



# LISTENING TO REFUGEE AND VULNERABLE MIGRANT WOMEN OF SOMALI ORIGIN ABOUT THE BODILY AND PSYCHOSOCIAL CONSEQUENCES OF FEMALE GENITAL MUTILATION IN GERMANY

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## Abstract

### Background

The World Health Organization (WHO) states that an expected 200 million women have experienced female genital mutilation (FGM) in Africa. The types of cutting vary depending on the individual's society or location, with four different types presently being practised. The Horn of Africa comprises Somalia, Djibouti, Kenya, Eritrea and Ethiopia, and WHO has listed the following four countries in order of prevalence of FGM practice, with Somalia at 98%, followed by Ethiopia at 92%, Djibouti at 93% and Eritrea at 89% of the female population. In addition to efforts being made to eradicate FGM by WHO, Non-governmental organisations, governments and women organisations, there is also a demand from those who have already undergone this procedure, whether they are in Africa or elsewhere in the world for help with the biopsychosocial consequences of FGM.

### Method

This paper presents the findings of a mixed-method study on the views of a group of vulnerable migrant women with FGM, as well as healthcare practitioners, who consider that there is an unmet demand for better interculturally sensitive healthcare in their adopted country –Germany. The mixed-method study comprised the participation of 48 female volunteers over 18 years of age, recruited with the help of Somali social workers. Using the Metaplan and a quantitative questionnaire, five workshops were conducted in the German towns of Fulda (N=16), Rathenau (N=9), Kassel (N=13) and Berlin (N=10). **analysis**

### Results

The investigation in Germany was conducted as part of MyHealth, which was a larger European project aimed at improving the healthcare access of vulnerable migrants and refugees (women and unaccompanied minors) newly arrived in Europe, by developing and implementing models based on information gained from a European multidisciplinary Learning Alliance. The overall data gathered revealed a high demand for information and attention to the issue of FGM by both the participants and healthcare professionals. The interaction during data gathering is also suggested a transfer of knowledge between the researchers and the participants, with the result that participants felt they had been heard and were then able to engage with the German healthcare system.

### Discussion

The study highlights the fact that the provision of healthcare in the host country can be improved by providing healthcare workers with intercultural communication skills, tools and cultural awareness training approaches. Moreover, these types of interventions could be adapted to help other vulnerable groups in different healthcare systems worldwide, particularly women's issues such as postnatal depression, FGM and menopause.

## Keywords

Female Genital Mutilation, Learning Alliance Methodology, Metaplan, Health Systems, Multiculturalism

### 1. INTRODUCTION

The World Health Organization (WHO) [1] states that an expected 200 million women have experienced female genital mutilation (FGM) in Africa. The WHO has defined FGM as a procedure that “involves the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons” [1]. The types of cutting vary depending on the individual’s culture or location, with four different types presently being practised. WHO has identified the types of cutting as: type 1, consisting of partial or total removal of the clitoris; type 2, consisting of partial or total removal of the clitoris and the labia minora; type 3, consisting of the narrowing of the vaginal orifice with creation of a covering seal by cutting the appositioning labia minora or labia majora; type 4, which consists of all other harmful procedures to the female genitalia, e.g. piercing or pricking [2]. The Horn of Africa is in east Africa, where type 3 FGM has been the dominant practice, and comprises Somalia, Djibouti, Kenya, Eritrea and Ethiopia [2, 3]. WHO has listed the following four countries in order of prevalence of FGM practice, with Somalia at 98%, followed by Ethiopia at 92%, Djibouti at 93% and Eritrea at 89% of the female population [1].

These four types of cutting (or *gudniin* in Somali) are also practiced outside Somalia and even outside Africa and can be found in Indonesia, Malaysia and Europe. 500,000 affected women and 180,000 girls live in Europe [4,5,6,7]. Some researchers believe that this is not a religious custom but is rooted in ancient Egypt [3,8]. The practice is considered to be a cultural practice with an imprecise origin in which the existence of the female gender is considered to be threatening [9,10]. Genital mutilation is also intended to prevent women and girls from being sexually active or even raped and is one of the reasons given to justify making every form of intercourse painful or impossible. In countries like Somalia, rapes have social consequences for the victim such as rejection, stigma and exclusion from society. Sexual assault also goes hand-in-hand with a devaluation of the female gender since the loss of virginity can also mean the loss of a future marriage or ‘marriageability’. Furthermore, in such social systems, girls and women who do not undergo this procedure or operation will be considered impure and unsuitable for marriage [3].

FGM has a range of bodily and psychological effects on women [11, 12], though the literature in general often suffers from methodological problems [13], such as separating the effects of FGM from other traumatic life events in subsequent psychopathological symptomatology. Köbach et al. [14] have addressed this issue and show that women with different forms of FGM display higher levels of post-traumatic stress disorder (PTSD) and dissociation symptoms regardless of their other traumatic life experiences.

Socially, the FGM debate has historically been heated, for example regarding respect for and rights to different ways of living, feminism and the right of women not to be disadvantaged because of their gender [15]. Today it is clearer that generalisations about universal rights or particular rights for one group or another do not work as had originally been thought. The categories of culture and identity are fluid and change daily through the enactment and re-enactment of identities, particularly when people interact with health services [16] as is the case in the research presented here. That FGM is a practice that causes harm to the body and psychosocial wellbeing of a particular group of women in different parts of Africa, Europe and Asia has already been established medically. The issue is to know where and to whom FGM takes place as well as how much suffering it causes, by listening to those who have experienced it and have to live with the consequences.

This study presents mixed-method research findings on the views of a group of vulnerable migrant women with FGM and healthcare practitioners. The study aimed to demonstrate a helpful research pilot study in Germany as part of other pilot research projects conducted in Barcelona (Spain) and Brno (Czech Republic). All the pilots' research projects were part of MyHealth, a more extensive European project to improve the healthcare access of vulnerable migrants and refugees (women and unaccompanied minors) newly arrived in Europe, by developing and implementing models based on information gained from a European multidisciplinary Learning Alliance. Thus, the sections below present the main trends in the literature about migrant women and FGM, the research methods used in the study, including its ethics, the main results, discussion, and conclusion.

### 2. MIGRANT WOMEN AND THE LITERATURE ON FGM

In Europe, and particularly Germany, the FGM experienced by women is mainly among migrants, especially female refugees, many of whom are of Somali origin. Although more than 500,000 girls and women have applied for asylum in Germany since 2012, their ‘integration perspectives’ [17] are not given enough attention. In General, the media still provides mostly negative images of refugees, such as the New Year's Eve nightlife attacks in Cologne [18]. Nonetheless, contrary to the negative media reports, different perspectives on the living conditions of female refugees are discussed in scientific literature. Pfeffer-Hoffmann occasionally emphasises the ‘traditional

understanding of roles' [19] with regard to international migration and multiple forms of discrimination as an obstacle to the integration of refugee women into the labour market [19]. In addition, there are numerous studies which, based on the target group's experience of violence before, during and after the flight, unquestionably call for a 'need to catch up for gender-sensitive analyses' [15,20] and the inclusion of violence protection concepts in reception facilities [20, 21].

Although the need for protection of female refugees was prioritised as a fundamental issue in the resolution 'Refugee women and international protection' by the United Nations High Commission for Refugees (UNHCR) Executive Committee as early as 1985, female refugees, who often flee for gender-specific reasons, have little chance of asylum [22,23,24]. The reason for this is the Geneva Refugee Convention, as it makes no reference to 'gender characteristics' [25]. 'They are often assumed to have just made up their experiences,' says Pelzer from Pro Asyl [26]. The manual presented by the UNHCR refugee commissioner is not only about improving the living conditions and protecting women on the move but also about their 'emancipation within their social environment' [23].

For women, the escape route is usually more dangerous, as they are often exposed to sexual violence. According to Rohr and Jansen, only a few women manage to flee across their own national borders [27]. Refugee women experience 'violence as a cause of flight, as a flight experience and in refugee camps' [28]. Stevens [29] and Schäfer [30] emphasise that specific experiences of violence in the form of sexual assault and 'sex as currency' or 'male protection' by smugglers and people smugglers are not uncommon [30].

'Gender-specific persecution' [31] is still difficult to prove, as it affects very intimate areas of female anatomy and represents experiences associated with shame or taboo. Gender-specific persecution includes forced marriage, domestic violence, 'honour' crimes, forced abortion, female genital mutilation and discrimination based on gender [30, 31]. Female-specific causes of persecution, such as veiling and circumcision or sexual mutilation, widow burning, chemical burns, flogging and stoning due to an alleged and only very rarely proven adultery, are particularly common in the killings of Somali women [27]. In their research, Schouler-Ocak and Kurmeyer show comprehensive 'care needs and recommendations for action' in the areas of language, living conditions, discrimination, health and the overall psychosocial situation of women [21]. At the time, women who had fled from Syria, Afghanistan, Iraq, Iran, Eritrea/Ethiopia, and Somalia and who were still living in refugee camps took part in the 'Female Refugee Study' and delivered detailed knowledge of the challenges in the host country [21].

According to the World Population Review, Somalia, a coastal state in East Africa, has a population of around 16 million [32]. Until the middle of the 19th century, this country, on the northeastern tip of Africa, was considered 'terra incognita' from a colonial European perspective [33]. During this period, from 1896, the country was divided into five regions and ruled by France, Great Britain and Italy [34]. Today the country is referred to as a 'failed state' [33]. From birth, Somali girls are subject to strict gender-specific rules. The lineage of the father or of an entire clan structure is continued through the sons. The life of Somali women is not only determined by but also controlled by their fathers. The birth of a boy is celebrated and viewed as the greatest joy. Girls, on the other hand, are seen as a burden whose role is to serve their fathers and brothers [35]. In Somalia we can describe a gender rule in which women are legally extremely restricted and are responsible for social activities that are then not valued [3]. The genital mutilation practices in Somalia form part of this gender hierarchy and the patriarchal mechanisms of oppression. As a war-torn and stateless country, girls and women in Somalia are considered to be the most vulnerable group; they are raped and try to save themselves in refugee camps. Sexual violence is rarely prosecuted in Somalia [36].

The term 'female genital mutilation' replaced the previous terms such as 'female genital cut' or 'female circumcision' in order to set a clear distinction between female circumcision and the male form of circumcision [37, 38]. FGM is a violation of the human rights of girls and women and, in most European countries, is an illegal practice. It is mostly carried out by traditional circumcisers, who often play other central roles in communities such as attending childbirths. In many settings, healthcare providers perform FGM due to the erroneous belief that the procedure is safer when medicalised [39]. FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue and interferes with the natural functions of female bodies. Health risks increase with the increasing severity of the procedure. WHO [1,2] lists several immediate complications to women's bodies with corresponding psychosocial effects in both the short and long term. In the short term, effects such as severe pain, excessive bleeding (haemorrhage), genital tissue swelling, fever, infections, urinary problems, wound healing problems, injury to surrounding genital tissue, shock and even death are reported. The list of long term consequences includes urinary problems (painful urination, urinary tract infections), vaginal problems (discharge, itching, bacterial vaginosis and other infections), menstrual problems (painful menstruations, difficulty in passing menstrual blood), scar and keloid tissue and sexual problems (pain during intercourse, decreased satisfaction), increased risk of childbirth complications (difficult delivery, excessive bleeding, caesarean section, need to resuscitate the baby) and new-born deaths. For example, the FGM procedure that seals or narrows a vaginal opening (type 3) needs to be cut open later to allow for sexual intercourse and childbirth (deinfibulation). Sometimes genital tissue is stitched again several times, including after childbirth, hence the woman goes through repeated opening and closing procedures, further increasing both immediate and long-term

risks. To this long list can be added psychological and psychiatric problems such as depression, anxiety, post-traumatic stress disorder, low self-esteem and emotional pain.

The reasons why female genital mutilations are performed vary from one region to another as well as over time and include a mix of complex sociocultural factors within families and communities. Some reviews have identified cultural tradition, sexual morals, marriageability, religion, health benefits and male sexual enjoyment [2,40] as factors facilitating the continuation of the practice.

Currently there are many international efforts to eradicate FGM, which are focused on education within communities to prevent it from being carried out [40]. For those women and girls who have already suffered this procedure, there is also a need for medical and psychological attention, as exemplified by the above-mentioned complications. The majority of post-FGM interventions concentrate on medical complications during maternity [41, 42]. However, there are disparities in the efforts to eradicate the practice between low and middle-income countries and high-income countries, such as the USA, UK and Germany, where the practice has been deemed illegal.

There is a general lack of non-maternity-focused care relating to FGM. An attempted meta-analysis of psychological interventions for post-FGM yielded no studies fitting criteria for a randomised control trial [43]. Similarly, across European countries, there is a lack of sexual counselling available to women with FGM [44]. A study of the involvement of national health systems in post-FGM interventions showed that health systems in many countries did not have measures in place to deal with the general bodily-psychosocial consequences of FGM, and this included Germany, which does not currently provide either psychological or sexual counselling for women with FGM [45].

Systematic reviews from the point of view of health practitioners reveal common themes of a feeling of inadequacy amongst health practitioners encountering patients with FGM in their work [46]. Medical practitioners in many different countries were often ignorant of the different forms of FGM, its illegality, and their obligation to report it. Evans et al., [47] identified many difficulties with FGM, including their own lack of education about the medical complications associated with it, overcoming the strong cultural taboos associated with talking about FGM, struggling to maintain professionalism against strong emotions evoked by the encounter with women who have suffered FGM, dealing with the influence of the family (particularly the husband) on the women's healthcare, guidelines relating to deinfibulation, and dealing with requests for reinfibulation after childbirth. Complementary reports were provided by female migrants and refugees with FGM when they reported their experiences with healthcare providers in destination countries. Many reported uncomfortable and humiliating misunderstandings with their medical caregivers because of the FGM, reactivation of the trauma of the original cutting during medical examinations, and the mutual silence of being too ashamed to talk about FGM [42].

Despite the extensive literature, it is difficult to ascertain just one single and simple reason for the existence of this practice. On the contrary, as presented in detail in the introduction above, the literature points to a very complex set of circumstances. The findings presented below to contribute to the worldwide (but particularly European and German) literature on the experiences of female migrants and refugees who have experienced FGM and the need for public health awareness about the issue.

### 3. METHODS

The findings reported here regarding FGM have to be understood in the context of a larger research project named MyHealth [48]. This was an EU-funded consortium of researchers looking into ways of increasing vulnerable refugees and migrants access to healthcare resources in various European destination countries. One major concern of this project was ensuring that the interventions were driven as much as possible by vulnerable migrants and refugees through the overall use of the Learning Alliance methodology. This is a methodology that seeks to attract health service users, in this case, vulnerable migrants and refugees, to the centre by bringing the various stakeholders to listen to their concerns when accessing and being provided with health services [49,50]. MyHealth research data collection and analysis in Germany was approved by the ethics commission of the Charité – Universitätsmedizin, Berlin EA4/185/17.

The rationale for working with female refugees from Somalia was due the lack of familiarity in this region with their needs, particularly regarding FGM issues. The lack of knowledge about this issue in healthcare systems makes it particularly important for healthcare workers to listen to these women and improve their knowledge about both FGM and specialised treatment contact points. Additionally, the Learning Alliance sought for ways to bring some empowerment to these women.

To this end, the research activity was focused on understanding the issues related to FGM experienced by a group of Somali migrants and refugee women in Germany and consisted of a mixed method using five qualitative workshops and a quantitative questionnaire in the German towns of Fulda (N=16), Rathenau (N=9), Kassel (N=13) and Berlin (N=10) in 2019–2020. Somali women voiced their difficulties regarding healthcare access as part of a health needs assessment. The workshop used the Metaplan Technique, an established and effective means of group discussion to reach a shared understanding of an issue, in this case health needs, through visual group discussions.

The Metaplan Technique is considered more engaging and efficient than a focus group due in part to visual aids such cards and posters, which help needs and solutions to be identified.

The second research tool used was a quantitative questionnaire about health status, especially regarding FGM. The general objective here was to work towards eliminating cultural, language, and other barriers barring access to the healthcare system for female refugees and to improve the knowledge and help-seeking behaviour of the target group of female refugees from Somalia. The specific objective was to begin to fill in the FGM knowledge gap in the healthcare system, to which the participants already have limited access due to a number of barriers. The activities were conducted in the Somali language with a social worker of Somali origin.

The interactive workshops and the application of the questionnaire took an average of three to four hours in various locations such as shelters, Space2grow in Berlin, grammar schools in Fulda and Kassel, and a counselling centre for refugees in Rathenau. Specific information regarding FGM presented during the workshop covered the following topics: education about FGM for both men and women, increased awareness of FGM in the healthcare system, obstetrics, saying no to FGM, mental healthcare and women's rights. Facts about FGM, socio-cultural reasons, health consequences, physical (bodily) consequences, psychological consequences, the legal situation in Germany and counselling and contact points, as well as specialised treatment centres, were also covered.

Meanwhile the questionnaire covered socio-demographics and included a tool for acceptance/participant satisfaction with the activities. The main questions were adapted from existing questionnaires such as Attitudes Toward Seeking Professional Psychological Help Scale-Short Form, General Health-Seeking Inventory, Socio-demographics and Tool Acceptance /Satisfaction. Thus, there were a total of 43 items rated on a Likert scale.



The administrative instructions were as follows: 'Please indicate your level of agreement or disagreement with each of these statements. Place an "X" mark in the box of your answer. There is no right or wrong answer. Your responses are anonymous and will not be identified with you in any way.' Additionally, there were three open-ended questions in the tool for acceptance/satisfaction. The anticipated administration time of the questionnaire survey alone was 20–25 minutes. Data was collected with pen and paper and was securely stored in locked files in the offices of the head of the research project at the Charité-Universitätsmedizin Berlin, Germany.



Analysis of the data collected was also related to the two stages. In the first stage, the Metanalysis Technique allowed a general breakdown to identify the main type of barriers or concerns faced by the women according to ideas/concerns, themes, number of participants who agreed and priority. Meanwhile in the second stage the data was analysed using the statistical package R, which facilitates the evaluation of the main responses.

#### 4. RESULTS

The results obtained through the two stages of data collection (Metanalysis and quantitative questionnaire) are presented according to the identity of the participating women, their main needs and the obstacles experienced by them when accessing health services in Germany on the one hand and, on the other, according to the themes of health-seeking attitudes and self-reported acceptance as identified by the questionnaire.




Most of the 48 women across all locations (Berlin, Fulda, Kassei and Rathenau) were married. More than half were living in a shelter or on the floor of their hosts, and one was homeless. All but two of the women were refugees and/or asylum seekers, the two exceptions having been reunited with their families. The mean age was 34. Regarding needs and obstacles faced by these Somalian women, language barriers were their principal concern or theme. Secondly, culture-specific sexual and reproductive health issues, such as female genital mutilation, were seen as an impediment during consultations. Thirdly, healthcare access for them was conditioned by the fact that they did not fully know their health rights in Germany and an illegal status created a fear of approaching the national healthcare system. The first and third identified results here follow international patterns in literature about the vulnerability of female migrants and refugees (the 'feminisation of migration'), for example in countries like Canada [51] and the United Kingdom [52]. The issue about FGM as the second significant result, however, emerged in this specific context as a very particular result for this particular group of women. Breaking the main themes down into more specific sub-themes or ideas, Table 1 shows the most specific ideas and concerns stated by the group, the number of participants who shared the same concerns and the priorities given.

Themes	Sub-themes/Ideas and concerns	What Type of Barrier/Concern seems to be a Priority?	
		Number of participants who agree	Rank of Priority
<b>Language Barriers</b>	<ul style="list-style-type: none"> <li>• Language difficulties</li> <li>• Lack of possibility of learning the language</li> <li>• Lack of Somali speaking staff</li> </ul>	 (13)	I
<b>Sexual and reproductive health</b>	<ul style="list-style-type: none"> <li>• Sexual and reproductive health</li> <li>• Female Genital Mutilation</li> <li>• Stigma/prejudice</li> </ul>	 (10)	II

<b>Sexual and reproductive health</b>	<ul style="list-style-type: none"> <li>• Being male or female</li> <li>• Cultural difficulties</li> <li>• Lack of skills and abilities of some to interpret and mediate interculturality.</li> <li>• Victims of biopsychosocial trauma due to sexual abuse during migration</li> <li>• Difficulties due to religion</li> </ul>	 (10)	II
<b>Barriers in accessing the healthcare system</b>	<ul style="list-style-type: none"> <li>• Self-restriction due to fear of being undocumented.</li> <li>• Stigma/prejudices</li> <li>• Language difficulties</li> <li>• Administrative difficulties</li> <li>• Lack of knowledge of rights to health</li> </ul>	 (5)	III

**Table 1: Barriers/Health needs of Immigrants recently arrived in Europe**

As pointed out earlier, the Learning Alliance methodology emphasises the need to listen to service users along with other stakeholders. In this case, the recommended solutions focused primarily on the training of health professionals and translators in FGM issues as the principal theme for this group of women. Secondly, they proposed language-based communication initiatives such as recruitment of more translators/cultural mediators, childcare so that mothers could go to German classes, the use of non-verbal communication/pictograms [53] as the MyHealth project did during the consultation and providing information in different languages. Thirdly, they recommended the facilitation of bureaucratic processes and healthcare access for the group through informative sessions on rights, raising awareness in the community of the situation in Somalia and the provision of legal advice and support. In addition to the FGM theme, which emerged specifically for this group of women, other themes related to international findings about the migration of women in which the precariousness of their migration status intersects with their vulnerability, dependency, ethnicity, age and class [54]. Of significant note was the participants' suggestion of awareness-raising campaigns among sexual and reproductive health professionals, as well as translators, about FGM. Do these female migrants and refugees feel more able to voice their needs and concerns, in contrast with those who are still in their original locations? The answer is almost certainly 'yes'. Table 2 illustrates the suggestions of the group of Somali women in the Berlin site specifically according to themes, specific ideas and concerns, the number of participants and rank order of the suggestions.

<b>What Solutions Do You Think Will Help to Resolve Barriers/Concerns Previously Selected?</b>			
<b>Themes</b>	<b>Ideas/Concerns</b>	<b>What Type of Barrier/Concern seems to be a Priority?</b>	
		<b>Number of participants who agree</b>	<b>Rank of Priority</b>
<b>Training and Education about FGM</b>	<ul style="list-style-type: none"> <li>• Increase trained personnel in health (mediators, psychologists, psychiatrists)</li> <li>• Create teams that go out in the community to work with men</li> <li>• Have professionals in the field of interculturality with knowledge of FGM</li> <li>• Spread information about FGM and obstetrics</li> <li>• Mental healthcare for woman with FGM</li> <li>• Improvement of knowledge of FGM in obstetricians and translators</li> </ul>	 (10)	I
<b>Facilitate communication to overcome language Barriers</b>	<ul style="list-style-type: none"> <li>• Hire more translators and cultural mediators</li> <li>• Better knowledge of FGM by translators</li> <li>• Provision of childcare, so that mothers can go to language school</li> <li>• Using nonverbal communication</li> <li>• Using pictograms to make things easier to understand</li> <li>• Offer information material in other languages</li> </ul>	 (10)	II
<b>Facilitation of bureaucracy and Access to health system</b>	<ul style="list-style-type: none"> <li>• Accessibility to the health system (at any point)</li> <li>• Facilitate the processing of the health card</li> <li>• Offer more preliminary information concerning rights</li> <li>• Acceleration of the asylum procedure</li> <li>• Increase awareness about the war in Somalia lasting for more than 30 years</li> <li>• Offer counselling</li> <li>• Make lawyers available</li> </ul>	 (8)	III

**Table 1: Metaplan recommended solutions; session with migrant and refugee Somali women, Berlin site**

There were a few Somali women attending the data collection sessions who did not strictly fit our target criteria of less than five years in Germany, which was the main target for the overall MyHealth project. However, it would have been unethical to turn them away, and they shared many of the concerns and characteristics of the strictly defined target group. Thus, in many ways, the main inclusion criteria were reduced to that of being Somali, demonstrating the need for higher flexibility when working with this type of vulnerable group.

While applying the quantitative questionnaire, there was a lot of demand for individual consultation after the formal gathering of the data, adding about an hour to each of the sessions. Thus, the original aim of carrying out a pre-post questionnaire comparison could not be achieved, as many of the women were illiterate and unfamiliar with the questionnaire format. The level of literacy in the native language of vulnerable migrants and refugees needs to be considered when providing services, on top of the language difficulties. Some of the translators had to fill in the questionnaires for the participants in a quasi-interview format. Our results, therefore, represent the post-seminar responses of the women. Some of the women also had to leave the workshop before time because they had to care for their children or husbands. Data collection activities with vulnerable groups also need to include consideration of these daily situations and offer some flexibility. A similar experience, in a research project on post-natal depression among African immigrant women in London, identified the need for the women to be offered support and space to have their babies with them while participating in some focus groups [52].

Because of shame and stigma, some women wanted to speak alone to a doctor and reported problems with German bureaucracy. Others related their stories and their complaints and asked for help. Some women were very concerned about their daughters who were still in Somalia. They were afraid that they would be circumcised, although they themselves were against it. They felt powerless and helpless.

The questionnaire was completed by 48 participants and their health-seeking attitudes demonstrated to whom the women would most likely turn when they need medical or general healthcare. Arranged from least likely to most likely shows that a medical doctor is the most likely person sought in an emergency, followed by a mental health professional. Thereafter, close family and religious authorities are more likely to be consulted. A minority would use helplines and lower utilisation of this resource could represent its perception as a last resort after direct professional and family help, or possibly also reflect the limited likelihood that a helpline is offered in the Somali language.

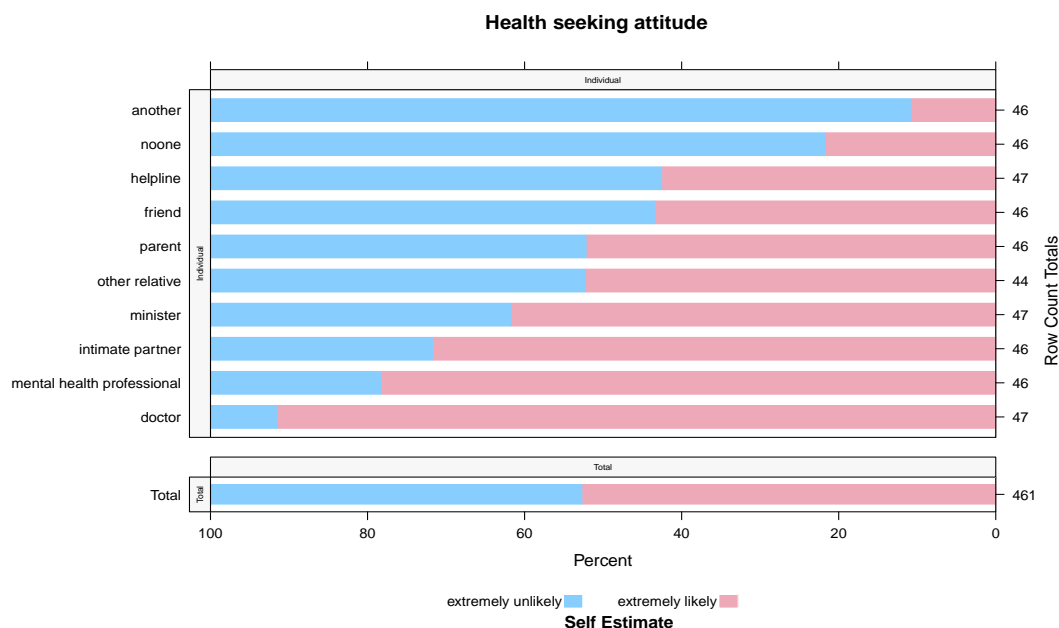
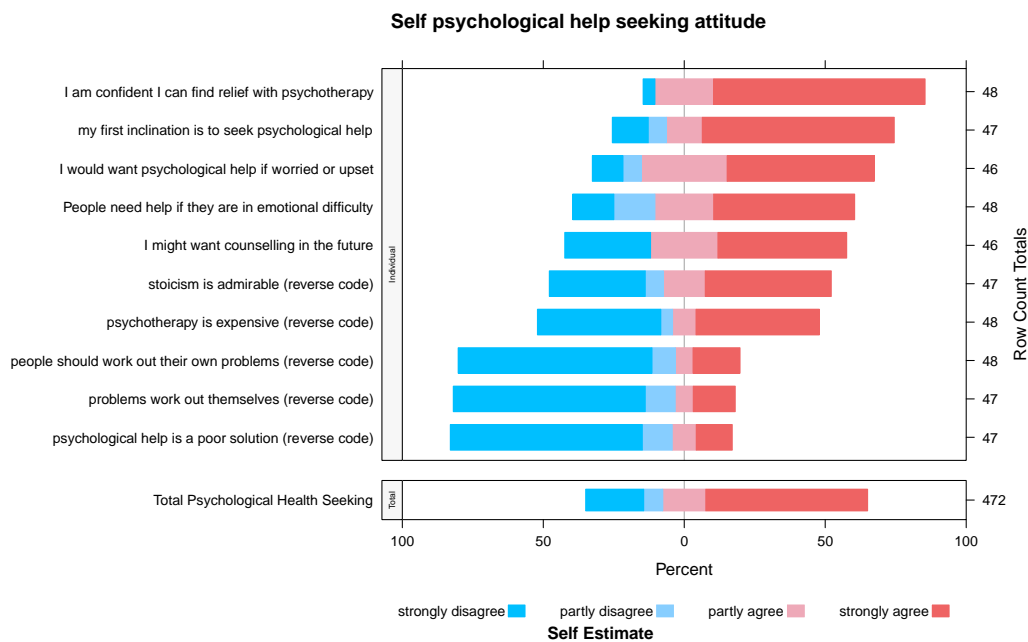


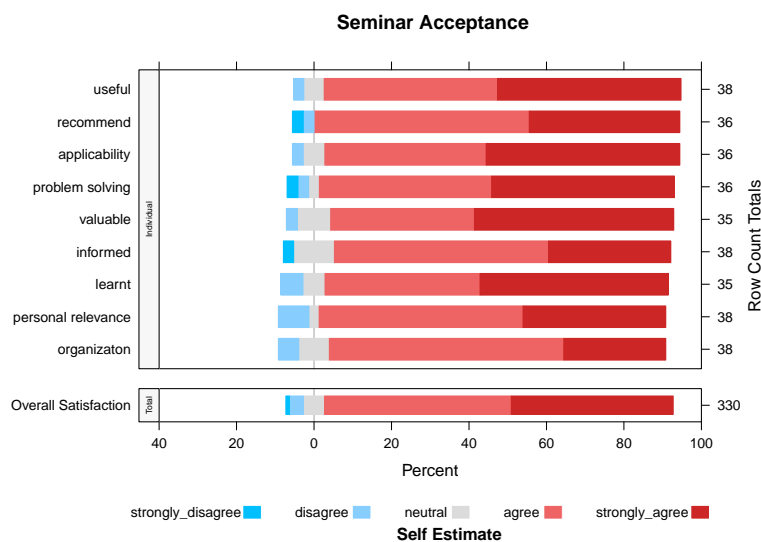
Figure 1 Health-seeking attitudes of vulnerable migrants

To explore the participants’ attitudes towards seeking help for mental health issues, we implemented a questionnaire on attitudes towards seeking psychological help (Figure 2). The overall attitude towards psychological help-seeking was positive, with 73% of responses showing either strongly or partly agreeing with statements validating this behaviour. Responses ranged from 96% being confident of finding relief in psychotherapy, to 79% disagreeing with the idea that psychological help is a poor solution.



**Figure 2 Psychological help-seeking attitudes. Reverse Code indicates questions measuring a negative attitude towards psychological help seeking. These scores are reversed in the calculation of the overall score**

Finally, the quantitative feedback on the activities showed an overall count of 90% positive ratings across all questions, with 5% neutral, and 5% negative. This result is interesting because it shows how vulnerable groups, particularly migrants and refugees, experience these activities in which they are questioned and listened to concerning what they have to say regarding their health and wellbeing. The need for health services to be inclusive by listening, particularly in highly multicultural societies, is not only a priority in Germany but also in other European countries [52]. This comes with an additional need to take a wider approach so that gender, ethnicity, class, religion and sexual orientation and other social considerations are taken into account when providing health services, as they aid appreciation of the complexities of working with groups within groups, especially those facing higher levels of exclusion and health inequality [15,16,49].



**Figure 3 Self-reported acceptance and satisfaction with the research activities**

It is interesting to note that the women regarded the research activities as an opportunity to be heard. They welcomed the idea of this type of seminar, which was oriented to facilitate communication between them and the health professionals. In a similar research project with African immigrant women facing post-natal depression symptoms in London, it was suggested to the health services that these types of activities could be permanent as they are not very costly and can significantly improve the communication of mental health issues faced by migrants and refugees, in the long run proving to be cost-effective [52].



## 5. DISCUSSION

The main results identified in this research demonstrate a full circle. The women involved were able to identify the main barriers experienced when accessing health services in Germany as well as the possible solutions and attitudes. The main barriers identified were language, culture-specific sexual and reproductive health issues, such as FGM, and difficulties accessing healthcare due to their insecure legal status or a lack of knowledge of their rights. Given the opportunity to be heard, they knew what solutions to suggest. They felt that solutions to their problems included training and educating their communities and health professionals about FGM, helping to overcome language barriers, assistance with bureaucracy and improved access to healthcare systems. They were able to demonstrate their attitudes to seeking healthcare, including psychological help, as well as what they thought of the research activities oriented toward listening to them.

As pointed out earlier, the literature [15,16,49] strongly addresses the issue that refugee women are in many cases the most vulnerable because they may be dependent and many do not speak the local language, unlike their husbands or male partners. The 'feminisation of migration' is a term that draws attention to the greater level of inequalities faced by female migrants and refugees.

The issue of verbal language and communication between service users (patients) and health professionals is one that is addressed in health services today through different types of training programmes. However, some critical aspects to be included in the definition of communication is that this includes not only verbal language but also nonverbal (facial/eye expressions), kinesics (body language) and proxemics (the amount of space people leave between each other), as research with older people has demonstrated [54]. Training health professionals to only understand communication in terms of verbal language is limiting and a source of possible conflict and tension when the service user or patient cannot use verbal language or comes from a different cultural background. The need for adjustment on both sides is challenging, and this is something the women addressed when suggesting the use of pictograms, using visual representations of human actions to facilitate communication [53].

Concerning the particular case of FGM, the women consulted showed that this persists as a common practice in many countries in spite of its debilitating bodily and psychosocial consequences and in spite of legal prohibition. In a review of FGM in the Horn of Africa, Gole [2] identified three major themes contributing to the perpetuation of FGM: maximising marriage opportunity by controlling a young woman's sexuality to improve marriage prospects [55,56]; religious and cultural norms (e.g. a rite of passage to womanhood) [56]; and limited education as a result of low socio-economic status [57, 58]. Interventions are frequently aimed at prevention by a focus on health education [59] and education on the medical consequences of FGM is effective in changing attitudes [60]. FGM is a violation of human rights [1], a serious bodily injury and a criminal offence and should therefore be recognised as a ground for asylum, although legal protections offered by EU countries are limited [61, 62].

The research presented here in the context of the Learning Alliance methodology also aimed at empowering these women in managing the negative medical and psychological consequences of FGM by providing them with information about medical and psychological help within the German healthcare system. The collective sharing of information on FGM did help the women to seek available help as well as confront the shame of talking about this sensitive subject openly. Such exchanges could thus contribute to the dissemination of information within communities where FGM is prevalent, and thereby work against the cultural forces sustaining the practice. The testing of such effects requires a larger systematic study.

The strong demand for individual consultation by the women during the data gathering process confirms other research findings that reveal the need for sexual counselling [44] and greater insight into FGM-related trauma [43] in the host states. The women did appear to show dissociative reactions to the occasionally confronting content of the issue. This is supported by the literature, showing a higher prevalence of PTSD and dissociative symptoms in women that is attributable to FGM independently of their other traumatic life events [63]. It is therefore surprising that there is a lack of studies testing interventions for this vulnerable group [43]. A culturally sensitive short-term intervention focused on treating the acute symptoms of PTSD, such as Narrative Exposure Therapy (NET) [30] could be profitably implemented in these groups and has the additional benefit of taking into account other common problems amongst this demographic, such as domestic violence [64].

The gathering of barriers, needs, solutions and attitudes in this paper could, with translation to other specific contexts, be directly adapted to other countries in which FGM is prevalent. More generally, participants were receptive to the dialogical format of the project and the fact that they were asked for their opinions on the problem and its solutions. The themes could be changed to suit the major health concerns of other groups or migrants and refugees, for example, psychoeducation for post-traumatic stress disorder in refugees fleeing persecution. The evaluation of the activities should be simplified to make pre- and post-questionnaire comparisons easier in groups with a low educational attainment, possibly using pictograms to minimise the use of verbal language. The same issues could be measured qualitatively in a discussion round prior to the seminar, and then compared with opinions afterwards. The level of education and literacy of migrants and refugees, including communication practices, plays an increasing part in worldwide research into health service provision to vulnerable

groups [16,49].

In addition, the results have shown a strong need for knowledge transfer and education of the women concerned as well as a need to empower them. It is important in this context to also offer counselling and treatment options. Furthermore, the education of and information transfer to healthcare practitioners is of great importance. They should be aware of FGM and its complications. Mental health professionals should pay particular attention to shame and stigma in dealing with women, and how agency and empowerment contribute to change shame and stigma [16]. FGM should be a part of cultural competence training for mental health professionals. It is particularly important that they are aware of the trauma-related disorders that follow FGM. Working with women who have suffered FGM requires that any interpreter involved also has knowledge of FGM. In multi-cultural societies like Germany, health services need to be more inclusive of diversity to avoid the perpetuation of health inequalities, and the attention of policy maker needs to be drawn to research results like the ones presented here [52].

## 6. CONCLUSION

FGM has been carried out on more than 200 million women in Africa, Asia, and Europe, causing damage to their bodies and psychological wellbeing, regardless of the type of cut with which they are inflicted, for no medical reasons. Somalia, located in the Horn of Africa, has a high percentage of this practice (98% of female population) that affects not only women in Somalia but also those women who have migrated to other countries. The research in Germany formed part of a larger European research project seeking to improve the healthcare access of vulnerable immigrants and refugees (women and unaccompanied minors), newly arrived in Europe, by using the Learning Alliance methodology. The aim of this paper is to present the results of a mixed-method study on the views of a group of vulnerable migrant women with FGM, as well as healthcare practitioners, who consider that there is an unmet demand for better interculturally sensitive healthcare in their adopted country. The mixed-method study (Metaplan and quantitative questionnaire) comprised the participation of 48 female volunteers over 18 years old, recruited through Somali social workers. The data gathered and discussed showed a high demand for information and attention to the issue of FGM by both the participants and healthcare professionals. It also suggested a transfer of knowledge between the researchers and the participants, with the result that participants felt they had been heard and were then able to engage with the German healthcare system. The paper also points out that the provision of healthcare in the host country can be improved by providing healthcare workers with intercultural communication skills and cultural awareness training. Finally, the paper also addresses the fact that these types of research could be adapted to listen to other vulnerable groups in different healthcare systems around the world.

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