How do women who are at risk of Female Genital Mutilation (FGM) experience the asylum process in the United Kingdom (UK)? – A study from the perspective of legal representatives

Accredited Community Research Course

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The student group

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Acknowledgements

I would like to take this opportunity to thank all the legal representatives, who took part in this research. Furthermore, I would like to say thanks to Sarah Elsing who mentored me throughout the research process.

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Executive Summary

This project is designed to explore how women experience the asylum process in the UK as potential victims of FGM. The information obtained will be used as part of the Evelyn Oldfield Unit's (EOU) accredited research report on this topic. The research report aims to raise awareness regarding FGM and the situation of asylum-seeking women in London.

Legal representatives, like solicitors and caseworkers were questioned on this topic. They were questioned regarding the history and situation of their clients who are at risk of FGM in their countries of origin and wish to seek protection by claiming asylum in the UK. In addition to interviews with legal representatives case studies of the respective clients, who have applied for asylum in Canada, USA and Ireland have also been considered.

The findings of this research represent that Article 3 of European Convention on Human Rights (ECHR), which states "No-one shall be subjected to torture or to inhuman or degrading treatment or punishment"[1] does not protect these women who fear persecution in their country of origin. This human right is arguably breached when a female is at risk of FGM against her will. The ECHR is an international treaty, which protects human rights and fundamental freedoms in Europe. Moreover, only a limited number of women who are at risk of FGM have been granted refugee status. The findings of this research signify that this is due to the fact that these women face difficulties in proving the genuine nature of their claim as well as providing sufficient evidence.

Statistics, which have been accounted for, demonstrate that many women are at risk of FGM every year and in order to protect themselves, they seek protection elsewhere such as the UK. However, a limited number of these women are granted asylum, others are either removed back to their country of origin or still remain in the UK but undocumented.

[1] www.echr.coe.int/Documents/Convention_ENG.pdf.

Chapter 1

(i)Central aim and research plan

The main aim of this research is to raise awareness of the asylum situation of women who are at risk of FGM and seek protection in the UK. They fear persecution as by returning to their country of origin they will be at risk of FGM.

In other contexts, the word that people use to describe FGM is 'female circumcision,' but in this research, it will be referred to as FGM. This is because I support the campaigns that view this practice as an act of mutilation and a breach of Article 3 of ECHR.

Legal representatives such as solicitors and caseworkers have taken part in this research in order to provide information regarding their FGM clients whom they have represented, assisted or supported.

I am training to be a solicitor and regularly support immigration solicitors as an interpreter (Farsi) therefore it was not challenging for me to approach these legal representatives. I made contact with the ones which I work with and others I emailed asking whether they have FGM clients and whether they can assist me.

In addition, I work for Refugee and Migrant Network Sutton (RMNS) as an immigration adviser. At EOU, I have been funded by the Trusts of London to carry out this research. I chose this topic as it is immensely interesting and currently very topical.

The chosen research methodologies for this research are interviews and case studies. The latter will describe the situation of specific women in more detail and clarify whether they have been successfully granted asylum in the UK.

RESEARCH PLAN

Sample:

Originally I planned to speak to women affected by FGM, FGM charities, solicitors and a few health specialists.

Timing:

To begin with, I planned as follows:

- Literature review, tool design in the first few months
- Questions to the Ethics panel before Christmas (I then had an exam so had to pause until February).
- I then conducted the analysis and typed up my notes and started the interviews.
- Then submitted my draft in March.

(ii) The purpose of this research

This research aims to raise awareness regarding FGM and the situation of asylum-seeking women in London. Upon completing this report, I wish to share it with different FGM charities (Forward, Equality-Now, Daughters of Eve and Manor Gardens Health Advocacy) as this will enable them to use this as evidence for their campaigns. One of the legal representatives who took part in this research has already asked for a copy of this report in order to support their clients' claim. The report will also be shared with the London Evening Standard Newspaper to support their awareness raising campaigns.

(iii) Background and literature review

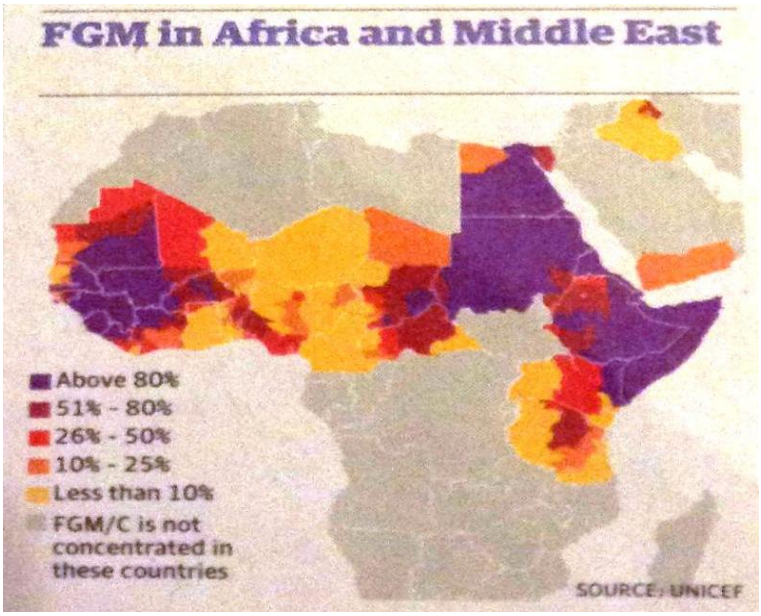
Female Genital Mutilation (FGM) has been defined by the World Health Organisation (WHO) as a procedure, which involves the removal of the external female genitalia or other injury to the female organs whether for cultural or any other reasons. The WHO recognises 4 different types of FGM[2].

Type I involves the removal of the prepuce with or without the removal of part or whole of the clitoris. Type II is the removal of the prepuce and clitoris together with partly or wholly removing the labia minora. Type III involves removing a part of the whole external genitalia and stitching the vaginal opening, which is also often referred to as infibulations. This type is the most extreme form of FGM and makes up 15% of all FGM cases. This type of FGM often involves using silk or thorns in order for the two sides of the vulva to be stitched

[2] Karlene Davis and Christine McCafferty, *Female genital mutilation*, page 6.

together. An overpass of wound tissue is then formed over the vagina, which only leaves a very small opening for the passage of urine and menstrual blood. Type IV includes piercing, pricking or the removal of the clitoris or the labia or stretching of the clitoris and or the labia cauterization or burning of the clitoris and surrounding tissues, scraping of the vaginal or cutting of the vagina and introduction of corrosive substances or herbs into the vagina[3].

According to the WHO, it is estimated that 138 million African women have undergone FGM and more than 3 million women are at risk of FGM annually. About 80% of these women have undergone type I or II[4].



The above map signifies the most FGM practicing countries in Africa.
Source: UNICEF as illustrated by the Independent Newspaper

According to UNICEF, in seven countries almost all women are cut. In Somalia, the prevalence is 97.9%, in Guinea 95.6%, in Sierra Leone 94%, in Djibouti 93.1% and in Egypt 91.1%. In Eritrea, the figure is 88.7% and in Mali, it is 85.2%[5].
The growing international consideration and acknowledgment that FGM is a breach of human rights has been shown in a statement, which was made by the United Nations High

[3] World Health Organisation, (1996) Female Genital Mutilation: An Information Pack, WHO, Geneva.
[4] World Health Organisation, (1996) Female Genital Mutilation: An Information Pack, WHO, Geneva.
[5] www.independent.co.uk/fgm

Commissioner for Refugees (UNHCR). The UNHCR in July 1994 stated that FGM, which causes brutal pain as well as permanent physical harm, amounts to a violation of human rights, including the rights of the child and can be regarded as persecution[6]. The endurance of these performances by the authorities or the reluctance to provide protection against them amounts to official agreement. Therefore, women can be deemed to be a refugee if either her or her daughter / daughters fear they will be forced to undergo FGM against their will, or she fears persecution for refusing to undergo or allow her daughter / daughters to undergo the practice[7].

Furthermore, under the 1951 Convention for the Status of Refugees, a refugee, according to the Convention, is someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group, or political opinion[8]. FGM can be categorised as persecution on the grounds of a person's adherence to a particular social group. The Immigration Appellate Authority's "Asylum Gender Guidelines" illustrate this provision as part of gender-based violence.

However, only a very small number of women have been granted asylum on the grounds of FGM. Many barriers obstruct the protection of women fleeing this violation of their bodily integrity, not least of which are concerns about traditional domination. Other barriers include credibility and the lack of firm evidence[9].

There are almost 20,000 women from FGM practicing countries who claim asylum in the European Union (EU) Member States, including the UK. In 2011 there were 2,410 FGM women who claimed asylum in the UK, however a limited number were granted refugee status. Previously, the Home Office has received applications from Somalia, Gambia and Eritrea, where FGM is very common and practiced the most in these countries[10].

The UNHCR and other similar agencies of the UN have said that refugee status should be granted to women who are fleeing their country in order to escape FGM[11].

[6] Amnesty International (1997) "Female Genital Mutilation and Asylum" in A Human Rights Information Pack, London.
[7] Amnesty International (1997) "Female Genital Mutilation and Asylum" in A Human Rights Information Pack, London.
[8] http://www.ohchr.org/EN/ProfessionalInterest/Pages/StatusOfRefugees.aspx
[9] Kassindja, F (1998) Do They Hear You When You Cry, Bantum Books, London.
[10] Too Much Pain, Female Genital Mutilation and Asylum in the EU (UNHCR)
[11] Too Much Pain, Female Genital Mutilation and Asylum in the EU (UNHCR)

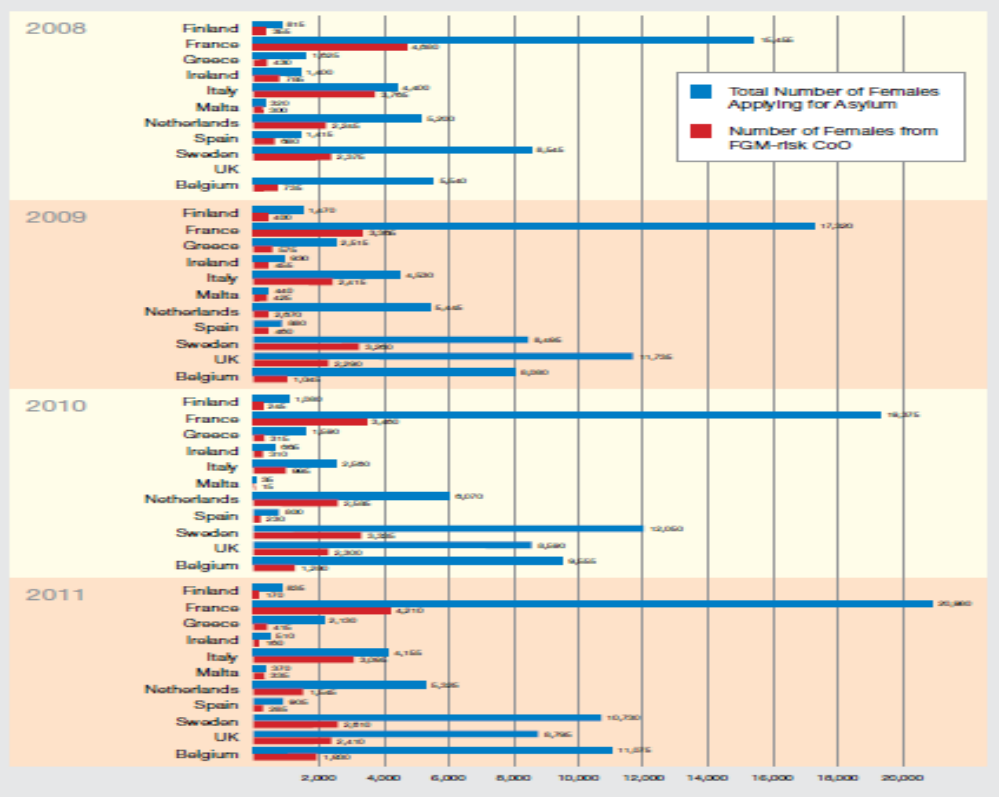
The Home Office reports that there have been successful asylum claims in the UK on this basis where removing the women may be opposing their article 3 ECHR which protects the right to be free from torture, inhumane or degrading treatment[12]. In 2013, over 25,000 women sought asylum from FGM practicing countries, however this number has slightly increased since 2008[13].

Country of Origin	Female applicants 2013*	Prevalence rate**	Estimated number of female applicants potentially affected by FGM 2013
Benin	45	12.9%	6
Burkina Faso	75	75.8%	57
Cameroon	490	1.4%	7
Central African Rep.	130	24.2%	31
Chad	105	44.2%	46
Côte d'Ivoire	605	38.2%	231
Djibouti	95	93.1%	88
Egypt	1,210	91.1%	1,102
Eritrea	4,120	88.7%	3,654
Ethiopia	795	73.3%	583
Gambia	315	76.3%	240
Ghana	355	3.8%	13
Guinea	1,570	96.9%	1,521
Guinea-Bissau	45	49.8%	22
Iraq***	3,480	8.1%	282
Kenya	220	27.1%	60
Liberia	35	65.7%	23
Mali	610	85.2%	520
Mauritania	195	72.2%	141
Niger	10	2%	0
Nigeria	3,655	27%	987
Senegal	305	25.7%	78
Sierra Leone	245	88.3%	216
Somalia	5,635	97.9%	5,517
Sudan	455	69.4%	316
Tanzania	70	14.6%	10
Togo	165	3.9%	6
Uganda	350	1.4%	5
Yemen	160	38.2%****	61
Total	25,545		15,826

Estimated number of women applicants potentially affected by FGM 2013
Source: United Nations High Commissioner for Refugees

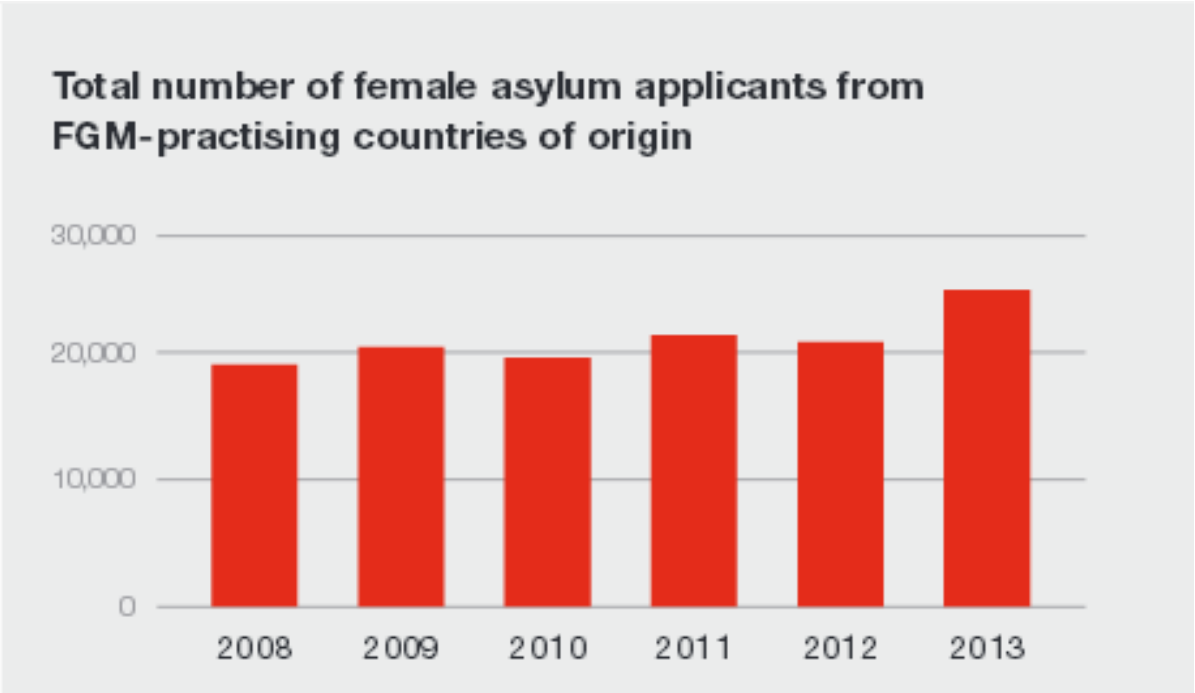
[12] Too Much Pain, Female Genital Mutilation and Asylum in the EU (UNHCR)
[13] Too Much Pain, Female Genital Mutilation and Asylum in the EU (UNHCR)

The above table represents the estimated number of applicants who are potentially affected by FGM in 2013. The table also signifies that Somalia had the highest of applicants 97% affected by FGM in 2013. Nigeria had a rate of 27% and Eritrea equalling to 88.7%. Therefore, during the year 2013 Somalia had the highest number applicants at risk of FGM.



Proportion of women applicants from FGM-risk Countries of Origin to
Total Number of women applicants in top 11 EU Member States
Source: United nations High Commissioner for Refugees

The above graph signifies the total number of applicants from FGM countries who applied for asylum in 11 EU Member States from 2008 – 2011. France has had the highest total number of females applying for asylum consecutively. In 2009, 12,000 applicants claimed asylum in the UK based on FGM. However, the number of applicants applying for asylum decreased in 2010 to 8,000. In 2011, there were around 11,000 FGM applicants. It can be concluded that in 2009 the UK had the highest number of applicants claiming for asylum based of FGM.



Total number of female asylum applicants from FGM-practising countries of origin
Source: United nations High Commissioner for Refugees

In 2013, over 25,000 women sought asylum from FGM practicing countries. This number has steadily increased since 2008. In 2013, these women applied for asylum mainly in Germany, Sweden, the Netherlands, Italy, France, the UK and Belgium[14].
Furthermore, Britain has purpose made laws against FGM but there were no prosecutions until recently in March 2014. France however, has no specific laws against FGM but there have been 29 trials and 100 convictions in the last three decades[15]. This suggests that the UK government does not see FGM as a major issue until recently.

The first UK prosecutions over FGM were announced recently by the Crown Prosecution Service (CPS). Dr. Dharmasena, will be prosecuted for an alleged offence while working at Whittington Hospital in London. His colleague Mr. Mohamed faces a charge of intentionally encouraging FGM. It was alleged that following a patient giving birth in November 2012, a

[14] Too Much Pain, Female Genital Mutilation and Asylum in the EU (UNHCR)
[15] www.independent.co.uk/fgm

doctor at Whittington Hospital repaired FGM that had previously been performed on the patient and allegedly carrying out FGM himself[16].

The CPS said "Having carefully considered all the available evidence, I have determined there is sufficient evidence and it would be in the public interest to prosecute Dr Dharmasena for an offence contrary to S1 (1) of the FGM Act 2003[17]. I am also determined that Mr. Mohamed should face one charge of intentionally encouraging an offence of FGM, contrary to section 44(1) of the Serious Crime Act 2007, and a second charge of aiding, abetting, counseling or procuring Dr Dharmasena to commit an offence contrary to S1 (1) of the FGM Act 2003[18].

The FGM Act 2003 replaced a 1985 Act, in England, Wales and Northern Ireland, raising the maximum penalty from five to 14 years in prison. It also made it an offence for UK nationals or permanent UK residents to carry out FGM abroad even in countries where it is legal[19].

(iv) Case Studies

In addition to interviews which were conducted with legal representatives, case studies have also been considered.

In the case of Khadra Hassan Farah, she was granted refugee status after fleeing her native Somalia with her 10 year old daughter, Hodan, because she feared that Hodan would be forced to undergo FGM if they remained. In this landmark ruling Canada was the first country to acknowledge that FGM is a form of persecution and acknowledged the protection rights of females threatened with FGM[20].

In another FGM and asylum case, Fauziya Kassindja, who fled Togo in 1984 for America, hours before she was to be subjected to FGM. Once in America she was imprisoned by the Immigration and Naturalisation Service. With the support and determination of a young law student a landmark decision was eventually reached, granting asylum to Fauziya and providing hope to others seeking refugee due to persecution on the basis of their gender[21].

[16] www.theguardian.com/uk
[17] www.theguardian.com/uk
[18] www.theguardian.com/uk
[19] http://www.bbc.co.uk/news/uk-26681364
[20] http://www.forwarduk.org.uk/key-issues/fgm/fgm-asylum
[21] Miller Bashir, 1998, Do They Hear You When You Cry, Bantom Books, London.

In addition to the above, a US Court recognised that fear of FGM was a well-founded fear under the 1951 Refugee Convention, granting asylum to an Ethiopian couple and their daughter who the couple feared would be subjected to FGM if they remained in Ethiopia. This decision overturned a previous decision made in 2004 which denied them asylum on the grounds that the panel believed the daughter would not be subjected to FGM without the approval of her parents. The judge who granted them asylum believed that in fact, the girls' parents may be powerless to prevent their daughter from undergoing FGM. He concluded that their fear was well-founded which was enough to grant them asylum, and they were not required to prove that their child was likely to undergo FGM[22].

Furthermore, Ireland has seen multiple cases of women who fled their countries to claim asylum due to fear of FGM and yet to date only two women had ever been granted refugee status on the grounds of FGM in Ireland. Nkechi Okolie arrived in Ireland with her three children. Nkechi had undergone FGM herself and did not want her daughters to also suffer FGM. She feared that if she was returned to her home country of Nigeria her daughters would be subjected to FGM, but the Irish state rejected her appeal on these grounds and in March 2005 they were deported back to Nigeria[23].

Also in Ireland, there has been the case of Pamela Izevbekhai, who also fled her native Nigeria with her two daughters to protect them from FGM. Despite having already lost one daughter to FGM in 1994, when the little girl bled to death at the age of 18 months, Pamela's husband's family were insisting that the other daughters also underwent FGM. In November 2005 Pamela lost her appeal for asylum, and consequently spent the next month in hiding following a deportation order but after a month was arrested by immigration officers. A decision made in January 2006 allowed Pamela to remain in the country until the next step in the legal process, which may result in her being ordered back to Nigeria. Pamela's case was rejected despite evidence that Pamela and her children face danger in their home country. The Irish government claims her children are not at risk in Nigeria and FGM is not specified as a risk in itself, even though both the European Union and the African Union, of which Nigeria is a member, recognise FGM as a human rights abuse and an illegal act[24].

[22] http://www.metnews.com/articles/2006/abeb010306.htm
[23] http://www.anarkismo.net/newswire.php?story_id=840
[24] Nigerian to Plea for Daughters' Asylum,

(v) FGM Health Risk

Immediate consequences of FGM include severe pain and bleeding, shock, difficulty in passing urine, infections, injury to nearby genital tissue and sometimes death. The performance can often result in death due to severe blood loss and the pain imposed by FGM does not stop at the initial performance, but continues as ongoing torture throughout the woman's life according to Manfred Nowak, United Nations Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.
Almost all women who have undergone FGM experienced pain and bleeding as a consequence of the performance. The event itself is traumatic as girls are held down during the procedure. Risk and complications increase with the type of FGM and are more severe and prevalent with infibulations[25].

Furthermore, to the severe pain during and in the weeks following the cutting, women who have undergone FGM experience various long-term effects - physical, sexual and psychological. Women also may experience chronic pain, chronic pelvic infections, development of cysts, abscesses and genital ulcers, excessive scar tissue formation, infection of the reproductive system, decreased sexual enjoyment and psychological consequences, such as post-traumatic stress disorder[26].

Additional risks from infibulations include urinary, menstrual difficulties, infertility, later surgery and painful sexual intercourse. Moreover, sexual intercourse can only take place after opening the infibulations, through surgery or penetrative sexual intercourse. Consequently, sexual intercourse is often very painful during the first few weeks after sexual initiation and the male partner can experience pain and complications.
When the woman is giving birth, the scar tissue might tear or the opening needs to be cut to allow the baby to come out. However, after giving birth, some women from ethnic communities are often sown up again to make them tight for their husband. Cutting and stitching of a woman's genitalia results in painful scar tissue[27].

A multi – country study by the WHO in six African counties, signified that women who had undergone FGM had considerably increased risks for adverse events during giving birth and that genital mutilation in mothers has negative effects in their newborn babies. According to this study, an additional one or two babies per 100 deliveries die because of FGM[28].

[25] http://www.endfgm.eu/en/female-genital-mutilation/what-is-fgm/effects-of-fgm/
[26] http://www.endfgm.eu/en/female-genital-mutilation/what-is-fgm/effects-of-fgm/
[27] http://www.endfgm.eu/en/female-genital-mutilation/what-is-fgm/effects-of-fgm/
[28] http://www.endfgm.eu/en/female-genital-mutilation/what-is-fgm/effects-of-fgm/

(vi) Methodology

In order to conduct this research, interviews and case studies, which are both types of qualitative research, were used. Qualitative research seeks to gather data, which is non-numeric. It provides depth and is associated with small-scale studies, understanding or explaining issues, description and richness in detail, information about attitudes, views and feelings, looking at things in context, stressing relationships and independencies[29].

Interviews are research tools where typically there is an interviewer and interviewee one to one (or there can be more but the emphasis is on one person). He questions can be very structured, semi-structured or unstructured. They have benefits, such as having the opportunity to obtain as much detailed information you require from the interviewee and/or as much information as they are willing to provide. Moreover, interviewees in one on one interview are not influenced by other participants, unlike focus groups[30].

However, interviews have drawbacks as well. They are time consuming, i.e. setting up, interviewing, feedback, reporting, and different interviewers may understand and transcribe interviews in different ways as they place emphasis on different issues[31].

Furthermore, case studies are also used in different contexts, but here they were used as a strategy for research, focusing on one particular or specific case in context. They lend themselves to exploring situations that can be typical, extreme, available, interesting or unique. Case studies focus on one instance, one person, one area or one organisation[32].

(vii) Ethical considerations

Researching the community requires considering what people within the community are saying, regardless whether you agree with them or not. It is essential to formulate the results and the methods of the research available to others, as the researcher is responsible for the collected information. People should only participate in a research, when they have provided their informed consent[33].

[29]http://files.arvac.org.uk/gettingstarted/Section2.pdf
[30] http://files.arvac.org.uk/gettingstarted/Section2.pdf
[31] http://files.arvac.org.uk/gettingstarted/Section2.pdf
[32] http://files.arvac.org.uk/gettingstarted/Section2.pdf
[33] http://files.arvac.org.uk/gettingstarted/Section2.pdf

In addition, community research often involves asking people about their life, experiences or their feelings. However, some research methods will ask more of people than others will. For example, a long one-to-one interview will reveal more about someone's life than a simple and quick questionnaire[34].

When legal representatives were interviewed, I ensured that I had their informed consent prior to commencing the interviews as they were intending to discuss sensitive information relating to their clients.

All data, which, has been recorded and collected, will be kept secure, private, and strictly confidential. There will not be any information in this report, which could identify the legal representative and will ensure all data is presented anonymously.

The data, which has been collected from the legal representatives, will be securely stored following on from the research process and will be destroyed in due course. All data will be passed to the Evelyn Oldfield Unit after the research process has been completed for safe and secure storage.

[34] http://files.arvac.org.uk/gettingstarted/Section2.pdf

Chapter 2: Research findings

As part of this research, 9 different legal representatives were interviewed regarding their FGM clients whom they had either worked with in the past or represented during the asylum process. Interviews are done on a one-to-one basis where the interviewee is asked a range of different questions on a specific topic.

Interviews with legal representatives were all taken face-to-face at their offices. Each interview lasted for about 40 minutes to an hour. The legal representatives which were interviewed were from Duncan Lewis Solicitors, Fadiga and Co solicitors, Bail for Immigration detainees (BID) and Praxis Community Projects.

Interviews

My first interviewee was an immigration solicitor who first met his client, named Grace[35], at Yarlswood Immigration Removal Centre. The solicitor managed to release his client from the Removal Centre by applying for temporary admission on the client's behalf. The client then decided to seek support of this solicitor to assist her with her asylum matter. Grace was born in Nigeria and initially came to the UK on a student visa to study. Close to the time of her visa expiry, her family back home informed her that upon her return she would be forced to undergo FGM. Her family believed that this is a tradition that needs to be performed. She feared persecution by returning to Nigeria as she did not wish to undergo FGM and decided to claim asylum in the UK with the assistance of a solicitor on the grounds of FGM. Under the United Nations Convention, she belongs to a particular social group as she fears persecution based on FGM. She is currently awaiting a decision from the Home Office.

My second interviewee was an immigration trainee solicitor. Bernadette was born in Nigeria and came to the UK on a visitor's visa in order to escape FGM. Her family believed that this is a tradition and a part of their culture and must be performed. She also suffers from a heart condition and has a defibrillator implanted in her body. She has claimed asylum on the basis of FGM as it is prevalent in Nigeria together with the fact that she believes her health will deteriorate. She has had her substantive asylum interview and upon receiving further medical evidence, her solicitor will make further representations in

[35] All names have been changed for the purpose of anonymity and confidentiality.

support of her asylum claim. The Home Office will make a decision on her case once her solicitor has submitted further representations. The client instructed him after a support group who visit detainees at the detention centre referred her to him. She is not receiving any support from the Home Office currently and is only receiving emotional support from her half sister who she is lives with.

My third interviewee was a solicitor who had come across Sarah and her daughter from Malawi when providing advice and support to asylum seekers at 'Surgery' in at a detention centre. 'Surgery' is a service run by the detention centre for the detainees to see solicitors and seek advice without appointments. Sarah and her daughter (Andre) came to the UK undocumented and claimed asylum upon arrival, as they feared persecution based on FGM. Sarah had already undergone FGM when she was young, however, did not want Andre to go through the same procedure. The Home Office refused their initial asylum application on the grounds that they had insufficient evidence. They appealed to the First Tier Tribunal but the judge ruled that the Country of Expert Report is not strong enough and there is no evidence to support that Andre would be forced to undergo FGM upon their return. A Country of Expert Report is a report, which confirms as to whether the client will be at risk of persecution in their country of origin. All reports are written by professionals who belong to institutions either in the UK or oversee. Whilst waiting for a decision to be made, both Sarah and Andre received NASS (National Asylum Support Service). However, both mother and daughter were refused asylum and they were deported back to Malawi.

My fourth interviewee was a caseworker. Misha came to the UK from Sierra Leone without any documents and claimed asylum upon arrival, as she feared FGM. The Home Office refused her initial asylum claim, due to insufficient evidence. She appealed to the First-Tier Tribunal; however, her appeal was dismissed, as the judge believed that there is not sufficient evidence to prove that she is subject to FGM upon her return. My interviewee assisted her and believed that she has the right to be granted asylum under the 1951 United Nations Convention as she had strong evidence and a strong case in the Country of Expert Report. Her case was discussed in the House of Lords and her claim was considered by Baroness Rendell stating that UNICEF and the United Nations have called for asylum status to be granted to these females who flee their country to escape FGM. In the end, she was granted Refugee Status.

My fifth interviewee was a caseworker who had applied for bail for the client to release her from detention initially. Nancy came to the UK from Namibia undocumented at the back of the lorry. She claimed asylum upon her arrival and was detained at Yarlswood IRC. She had escaped Namibia as her family had forced her to undergo FGM and she did not wish to experience this procedure. Both her initial claim and her appeal to the Home office and the First-Tier Tribunal were refused on the basis that there was not sufficient evidence that she

would be subjected to FGM upon her return. She has been detained again at Yarlswood IRC and is awaiting removal directions by the Home Office.

My sixth informant was a solicitor. A mother (Sylvie) and her daughter (Arllette) were both from Sierra Leone. Sylvie had undergone FGM however did not want her daughter to experience it as well. Sylvie and Arllette both came to the UK as student dependants as her husband had obtained a student visa to study in the UK. The client's husband did not believe in FGM and had told his wife's family that he does not wish their daughter to undergo FGM even though his wife's family were very keen as they had strong beliefs for this tradition and culture. Upon living in the UK for a couple of years, the client and her husband divorced and as they were his dependants, they are forced to go back. The client knew that as she is no longer married to this man, her family will force her daughter to undergo FGM and she did not want her daughter to undergo FGM. The client has therefore claimed asylum as she fears persecution based on FGM. The client and her daughter are being supported by the Home office and live in NASS accommodation and receive financial support as they have a pending application with the home office. My interviewee is very positive about this case and believes there is 89% chance of success.

My seventh informant was also a solicitor also. Benasa came here to study on a student visa from Nigeria, but did not want to go back as she knew that she will be forced to undergo FGM. However, she did not know that she can apply for asylum based on her fear of FGM and therefore overstayed her visa for more than 6 years because she was terrified that she will be forced to undergo FGM. She obtained advice and representation from a solicitor and they assisted her to claim for asylum based on her well-founded fear of persecution due to FGM. The Home Office refused her initial claim as they stated that there was insufficient evidence and they argued that, had her family wanted to carry out FGM on her, they would have done it when she was younger and on that basis they refused her. As there were, insufficient grounds in her asylum claim she did not have the right to appeal to the First-Tier Tribunal as the merits within her case were less than 50%. She was removed from the UK.

My eighth interview was with an immigration caseworker. A mother Grace and her two daughters (Anita and Nicole) came to the UK from Nigeria as visitors on a false passport which had been given to them by a Pastor in Nigeria. The mother had already undergone FGM however did not want her daughters to undergo this procedure. They came to the UK to seek asylum. Their initial claim was refused by the Home office stating that from the information obtained in the objective evidence; it was considered that Non-Governmental Organisations (NGOs) in Nigeria were willing to offer protection to females at risk of experiencing FGM. They then appealed to the First-Tier Tribunal and whilst waiting for a decision they were receiving NASS accommodation from the Home Office as they had a

pending application. However, their appeal was also refused and they were removed back to Nigeria, as the judge stated that the mother and her two daughters could relocate internally within Nigeria to Lagos so as to avoid the risk of FGM being carried out.

My ninth interviewee was a caseworker supports and advices vulnerable refugees and asylum seekers. Sarah came to the UK with her two daughters (Eyram and Audrey) and her husband. The families of both the mother and father were very keen for Audrey and Eyram to undergo FGM; however they refused and left the country and came to the UK illegally to claim asylum. They have not yet received their initial decision from the Home Office and are still waiting. She believed that their case has a high chance of succeeding as the rate of FGM in Somalia is extremely high, 97.9% and that they had sufficient evidence to prove that their daughters will be at risk of FGM by their families upon their return. They are currently receiving NASS accommodation from the Home Office.

Chapter 3: Discussion

The findings of this research represent that many women were unsuccessful in their asylum claims and were not granted refugee status by the Home Office, either due to having insufficient evidence or their Country of Expert report not being strong enough to support the clients claim. Many applicants have pending cases and will not be able to work or study until they receive a decision from the Home Office. In addition, the applicants that fail their calm are usually given removal directions and are sent back to their country of origin. Furthermore, even though in theory it is about the client who wishes to receive refugee status in order to be able to stay in the UK, it appears that immigration judges focus more on the country of expert report and other evidence provided by the client. Furthermore, the literature review focuses on the credibility of FGM rather than asylum literature and statistics which show the percentage of women at risk of FGM.

Chapter 4

(i) Conclusions

In conclusion, it is illustrated that millions of women are at risk of FGM and they claim asylum across the EU Member States including the UK, in order to protect themselves from FGM. However, limited number of applicants are granted asylum, the remaining are either deported back to their country of origin or still remain undocumented in the UK. This is because they have insufficient evidence or are unable to prove that their case is of a genuine nature. Furthermore, the governments are not addressing the importance of FGM and how people are affected by it as their human rights are being breached. In addition, NGOs such as FGM charities that are tackling this issue as it is a human right violation have access to a wide range of international and regional mechanisms in order to enable them to combat this practice. Furthermore, the experience of different nations around the world in dealing with FGM reveal that no single approach can eliminate this tradition / culture and that criminal laws such as the FGM Act by themselves will not change people's behaviour and their thoughts against this tradition / culture. In order to prevent parents to send their children back during the summer school holiday, the government will need to and must devote much attention and resource to a multi – strategy approach in order for this to be prevented.

(ii) Recommendations

Recommendations are required in order to enable us to propose the necessary amendments.

Taking into account the psychological needs and cultural identity of the people involved in this performance, government should inform women and men about FGM and discourage them from performing or promoting FGM. Educational programmes on FGM require be expanding and developing as many parents send their children over the summer holiday to have FGM performed on them. Furthermore, doctors should also put together health promotion and counselling sessions against FGM into their work and why it should not be performed. In addition, National Medical Association (NMA) should eliminate public and professional awareness of the damaging effects of FGM and should also instruct

governmental action in preventing the practice of FGM. The NMA should corporate in organising an appropriate preventative and legal strategy when a child is at risk of undergoing FGM. Lastly, legal representatives will need to ensure that the professionals writing the Country of Expert report for the client have sufficient knowledge and can produce a strong report in order to assist the client's case.

(iii) The strengths and limitations of research

I had set out to raise awareness on asylum seeking females through this research and it has certainly been extremely challenging for a number of reasons.

From the outset, when I proposed my research, the Ethics Panel had concerns that the research may not be viable given the research methods proposed. I had planned to interview women who are at risk of FGM, however it proved to be impossible as firstly, and those who were legally represented were unwilling to divulge details about the torture that they had suffered. In addition, I also found that some legal representatives would be unwilling to accommodate my request. I had to adapt my method of research and persuade the Panel that the information would be assimilated by interviewing the legal representatives. They would be providing second hand knowledge about the experiences of their respective clients in the strictest of confidence.

As part of my research, I was collating statistics in respect of women, who had been successfully granted asylum in the UK. I corresponded with the Home Office making a specific request for statistics; however their response provided me with statistics of women who had claimed asylum in general. It was made clear to me that no such statistics were available, which did hinder my research to a certain extent.

However, there were a number of encouraging points which were not so challenging for me to obtain. Accessing a range of useful and helpful journals and articles which I required were on the database of my law school and as I am a member I could easily login and have access.
The interviewees were easily accessible for me as I work with many of them. Moreover, I attended several different FGM forums and obtained useful; information which I used.

In terms of my plan:

Timing

This was ok for me. I was struggling as I had exams and could have benefited from more time. After my first submission, I was granted more time, and then was able to add some more points of interest e.g. an FGM health risk was a later addition.

Tools

The tools worked out well. I did not have any major problems. When I had originally wanted to speak to clients too, a focus group could have been more effective but as the Ethics panel did not allow this, I felt the tools I used were the best choice.

Sampling

Covered in the above.

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