Female genital mutilation in Britain

J A Black, G D Debelle

Much has been written about female genital mutilation in Africa, but little attention has been paid to its existence in Britain. Though it has been illegal in this country since 1985, it is practised secretly or children are sent abroad to have the operation. From the social worker's point of view it is technically a form of child abuse which poses special problems. Black and Debelle review the historical background of female genital mutilation and describe its medical complications. Gallard discusses the problem in France, and Walder considers why such mutilation still continues in Britain.

This article is concerned with female genital mutilation in Britain. The term is preferable to female circumcision, which is inaccurate and implies a minor operation equivalent to male circumcision. In many cultures the operation entails an extensive mutilation, with profound social, sexual, and medical consequences.

Historical background

It is uncertain when female genital mutilation was first practised, but it certainly preceded the founding of both Christianity and Islam. There is no basis for the belief that the procedure was advocated or approved by Mohammed nor is it in any way part of the Islamic faith. Though the operation is largely confined to Muslims, it is also performed in certain Christian communities in Africa. Female genital mutilation is practised in various forms in over 20 African countries and also in Oman, the Yemen, and the United Arab Emirates and by some Muslims in Malaysia and Indonesia[1]; it is not practised in Iran, Iraq, Jordan, Libya, or Saudi Arabia.

What is female genital mutilation?

There are three types of operation. In the least mutilating form, known misleadingly as the "Sunna" procedure (meaning "following the Prophet's tradition"), the prepuce of the clitoris is removed; this is the only procedure which can be correctly called circumcision. In the most extensive form, called "infibulation" or in Sudan "the Pharaonic procedure," the clitoris, the labia minora, and the medial part of the labia majora are excised and the sides of the vagina are then stitched together, leaving a small opening for urine and menstrual blood, patency being preserved by a sliver of wood. The term infibulation refers to the use of a clasp (infibula) to keep the cut edges of the vagina together. In the intermediate form of operation ("excision") the clitoris is wholly or partly removed, together with part of the labia minora whose cut edges are sutured together to leave a small opening. In women who have had a procedure involving stitching together of the sides of the vagina, resuture is usually requested after delivery; this is not illegal (see below).

Complications are largely confined to the two more extensive operations. Early complications such as primary or secondary haemorrhage, sepsis, septicaemia, and tetanus are unlikely if the operation is performed by a skilled practitioner under good conditions. Long term complications include dyspareunia due to introital or vaginal stenosis, poor urinary stream, urinary tract infection, haematocolpos, vesicovaginal or rectovaginal fistula (after a prolonged delivery), keloid formation, and implantation dermoids. Soleiman Fayyad gives a horrifying account of the death of a woman in Egypt after the operation was done by force.[2] Couples may complain of infertility, though the real problem is the inability of the husband to achieve penetration (D Paintin, personal communication). In Africa, prolonged or obstructed labour may occur if there is inadequate obstetric care. Dirie and Lindmark in Somalia found that even in otherwise normal deliveries anterior and mediolateral episiotomies were required.[3]

There are no figures for the incidence of emotional or psychological effects, but it is probable that this would be small in communities where social pressures are strongly in favour of the operation. Conversely, in such circumstances, the unoperated girl may be the object of disapproval and derision.

In Britain, with proper obstetric care there is rarely any difficulty in the second stage of labour, though an incision of the web of tissue across the vagina is often necessary (D Paintin, personal communication). In hospitals unused to looking after women with genital mutilation there may be hostility and incomprehension, particularly if the woman requests resuturing.

To appreciate why this operation is performed some understanding is required of the cultural background associated with female genital mutilation. In the least destructive operation, when only the prepuce of the clitoris is removed, the object is to reduce the woman's sexual desire and hence to ensure her virginity until she is married. The more extensive operations, involving stitching of the vagina, have the same aim of ensuring chastity until marriage. The reduction in the size of the vaginal orifice is supposed to increase the husband's enjoyment of the sexual act; there is no good evidence for this and initially penetration may be difficult and painful for both partners. From the family's point of view the operation ensures a satisfactory bride price; an eligible man would not consider marrying a girl who had not had the operation. The procedure is arranged by the mother or grandmother and in Africa is usually performed by a traditional birth attendant, a midwife making a little extra money, or by a professional exciser. Female genital mutilation is supported and encouraged by men; indeed the operation can be regarded as an exercise in male supremacy and the oppression of women.

The situation in Britain

During the past three or four decades ethnic groups who practise female genital mutilation have immigrated to Britain, mainly as refugees. The main groups are from Eritrea, Ethiopia, Somalia, and the Yemen. It has been estimated that in their own countries over 80% of women have had the operation,[4] which is invariably infibulation. There is evidence that the operation is being performed illegally in Britain (see below) by medically qualified or unqualified practitioners and that children are being sent abroad for a "holiday" to have it done. In Britain the procedure is usually performed between the ages of 7 and 9 years.

Victoria Mill House, Framlingham, Woodbridge, Suffolk IP13 9EG
J A Black, *retired consultant paediatrician*

Children's Services Unit, South Birmingham Health Authority, Birmingham
G D Debelle, *consultant community paediatrician*

Correspondence to: Dr Black.

BMJ 1995;310:1590-4

REX FEATURES SIPA/SARKKA-ZETA

In whose interests?

International statements

Female genital mutilation was made illegal in Britain by the Prohibition of Female Circumcision Act 1985. Under this act it is an offence to "excise, infibulate, or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person" or "to aid, abet, or procure the performance by another person of any of these acts on that other person's own body." A person found guilty of an offence is liable to a fine or to imprisonment for up to five years, or to both, if convicted on indictment before a judge and jury in a crown court, or on summary conviction in a magistrate's court to a fine or imprisonment for up to six months, or to both. In Britain there have been no prosecutions under the act, but convictions have been obtained in France. In 1993 a medical practitioner was brought before the General Medical Council charged with performing female circumcisions while knowing that the operation was illegal; he was struck off. Legislation prohibiting female genital mutilation has also been passed in Sweden and Belgium and in some states in America.

In 1959 the general assembly of the United Nations adopted the Convention on the Rights of the Child, which states (article 24, paragraph 3) that "States Parties shall take all effective and appropriate measures to abolish traditional practices prejudicial to the health of children." In 1982 the United Nations human rights subcommission of the World Health Organisation assured governments of its readiness, together with Unicef, to support national efforts against female genital mutilation. The practice was again condemned by the WHO in 1986[5] and by the International Planned Parenthood Foundation and in the African Charter on the Rights and Welfare of the Child. The Foundation for Women's Health, Research, and Development (FORWARD) has campaigned tirelessly in Britain and elsewhere for the abolition of female genital mutilation. FORWARD receives some financial support from the Department of Health. The whole subject has been comprehensively reviewed by Dorkenoo and Elworthy.[6] Recently the World Medical Association condemned female genital mutilation,[7] and the problem has been discussed in this journal, though with little mention of the problem in Britain.[7 8]

Child protection and female genital mutilation

In Britain female genital mutilation is regarded as a form of child abuse, though this term should not be used when discussing the procedure with families as it would be greatly resented. Female genital mutilation differs from other forms of child abuse in that it is done with the best intentions for the future welfare of the child, there is no possibility of its repetition during childhood, and it is approved by sections of the communities in which it is practised. As Korbin has put it, "The first level encompasses practices that are viewed as acceptable within the culture in which they occur, but as abusive or neglectful by outsiders."[9] Female genital mutilation in Britain presents a cross cultural problem.

Female genital mutilation may present in a variety of ways. Firstly, it may be known that a woman who has had the operation herself also approves of it for her daughters, who are therefore at risk. Secondly, a doctor, nurse, teacher, social worker, or other professional (or a neighbour or friend) may discover that a girl has had the operation; though there is little point in prosecuting the parents for something which has already occurred, younger girls in the family would be at risk. Thirdly, one of the categories of people mentioned above may suspect that a family is preparing to have their child sent away to have the operation.

It is not easy to make the right decision when it is suspected or known that a child is at risk; action should depend on the degree of urgency. As with other forms of child abuse, a child likely to suffer "significant harm" is subject to a joint police and social services investigation and case conference and her name should be put on the child protection register; this alerts social workers and others, allocates a key worker, and requires a review case conference. Anyone, not necessarily a health professional or social worker, can report their suspicions to the social services department.

Under the Children Act 1989 various procedures are available.[10] As a preliminary measure a child assessment order can be made if the parents do not agree to an informal assessment; the assessment order is made by the court, with specific conditions attached. An assessment order provides no protection for the child and lasts for seven days from the date specified in the order. If further action is thought necessary by the court a "prohibited steps order" can be taken out; this prohibits the parents or any other person from carrying out a specified action without the consent of the court; this order ceases when the girl reaches the age of 16 years. Alternatively, a supervision order may be made; this lasts initially for one year, with a maximum of three years. In a more urgent situation an emergency protection order (replacing the place of safety order) may be taken out; this authorises removal, if necessary, of the child from the place where she normally lives. It lasts for eight days with a possible extension for a further seven days. Finally, a care order can be made; this would be used only in extreme cases. The Children Act now restricts the use of wardship where the act provides appropriate remedies.

In such sensitive cases any action aimed at interfering with the customs and traditions of a particular ethnic group may be regarded as racist. Equally, a failure by a social services department to pursue a proper course of action for fear of an accusation of racism or because of antagonism in the community is in a perverse way a form of racism in that it is a retreat based on racial considerations to the detriment of the welfare of the child.

Social services departments should take the lead in developing awareness of female genital mutilation and how to approach it. The departments should have a policy for the education, by meetings and circulation of advisory literature, of its own staff, health professionals, and teachers.[11] In areas with a sizeable number of families belonging to an ethic group which practises female genital mutilation a joint consultative body should be set up, to include community leaders in addition to the relevant professionals. Hedley and Dorkenoo have suggested that specially trained

advisers should be available to give support and advice to social workers and others in contact with families in whom female genital mutilation is an important issue.[4] These advisers would normally be health visitors, midwives, or social workers. Whenever possible there should be close liaison with local community groups, which should be supported in campaigns against female genital mutilation; such groups may be able to supply someone of the appropriate ethnic group (or in the case of the Somalis, tribe) to talk to parents. The cooperation of local press and radio stations should be sought, and help should be requested from local newspapers and news sheets in the relevant languages.

As with other conditions largely confined to certain ethnic groups (for example, sickle cell disease and thalassaemia), services are likely to be well developed in areas with a large population of groups who practise female genital mutilation, whereas in areas with a small population of these groups services may be inadequate or non-existent. Such areas should seek advice and skill from better organised areas.

Female genital mutilation tends to be considered mainly from the woman's point of view and has become identified as a feminist issue. This seems a mistaken policy as female genital mutilation would die out if men ceased to insist on it. It is therefore important that men should be included and involved in educational programmes.

Conclusion

Assuming that the size of the population in Britain of ethnic groups practising or favouring female genital mutilation remains more or less unchanged, it seems probable that, as adaptation and acculturation occur, the practice will die out within a few generations. This is not, however, an argument for complacency or inaction.

Meanwhile, there is much to be done. From our own inquiries there seems to be a conspiracy of silence in medical circles; there is also widespread ignorance. None of a number of well known obstetric and paediatric textbooks mentions female genital mutilation. The National Society for the Prevention of Cruelty to Children has no information or instructional material.

It is time that this problem was more widely and openly discussed.

FORWARD is based at Africa Centre, 38 King Street, London WC2E 8JT.

1 Sami IR. Female circumcision with special reference to the Sudan. *Ann Trop Paediatr* 1986;6:99-115.
2 Fayyad S. *Voices*. London: Marion Boyars Publishers, 1993: 102-7.
3 Dirie MA, Lindmark G. A hospital study of the complications of female circumcision. *Trop Doct* 1991;21:146-8.
4 Hedley R, Dorkenoo E. *Child protection and female genital mutilation*. London: FORWARD, 1992.
5 World Health Organisation. A traditional practice that threatens health—female circumcision. *WHO Chronicle* 1986;40:31-6.
6 Dorkenoo E, Elworthy S. *Female genital mutilation: proposals for change*. London: Minority Rights Group, 1992.
7 Richards T. Female genital mutilation condemned by WMA. *BMJ* 1993;307: 957.
8 Ladjali M, Rattray TW, Walder RJW. Female genital mutilation. *BMJ* 1993;307:460.
9 Korbin JE. Cross-cultural perspectives and research directions for the 21st century. *Child Abuse Negl* 1991;15(suppl 1):67-77.
10 Department of Health. *The Children Act 1989: an introductory guide for the N.H.S.* London: HMSO, 1991.
11 Webb E, Hartley B. Female genital mutilation: a dilemma in child protection. *Arch Dis Child* 1994;70:441-4.

(Accepted 7 February 1995)

Female genital mutilation in France

Colette Gallard

The French Family Planning Association first protested to the World Health Organisation in 1977 about its continuing silence concerning the genital mutilation of girls in Africa and the Far East; that same year the French delegate to the regional council of the International Planned Parenthood Federation brought the issue before its medical commission.

At the time, this protest was based more on feminist concern for the defence of women's rights than on the family planning association's experience of female genital mutilation; but over the next few years, with the arrival in France of African immigrants' wives and families, mother and child protection centres and family planning centres, where our members worked as counsellors, saw the problem surface in a tangible way.

Some of these centres are in areas with high migrant populations, and coming face to face with the facts of female genital mutilation was often quite a brutal experience. The social pressure of these traditions and their psychological repercussions on women, as well as the physical damage inflicted, were first brought home to me through seeing a happy, communicative little Malian girl whom I had followed from birth, return from a "holiday" in Mali rendered aphasic from shock (and needing several years of psychotherapy to speak again); the traditions became very clear as I talked with her horrified mother.

In France, in the family planning association as elsewhere, the first reaction to the facts was to consider that westerners should not intervene in this cultural issue. It was only after a long period of raising awarness among medical and paramedical staff, magistrates, institutions, and the general public that the problem began to be seen as something other than just an example of folklore or a barbarous sign of underdevelopment.

Sadly, it took the death of two little girls in 1982 to bring the issue out into the open and to oblige the authorities to take a stand on the perpetration of these practices in France.

Methods of action

Action was undertaken in two main fields. Firstly, we aimed at prevention. A paediatrician working at a mother and child protection unit produced an information booklet on the different forms of female genital mutilation and their medical consequences, particularly during labour.[1] This was for medical and paramedical staff and (a major priority) for interpreters. Discussions were organised for the women who attended the centres.

At the initiative of a working party set up by Yvette Roudy, minister for women's rights, measures were proposed for information to be given through French consulates to immigration candidates (generally men) and then, after their arrival, through immigrant workers' associations by using leaflets and illustrated material on general family legislation in France (non-recognition of polygamy, compulsory schooling, vaccinations, etc) as well as on the prohibition of and punishment for female genital mutilation.

At the same time, hospital teams began studying

French Family Planning Association, 4 Irénée Square, 75011 Paris, France
Colette Gallard, *family planning counsellor*