Salmon, D., Olander, E. K., & Abzhaparova, A. (2020). A qualitative study examining UK female genital mutilation health campaigns from the perspective of affected communities. *Public Health, 187*, 84-88. doi: 10.1016/j.puhe.2020.07.038

## Abstract

### Objectives

Female genital mutilation (FGM) is a worldwide problem associated with severe health risks. In the UK preventative public health campaigns have been developed to eradicate FGM. The aim of the current study was to elicit the views about FGM public health campaigns from the perspective of a UK Somali community.

### Study design

Three focus groups and one interview were conducted with 16 community members.

### Methods

Using posters and leaflets focused on UK FGM prevention, photo-elicitation was employed to encourage participants to discuss the usefulness and implications for national public health messages aimed at eradicating FGM. Data was subjected to inductive thematic analysis.

### Results

Participants were positive about the aims of the campaigns presented within the research believing such campaigns were necessary and increased awareness of FGM. However, participants felt the campaigns also carried risks of enhancing stereotypes in terms of ethnicity, gender and religion. For example, some images were perceived to suggest that FGM was only relevant to Sub-Saharan women, though it is also prevalent in other populations. Some fathers reported feeling unfairly targeted in campaigns that focused on the role of mothers in protecting daughters from FGM. Participants were also concerned that some poster images may suggest that FGM was associated with Islam and perceived as a religious issue, rather than a cultural one. Fears were identified that this could lead to stigmatisation and hostility towards those affected.

### Conclusions

The research findings suggested that actively working with affected communities to develop

messaging that counters negative stereotyping and associated hostility should be a priority.

**Keywords;** Female genital mutilation, female genital cutting, stigma, poster, public health, qualitative

**Highlights**

- Public health campaigns often focus on eradicating FGM using a range of messages for targeted audiences.
- From the perspective of affected communities' campaigns are seen as necessary and important in awareness.
- Some campaigns potentially reinforce stereotypes in terms of ethnicity, gender and religion.

  Working with affected communities to produce appropriate messaging within campaigns is needed to maximise their effectiveness and prevent stigma and hostility towards those affected.

## Introduction

Female genital mutilation (FGM; alternatively known as female genital cutting, FGC) refers to a procedure involving injury to or partial/total removal of the external female genitalia for non-medical reasons The World Health Organization (WHO) classifies FGM into four types, ranging from partial or total removal of the clitoris (type I) to infibulation (type III). Type IV includes all other procedures including pricking and piercing.[1] Worldwide, it is estimated that over 200 million girls and women have undergone FGM, mainly in African, Middle Eastern and Asian countries.[1] However, with increasing international migration FGM exists globally and not only in traditionally practicing countries. Education and prevention of FGM is an international issue affecting communities worldwide.

FGM has no health benefits and is instead associated with physical ill-health such as increased risk of infections and obstetric problems,[1] and mental health problems, such as post-traumatic stress disorder.[2] Worldwide a number of strategies have been implemented in an attempt to abolish FGM, including making the practice illegal in a number of countries including the UK. Additionally, numerous local and national health promotion efforts have been implemented.[3] Providing information about the health risks associated with FGM has been the most common approach towards eradicating FGM, with mixed results.[4] Whilst it is now acknowledged that health information is likely to be insufficient to change the practice on its own, it is still a key aspect of interventions.[4] Thus, the aim of the current study was to explore, using a qualitative approach, the views of individuals from an affected community in the UK on the usefulness and potential impact of a number of public health messages aimed at eradicating FGM.

## Methods

The consolidated criteria for reporting qualitative research checklist[5] has been completed and can be found in additional information.

### *Participants and recruitment*

This study was conducted in the South West of England, in a city with relatively high rates of FGM; 14.8 per 1,000.[6] The aim was to recruit participants from communities who had been targeted by FGM campaigns. Recruitment was done via six local community groups. These community groups were part of the authors' research networks. Participants had the researchers and the research introduced to them initially through community workers and then the researchers themselves. All participants were given information sheets, made available in Arabic, English and Somali, although all focus groups were conducted in English. The information sheets outlined the aims of the research, and how the research would be conducted including issues of confidentiality and right to withdraw, researchers also explained how the outcomes of the research would inform public health educational initiatives going forward. Consistent with purposive sampling techniques, the target population was recruited to represent a range of ages and ethnic backgrounds. Nevertheless, it was a challenge to recruit widely and those who volunteered were all from within the Somali community. Whilst it is often older women in the family deciding on whether girls should undergo FGM,[3] men's views are also important as they too can either prevent or support the practice.[7] Consequently, three groups from the community were recruited – mothers, fathers and young women. The aim was to also interview young men, but none volunteered, potentially believing the topic was not relevant to them, or viewing it as an embarrassing topic to discuss. Young men's views remains an area to be explored in further research. Sixteen participants took part in the study. Four mothers who were meant to attend were unable to do so due to childcare responsibilities and family commitments. Focus groups were

held with seven mothers (1-7 children, 4-10 years living in the UK) and five fathers (2-6 children, 7-11 years living in the UK). Four young women (aged between 17 – 20 years) also participated (no children, 3-18 years living in the UK), three of them in a focus group, and one young woman in an individual interview. All participants were of Somali descent and interviewed once.

***Procedure***

Focus groups were conducted by two experienced female qualitative researchers (first and third author) and set in community venues, where privacy could be maintained and participants felt familiar and comfortable. One researcher was white British (DS) and the second (AA) described herself as a member of an ethnic and religious minority identifying as Muslim from Kazakhstan. DS had a long career in young people's sexual health practice and research, and AA in health inequalities within Black Asian Minority Ethnic communities. Both interviewers had PhD's at the time of the interviews, both working as academics within higher education. The focus group/interview questions centered on collecting participants' views on different types of FGM campaign materials (posters and leaflets). These were chosen as they articulated a number of dominant themes within current UK FGM campaigns. These materials focused on the criminalisation of FGM (West Midlands Police and Crime Commissioner); appealing to mothers to protect their daughters from FGM (National Society for the Prevention of Cruelty to Children); information and help regarding FGM (local National Health Service) and the representation of FGM as a form of child abuse (Home Office, Department of Health and Department of Education). All four campaigns focused on readers taking individual responsibility for preventing or reporting FGM, and as such centered around informing individuals what to do. This is in contrast to other health education which may focus on building confidence or developing skills.[8]

The campaign materials acted as triggers to facilitate a discussion with participants and develop an in-depth understanding of the socio-cultural context in which the public health messages about FGM were understood. This process enabled participants to expose aspects of the campaigns they found to be uncomfortable or rarely discussed. Questions focused around five areas of meaning outlined by Johnny and Mitchell[9]

**Surface -** What do you think of this poster/leaflet?
**Narrative** - What does this message tell you and how does it make you feel?
**Intended** - Who is this message is directed at and what is its intention?
**Oppositional -** What are the implications of this message?
**Ideological** - To what extent do you think the community would take on the messages and what are the wider implications (social, cultural, or political)?

Focus groups and the interview took between 60-90 minutes and were digitally recorded and professionally transcribed, supported by field notes to provide context during data analysis. Ethical approval was received from the XXX [redacted for peer review]. All participants provided written consent ahead of data collection.

***Data analysis***

During the focus group with mothers, a small number of participants did return to speaking Somali. Whilst other participants translated on their behalf, a qualified Somali translator was also employed as part of the data transcription process to ensure that all data was accurately captured. While the researchers offered to return transcripts to participants, this was not taken up, consequently none were returned to participants for comment/correction. Thematic analysis within a realist paradigm was chosen. This included analysis using an inductive approach, where identified themes were linked to the data.[10] The data was analysed by all three authors using the following steps; firstly, all transcripts were read once to enable the authors to become familiar with the data. Secondly, the transcripts were read again and initial themes were identified and noted. Thereafter themes were refined by comparing the text included and excluded in each theme, before the essence of each theme and subtheme was identified. Data saturation was considered to be reached when new no new themes or sub-

themes were identified. To ensure participant anonymity, quotes are attributed to a participant group (i.e. mother, father, young women) not individuals, nevertheless extracts were drawn from across the range of participants taking part. Data saturation was considered to be reached when no new themes or sub-themes were identified.

[Insert table 1 here]

**Results**

Participants reported that the posters/leaflets raised awareness of FGM and its associated health risks and illegality. The participants also agreed that such materials should be available in affected and non-affected communities to foster collaborative working to eradicate FGM. Two young women told us:

> *Not a lot of people are aware of it even though it's a huge problem, not a lot of people are aware of it because ask a couple of people do you know what FGM is? And they are like I know it stands for something but what is it? They are like I don't know what it talks about to be honest so they don't know the knowledge what it's all about so I think one of these leaflets kind of helps… (Young woman)*

> *Not just the affected one I think all the communities needs to actually be aware of it, discuss about it and actually put steps forward to actually stop this... (Young woman)*

However, a number of concerns were raised regarding the written and visual information on the posters. These concerns focused on *past* practice within communities being seen as *current* practice, and *whom* the posters suggested were the perpetrators of FGM, which included misconceptions about ethnicity, gender and religion. This is the focus of four themes

highlighted below under the headings of: 'Nobody circumcises nowadays'; 'Not just an 'African problem'; Are Men behind FGM? and 'Nothing to do with religion'. Taken together they suggest how the resources built upon pre-conceived views of race and religion and could contribute to the stigmatization of the target population. The final theme 'Talking to the community, not about them' are findings that explore how the active involvement of affected communities would recognize and harness their positive contribution to campaigns, and improve outcomes.

***'Nobody circumcises nowadays'***

This theme centres on the participants view that FGM does not occur in the UK and it was an outdated practice. While participants recognised that FGM may still happen in some African countries, it was reported as rare in their (i.e. Somali) communities and generally not believed to occur in the UK. However, it was felt that this change in attitudes and practice towards FGM in affected communities was not recognised by wider British society, leaving some participants concerned that the posters continued to perpetuate the view that women in these communities in the UK were still at risk of FGM.

> *... I have 100 friends who have got children who are young girls and none of them ever told me that they were going to do it. (Father)*

> *If the white British see the posters it is embarrassing for us – people are now emancipated and nobody circumcise their daughters nowadays (Translator, Mothers focus group).*

***Not just an 'African problem'***

This theme concerns the idea that FGM only occurs in Africa and in Africans, potentially leading to women from other ethnicities not being identified as at risk. The participants believed that some of the poster photographs and images used showing women of African descent, suggested that FGM was an African or Sub-Saharan issue, although FGM is also prevalent in many other countries. It could suggest that those developing the resources were unaware of who is at risk of FGM.

> *No but I would say this one it's just like showing their face, revealing the identity who these people like the people who practice it like African community where it could be practice people from Arab or an African... (Young woman)*

> *I have got one issue which caught my eye when I first looked at it and most of the pictures I have seen within FGM it portrays that it's a sub Saharan African problem and it's not the major problem of FGM comes from... the roots of the problem is in Egypt and you never see you know Egyptians pictured here. (Father)*

By failing to depict images from a variety of ethnicities and populations, participants were worried that concern would focus on Sub-Saharan African girls only, leaving girls from other ethnicities who may be at risk of FGM, to be hidden and unprotected. Two young women told us

> *Other people that actually go through this that might go under the radar, for example if I'm a white British teacher right I might have... a class of like 30 children some of them are ethnic minority I would assume it will be those African girls might go through this... (Young woman)*

*...background yeah so those people like you know Asians like they would go under the radar so they are thinking like that this doesn't affect them I mean so yeah so... (Young woman)*

***Are Men behind FGM?***

This theme presents results on how the role of mothers and fathers are sometimes contrasted within the public health campaigns. The NSPCC poster which stated 'Be the mother who ends female genital mutilation in your family' prompted all participants to discuss whose responsibility it was to prevent FGM. Some fathers suggested that these posters implied fathers were responsible for making decisions on FGM, and possibly supported the practice.

*Those who are outside of the affected communities and know little about FGM might think that the mother is protecting their girls from us, the men, the fathers. (Father)*

Other participants highlighted that some campaigns implied that the perceived oppressive nature of Islam towards women, led fathers to dominate decision making within family life, including decisions about FGM:

*I don't know because they think that Muslim women are oppressed you know men can do anything to the women, men are dominating you know all these stereotypes and they think like ok that's it it's just like our it's for Muslim women so it's very important to say it's not a religious thing it's a cultural thing... (Young woman)*

In contrast, participants also discussed the dominant role of female family members in decision making, indicating that the opinions of men within the family were not always

considered. It was suggested that FGM was not practiced in England largely because those family members promoting FGM live outside England and this lessened their influence.

> *The mother is always involved because you would know like this wouldn't happen to your child without your permission at the end of the day so in a way like if you are involved a lot, a little you would know about it. (Young woman)*

> *...the people who move to Europe or American it's (FGM) still less because those families' structures are not the same they are not extended families granny or mother-in-law are not around. (Father)*

***'Nothing to do with religion'***

This theme centres around religion and its assumed associated with FGM. Despite not being explicitly mentioned within any of the posters/leaflet, all participants discussed Islam in relation to FGM. Participants reported being aware that FGM was not a requirement of Islam, but rather an 'old fashioned' practice embedded in culture. However, it was recognised that individuals from non-affected communities still associated FGM with Muslims, enforcing stereotypes.

> *... for instance, most of the people here in UK think FGM is a Muslim issue and it's not (Father)*

> *This is sin and our religion does not allow it (Translator, mothers focus group)*

*FGM is nothing to do with religion it's more like a culture thing so it depends where you come from you know it's nothing to do with religion because there's some people that are... like automatically people would think that it's all about only Muslim people that would practice FGM. (Young woman)*

Consequently, there was a worry amongst the participants that the materials could contribute to labelling Muslims as individuals that are at risk of FGM.

***'Talking to the community, not about them'***

This last theme focuses on participants view on how to best develop resources regarding FGM including how to eradicate the practice without creating stigma. The potential labelling of individuals worried a number of participants, who expressed that this combined with a lack of consultation with their communities created stigma, and misunderstandings about their culture and community.

*... but there is no dialogue between the community and whether it's our police or local council there is no dialogue and we should not talk about the community we should talk to the community um unless we talk together we can't defeat this FGM but if we but if we put stigma on to the community they are from that undermines the efforts. (Father)*

In particular, messaging that focused on criminalisation using symbolism such as 'a bloody hand' surrounded by red-coloured words, including 'crime,' 'illegal,' and 'prison' were perceived to undermine the agency of affected communities. This appeared to ignore their own collective efforts to end the practice in terms of education and campaigning from within

the communities themselves. This raised questions about where authority lay. Fathers, believed authority lay with local community leaders:

> *What I do not see here is awareness about community efforts, the role of the community leaders in tackling FGM. Instead, affected communities are being talked about and not talked to' (Father).*

Giving voice to religious leaders was also articulated as important particularly from the perspective of the mothers and daughters. Imams were a trusted source of guidance within communities, and were able to influence attitudes within the communities they serve or represent. Young women reported needing support from religious leaders to help persuade the older generation that FGM was not required by religious doctrine.

**Discussion**

This qualitative study with individuals from a Somali community identified a number of important factors to consider when designing and disseminating public health campaigns targeting FGM. Overall, the campaign materials were well received by participants and seen to raise awareness. However, there were strong suggestions that greater cultural sensitivity and collaboration with the affected communities is needed to ensure effective messages are developed. In particular, participants raised the role of reinforcing uninformed beliefs or stereotypes associated with FGM in relation to current practice, ethnicity, gender and religion.

While the problem of FGM as a significant public health issue has been recognised and actioned in the UK through the publication of guidelines from the Royal College of Obstetricians and Gynaecologists[11] and recommendations for healthcare professionals from

England's Department of Health,[12] prevalence data suggests that 98% of all detected cases of FGM took place approximately 10 years ago.[13] Further, where data was available it showed that 87% of FGM was conducted outside of the UK. These data confirm participants' beliefs that FGM is rarely conducted in the UK and suggest that resources may be better spent in countries where FGM takes place. Worth noting is that whilst participants believed the practice of FGM rare in the UK, they still considered campaign materials necessary for raising awareness.

Images were identified as important, participants were concerned that one of the campaign posters portrayed the fathers as the perpetrators responsible for FGM, when it is often the women in the family who make this decision.[14] Several poster images also suggested that FGM was a Sub-Sahara African issue, when it is also prevalent in other countries. Whilst the materials used in this study were aimed at affected communities, they are also seen by wider UK society, who are likely to form opinions about FGM and those who are at risk. Our participants reported that these images will stigmatise those who were affected and contribute to a culture of hostility and misunderstanding. The results of these misunderstandings can be seen in practice where most children referred to one FGM clinic, did not have FGM.[15]

Whilst not explicitly depicted on any of the campaign material posters or leaflets, the participants reported concern that FGM was seen as a practice related to Islam. Recent research has shown consistent confusion regarding whether FGM is dictated by Islam or not[7] and more work is needed to clarify this misperception.[3] Considering FGM is not a practice related to Islam, it is worth noting that religious leaders are often seen as 'guardians of the community' with the potential to reinforce campaign messages, an important aspect of creating successful campaigns.[16] This could in turn make FGM to be seen as a religious issue.

### *Strengths and limitations*

A significant number of studies have used visual methodology as a way of discussing sensitive areas.[17, 18] The advantages of using it here was that it allowed participants to not only refine but also re-define the area of interest through open discussion of health promotion materials, including exposing aspects of both FGM and campaigns that were uncomfortable, previously unknown or not openly discussed. That said, all four campaigns were statutory health education materials and our findings may have changed if resources from community organisations had been chosen. This could be explored in future research.

Both mothers and fathers were interviewed, with the latter group rarely included in these types of studies.[7] These strengths need to be considered with some limitations. Participants self-selected to be part of this study, aa larger sample size including participants from a wider range of affected communities would have further strengthened our findings.

### *Conclusion*

In summary, this qualitative study has identified a number of factors that need to be considered when developing public health campaigns. These factors include who will see the campaign, and implicit assumptions the message may portray to both the affected communities and individuals outside these communities to avoid stigmatizing individuals. Actively working with affected communities to develop messaging that counters negative stereotyping and associated hostility should be a priority for practitioners and researchers alike.

**Acknowledgements**

We would like to thank and acknowledge the contribution of all those community leaders, and participants who gave up their time to make the study happen.

**Funding**

This research did not receive any specific grant from funding agencies in the public, commercial or not-for-profit sectors. However, the XXX [redacted for peer review] paid a number of costs associated with the research field work including travel, postage, transcription and refreshments for participants.

**Competing interests**

None declared

**Ethical approval**

Ethical approval was received from the XXX [redacted for peer review]. All participants provided written consent ahead of data collection.

**Declarations of interest:** none

**Contributors**

[Redacted for peer review] All authors have approved the final version of this manuscript.

**References**

1. World Health Organization. Female genital mutilation. 2017 [Accessed 4 September 2019]; Available from: http://www.who.int/mediacentre/factsheets/fs241/en/.

2. Mulongo P, Hollins Martin C, McAndrew S. The psychological impact of Female Genital Mutilation/Cutting (FGM/C) on girls/women's mental health: a narrative literature review. Journal of Reproductive and Infant Psychology. 2014; 32:469-85.

3. Alhassan YN, Barrett H, Brown KE, Kwah K. Belief systems enforcing female genital mutilation in Europe. International Journal of Human Rights in Healthcare. 2016; 9:29-40.

4. Johansen REB, Diop NJ, Laverack G, Leye E. What works and what does not: a discussion of popular approaches for the abandonment of female genital mutilation. Obstetrics and Gynecology International. 2013; 2013:10.

5. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care. 2007; 19:349-57.

6. Macfarlane AJ, Dorkenoo E. Prevalence of Female Genital Mutilation in England and Wales: National and local estimates. London: City University London in association with Equality Now 2015.

7. Catania L, Mastrullo R, Caselli A, Cecere R, Abdulcadir O, Abdulcadir J. Male perspectives on FGM among communities of African heritage in Italy. International Journal of Human Rights in Healthcare. 2016; 9:41-51.

8. Waigwa S, Doos L, Bradbury-Jones C, Taylor J. Effectiveness of health education as an intervention designed to prevent female genital mutilation/cutting (FGM/C): a systematic review. Reproductive health. 2018; 15:62.

9. Johnny L, Mitchell C. “Live and Let Live”: An Analysis of HIV/AIDS-Related Stigma and Discrimination in International Campaign Posters. Journal of Health Communication. 2006; 11:755-67.

10. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology. 2006; 3:77-101.

11. Royal College of Obstetricians and Gynaecologists. Female Genital Mutilation and its Management. Green-top Guideline No. 53. 2015 [Accessed 4 September 2019]; Available from: https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf.

12. Department of Health. Female genital mutilation risk and safeguarding; guidance for professionals. London2016 [Accessed 4 September 2019]; Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/525390/FGM_safeguarding_report_A.pdf.

13. NHS Digital. Female Genital Mutilation (FGM) Enhanced Dataset. April 2016 to March 2017, England, experimental statistics. 2017 [Accessed 4 September 2019]; Available from: https://files.digital.nhs.uk/publication/g/c/fgm-apr-2016-mar-2017-exp-rep.pdf.

14. Brown K, Beecham D, Barrett H. The applicability of behaviour change in intervention programmes targeted at ending female genital mutilation in the EU: integrating social cognitive and community level approaches. Obstetrics and Gynecology International. 2013.

15. Creighton SM, Dear J, de Campos C, Williams L, Hodes D. Multidisciplinary approach to the management of children with female genital mutilation (FGM) or suspected FGM: service description and case series. BMJ Open. 2016; 6.

16. Østebø MT, Østebø T. Are Religious Leaders a Magic Bullet for Social/Societal Change?: A Critical Look at Anti-FGM Interventions in Ethiopia. Africa Today. 2014; 60:82-101.

17. Orr N, Phoenix C. Photographing physical activity: using visual methods to ‘grasp at’the sensual experiences of the ageing body. Qualitative Research. 2015; 15:454-72.

18. O’Connell R. The use of visual methods with children in a mixed methods study of family food practices. International Journal of Social Research Methodology. 2013; 16:31-46.

Table 1. Summary of themes

| **Main themes** |
| --- |
| ‘Nobody circumcises nowadays’ |
| ‘Not just an African problem’ |
| Are men behind FGM? |
| ‘Nothing to do with religion’ |
| ‘Talking to the community, not about them’ |

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

| No | Item | Guide questions/description Authors answer | Manuscript page number |
|---|---|---|---|
| **Domain 1: Research team and reflexivity** | | | |
| Personal Characteristics | | | |
| 1. | Interviewer/facilitator | DS and AA conducted the interviews | 5 |
| 2. | Credentials | Both researchers have PhDs | 5 |
| 3. | Occupation | One interviewer work as a research professor, the second researcher worked as a lecturer at the time of the study. | 5 |
| 4. | Gender | Both researchers were female. | 5 |
| 5. | Experience and training | Both researchers had extensive experience in conducting interviews and focus groups, both through formal and informal training. | 5 |
| Relationship with participants | | | |
| 6. | Relationship established | The relationship was established through community groups who were part of the academic's research networks. | 4 |
| 7. | Participant knowledge of the interviewer | Participants had the researchers and the research introduced to them initially through community workers and then the researchers themselves. | 4 |

| No | Item | Guide questions/description Authors answer | Manuscript page number |
|---|---|---|---|
| | | All participants were given information sheets, made available in English and Somali. This outlined the aims of the research, and how the research would be conducted including issues of confidentiality and right to withdraw, researchers also explained how the outcomes of the research would inform public health educational initiatives going forward. | |
| 8. | Interviewer characteristics | One researcher was white British (DS) and the second described herself as a member of an ethnic and religious minority identifying as Muslim from Kazakhstan. DS had a long career in young people's sexual health practice and research, and AA in health inequalities within BAME communities. | 5 |
| **Domain 2: study design** | | | |
| Theoretical framework | | | |
| 9. | Methodological orientation and Theory | Thematic analysis within a realist paradigm | 6 |
| Participant selection | | | |
| 10. | Sampling | Purposive | 4 |
| 11. | Method of approach | Recruitment was done face-to-face via six local community groups. | 4 |

| No | Item | Guide questions/description Authors answer | Manuscript page number |
|---|---|---|---|
| 12. | Sample size | 16 | 4 |
| 13. | Non-participation | Four mothers dropped out, due to childcare and family commitments | 4 |
| Setting | | | |
| 14. | Setting of data collection | Community centres | 4 |
| 15. | Presence of non-participants | No-one else was present besides the participants and researchers | 4 |
| 16. | Description of sample | Somali descent, age and time lived in UK. The parents were also asked how many children they had. | 4-5 |
| Data collection | | | |
| 17. | Interview guide | The interview schedule was developed through a set of questions and prompts, a broad outline of which are included in the paper. This was initially piloted through two Somali PhD students connected to the research centre the researchers belonged to. | 6 |
| 18. | Repeat interviews | All participants were interviewed once. | 5 |

| No | Item | Guide questions/description Authors answer | Manuscript page number |
|---|---|---|---|
| 19. | Audio/visual recording | Data was captured by audio recorder. | 6 |
| 20. | Field notes | Yes field notes were taken to provide context during data analysis. | 6 |
| 21. | Duration | The interview and focus groups took between 60 and 90 minutes. | 6 |
| 22. | Data saturation | Data saturation was considered to be reached when new no new themes or sub-themes were identified. | 6 |
| 23. | Transcripts returned | While the researchers offered to return transcripts to participants, this was not taken up, consequently none were returned to participants for comment/correction | 6 |
| **Domain 3: analysis and findings** | | | |
| Data analysis | | | |
| 24. | Number of data coders | All three authors coded the data. | 6 |
| 25. | Description of the coding tree | No coding tree was produced. | N/A |
| 26. | Derivation of themes | Themes were derived from the data. | 6 |

| No | Item | Guide questions/description Authors answer | Manuscript page number |
|---|---|---|---|
| 27. | Software | No software was used for data analysis. | N/A |
| 28. | Participant checking | Participants did not provide feedback on the findings | 6 |
| Reporting | | | |
| 29. | Quotations presented | Participant quotes have been included to illustrate themes. Quotes have not been attributed to specific participants to maintain anonymity. | 7-13 |
| 30. | Data and findings consistent | The data presented is consistent with the findings | 7-13 |
| 31. | Clarity of major themes | All themes have been presented in the manuscript. | 7-13 |
| 32. | Clarity of minor themes | Minor themes and contrasting views are discussed in the results section | 7-13 |