K. (2006). An assessment of the application of 'Critical Systems Heuristics' to a policy development process. *Systemic Practice and Action Research, 19*, 503-521.

Macfarlane, A. (2019). Misleading use of FGM statistics compounds concerns about their reliability. *BMJ, 364*, l927. doi:10.1136/bmj.l927

Macfarlane, A. J., Dorkenoo, E. (2015). *Prevalence of Female Genital Mutilation in England and Wales: National and local estimates* Retrieved from London: http://openaccess.city.ac.uk/12382/

Mackie, G. (1996). Ending Footbinding and Infibulation: A Convention Account. *American Sociological Review, 61*(6), 999-1017. doi:10.2307/2096305

Mackie, G. (2003). Female Genital Cutting: A Harmless Practice? *Medical Anthropology Quarterly, 17*(2), 135-158. doi:doi:10.1525/maq.2003.17.2.135

Mackie, G., LeJeune, J. . (2009). *SOCIAL DYNAMICS OF ABANDONMENT OF HARMFUL PRACTICES: A NEW LOOK AT THE THEORY* Retrieved from https://unicef.at/fileadmin/media/Infos_und_Medien/Info-Material/Maedchen_und_Frauen/FGM_Abandonment_Social_Dynamics.pdf

Mathers, N., & Rymer, J. (2015). Mandatory reporting of female genital mutilation by healthcare professionals. *British Journal of General Practice, 65*(635), 282-283. doi:10.3399/bjgp15X685141

May, T. (1997). *Social Research: Issues, Methods and Process. (2nd edition)* Buckingham and Philadelphia: Open University Press

McChesney, K. Y. (2015). Successful approaches to ending female genital cutting. *Journal of Sociology and Social Welfare, 42*(1), 3-24. Retrieved from https://www.scopus.com/inward/record.uri?eid=2-s2.0-84944901421&partnerID=40&md5=7439167d78469cf313404d8a839d2a24

Meadows, D. (2008). *Thinking in Systems*. White River Junction: Chelsea Green Publishing.

Michie, S., van Stralen, M. M., & West, R. (2011). The behaviour change wheel: a new method for characterising and designing behaviour change interventions. *Implement Sci, 6*, 42. doi:10.1186/1748-5908-6-42

Midgley, G. (2000). *Systemic Intervention: Philosophy, Methodology and Practice (Contemporary Systems Thinking)*. New York: Kulwer Academic/Plenum.

Midgley, G. (2006). Systemic intervention for public health. *American journal of public health, 96*(3), 466-472. doi:10.2105/AJPH.2005.067660

Mingers, J. (2000a). The Contribution of Critical Realism as an Underpinning Philosophy for OR/MS and Systems. *The Journal of the Operational Research Society, 51*(11), 1256-1270. doi:10.2307/254211

Mingers, J. (2000b). The contribution of critical realism as an underpinning philosophy for OR/MS and systems. *Journal of the Operational Research Society, 51*(11), 1256-1270. doi:10.1057/palgrave.jors.2601033

Mingers, J. (2004). Re-establishing the real: Critical realism and information systems. In J. Mingers & L. Willcocks (Eds.), *Social Theory and Philosophy*

for Information Systems Social Theory and Philosophy for Information Systems.

Mingers, J. (2011). The Contribution of Systemic Thought to Critical Realism. *Journal of Critical Realism, 10*(3), 303-330. doi:10.1558/jcr.v10i3.303

Mingers, J. (2014). *Systems Thinking, Critical Realism and Philosophy: A Confluence of Ideas*.

Mingers, J., & Rosenhead, J. (2004). Problem Structuring Methods in Action. *European Journal of Operational Research, 152*, 530-554. doi:10.1016/S0377-2217(03)00056-0

Mingers, J., & Taylor, S. (1992). The Use of Soft Systems Methodology in Practice. *Journal of the Operational Research Society, 43*(4), 321-332. doi:10.1057/jors.1992.47

Morgan, G. (1993). *Imaginization, the art of creative management*. Newbury Park, California: Sage.

Morison, L. A., Dirir, A., Elmi, S., Warsame, J., & Dirir, S. (2004). How experiences and attitudes relating to female circumcision vary according to age on arrival in Britain: a study among young Somalis in London. *Ethn Health, 9*(1), 75-100. doi:10.1080/1355785042000202763

Naftalin, J., & Bewley, S. (2015). Mandatory reporting of FGM. *British Journal of General Practice, 65*(638), 450-451. doi:10.3399/bjgp15X686437

Nour, N. M., Michels, K. B., & Bryant, A. E. (2006). Defibulation to treat female genital cutting: effect on symptoms and sexual function. *Obstet Gynecol, 108*(1), 55-60. doi:10.1097/01.aog.0000224613.72892.77

O'Brien, O., Baldeh, B.,Sivapatham, S., Brown, E., O'May, F. (2016). *MY Voice: a participatory action research project with men, women and young people on female genital mutilation (FGM) in Scotland*. Retrieved from http://www.waverleycare.org/waverley_care/my-voice-fgm-project/

O'Brien, O., Baldeh, B., Hassan, J., Baillie, M. . (2017). *My Voice 2: Women and Female Genital Mutilation (FGM)in Scotland: A Participatory Action Research Project*. Retrieved from http://www.waverleycare.org/wp-content/uploads/2017/09/MyVoice-2017_web-Copy.pdf

O'Neill, S., Bader, D., Kraus, C., Godin, I., Abdulcadir, J., & Alexander, S. (2020). Rethinking the Anti-FGM Zero-Tolerance Policy: from Intellectual Concerns

to Empirical Challenges. *Curr Sex Health Rep, 12*(4), 266-275. doi:10.1007/s11930-020-00299-9

Obermeyer, C. (1999). Female Genital Surgeries: The Known, the Unknown, and the Unknowable. *Medical Anthropology Quarterly, 13*, 79-106. doi:10.1525/maq.1999.13.1.79

Obermeyer, C. (2005). The consequences of female circumcision for health and sexuality: An update on the evidence. *Culture, health & sexuality, 7*(5), 443-461. doi:10.1080/14789940500181495

Female Genital Mutilation Act 2003, (2003).

Prohibition of Female Genital Mutilation (Scotland) Act 2005, (2005).

Serious Crimes Act 2015, (2015).

Parliament. (2016). *Female genital mutilation: abuse unchecked*. London: UK Parliament

Pazdor, M. R. (2009). *Female Genital mutilation in France and the UK: the role of Non-Governmental organisations in policy formation*. Retrieved from file:///C:/Users/0802529I/Downloads/ubc_2009_fall_pazdor_margery%20(2).pdf

Peters, D. H. (2014). The application of systems thinking in health: why use systems thinking? *Health Research Policy and Systems, 12*(1), 51. doi:10.1186/1478-4505-12-51

Pidd, M. (2001). The future of OR. *Journal of the Operational Research Society, 52*, 1181-1190.

Plsek, P. (2001). *'Why won't the NHS do as its told' [Plenary address, NHS Conference, July 2001]*

PPAN. (2012). *Seven Things to Know about Female Genital Surgeries in Africa* (0093-0334). Retrieved from https://onlinelibrary.wiley.com/doi/abs/10.1002/hast.81

RCM, R., RCOG, Equality Now, UNITE (2013). *Tackling FGM in the UK: Intercollegiate recommendations, for identifying, recording and reporting*. Retrieved from London:

RCOG. (2013). Intercollegiate Group draws up ground-breaking recommendations for tackling Female Genital Mutilation. Retrieved from

https://www.rcog.org.uk/en/news/intercollegiate-group-draws-up-ground-breaking-recommendations-for-tackling-female-genital-mutilation/. https://www.rcog.org.uk/en/news/intercollegiate-group-draws-up-ground-breaking-recommendations-for-tackling-female-genital-mutilation/

Refaat, A. (2009). Medicalization of female genital cutting in Egypt. *East Mediterr Health J, 15*(6), 1379-1388.

Reisel, D., & Creighton, S. M. (2015). Long term health consequences of Female Genital Mutilation (FGM). *Maturitas, 80*(1), 48-51. doi:10.1016/j.maturitas.2014.10.009

Reynolds, M., Howell, S. (2010). Introducing Systems Approaches. In M. Reynolds, Howell, S. (Ed.), *Systems Approaches to Managing Change: A Practical Guide*. London: Springer Verlag.

Rodriguez-Ulloa, R., & Paucar-Caceres, A. (2005). *Soft System Dynamics Methodology (SSDM): Combining Soft Systems Methodology (SSM) and System Dynamics (SD)* (Vol. 18).

Rodríguez-Ulloa, R. A., Montbrun, A., & Martínez-Vicente, S. (2011). Soft System Dynamics Methodology in Action: A study of the Problem of Citizen Insecurity in an Argentinean Province. *Systemic Practice and Action Research, 24*(4), 275-323. doi:10.1007/s11213-010-9187-z

Schick, V. R., Rima, B. N., & Calabrese, S. K. (2011). Evulvalution: The Portrayal of Women's External Genitalia and Physique across Time and the Current Barbie Doll Ideals. *The Journal of Sex Research, 48*(1), 74-81. doi:10.1080/00224490903308404

Scottish Parliament, I. C. (5 September 2019). *Female Genital Mutilatin (Protection and Guidance)(Scotland) Bill, SB 19-56*. Retrieved from https://sp-bpr-en-prod-cdnep.azureedge.net/published/2019/9/5/Female-Genital-Mutilation--Protection-and-Guidance---Scotland--Bill/SB%2019-56.pdf

ScottishGovernment. (2016). *SCOTLAND'S NATIONAL ACTION PLAN TO PREVENT AND ERADICATE FEMALE GENITAL MUTILATION (FGM) 2016-2020*. Retrieved from https://www2.gov.scot/Resource/0049/00493752.pdf

ScottishGovernment. (2017). *Responding to female genital mutilation: multi-agency guidance*. Retrieved from

https://www.gov.scot/publications/responding-female-genital-mutilation-fgm-scotland-multi-agency-guidance-978-1-78851-364-7/

ScottishGovernment. (2019). *Scotland's National Action Plan to Prevent and Eradicate Female Genital Mutilation (FGM) –Year Three Progress Report*. Retrieved from https://www.gov.scot/publications/scotlands-national-action-plan-prevent-eradicate-female-genital-mutilation-fgm-year-three-progress-report/pages/3/

Senge, P., Kleiner, A., Roberts, C., Ross, R., Smith, B. . (1994). *The Fith Discipline Fieldbook*. London: Nicholas Brealey.

Shahawy, S., Amanuel, H., & Nour, N. M. (2019). Perspectives on female genital cutting among immigrant women and men in Boston. *Social Science & Medicine, 220*, 331-339. doi:https://doi.org/10.1016/j.socscimed.2018.11.030

Shahvisi, A. (2016). Cutting slack and cutting corners: An ethical and pragmatic response to Arora and Jacobs' 'Female genital alteration: A compromise solution'. *Journal of Medical Ethics, 42*(3), 156-157. doi:10.1136/medethics-2015-103206

Shahvisi, A. (2017). Why UK doctors should be troubled by female genital mutilation legislation. *Clinical Ethics, 12*(2), 102-108. doi:10.1177/1477750916682671

Shell-Duncan, B., Hernlund, Y. (2000). *Female "circumcision" in Africa: Culture, Controversy, and Change*: Lynne Rienner Publishers.

Shell-Duncan, B., Wander, K., Hernlund, Y., & Moreau, A. (2011). Dynamics of change in the practice of female genital cutting in Senegambia: testing predictions of social convention theory. *Soc Sci Med, 73*(8), 1275-1283. doi:10.1016/j.socscimed.2011.07.022

Sims-Schouten, W., Riley, S. C. E., & Willig, C. (2007). Critical Realism in Discourse Analysis: A Presentation of a Systematic Method of Analysis Using Women's Talk of Motherhood, Childcare and Female Employment as an Example. *Theory & Psychology, 17*(1), 101-124. doi:10.1177/0959354307073153

Smith, S. P., & Johnston, R. B. (2014). How Critical Realism Clarifies Validity Issues in Information Systems Theory-Testing Research. *Scand. J. Inf. Syst., 26*, 1.

Smithson, J. (2000). Using and analysing focus groups: Limitations and possibilities. *International Journal of Social Research Methodology, 3*(2), 103-119. doi:10.1080/136455700405172

Sterman, J. D. (2001). System Dynamics Modeling: Tools for Learning in a Complex World. *California Management Review, 43*(4), 8-25. doi:10.2307/41166098

Sterman, J. D. (2006). Learning from Evidence in a Complex World. *American journal of public health, 96*(3), 505-514. doi:10.2105/AJPH.2005.066043

Stroh, D. P. (2015). *Systems thinking for social change : a practical guide to solving complex problems, avoiding unintended consequences, and achieving lasting results*. White River Junction, Vermont: Chelsea Green Publishing White River Junction, Vermont.

Tonkiss, F. (2004). Using focus groups. In C. F. Seale (Ed.), *Researching Society and Culture*. London: Sage.

Toubia, N. (1994). Female genital mutilation and the responsibility of reproductive health professionals. *International Journal of Gynecology & Obstetrics, 46*(2), 127-135. doi:10.1016/0020-7292(94)90227-5

Toubia, N. F., & Sharief, E. H. (2003). Female genital mutilation: have we made progress? *International Journal of Gynecology & Obstetrics, 82*(3), 251-261. doi:https://doi.org/10.1016/S0020-7292(03)00229-7

Ugarte-Gurrutxaga, M., Mazoteras-Pardo, V., de Corral, G. M., Molina-Gallego, B., Mordillo-Mateos, L., & Gómez-Cantarino, S. (2023). "Nurses and health professionals facing female genital mutilation: a qualitative study ". *BMC Nursing, 22*(1), 408. doi:10.1186/s12912-023-01549-6

Ulrich, W. (1983). *Critical Heuristics of Social Planning: A New Approach to Practical Philosophy*. Bern, Switzerland: Verlag Paul Haupt.

Ulrich, W. (1996). *A Primer to Critical Systems Heuristics for Action Researchers. Hull, UK*: University of Hull, Centre for Systems Studies.

Ulrich, W., Reynolds, M. (2010). Critical Systems Heuristics In M. Reynolds, Howell, S. (Ed.), *Systems Approaches to Managing Change: a practical guide* (pp. 243-292). London: Springer Verlag.

UNICEF. (2013). *Female Genital Mutilation/Cutting: a statistical overview and exploration of the dynamics of change*. Retrieved from New York: https://www.unicef.org/publications/index_69875.html

UNICEF. (2016). Female Genital Mutilation/Cutting: A Global Concern (Report). Retrieved from https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf. Retrieved 22/01/19, from UNICEF https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf

Varol, N., Turkmani, S., Black, K., Hall, J., & Dawson, A. (2015). The role of men in abandonment of female genital mutilation: a systematic review. *BMC public health, 15*, 1034. doi:http://dx.doi.org/10.1186/s12889-015-2373-2

Veale, D., & Daniels, J. (2012). Cosmetic clitoridectomy in a 33-year-old woman. *Archives of sexual behavior, 41*(3), 725-730. doi:10.1007/s10508-011-9831-4

Vloeberghs, E., van der Kwaak, A., Knipscheer, J., & van den Muijsenbergh, M. (2012). Coping and chronic psychosocial consequences of female genital mutilation in the Netherlands. *Ethn Health, 17*(6), 677-695. doi:10.1080/13557858.2013.771148

Vogt, S., Efferson, C., & Fehr, E. (2017). The risk of female genital cutting in Europe: Comparing immigrant attitudes toward uncut girls with attitudes in a practicing country. *SSM Popul Health, 3*, 283-293. doi:10.1016/j.ssmph.2017.02.002

Vogt, S., Zaid, N., Ahmed, H., Fehr, E., Efferson, C. (2016). Changing cultural attitudes towards female genital cutting. *Nature, 538*, 506. doi:10.1038/nature20100 https://www.nature.com/articles/nature20100#supplementary-information

Von Bertalanffy, L. (1968). General system theory. *New York, 41973*(1968), 40.

Walker, A., Pratibha, Parmar. (1993). *Warrior Marks: Female Genital Mutilation and the Sexual Blinding of Women*. . New York: Harcourt Brace.

Walley, C. J. (1997). Searching for "Voices": Feminism, Anthropology, and the Global Debate over Female Genital Operations. *Cultural Anthropology, 12*(3), 405-438. doi:10.1525/can.1997.12.3.405

Wasige, J., & Jackson, I. (2018). Female genital mutilation: A form of gender-based violence. In *The Routledge Handbook of Gender and Violence* (pp. 196-207): Taylor and Francis.

Webb, E., & Hartley, B. (1994). Female genital mutilation: a dilemma in child protection. *Archives of Disease in Childhood, 70*(5), 441-444. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/8017971

https://www.ncbi.nlm.nih.gov/pmc/PMC1063288/

Weston, J. (2017). Female genital mutilation: The law as it relates to children. *Archives of Disease in Childhood, 102*(9), 864-867. doi:10.1136/archdischild-2017-313090

WHO. (1999). *Female genital Mutilation - Programmes to Date: What works and what Doesn't - A Review*. Retrieved from Geneva:

WHO. (2006). Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. *The Lancet, 367*(9525), 1835-1841. doi:10.1016/S0140-6736(06)68805-3

WHO. (2008). *Eliminating Female Genital Mutilation, An interagency statement*. Retrieved from http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf

WHO. (2012). *Understanding and addressing vioence against women: female genital mutilation*. Retrieved from Geneva: http://www.who.int/reproductivehealth/topics/violence/vaw_series/en/

Wuest, S., Raio, L., Wyssmueller, D., Mueller, M., Stadlmayr, W., Surbek, D., & Kuhn, A. (2009). Effects of female genital mutilation on birth outcomes in Switzerland. *BJOG: An International Journal of Obstetrics & Gynaecology, 116*(9), 1204-1209. doi:10.1111/j.1471-0528.2009.02215.x

Yoder, P., Abderrahim, N., Zhuzhuni, A. . (2004). *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis* Retrieved from Claverton,Maryland:

Yoder, P. S., Khan, S. (2008). *Numbers of women circumcised in Africa: The Production of a Total*. Retrieved from Claverton, Maryland:

Yoder, P. S., Wang, S., & Johansen, E. (2013). Estimates of female genital mutilation/cutting in 27 African countries and Yemen. *Studies in Family Planning, 44*(2), 189-204. doi:10.1111/j.1728-4465.2013.00352.x

APPENDICES

APPENDIX 1: REFLEXIVE JOURNAL

1. Terminology:

I chose to use the term Female Genital Mutilation (FGM/C) because while the term "cutting" was less judgement laden than "mutilation", FGM/C retained recognition of the potentially very severe impact of the practice.

2. Positioning myself:

My position in conducting this research was twofold. It was participatory to the extent that I conducted a qualitative analysis of the data and created the models used. This meant that my interpretation of findings structured the discussion of the issues. It was also observatory, as I had a "birds eye view" of all the stakeholder groups involved and their contributions in the interviews and the workshops. I tried to steer workshop proceedings in a neutral way, open to what may come up in discission. In terms of my hopes in influencing the system for improvement, I hope this research supports the community voice being taken seriously, as there is a strong knowledge and power imbalance in the situation.

I approached this thesis with an interest in systems thinking as a systematic way to approach complex problem issues. I wished to apply it to the issue of FGM/C, the complexity of which I became aware of while taking part in a large systematic review on clinical interventions in the issue.

Personal reflection:

I grew up in a country where FGM/C is variably present in different regions. Some minority ethnic group practiced this, although not in my own ethnic background. I also have a clinical background and am biracial.

I was aware of its existence only in theory as a thing practiced "out there somewhere". It was only on taking up this research that I looked at the numbers and was shocked at apparent rates of the practice. I had first heard of it when I overheard two classmates in senior high school in Nigeria casually discussing the practice which was apparently carried out in their ethnic group, where something

was cut out and one had to walk carefully for a few days after, so things don't “get gummed closed”. They hadn't gone through it at the time, and I had no idea of exactly what was cut out. Neither probably did they, likely just aware of traditional lore about it. I didn't know what to make of it, but they didn't seem shocked by it or for that matter apprehensive or uncomfortable, and I forgot about it. It came back to memory while writing this thesis, but perhaps having that experience allowed me to be receptive to a more complex view of the issue than had my only exposure been a narrative of grievous abuse and a video clip of a terrified little girl screaming.
In addition, virtually across the country, with no ethnic distinctions I am aware of, infant male circumcision is a social norm, universally accepted, routinely medicalised, and not known to be associated with harm or loss of function.

I only realised the baseline understanding this gave me with respect to the issue of FGM/C when one of my participants said during an interview that he’d thought circumcision was something parents decided to do, off their own bat. This shocked me, and I realised the degree of lack of understanding of the issue in this situation.

I can also understand how men/boys would be utterly clueless about the practice, as apparently it had nothing to do with them and did not involve them, other than as a father possibly being told by his female relatives that his daughter was getting this traditional thing done. If he is aware that all the women around him see this thing as good and necessary for his daughter and he did not question the cultural lore about it, a man may not be inclined to probe further into this “women's business”. Unless of course he has reason to question or oppose it, which would be why awareness raising on the issue among men, and de-mythologising it is so important.
It is not something that comes up in normal conversation. I mentioned that I'm doing this research to a longstanding close friend from an ethnic group which traditionally practiced it, and that was when she mentioned that her mother had refused to have it done on her, so she and her sister were spared the issue.

In my surprise about the rates of the practice, I had to check with some classmates from medical school about their recollections. I found that of the three I asked,

two were similarly surprised about the statistics for the region, while one seemed quite aware of the extent of the practice. The hospital was in a multiethnic, urban city. I also spoke about it with my father, a retired clinician. All had a uniformly negative view of the practice. My dad in particular described it as 'wickedness to people' and this just considering type 1&2 which he was aware of. He was appalled upon learning about type 3, which he had not even heard of. The difficulty of wrapping the head around the practice extends not just to western onlookers, but to people in countries where this is practiced who are not from actually practicing communities, or those from practicing communities dissociated from the practice. The statement that perspectives are diverse in affected communities is not a platitude.

Recruitment:

In recruiting participants, one responded to my invite because she recognised my ethnic surname, as her background was from the same region of Nigeria. In the course of her interview, she made references to Mary Slessor, a woman whose name I was well familiar with but who seems relatively unknown in Scotland, a Scottish Christian missionary who is credited with stopping the killing of twins in a region in southeast Nigeria, which was a normative practice there at the time. She spoke of her as a model for engagement, as a foreigner working to stop a harmful cultural practice. Mary Slessor was actually on the Clydesdale bank £10 banknote for a while, however it is no longer in circulation.

With another community group, I initially attended an event on FGM/C they were running for African women. This may not have been a viable avenue had I been a young white Scottish man interested in researching the subject. People would likely have been less open and more guarded. As it was, I was invited to introduce myself and explain the premise of my research, which they found interesting.

My ethnic background could have placed me as an ‘insider’ who could better understand their perspective and position. The challenge of insider status could be that dissenting voices to the accepted narrative are less likely to open up and challenge the going narrative, which in Scotland is against FGM/C. However, this research was not exploring personal experiences of FGM/C, and the participants

engaged as members of groups actively working against FGM/C in their communities, in is line with that of public bodies in Scotland. But the issue remains a sensitive one, with racial sensitivities. In the event, all participants seemed to feel comfortable and speak candidly.

Running the workshops:

In running the workshops, had to take a stand back and become aware that I cannot control the process, and neither can I anticipate the outcome. I could only steer the process, providing the structure and tools; and that this constraint was a strength for the study, as it allowed the emergence of a rich picture of multiple views, perspectives and contributions.

This was very different from my previous professional role in which sensitive issues were also discussed. That was more prescriptive in managing a specific problem. It was my duty to educate on the problem, its causes, its complications, and management; and offer suitable treatment options.

Here I had no 'treatment' to offer from my own end. The role was more putting tools on the table and supporting participants to unpack the situation as much as possible within the available time frame while being aware of my limited understanding of the multiple contexts present.

Sensitivities noted:

The subject is an emotive one. This was underscored by experience I had chairing an FGM webinar, where one speaker quite aggressively confronted another for emphasising the importance of community engagement, insisting that it was racist to approach the issue as a cultural practice. She declared it simply a criminal practice which should be treated as such. It highlighted the tension for some between approaching FGM/C as a harmful traditional practice vs. as grievous abuse.

In my view, if a practice is community driven then one needs to address the drivers in the community which perpetuate the practice. I also think understanding of 'abuse' cannot be entirely deprived of intention and context. In addition, an unnuanced declaration that FGM/C is grievous abuse which everyone should know as such, implies that countries with a prevalence rate of 70-90% are simply nations of criminals who deliberately harm and exploit their children. What are the implications of such a position?

I think FGM/C is too complex for such an approach. I hope in this thesis I have been able to fulfil the aims of building understanding of the issue and its complexities, as well as showing how addressing it could be improved.

APPENDIX 2: ADAPTATIONS DUE TO COVID

The research was originally meant to include face to face interviews and workshops. This had to be changed into an online format.

Interviews were carried out over Microsoft Team/Zoom.

MIRO was identified as an online tool which has the capacity to support the type of interaction which was required by the workshops, as well as input from multiple participants at the same time. A training webinar on its use was completed.

APPENDIX 3: LITERATURE SEARCH STRATEGY

The background literature review was not a systematic review of literature on the topic. It however was approached in a structured way. SCOPUS, Pubmed, and EMBASE searches were conducted, and relevant literature, including from reference lists, manually extracted. UK and Scottish government websites were used to obtain policy statements on FGM/C.

Aims and Objectives

The overall aim of this literature review was to gain an overview of the academic literature emerging on the subject of Female Genital Mutilation/Cutting in the UK in the past 10 years, specifically literature related to what drives the practice or its abandonment, with a view to find the focus of recent research, the types of literature available, the themes emerging in this area, identify any gaps in the literature, and come up with a working research question for my thesis.

Its specific objectives were to examine the literature on FGM/C in the UK through this lens in the following areas:

-Causes and drivers

-Political debate and legislation

-Policy guidelines

-Current practice for identifying cases (response/proactive) and dealing with them; and

-Challenges to prevention and mitigation

Methods

The broad questions driving this literature review were: ‘What drives the practice of FGC in the UK?’, ‘What drives abandonment of FGC in the UK?’ and ‘How has the practice of FGC adapted to policy?’

Searches for systematic reviews, surveys, case reports, qualitative studies and practice literature were conducted using the databases listed in the table below.

Database	**Rationale**
Scopus	It is the largest database for peer reviewed literature in the social sciences, and the bulk of the articles for this review will probably be sourced here.
PubMed	To check for any relevant articles missed on Scopus, especially recently published ones
Embase	This database will be used to check for and relevant articles missed in the searches above.

The reference lists of articles included in the review were hand-searched for relevant literature missed in the searches.

UK (www.gov.uk) and Scottish (www.gov.scot) government websites were used to obtain UK and Scottish government policy statements on FGM/C.

The key terms used for the searches were be: female genital mutilation, female genital cutting, female circumcision, as well as policy, prevention, causes, risk factors, drivers, legislation, legal, community.

NOT Boolean command were used to exclude articles on areas not relevant to the review such as clinical treatment.

'Limits' functions were used to limit the search to articles relevant to UK/Europe/N America

Google scholar was searched with the keywords FGM, thesis, UK. The first three pages were searched for relevant entries.

This review was aimed at increasing understanding of what drives the practice and what drives abandonment of FGM/C the UK, and how practice has adapted to policies aimed to prevent FGM/C. Included in the review was research literature (systematic reviews, surveys, case reports, qualitative studies) as well as practice literature (discussion papers, debate, practice reports) which provided a relevant

picture of how the policies were being implemented and any difficulties associated with this.

Included were articles whose focus was FGM/C in the UK. Relevant studies found in the searches which were focused on FGM/C in Europe and North America by communities from traditionally practicing countries were also included as the experiences/findings/driving factors may be parallel to that in the UK.

Excluded were articles focused on FGM/C in traditionally practicing societies as this review asked what drives practice/abandonment in the UK; articles with a clinical/surgical focus as they did not address the factors driving the practice of FGM/C but rather the physiological complications associated with it; and articles not published in English as translation was beyond the capacity of this reviewer.

APPENDIX 4: SAMPLING FRAMEWORK

Stakeholder			Contact	Method of contact
Community and Non-governmental organisations	KWISA Kenyan Women in Scotland Association	KWISA provides support and information for African Women on FGM and other harmful traditional practices www.facebook.com/kwisauk/ www.kwisa.org.uk	4th Floor, Hayweight House, 23 Lauriston Street, Edinburgh EH3 9DQ Tel: +44 (0)131 281 7347 Email: admin@kwisa.org	Already known to researcher
	Saheliya	Saheliya is a BME women's mental health support organisation, based in Edinburgh and Glasgow, and with projects in other parts of Scotland, providing well-being services and practical help to access health services, benefits, housing, legal representation, and learning activities. www.saheliya.co.uk	125, McDonald Road, Edinburgh, EH7 4NW Edinburgh tel: 0131 556 9302 St Rollox House, 130 Springburn Road, Glasgow, G21 1YL Glasgow tel: 0141 552 6540 Edinburgh email: info@saheliya.co.uk Glasgow email: admin.glasgow@saheliya.co.uk	Website
	Amina Muslim	Amina works with mainstream agencies to	Greyfriars Charteris Centre	Website

	Women's Resource Centre	establish the barriers that prevent Muslim women from accessing services and participating in society. They provide direct helping services and community development to Muslim women https://mwrc.org.uk/	138/140 The Pleasance; Edinburgh; EH8 9RR 0131 667 9199 1/3 6 Whitehall Crescent; DUNDEE; DD1 4AU Tel: 01382 787 450 Citywall House, 32 Eastwood Avenue, Glasgow, G41 3NS 0141 212 8420 info@mwrc.org.uk	
	Women's Support Project	Provide information, resources and training on FGM. Glasgow based support group for women who have had FGM, and can provide information on support available across Scotland www.womenssupportproject.org.uk	Adelphi Centre, 12 Commercial Road, Glasgow G5 0PQ Tel: 0141 418 0748 Email: enquiries@womenssupportproject.org.uk	Website
	Shakti	SHAKTI WOMEN'S AID provides support, advocacy and information to all black / minority ethnic women, children and young people experiencing or fleeing	57 Albion Road, Edinburgh, EH7 5QY Tel: 0131 475 2399 Email: info@shaktiedinburgh.co.uk	Website

		domestic abuse or forced marriage. http://shaktiedinburgh.co.uk/		
	Roshni	Roshni is a registered charitable organisation with offices in Glasgow and Dundee. The aim of the charity is primarily to ensure the safety of children, young people and adults within the minority ethnic communities. www.roshni.org.uk	Baltic Chambers. Suite 339. 50 Wellington Street. Glasgow. G2 6HJ Tel: 0141 202 0608 Email: info@roshni.org.uk	Website
	Hemat Gryffe Women's Aid	Hemat Gryffe provides support, advice and temporary accommodation to women and children from the BME community who experience domestic abuse or forced marriage. https://www.hematgryffe.org.uk/	Tel 0141 353 0859 Email: womensaid@hematgryffe.org.uk	Website
	Waverley care	Provides support for those affected by FGM	12 Queens Crescent Glasgow, G4 9AS 0141 332 2520,	Website

		www.waverleycare.org	3 Mansfield Place Edinburgh EH3 6NB For communications and research queries: comms@waverleycare.org For African Health Project queries: ahpglasgow@waverleycare.org	
	Scottish Refugee Council	The Scottish Refugee Council works with refugees and asylum seekers across Scotland.	(Glasgow – Main Office) 6th Floor, Portland House 17 Renfield Street Glasgow, G2 5AH 0141 248 9799 info@scottishrefugeecouncil.org.uk	Website
Statutory Services	Scottish Children's Reporters Administration (SCRA)	www.scra.gov.uk	Information & Research Team Ochil House Springkerse Business Park Stirling FK7 7XE Email: Gillian.Henderson@scra.gov.uk	Already known to researcher
	Social services	Social Work Scotland	Mansfield Traquair Centre	Contact Service to

		www.socialworkscotland.org	15 Mansfield Place Edinburgh EH3 6BB **Phone:** 0131 281 0853 **Email:** admin@socialworkscotland.org	identify the most relevant person
	Police	Police Scotland www.scotland.police.uk		Contact Service to identify the most relevant person
	Education	Education Scotland www.education.gov.scot	Official Correspondence Unit, Education Scotland, Denholm House, Almondvale Business Park, Almondvale Way, Livingston. EH54 6GA 0131 244 4330 enquiries@educationscotland.gov.scot	Contact service to identify the most relevant person
	Health Services	NHSGGC Care Pathway for Revision of Female Genital Mutilation (FGM) Glasgow Royal Infirmary	FGM Clinical Lead (rtd)	Already known to researcher
		NHS Scotland specialist services for FGM From <https://www.fgmnetwor	St John's Hospital at Howden, Howden Road West, Howden, Livingston,	Contact service to identify the most

		k.org.uk/clinics/nhs-scotland-specialist-services-for-female-genital-mutilation-2/>	West Lothian, EH54 6PP 0131 536 1511 Alison.m.scott@nhslothian.scot.nhs.uk	relevant person
		Gender-based Violence Services From <https://www.nhsggc.org.uk/your-health/health-issues/covid-19-coronavirus/for-nhsggc-staff/staff-support-and-wellbeing/protection-from-abuse/gender-based-violence-services/	kath.gallagher@ggc.scot.nhs.uk	Contact Service to identify the most relevant person

APPENDIX 5: CONSENT FORM FOR INTERVIEWS

University of Glasgow | College of Medical, Veterinary & Life Sciences

Centre Number:

Project Number:

Participant Identification Number for this trial:

Title of Project: Addressing Female Genital Mutilation/Cutting in Scotland

Name of Researcher: Elizabeth Inyang

CONSENT FORM	Please initial box
I confirm that I have read and understood the Participant Information Sheet version 0.5 dated 29.01.2021.	☐
I confirm that I have read and understood the Privacy Notice version 0.2 dated 29.01.2021.	☐
I have had the opportunity to think about the information and ask questions, and understand the answers I have been given.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	☐

I confirm that I agree to the way my data will be collected and processed and that data will be stored for at least 10 years in University archiving facilities in accordance with relevant Data Protection policies and regulations. ☐

I understand that identifiable data and information I provide will be kept confidential and will be seen only by study researchers and regulators whose job it is to check the work of researchers. ☐

I understand that confidentiality may be broken if I say anything which suggests that I or another person may be at risk of immediate and serious harm. ☐

I agree that my name, contact details and data described in the information sheet will be kept for the purposes of this research project. ☐

I understand that if I withdraw from the study, my data collected up to that point may be retained and used for the remainder of the study. ☐

I agree to take part in the study. ☐

I agree to my interview being recorded. ☐

I understand that the recorded interview will be transcribed word by word and the transcription stored for at least 10 years in University archiving facilities in accordance with Data Protection policies and regulations. ☐

I understand that my information and things that I say in the interview may be quoted in reports and articles that are published about the study, but my name will not be revealed. ☐

I agree that my anonymised data may be made available to other genuine researchers on request for purposes of research and teaching, if they have scientific and ethical approval and agree to preserve the confidentiality of this information as set out in this form. ☐

_____	_____	_____
Name of participant	Date	Signature/Initials
_____	_____	_____
_____	_____	_____
Researcher	Date	Signature/Initials

(1 copy for participant; 1 copy for researcher)

APPENDIX 6: CONSENT FORM FOR WORKSHOPS

University of Glasgow | College of Medical, Veterinary & Life Sciences

Centre Number:

Project Number:

Participant Identification Number for this trial:

Title of Project:

Addressing Female Genital Mutilation/Cutting in Scotland

Name of Researcher: Elizabeth Inyang

CONSENT FORM	Please initial box
I confirm that I have read and understood the Participant Information Sheet version 0.5 dated 29.01.2021.	☐
I confirm that I have read and understood the Privacy Notice version 0.2 dated 29.01.2021.	☐
I have had the opportunity to think about the information and ask questions, and understand the answers I have been given.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	☐
I confirm that I agree to the way my data will be collected and processed and that data will be stored for at least 10 years in	☐

University archiving facilities in accordance with relevant Data Protection policies and regulations.

I understand that all identifiable data and information I provide will be kept confidential and will be seen only by study researchers and regulators whose job it is to check the work of researchers. ☐

I understand that confidentiality may be broken if I say anything which suggests that I or another person may be at risk of immediate and serious harm. ☐

I agree that my name, contact details and data described in the information sheet will be kept for the purposes of this research project. ☐

I understand that if I withdraw from the study, my data collected up to that point will be retained and used for the remainder of the study. ☐

I agree to take part in the study. ☐

I agree to the workshop being recorded. ☐

I understand that the recorded workshop will be transcribed word by word and the transcription stored for at least 10 years in University archiving facilities in accordance with Data Protection policies and regulations. ☐

I understand that my information and things that I say in the workshop may be quoted in reports and articles that are published about the study, but my name will not be revealed. ☐

I agree that my anonymised data may be made available to other genuine researchers on request for purposes of research and teaching, if they have scientific and ethical approval and agree to preserve the confidentiality of this information as set out in this form. ☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
_____	_____	_____
Researcher	Date	Signature

(1 copy for participant; 1 copy for researcher)

APPENDIX 7: PARTICPANT INFORMATION SHEET

PARTICIPANT INFORMATION SHEET

Study title

Addressing Female Genital Mutilation/Cutting in Scotland.

You are being invited to take part in a research study. Before you decide, it is important for you 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. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The purpose of this study is to increase understanding of the issue of FGM/C in Scotland, and to co-create with stakeholders recommendations for how the situation could be improved.

Many elements are involved in addressing FGM/C in Scotland: culture, family, individual rights, health, the law and policing, and the challenge of cultural differences. This means that the full picture is often hard to see, which limits the understanding of the situation. It also creates a high risk of unintended consequences in the strategies designed to address it, as well as a challenge in developing strategies that best fit the need.

There is therefore a need for research which brings together the multiple viewpoints present in order to create a better understanding of the wider situation.

Why have I been invited to participate?

I am inviting participants from community groups, NGOs and statutory services to take part in this research. You have been chosen because you are involved in addressing the practice of FGM/C in Scotland.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

What will I be asked to do if I take part?

You will be asked to take part in an interview, lasting about 1 – 1 ½ hour, which will be conducted online on Teams or Zoom, or if you prefer, by phone. You will be asked about your role, perspective and goals and challenges with respect to addressing FGM/C in Scotland. I am interested in your views as an individual, and not in any official line of your organisation. You will then be invited to attend two online workshops with other participants from voluntary and statutory organisations, to further explore the situation and then come up with recommendations on how it may be improved. The workshops will be held on Teams and recorded. Taking part in the interviews does not commit you to taking part in the workshops.

What are the possible disadvantages and risks of taking part?

The issue of FGM/C is a sensitive one. This research will not include questions about personal experience of the practice, but rather how it is addressed in the public sphere. However, it is still possible that the discussion may become upsetting to some participants.

In that case, the interview can be stopped at any time, or you can ask the interviewer to move on to another question. You can withdraw from the workshop at any time.

What are the possible benefits of taking part?

Taking part in this research will allow you to contribute to academic research by providing your perspectives on this issue; engage with other stakeholders; gain understanding of the issues through the perspective of other stakeholders; explore how the situation could be improved; and find ways of collaboration with other stakeholders to further shared purposes.

Will my taking part in this study be kept confidential?

Everything you tell us will be kept strictly confidential. This confidentiality may only be broken if you say anything which suggests that you or another person may be at risk of immediate and serious harm.

Data will be kept on secure password protected university servers which are regularly backed up. The transcripts of the recordings will be de-identified (names, dates and places removed), and access limited to principal researcher and the supervision team.

There will remain a possibility of deductive disclosure of your identity, as the type of social or professional role played by participants will be reflected in the research, and so narrow the field of potential identity.

Because of the small number of people working on this issue in Scotland, it is possible that you may know other members of the group at workshops.

What will happen to my data?

The University is responsible for looking after your data and using it properly. Researchers from the University of Glasgow collect, store and process all personal information in accordance with the General Data Protection Regulation (2018). All study data will be held in accordance with The General Data Protection Regulation (2018)

If you withdraw from the study following completion of the interview, we will keep the data that we have already obtained from you, as data analysis would have commenced and individual data extraction will not be possible.

The data will be stored in archiving facilities in line with the University of Glasgow retention policy of 10 years from date of archiving, or where a data request is made, from date of last data request. After this time, the data will no longer

considered useful for research and it will be securely destroyed in accordance with the relevant standard procedures.
Your data will form part of the study result that will be published in expert journals, presentations and a student thesis. Your name will not appear in any publication.
Your anonymised data may be made available on request to other researchers based within or outside this University for purposes of research and teaching.
You can find out more about how we use your data in the Privacy Notice you will receive.

What will happen to the results of the research study?
It is hoped that this research will help to improve how FGM/C is addressed in Scotland. It will be used to complete a PhD thesis. It will also be used for journal publications and for presentations. Direct de-identified quotes from participants may be used in the thesis and publications arising from it. A summary sheet of the study results will be provided to participants when the study is completed which will be in about two years' time.

Who is organising and funding the research?
I am conducting this study as part of a self-funded PhD research project which is supported by the MRC/CSO Social and Public Health Sciences unit, University of Glasgow.

Who has reviewed the study?
All research in the University of Glasgow is looked at by a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and approved by the College of Medical, Veterinary and Life Sciences Ethics Committee.

Contact for Further Information
If you would like more information about this project, you can contact myself,

Elizabeth Inyang, at e.inyang.1@research.gla.ac.uk.
You can contact my supervisor at Kirstin.Mitchell@glasgow.ac.uk.

Thank you very much for considering taking part in this research.

APPENDIX 8: PRIVACY NOTICE

Privacy Notice for Participants

Addressing Female Genital Mutilation/Cutting in Scotland

Your Personal Data

The University of Glasgow will be what's known as the 'Data Controller' of your personal data processed in relation to your participation in the PhD research project 'Addressing FGM/C in Scotland'. This privacy notice will explain how The University of Glasgow will process your personal data.

Why we need it

We are collecting your basic personal data such as name, and contact details in order to contact, and correspond with you with regard to your participation in the research. We will only collect data that we need in order to provide and oversee this service to you.

Legal basis for processing your data

We must have a legal basis for processing all personal data. In this instance, the legal basis is Public task/Official authority. For the special categories of data, such as health data we collect, the legal basis is scientific and historical research.

What we do with it and who we share it with

All the personal data you submit is processed by the principal investigator and staff at the University of Glasgow in the United Kingdom.

The data will be archived on secure encrypted servers in the University of Glasgow.

The DOI for the study will be put into University of Glasgow Enlighten, through which it will be discoverable.

Consent to share research data will be requested from participants, and anonymised data may be made available to genuine researchers on request for purposes of research and teaching.

How long do we keep it for

Your data will be retained by the University of Glasgow for at least 10 years. After this time, if the data are no longer considered useful for research they will be securely destroyed in accordance with the relevant standard procedures.

What are your rights?*

It is your right to withdraw from the study at any time if you wish to.

Withdrawal of the data you provide towards the study is only possible before the commencement of data analysis.

You can request access to the information we process about you at any time. If at any point you believe that the information we process relating to you is incorrect, you can request to see this information and may in some instances request to have it restricted, corrected or, erased. You may also have the right to object to the processing of data and the right to data portability.

If you wish to exercise any of these rights, please submit your request via the webform or contact dp@gla.ac.uk.

*Please note that the ability to exercise these rights will vary and depend on the legal basis on which the processing is being carried out.

Complaints

If you wish to raise a complaint on how we have handled your personal data, you can contact the University Data Protection Officer who will investigate the matter.

Our Data Protection Officer can be contacted at dataprotectionofficer@glasgow.ac.uk

If you are not satisfied with our response or believe we are not processing your personal data in accordance with the law, you can complain to the Information Commissioner's Office (ICO) https://ico.org.uk/

APPENDIX 9: INTERVIEW SHCHEDULE

1. Could you tell me how you got involved in FGM/C work?
   Probe: When was this?
2. What is your current role?
   Probe: How does it address FGM/C? What other professionals/organisations do you interact with on FGM/C?
3. What do you think makes FGM/C an important/relevant issue?
4. Do you work directly with women/girls who have experienced FGM?
   Probe: What numbers of women with FGM do you see in your work? Perhaps a monthly/yearly average? Are they 1st or 2nd generation in the UK? How commonly seen if 2nd ?
5. What do you think are the key challenges the women/girls you encounter are dealing with?
   Probe: Physical? Psychological? Social? Due to living in Scotland?
6. What would you say is the key thing you are trying to achieve in addressing FGM/C?
   Probe: Why is this key for you?
7. Who do you think should benefit from your work in addressing FGM/C?
   Probe: Why do you think so? Who else do you think benefits? How?
8. What has been your most challenging experience in addressing FGM?
   Probe: Why was it so difficult? How did you deal with it? What other challenges do you face?
9. What would you say has been your most positive experience in dealing with FGM?
   Probe: What made it good?
10. Are there specific additional resources/knowledge/skill would you wish to have in your work in addressing FGM/C?
    Probe: What would they be? Are they hard to access/obtain?

11. How would you measure success in your work?
    Probe: Is it challenging to get a good measure of success? (Why, Why not?)

12. What, for you, are the key issues surrounding FGM/C?
    Probe: Health, social, cultural, legal? Do you think there are specific issues important for communities in diaspora? In Scotland in particular?

13. Who (which bodies/organisations/people) should be in control of efforts (policy and practice) to address FGM/C in Scotland?
    Probe: Could you tell me why you think so?

14. What aspects of policy and practice should be within their control?
    Probe: Can you tell me why you think this?

15. What aspects of policy and practice should be outside of their control?
    Probe: Can you tell me why you think this?

16. Who/what do you think are your best source of knowledge/skill for your work in addressing FGM/C?
    Probe: Why do you think so? What support do they need to be more helpful to you? What would assure/assures you that their input is good?

17. Do you think those who currently seek to practice FGM/C be allowed to practice some form of female genital cosmetic surgery instead?
    Probe: Why do you think so? What form? Should someone advocate for them? Who?

18. What do you think needs to be considered when reconciling/trying to build bridges between those with differing approaches to FGM/C?
    Probes: Are there particular issues of sensitivity? Unavoidable conflicts?

19. Do you think the language used to discuss this issue is important?
    Probes: To others? To you? Can you tell me why?

20. Do you think there is a role for men in addressing FGM/C?
    Why do you think so? If yes, what role?

21. What do you think are the priorities for other stakeholders in addressing FGM/C in Scotland?
    Probe: Why do you think they have those priorities?

22. Is there anyone else you think I should speak to on this issue?

APPENDIX 10: WORKSHOP 1 SCHEDULE

Workshop 1 Schedule

Notes for moderator:

1. To give tech support to participants with Miro.
2. to do timekeeping for activities

5min: Introductions and housekeeping
20 min intro: use of Miro/Ice breaker
40 min: Rich picture exercise
10 min: BREAK
20 min: Perspective exercise
20min: Context exercise
5 min: round up.
2 hrs: Total

Schedule:

Start

-Welcome.
-Confirm consent for recording.
-Start recording.
-Introduce self, introduce moderator.
-Give purpose of workshop; to explore perspectives, aims, priorities and context in addressing FGM/C in Scotland in order to better understand the situation.
- Invite participants to communicate their perspectives, with respect for that of others, with the ultimate aim of increasing understanding of the situation.
-Remind and reassure participants that they can stop at any time and sit out any questions.
-Remind and reassure participant regarding data privacy and security

-There will be a 10 min comfort break halfway through
-Ask if any questions before starting
-Ask participants to introduce themselves.
Lets get started.

Use of Miro/Ice breaker/warm up exercise

1.We will be using the Miro online whiteboard. Did you have a chance to sign in? Share screen to demonstrate.

Zooming:
In Miro: lower right
Laptop + trackpad: place two fingers on trackpad, pinch and expand
Desktop + mouse: click on any point on the board, use +/- keys
In Miro: lower right
Moving around on board:
Laptop + trackpad: place two fingers on trackpad, move lt/rt
Desktop: click, hold and drag
Follow facilitator using icon at top left.
Pick a sticky note and comment.

2.Stop sharing screen, reassure that they should ask for help is stuck, moderator there to help.

Share the link in chat. (If you get pop up, please ignore)
Share screen again (for recording)

3.Invite participants to start posting on the ice breaker exercise.
Get dialogue going between participants, maybe a laugh about food items

Rich picture exercise:

-Present aims of workshop again:
Addressing FGM/C in Scotland is a complex issue, involving multiple stakeholders, many elements, many viewpoints. It is a challenging issue where the full picture is often hard to see. There is a need for research which brings together the multiple viewpoints present in order to create a better understanding of the wider situation.

Rich picture is: An informal diagram showing the elements present in an issue, and the links between them; including structures, issues, processes, conflicts, emotions.
Here a visual summary of the situation, roles, priorities and challenges. Rich pic not meant to be exhaustive, but to provide a good overview of situation.

Explain that data from interviews were used to create models.

Models therefore include input from stakeholders who may not be present in this workshop. Note that areas in white are stakeholders who exist but were not interviewed.

This is how I see the situation. (Explain the picture)

Feedback invited from the participants.
Have a look, zoom in and move about.
What do you think of the picture? Why do you think so?
About your section, is it a good representation?

Invite participants to answer questions on the left using post its.
Tease out depth and richness by probing into post it comments.
Present the questions one at a time, engage with posts

After penultimate question, give a few minutes for participants to look over everyone's answers
Answer last question: 'Any other contributions?'

BREAK 10 min

Perspective exercise:
Introduce exercise: To build understanding of perspectives present and their possible implications.

Remind that these were perspectives expressed, directly or tangentially by participants who may also not be present here.

Vote on initial questions.
Engage with votes. Interesting…most agreed on one, least agreed on
Present questions one by one to participants.
Interact with answers posted.

After penultimate question, give a few minutes for participants to look at others input.
Last question ‘Any other contributions?’

Context exercise
Introduce the exercise and purpose: To understand where more influence is needed, build understanding of capacities across stakeholder groups.
Not aimed at getting perfect answers but to help think about the issues and where they lie.
Explain context frame.
Explain that in this exercise for ease they will click and drag the challenges to the relevant context area.
Participants from same stakeholder group to work on same board.

Present questions one by one. Engage as they write.
After penultimate question, give a few minutes for participants to look over other’s answers.
Last question: ‘Any other comments?’

Conclusion.
Thank everybody for their time and input
Explain that the insights from this Workshop and from the interviews will be used for the next workshop to find ways to improve the situation.
Hope to see them there.
End recording

APPENDIX 11: WORKSHOP 2 SCHEDULE

FGM/C WORKSHOP 2 SCHEDULE

Notes for moderator
1.to keep timings
2. if necessary to help with tally of votes for selection relevant issues to discuss using the models
3.to help with putting sticky notes of action items on the models and table

Timings:
5 min intro and housekeeping
5 min icebreaker
5 min to explain format
10 min to present issues and models
5 min vote to select issues the group will discuss
40 min issue 1. (20 min discussion of model, selection of critical issues. 20 min tabulating)
BREAK 5 min
40 min issue 2. (20 min discussion of model, selection of critical issues. 20 min tabulating)
5 min round up

Schedule:

Start:
-Welcome
-Confirm consent for recording
-Start recording

-Introduce self and moderator

-Give purpose of workshop: *-To look at stakeholder aims, what activities would be needed to achieve them, and which activities are desirable and acceptable to improve the situation of addressing FGM/C in Scotland*

-Remind that this is a participatory process and you are invited to make your contributions with respect for that of others
- remind and reassure about data privacy
-you are free to stop at any time

-any questions before starting?
-ask participants to introduce themselves

Warm up exercise:
Where in the world would you like to be in just now and why?

Intro:
Review workshop aim: find ways to improve the situation.
Introduce tools:
List of relevant issues; and models depicting key activities for these issues, a table to help guide discussion on critical issues that could be improved
It is impossible to work through all in the given time, we will look at 2-3 of greatest interest to the group

Present the relevant issues and models.

Selection of relevant issues for discussion:

Ask which 3 of these are of greatest interest to participants.
-Which do you think are the most important of these, to you? Do we agree that these would be useful to discuss?

Keep a tally of responses. Highest scoring to be discussed first etc.

Discussion of models:

Prompts for model discussion:

-Do you think this process would actually achieve the purpose?

-Are there problems/challenges with the process? At what step?

-What improvement is required here?

-What activities/tasks would need to be in place in order to achieve the desirable steps?

-Any final contributions?

Prompts for filling in table:

-Do these activities exist already? If yes, who is responsible for them? What is the improvement we are looking for?

-If not, what would be needed to put them in place? Are there resources to support these tasks?

-For the consensus tasks: Which of the other participants think these tasks are worth supporting? To what extent?

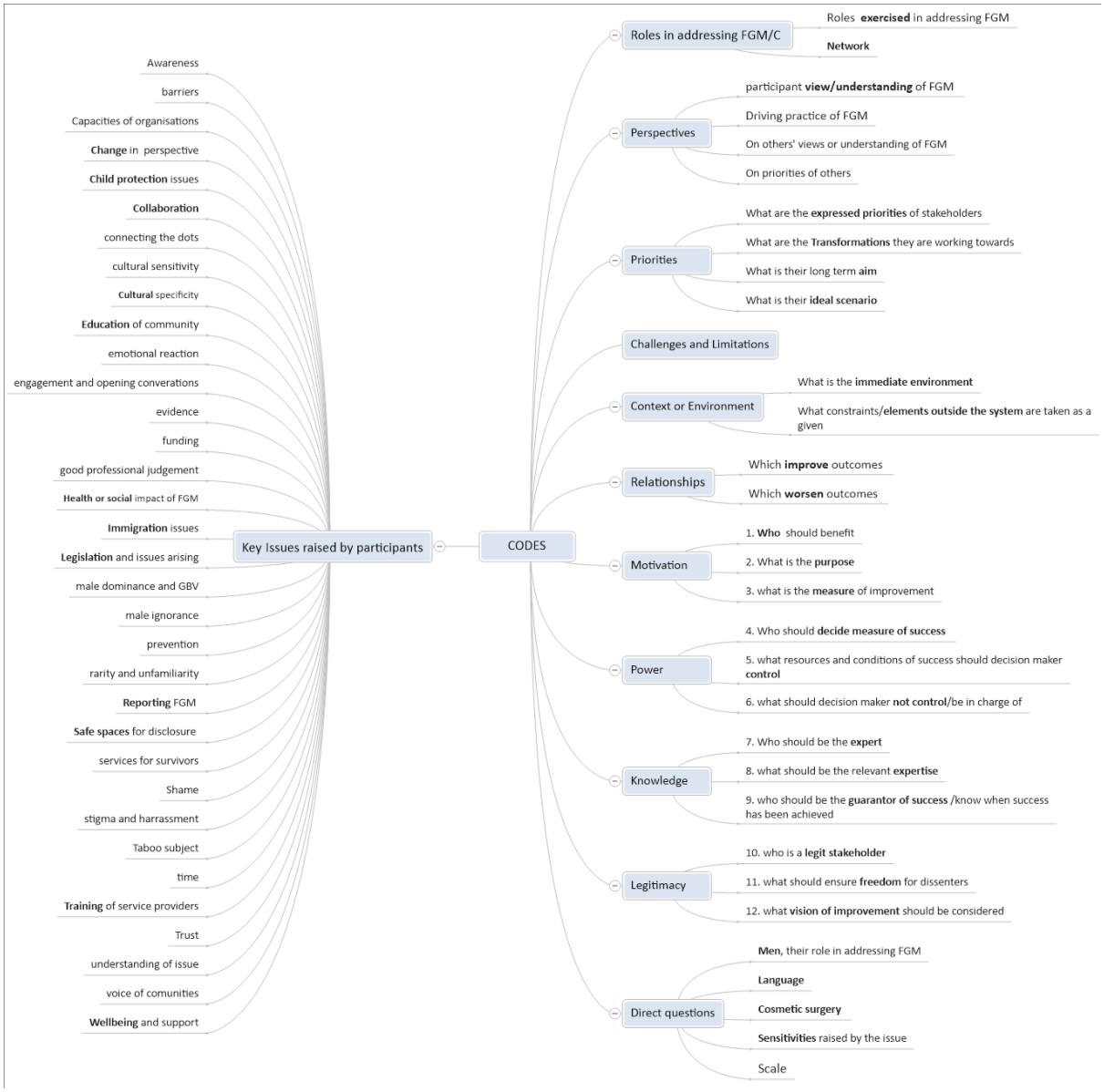
-Any final contributions?

Thank the participants for their time, presence, and contributions.

-End recording

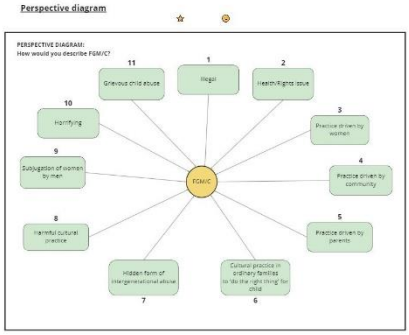
APPENDIX 12: CODING FRAMEWORK

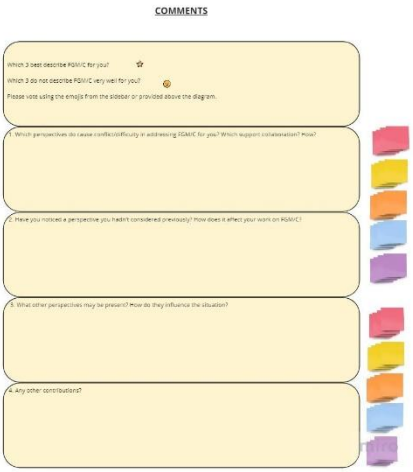
Image of the working coding framework:



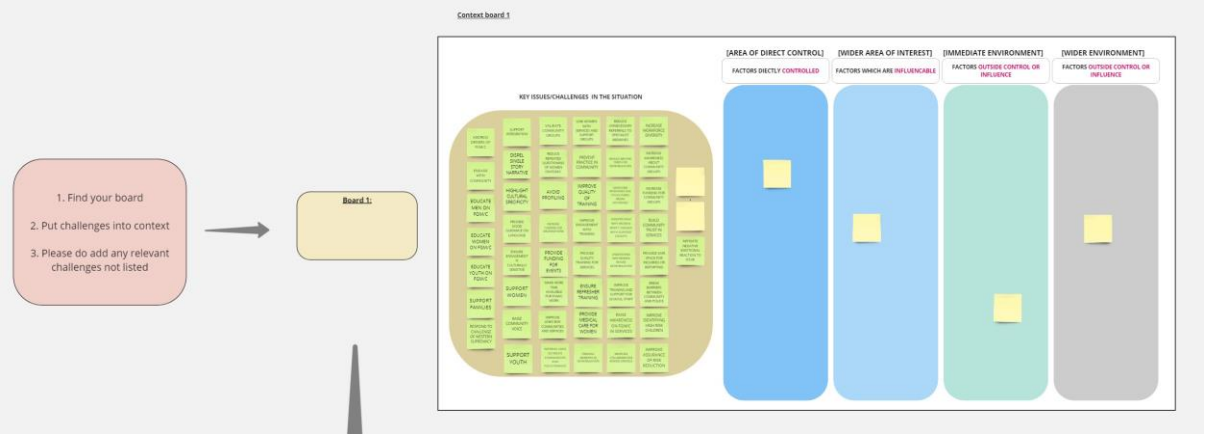
APPENDIX 13: PERSPECTIVE EXERCISE, WORKSHOP 1

The purpose of this exercise is to build understanding of perspectives present, and their possible implications





APPENDIX 14: CONTEXT EXERCISE, WORKSHOP 1



APPENDIX 15: PURPOSEFUL ACTIVITY MODELS 2-10, WORKSHOP 2

(please zoom in)

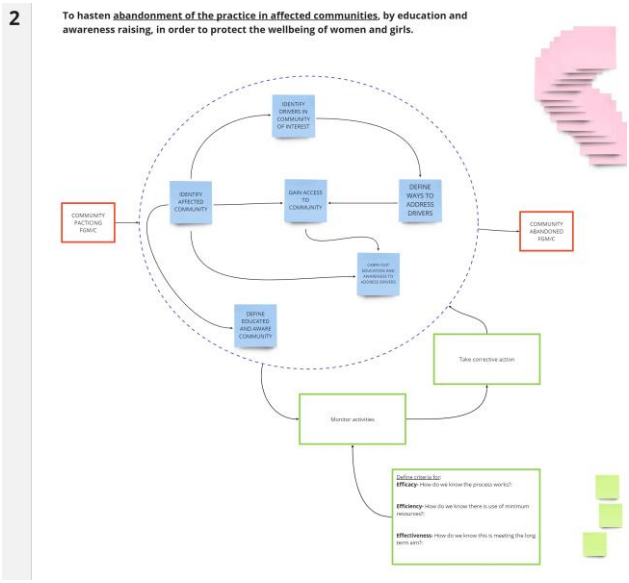


Fig 1. PAM (2) to hasten abandonment of FGM/C in affected communities.

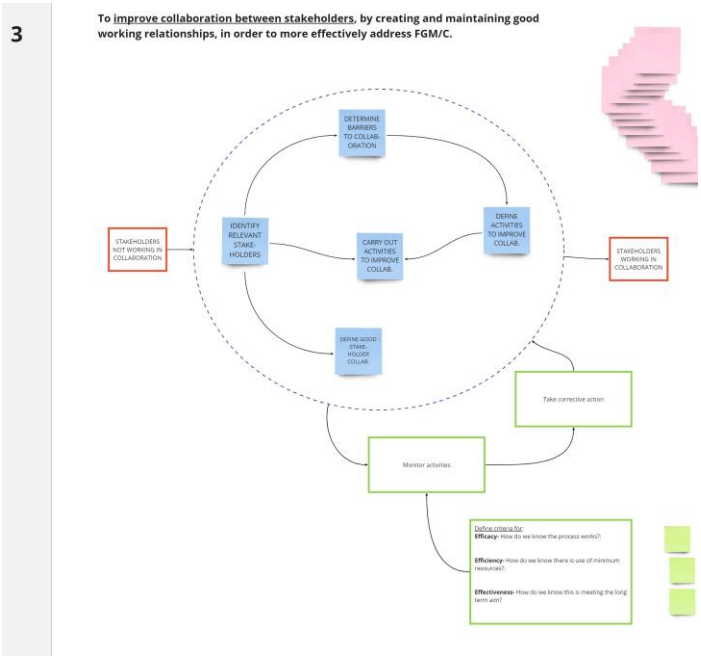


Fig.2 : PAM (3) to improve collaboration between stakeholders

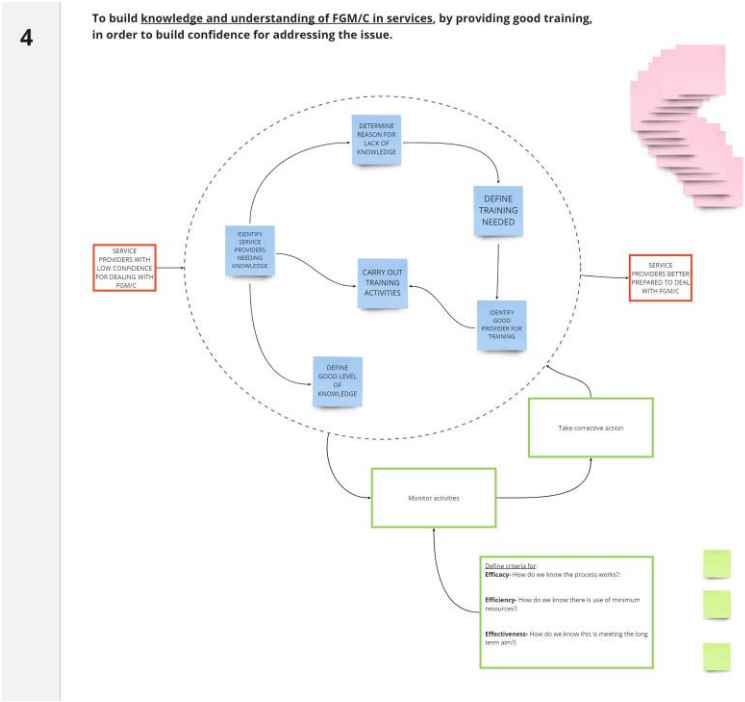


Fig.3 : PAM (4) to build knowledge and understanding of FGM/C in statutory services

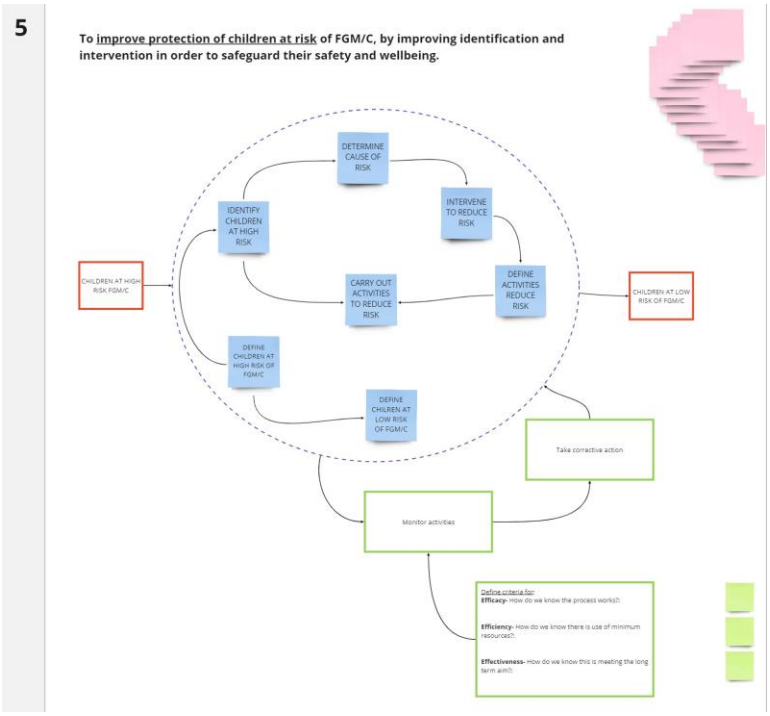


Fig.4 : PAM (5) to improve protection of children at risk of FGM/C

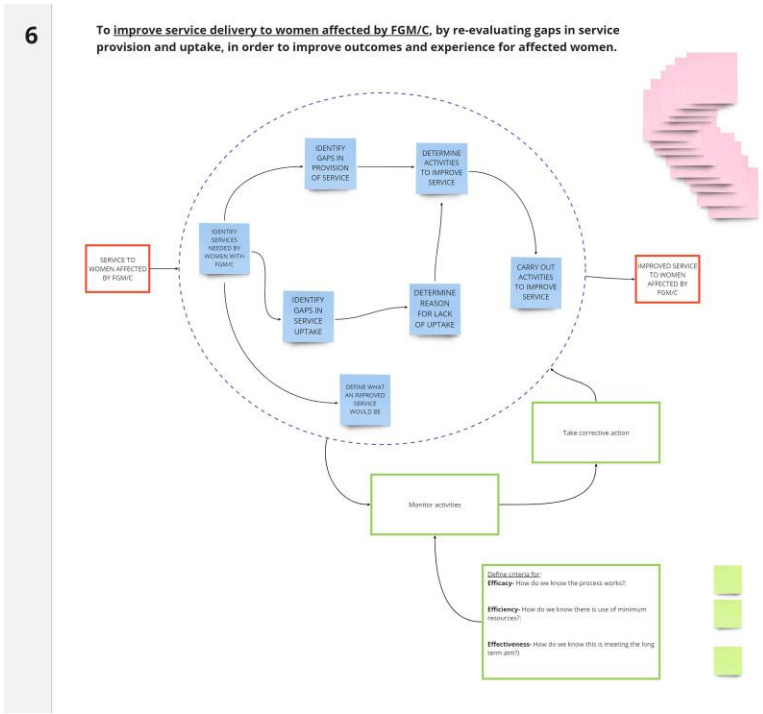


Fig.5 : PAM (6) to improve service delivery to affected women and girls

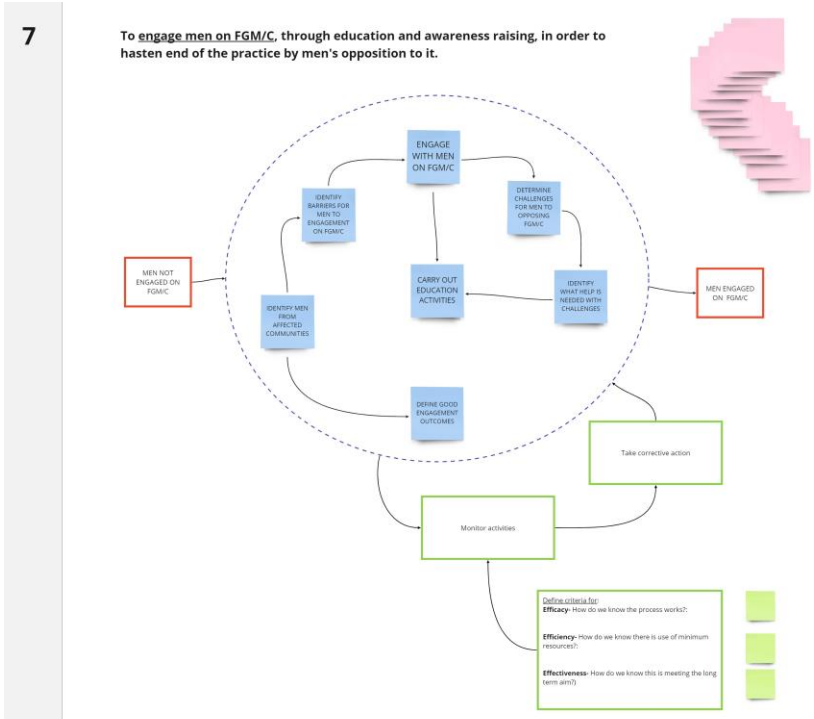


Fig.6 : PAM (7) to engage with men on FGM/C

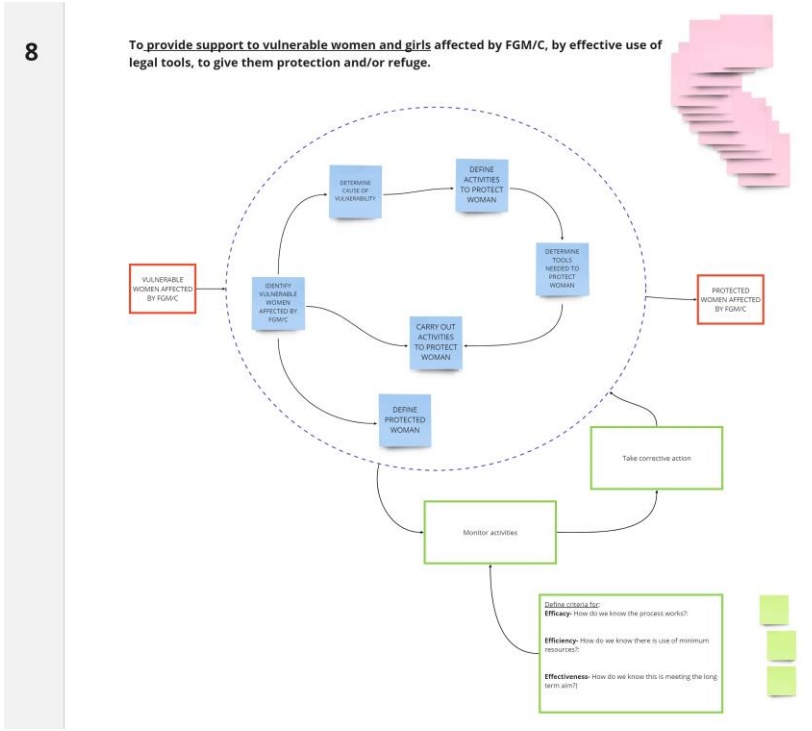


Fig. 7: PAM (8) to support vulnerable women and girls

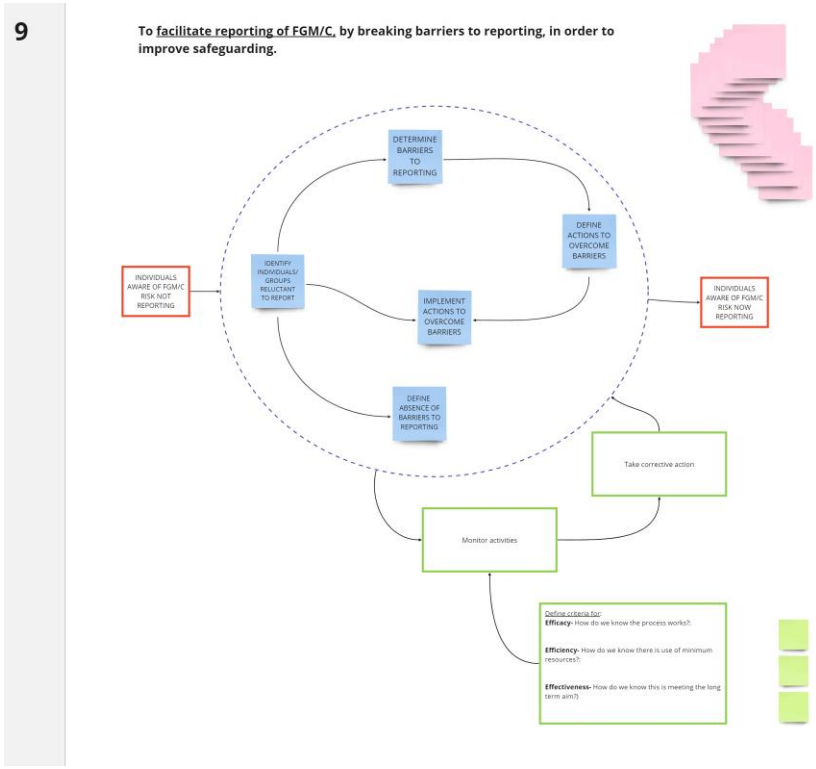


Fig 8: PAM (9) to facilitate reporting of FGM/C

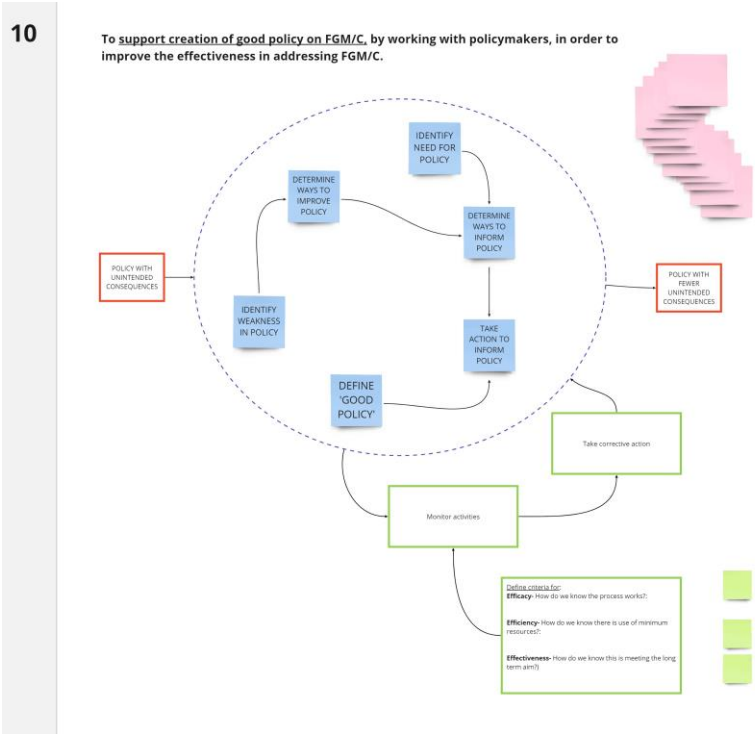


Fig.9: PAM (10) to support creation of good policy on FGM/C

APPENDIX 16: SELECTION OF PAMs FOR USE IN WORKSHOP 2

Selection of PAMs for discussion

The ten models of purposeful activity in addressing FGM/C in Scotland were presented to stakeholders in workshops. Time constraints meant that a selection of which PAMs to discuss had to be made. Each workshop participants chose their top three PAMs of interest, and the two most requested PAMs were selected for discussion. Where there was a tie, participants cast their vote on which option should make the top two.

Offered as a frame of the ideal. Corrections invited. One participant suggested switching the order of two elements in their chosen diagram. This however did not affect discussion of gaps (between ideal and reality) and solutions (how to bridge the gap) as each element was discussed on its own merit.

Models chosen by stakeholders in order of frequency:

MODEL and its focus	**Nr of times chosen**	**Stakeholder groups choosing the model**	**Ultimately selected for group discussion**
1 service access	7	Community 3, NGO, Health, Police, Education	Yes, 2x
4 knowledge	6	Community, NGO 2, Health, Social, Education	No
8 vulnerable W	4	Community, NGO, Health, Social	Yes
5 CP	4	Social 2, Police, Education	Yes
3 collaboration	3	Community, NGO 2, Social	Yes, 2x

7 men	3	Community, NGO 2	Yes
9 reporting	2	Social, Police	No
10 policies	2	Community 2	Yes
2 abandonment	1	NGO	No
6 service gaps	0	-	No

Undiscussed were 4 (knowledge) 2 (abandonment) and 9 (reporting). 2 and 9 were only selected by or 2 stakeholders. These therefore, would fall under multiple perspectives? 4(knowledge) was frequently selected so of high interest to the stake holder groups, but never made it into everybody's top two, so didn't get discussed. This is a limitation/loss.

3 (collaboration) was selected twice. So a consensus choice. However discussion on collaboration made it into all workshops, even where it was not chosen at all, showing it is of high relevance.

Unselected was 6 (gaps in service delivery). Possibly neglected because 1 also covered service provision (access), and therefore overlapped; and/or because it may be more doable to improve access to existing service than to address the shortcomings within a service? (also the model was the first on the list and was used to illustrate workshop format so there might have been a bias towards choosing it.)

Models by workshop:

Workshop	Stakeholder groups present	Models picked by participants	Models selected for discussion by tally	

2a	Community groups	1 Service access 7 men 8 support VWG 4 knowledge 10 policy 3 collaboration	1 service access 10 policy	
2b	NGO Social service Health care	4 knowledge 8 support vulnerable women 1 men 5 CP 9 reporting	8 support VWG 1 service accessible	
2c	NGO	3 collaboration 4 knowledge 7 men	3 collaboration 4 knowledge 7 men	
2d	NGO Education Police Social service	3 collaboration 4 knowledge 5 CP 9 reporting 1 services 7 men 2 abandonment	5 CP 3 collaboration	

APPENDIX 17: CRITICAL SYSTEMS HEIRISTICS 12 QUESTIONS

Table of Critical systems heuristics 12 questions. (Adapted from Ulrich 1996, p.44):

	BOUNDARY JUDGEMENTS INFORMING SYSTEM BOUNDARIES			
SOURCE OF INFLUENCE	**SOCIAL ROLES** *(Stakeholders)*	**SPECIFIC CONCERNS** *(Stakes)*	**KEY PROBLEMS** *(Stakeholding issues)*	
Sources of MOTIVATION	**1.Beneficiary** Who ought to be/is the intended beneficiary of the system?	**2. Purpose** What ought to be/is the purpose of the system?	**3.Measure of improvement** What ought to be/is the system's measure of success?	***The involved***
Sources of CONTROL	**4.Decision maker** Who ought to be/is in control of the conditions of success of the system?	**5.Resources** What conditions of success ought to be/are under the control of the system?	**6.Decision control environment** What conditions of success ought to be/are outside the control of the decision maker?	
Sources of KNOWLEDGE	**7.Expert** Who ought to be/is providing relevant knowledge/skills for the systems?	**8.Expertise** What ought to be/are relevant new knowledge and skills for the system?	**9.Guarantor** What ought to be/are regarded as assurances of successful implementation?	
Sources of LEGITIMACY	**10. Witness** Who ought to be/is representing the interests of those negatively affected by but not involved in the system?	**11.Emancipation** What ought to be/are the opportunities for the interests of those negatively affected to have expression and freedom from the worldview of the system?	**12. Worldview** What space ought to be available for reconciling differing worldviews regarding the system among those involved and affected?	***The affected***

APPENDIX 18: RESOURCE LIST

RESOURCES PROVIDING HELP WITH FGM/C

KWISA Kenyan Women in Scotland Association	KWISA provides support and information for African Women on FGM and other harmful traditional practices www.facebook.com/kwisauk/ www.kwisa.org.uk	4th Floor, Hayweight House, 23 Lauriston Street, Edinburgh EH3 9DQ Tel: +44 (0)131 281 7347 Email: admin@kwisa.org
Saheliya	Saheliya is a BME women's mental health support organisation, based in Edinburgh and Glasgow, and with projects in other parts of Scotland, providing well-being services and practical help to access health services, benefits, housing, legal representation, and learning activities. www.saheliya.co.uk	125, McDonald Road, Edinburgh, EH7 4NW Edinburgh tel: 0131 556 9302 St Rollox House, 130 Springburn Road, Glasgow, G21 1YL Glasgow tel: 0141 552 6540 Edinburgh email: info@saheliya.co.uk Glasgow email: admin.glasgow@saheliya.co.uk
Amina Muslim Women's Resource Centre	Amina works with mainstream agencies to establish the barriers that prevent Muslim women from accessing services and participating in society. They provide direct helping services and community development to Muslim women https://mwrc.org.uk/	Greyfriars Charteris Centre 138/140 The Pleasance; Edinburgh; EH8 9RR 0131 667 9199 1/3 6 Whitehall Crescent; DUNDEE; DD1 4AU Tel: 01382 787 450 Citywall House, 32 Eastwood Avenue, Glasgow, G41 3NS 0141 212 8420 info@mwrc.org.uk
Women's Support Project	Provide information, resources and training on FGM. Glasgow based support group for women	Adelphi Centre, 12 Commercial Road, Glasgow G5 0PQ

	who have had FGM, and can provide information on support available across Scotland www.womenssupportproject.org.uk	Tel: 0141 418 0748 Email: enquiries@womenssupportproject.org.uk
Shakti	SHAKTI WOMEN'S AID provides support, advocacy and information to all black / minority ethnic women, children and young people experiencing or fleeing domestic abuse or forced marriage. http://shaktiedinburgh.co.uk/	57 Albion Road, Edinburgh, EH7 5QY Tel: 0131 475 2399 Email: info@shaktiedinburgh.co.uk
Roshni	Roshni is a registered charitable organisation with offices in Glasgow and Dundee. The aim of the charity is primarily to ensure the safety of children, young people and adults within the minority ethnic communities. www.roshni.org.uk	Baltic Chambers. Suite 339. 50 Wellington Street. Glasgow. G2 6HJ Tel: 0141 202 0608 Email: info@roshni.org.uk
Hemat Gryffe Women's Aid	Hemat Gryffe provides support, advice and temporary accommodation to women and children from the BME community who experience domestic abuse or forced marriage.	Tel 0141 353 0859 Email: womensaid@hematgryffe.org.uk

	https://www.hematgryffe.org.uk/	
Waverley care	Provides support for those affected by FGM www.waverleycare.org	12 Queens Crescent Glasgow, G4 9AS 0141 332 2520, 3 Mansfield Place Edinburgh EH3 6NB For communications and research queries: comms@waverleycare.org For African Health Project queries: ahpglasgow@waverleycare.org

APPENDIX 19: RECRUITMENT DETAILS

Community groups: Contact was made with nine (of which two self-referrals); five were non-uptakes (one interested but unable to participate at this time, one not focused on FGM/C, two had no room for research, one not active). Four recruited.

NGOs: Contact made with nine (two self-referrals); five non uptakes (one no interest, one not taking student research, two no response, one initial interest but then no further response)**. F**our recruited.

Health service: Contact made with nine (of which one self-referral); five exclusions (no response). Four recruited

Social work: Contact made with seven (of which two self-referral); two non-uptake (one not directly involved with FGM/C, one no response). Five recruited.

Scottish Children's Reporter Administration SCRA (Legal service): one self-referral, one recruited.

Police: Contact made with four (two self-referral); two recruited (one lost due to delay in Police R&I permissions), two non-uptakes (one not best placed to assist directly, one no response)

Education: Contact made with seven, six non uptake (no experience of addressing FGM/C). Education R&I permissions for Glasgow were declined due to perception that this was not a good use of staff time.

Policy and Legislation: Contact made with one; zero recruited, (initial interest but then no response)

APPENDIX 20: PARTICIPANT CODING KEY

COM: Community Group

MB: Men based outreach

WB: Women based outreach

BB: Broad based outreach

NGO: Non-Governmental Organisation

STAT: Statutory service

Social: Social care services

Legal: Legal services

Health: Health care services

Edu: Education