

THE EMPEROR'S NEW CLOTHES? THE DANGERS OF THE ANTI-FGM CAMPAIGN

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Bríd Hehir started her career in Ireland before working as a volunteer nurse for four years in Africa where she developed an interest in international development and the politics of healthcare. She then worked in a variety of positions in the National Health Service, in Britain, until 2011 - as a nurse, midwife and specialist health visitor and senior manager. During that time she retained a keen interest in development and health care in both the developed and developing world. She has been a charity fundraiser for three years.

Introduction

In March 2014, my article, 'FGM Declining Globally' was published by the Royal College of Nursing's *Nursing Blog*. I explained why, despite having witnessed the death of a girl from FGM in Ethiopia, I disagreed with the thrust of anti-FGM campaigns and their desire to prosecute 'cutters'. I suggested that 'in the interest of our common humanity, we leave the issue alone. The practice is already illegal... Pursuing a witch hunt against perpetrators... will only drive it underground... information can be passed to the families sensitively by health care professionals. Prosecuting and name calling is insensitive'.

The article was 'hidden' (in other words, censored) on 7 March, following a complaint, the originator or nature of which I've never been told. The blog had attracted eight comments by then; five positive and three negative. After an investigation by the editorial team, it was 'unhidden' with an apology, three days later. [Critics](#) had accused me of supporting girls being tortured, called me racist for not supporting their type of intervention, and accused me of being ideologically driven. I'd inadvertently stumbled into a minefield.

Campaigners' opposition to FGM is premised on the belief that child welfare is paramount; such an attitude is laudable. But a legitimate concern about protecting children from FGM has morphed into a moral trial of immigrants' harmful traditional practices (HTPs). FGM adherents and practitioners have been tried in the court of public opinion and found guilty. FGM is believed to underscore violence and discrimination against women and girls, support women's oppression and their control within patriarchal communities, as well as being child abuse and a human-rights violation.

An ever-increasing number of critics occupy the moral high ground, scarcely able to comprehend that this 'barbaric' practice with 'tip of the iceberg' projections of incidence, continues into the twenty-first century. The practice is viewed through a limited 'right or wrong' prism, encouraging gross intolerance of adherents to it, with what appears to be a deliberate unwillingness to want to understand why some people continue the practice.

While it's rhetorically acknowledged that persuasion is the best way forward to reduce the incidence of FGM, this approach has come to play second fiddle to coercion, as exemplified by the desire to find and prosecute practitioners and or collaborators at all costs. In [France](#), more than 100 adults have been [jailed](#) for committing or permitting FGM.

History

Although the origins of FGM are contested, the practice dates back at least 2,000 years and its main locus is Africa: in Chad, Niger, Nigeria, Togo, Burkina Faso, Ghana, Côte d'Ivoire, Liberia, Sierra Leone, Guinea, Guinea Bissau, Sénégal, the Gambia, Mauritania, Egypt, Sudan, Djibouti, Ethiopia, Somalia, Somaliland and Mali. There, the practice is mostly known in English as cutting, genital modification or circumcision, not mutilation. But because FGM has become the label commonly used here I will, as shorthand, refer to the practice as FGM, while recognising the associated negative connotations with the term.

FGM means the ritual removal of some or all of the external female genitalia for a [variety of reasons](#). Clitoridectomy used to be practised in the UK and USA in the nineteenth and early twentieth centuries as a way of preventing women from masturbating, reducing hysteria and mental illness. In her article on this history, the writer [Martha Coventry](#) quotes the Victorian gynaecologist Isaac Baker Brown, who claimed that after clitoridectomy 'intractable women became happy wives; rebellious teenage girls settled back into the bosom of their families; and married women formerly averse to sexual duties became pregnant'. Up to the mid-twentieth century, what was termed 'female circumcision' was viewed as a domestic matter that had nothing to do with the state. From the 1960s, feminist activists in the West and from some African nations helped transform the conceptualisation of cutting into a [gender-based, human-rights violation](#). This orientation wasn't universally welcomed, however, and some African women, who were attempting to end the practice in their own way, began to criticise Western feminists for their writings on the subject.

For example, the Association of African Women for Research and Development [stated](#) in 1983: 'In trying to reach their own public, the new crusaders have fallen back on sensationalism, and have become insensitive to the dignity of the very women they want to "save". They are totally unconscious of the latent racism which such a campaign evokes in countries where ethnocentric prejudice is deeply rooted.'

Nevertheless, since 2003, 6 February has been marked as [Zero Tolerance to FGM Day](#). Interest mushroomed from 2012, when the [United Nations General Assembly](#) voted to intensify efforts to persuade people to abandon FGM. We are now invited to '[Help End FGM in a Generation](#)'; to 'Break the silence; Take a stand; Join the movement'. This year, the UK government [announced](#) the appointment of a consortium of leading anti-FGM campaigners and development communications experts to deliver a global

campaign to end FGM. An FGM prevention programme was [launched](#) at the Girl Summit in London by the Department of Health and NHS England and £1.4million funding was made available towards this. A new £6.5million UK-led, international anti-FGM programme 'The Girl Generation: Together to End FGM' was launched in London and Nairobi on 10 October. The campaign intends to work with 10 African countries over four and a half years to try and raise awareness about FGM.

And to help ensure that we understand that FGM is everyone's business, [The Little Stitches](#), a theatre production about FGM, recently toured some London theatres to packed audiences and widespread acclaim. It suggested that 137,000 women in the UK are living with the consequences of FGM. The show contributed to other FGM 'awareness-raising' initiatives that coincided with the so called '[cutting season](#)', when girls are flown abroad during school holidays to be 'mutilated'.

Types of FGM

FGM has been classified by the [WHO](#) into four types, although it's not always easy to identify precisely the procedure that's been undergone. Type I includes reduction of the clitoral hood and/or tissue. Type II involves partial or complete labial reductions as well as reduction of protruding parts of clitoral tissue. Approximately [90 per cent](#) of all FGM cases fall into one of these categories. But that's not the impression we get. We are encouraged to believe that Type III, which involves Type I or II, followed by narrowing and sealing the vulva with stitches or thorns – 'infibulation' - predominates. The latter practice occurs largely in Northeast Africa. Type IV covers 'all other practices' and includes, for example, clitoral pricking, incising, labial stretching and is less associated with harm or risk than Types I-III. Despite training, many midwives and doctors remain unable to distinguish between Types II and III. But irrespective of type, FGM is deemed by some to be what the victim self-determines it to be; it's '[a survivor's own story](#)'. Sometimes it seems almost as if awareness raisers get a perverse pleasure in 'educating' us about types of FGM and appear not to have qualms about exaggerating the extent, degree and prevalence of the practice.

That it's not always possible to identify the type undertaken was confirmed by a paediatrician, Dr Deborah Hodes, the London Borough of Camden's named doctor for child protection. She has a long career in the field of child protection in London and is co-author of [The Child in Mind](#), (2004), revised in 2006 and 2007, although FGM is not mentioned within any edition.

In her [evidence to the Commons Select Committee](#), Hodes wrote: 'It needs to be acknowledged that identifying the Type of FGM is difficult and in the children I have seen, most have no signs as they have had type IV.'

Prevalence

Although precise data is unavailable, the WHO estimates that 100-140million women worldwide have been subject to it and three million girls continue to be at risk each year. Five girls are estimated to be cut every minute.

Fortunately, the incidence seems to be falling. According to a July 2014 [UNICEF](#) report, the number of girls who are subjected to FGM worldwide is around a third lower now than it was 30 years ago.

Yet many widely quoted figures for FGM seem to bear little relation to reality. In Britain, there is [scant evidence](#) that FGM is being carried out on any significant scale, if at all. Until recently, it was [estimated](#) that 66,000 women and girls were likely to have undergone FGM in England and Wales. The figure was based on the 2001 census and birth registrations data and was widely regarded as a 'tip of the iceberg' estimate. That number has just been [revised upwards](#) to take account of changes in immigration from [FGM practising countries](#). Girls and women aged 15-49 who've undergone FGM are now estimated at 103,000.

In addition, the authors suggest there are approximately 24,000 women over the age of 50 who have had FGM, who were born in FGM-practising countries, and nearly 10,000 girls aged 0-14 born in FGM-practising countries who have undergone or are likely to undergo FGM. Combining the figures for the three age groups, approximately 137,000 women and girls with FGM, born in countries where FGM is practised, were permanently resident in England and Wales in 2011. And they suggest these figures might still be underestimates.

So by looking at the countries in which FGM traditionally occurs, estimating its prevalence there and then projecting these estimates on to the relevant immigrant communities in England and Wales, the researchers assume that the behaviour of immigrants is fixed in regard to FGM and will not change. That assumption seems to be based more on prejudice than hard facts.

In the [USA](#), FGM was banned in 1997 and 227,887 women and girls were assessed as 'at risk' in 2000. Despite it being illegal, [activists](#) say the U.S. is far behind the UK when it comes to dealing with the issue, and estimates that hundreds of thousands of girls are at risk each year. In July 2014, President Obama [called](#) for the elimination of the "barbaric" practice FGM and is commitment to identifying the size and scope of the problem: 'there's no excuse...Female genital mutilation – I'm sorry, I don't consider that a tradition worth hanging on to. I think that's a tradition that is barbaric and should be eliminated. Violence towards women – I don't care for that tradition. I'm not interested in it. It needs to be eliminated.'

Across most of [Europe](#), FGM is considered a crime, but there is no reliable evidence of its prevalence. In some countries, a principle of extra-territoriality renders it possible to prosecute the practice even when committed outside the country's borders. Within Britain, France is considered a leader in the fight against FGM.

[London's first specialist clinic](#) for child victims of FGM opened in Sept 2014 at University College London Hospitals and will offer medical treatment and psychological help to girls up to 18 who have undergone FGM. The hospital already runs one of the 14 [NHS African Well Women's Clinics](#), with nine in London. Dr Hodes [told](#) the *London Evening Standard* that the decision to begin the specialist service had been prompted by the 'increasing' number of cases that she and colleagues were receiving. But no actual evidence has been made publicly available of this increase London-wide. The clinic will be held once a month while demand is assessed.

Given the claims about FGM prevalence, and considering that the British government's [FGM poster campaign](#) focuses largely on Somali, Kenyan and Nigerian communities, it is surprising that few children who've undergone FGM Types I-III are being identified in London. Most people of [Kenyan origin](#) live in London and the East Midlands and [Nigerians](#) are overwhelmingly concentrated in south London. So for example, the [London Borough of Newham](#), which has 'one of the youngest and most diverse local authorities in the UK, with 83 per cent of the population identifying as Black, Asian and Minority Ethnic', reports that 'because of the demographics of Newham, we would expect to see high numbers of recorded female genital mutilation; however, this is not the case'. According to its children safeguarding data, there were only six recorded cases of FGM in Newham in 2013. Five were reported to the police.

The high figures for the [prevalence of FGM](#) that are widely quoted, despite this lack of evidence, are justified on the basis that FGM is a hidden crime, making prevalence difficult to determine. So policymakers are attempting to remedy a problem with little to no idea of its actual scale. Could it be that the emperor has no clothes?

Leyla Hussein, a psychotherapist who runs a support group for survivors of FGM, has [suggested](#) that the actual number of girls and women 'at risk' of FGM today are more likely to be triple the quoted number – arriving at a figure of 72,000, because women who've undergone FGM are likely to have their daughters cut.

But the Victoria Climbié Foundation begs to differ and suggests: 'For every victim of FGM to be viewed as a potential perpetrator is of grave concern. Given the change of demographics in the UK, we have come across many FGM survivors who had the practice performed on them outside of this country. Anecdotal evidence strongly suggests that the relevant communities are shifting from the practice of FGM, albeit ingrained within their belief system, having understood the health implications and the fact that it is unlawful. Many members of the community have also begun to speak out against the procedure on women and girls. Thus it is our view that we should first seek to offer appropriate measures of support rather than automatic referral to Children's Social Care.'

Despite any real evidence, campaigners are keen to promote that 'cutting' also happens within the UK. [Hussein](#) told the Committee that she could cite examples of 'cutting' in Britain up to 2002 but has been told, anecdotally, of cutters still operating in London - in Brixton and Leytonstone. She thinks she's not being given precise details because 'knowing could potentially ruin a cutter's business'.

The [UK Border Force](#) also believes that cutters are operating in the UK: 'Instead of the girls being removed from the UK to go back to the country of origin to have this procedure carried out, now there are cutters travelling from the country of origin to the UK to carry it out in London and in other cities.' In contrast, the [Victoria Climbié Foundation](#) suggests: 'Many within the community do not know of the practice being carried out in the UK and to-date there has been a lack of evidence in this regard.'

Could it be that campaigners want to portray the problem as bigger than it actually is so as to give their campaigns and organisations added legitimacy as well as a platform to pontificate from?

Despite the lack of hard evidence on the scale of the FGM problem, a worrying consensus that allows little opposition has developed in regard to how this '[barbaric](#)' problem should be dealt with. The moral high ground is occupied by politicians, celebrities, organisations and groups keen to demonstrate their anti-FGM credentials. Not challenging that consensus is deemed [racist](#). A variety of campaigners and organisation have a national and global presence, ranging from broadsheets like the [Guardian](#) to organisations as diverse as the [NSPCC](#), [Manor Gardens](#), [Daughters of Eve](#), [Forward](#), [Desert Flower](#), the [UN](#), the [World Health Organisation](#) and [the EU](#). In 2014, London's *Evening Standard* newspaper and two of its journalists won 'special recognition' in UN-backed awards for their [campaigning](#) coverage of the problem.

Most reports carry heart-rending stories, often with associated dramatic visuals, about girls/women who've undergone FGM and are living with traumatic consequences - physically, psychologically, sexually and socially.

It was into this minefield that I first dipped my toe when my [Nursing Blog](#) article was censored and I was accused of supporting torture and racism. The allegation of racism was, of course, deliberate, based on the assumption that those of us who question the focus of the anti-FGM campaigns are indirectly supporting FGM by being overly sensitive to minority ethnic sensibilities. The dangers of refusing to act out of a fear of being labelled 'racist' were made clear in the northern English town of Rotherham. There, [fear of being labelled 'racist'](#) is thought to have left maybe 1,400 children in the hands of abusers.

This line was, for example, taken by [Leyla Hussein](#), who said to the Home Affairs FGM Committee: 'For me, you are being racist if you stay silent because you are saying a girl who is a brown colour is allowed to go through this, but for a girl who is white, blonde and blue-eyed, it would be an outrage'. And [Linda Weil-Curiel](#), a French lawyer, suggested: 'People talk of culture and tradition, but children have a fundamental human right not to be mutilated. It is racist to think otherwise'.

Others have questioned this deliberate put-down and turned it on its head by questioning the use of the word 'barbaric' in relation to FGM. The [Guardian](#), was singled out for particular attention in this regard by blogger [Matthew Smith](#), who explained that the word has been used for centuries to mean 'foreign' – that is, 'not us, therefore against us and/or less than us'. Smith rightly asks: 'Why do we use this imperialist put-down to refer to cultural practices we don't like?'

'Barbaric' is also the adjective currently being used to describe supporters of the Islamic State (IS). Are supporters or practitioners of FGM really the same as IS? I don't think so.

In Britain, from March to May 2014, a [Commons Select Committee](#) held an inquiry into FGM. Advance [written evidence](#) had been submitted by 52 parties, such as the NSPCC, the Local Government Association, health and social care specialists, the police, campaigners, etc. The inquiry was designed to look at what should be done to protect girls at risk of FGM, and why there had not yet been a successful prosecution for the crime in the UK, despite it being a specific offence since 1985, when the Prohibition of Female Circumcision Act 1985 criminalised the carrying out of, aiding or abetting an act of FGM. This Act was replaced and extended by the Female Genital Mutilation Act 2003, which came into force in 2004. With the new Act, the scope for prosecuting was extended to include outlawing the taking of a girl abroad for FGM. The maximum penalty for breaking the law was also increased in 2004 from five to 14 years imprisonment. Even before there was a specific FGM offence on the statute book, those carrying out acts of FGM could have been prosecuted for the offence of [assault occasioning actual bodily harm](#).

Twenty one witnesses representing campaigning/pressure groups, MPs, royal medical colleges, the NSPCC, health and social care professionals, the police and others gave oral evidence. Some [witnesses](#) provided gruesome and upsetting descriptions of their own experience of being cut as children. Some professionals came under pressure to explain why their organisations didn't have FGM on their radar or report instances to the police. The police were criticised for being too passive, waiting for survivors to come forward and report FGM; they'd investigated only 200 FGM-related cases in the previous five years. In 1993 and 2000, two doctors were struck off by the General Medical Council: one for performing FGM and the other for agreeing to carry out the procedure. The police hadn't prosecuted either.

The new director of public prosecutions (DPP), Alison Saunders, reported that the Crown Prosecution Service is hopeful of a conviction soon. Dr Dhanuson Dharmasena is being [prosecuted](#) for an offence contrary to S1(1) of the Female Genital Mutilation Act and Hasan Mohamed will face one charge of intentionally encouraging an offence of FGM, contrary to section 44(1) of the Serious Crime Act and a second charge of aiding, abetting, counselling or procuring Dr Dharmasena to commit an offence contrary to S1(1) of the Female Genital Mutilation Act. They [allegedly](#) re-infibulated a woman previously subjected to FGM and who'd given birth in London's

Whittington Hospital, in November 2012. Their trial is scheduled for January 2015.

But this was publicly criticised as a 'political' prosecution by [Dr Katrina Erskine](#), a leading gynaecologist. She accused the new DPP of putting politics before the welfare of women by announcing the historic prosecution days before she was due to appear in front of the Committee and said: 'It will put off midwives and doctors involved in caring for women with FGM and it distracts from where our main focus should be which is on driving out the real practice of FGM which is barbaric. I cannot help suspecting this has something to do with the DPP being up before the Home Affairs Select Committee and she needs something to say.'

Representatives from [France](#), whose FGM preventative work and management is considered a leader in the field, described their approach. Children up to the age of six have regular medical check-ups, including genital examinations. Although not mandatory, receipt of social security is dependent on participation. 'At risk' girls have medical examinations every year and whenever they return from abroad. Acts of omission are also criminalised. Failure to assist a person in danger can result in a heavy fine or imprisonment.

The select committee's [report](#) paid tribute 'to the work of a small number of individuals and groups who have worked tirelessly to raise awareness of FGM' and made a number of recommendations for achieving successful prosecutions:

- working with professionals in the health, education, social care and other sectors to ensure the safeguarding of at-risk girls;
- changes to the law;
- improved working with communities to abandon the practice; and
- better services for women and girls living with it.

Although the Royal College of General Practitioners had raised concern that it was often difficult to ask questions about FGM sensitively and directly, the Committee has recommended 'the inclusion of [mandatory questioning on FGM](#) for antenatal booking interviews and at GP registration' in its report.

The NSPCC, a leading child-protection charity which is constantly on the lookout for new forms of child abuse, has led the way in encouraging the public to believe that FGM is rife in modern Britain. It's become the main player in the field and the organisation to whom all are encouraged to refer or report concerns about FGM to. Significant resources have been granted

to the charity to support a dedicated, free 24-hour [FGM helpline](#) for people in the UK. This was launched in June 2013 and is well publicised.

In supplementary [evidence to the Commons Select Committee](#), Lisa Harker, NSPCC Director of Strategy, Policy and Evidence, advised that calls to the helpline were primarily received from professionals, relatives, carers or other concerned individuals. And in the nine months 'from launching the helpline on 24 June 2013, through to 31 March 2014 (*presumably she meant 2014*), we have received 198 contacts with 87 referrals made to the police'. The helpline is not exactly busy, is it? Twenty two contacts a month on average seems rather low.

Writer Saleha Ali, in a critical piece for [Spiked](#), suggested that in launching this helpline, the NSPCC 'is okaying suspicion of dark-skinned families' and of racist curtain-twitching by 'actively stoking mistrust between and among communities in the UK'.

Challenging the tidal wave

Opposing FGM is not controversial. Who would favour assaulting girls and mutilating their genitals? It's akin to asking banal, low horizon questions like '[Should girls be educated?](#)' or being invited, to "Like" (on Facebook) if you think every girl should be able to go to school or if you want to put an end to forced child marriage.

But we need to question *how* the practice of FGM is being opposed and consider the consequences because something so deeply embedded in some cultures as FGM needs to be dealt with understanding, tact, sensitivity and awareness.

However, in their zeal to bring adults to justice and secure a prosecution, the approach of some activists, organisations and campaigners leaves a lot to be desired. Demands for coercive measures include [mandatory genital exams](#) (MP Diane Abbott), [immigrants to sign an FGM declaration before entering the UK](#) (MEP Marina Yannakoudakis), [police operations at British airports to warn parents about taking their children abroad to undergo FGM](#) (Met Police Assistant Commissioner Mark Rowley), [compulsory teaching in schools](#) (Nick Clegg), [checks on holiday plans for FGM clues](#) (Association of Teachers and Lecturers), [and teaching children as young as five how to protest their parents' FGM plans](#) (NSPCC).

Fortunately, not everybody feels the need to suggest other measures in this vein or allows themselves to be railroaded into supporting what's become a crusade against FGM. A number have raised concerns.

The [Hastings Centre](#) report by the Public Policy Advisory Network on Female Genital Surgeries in Africa (2012) provides a thoughtful and comprehensive critique of the 'facts'. In it, the authors suggest that Western media coverage about FGM has been 'hyperbolic and one-sided, presenting them uniformly as mutilation and ignoring the cultural complexities that underlie these practices'. As the report is not easily accessed, Professor Lisa Wade has helpfully [summarised](#) the authors' concerns:

- Using the word 'mutilation' is counterproductive because some people who support genital cutting believe that a cut body is a more aesthetically pleasing one. People in communities where cutting occurs largely find the term 'barbaric' confusing or offensive;
- Media coverage usually focuses on one of the rarer types of genital cutting when just 10 per cent of cases involve infibulation (Type III);
- Research has shown that women with cutting are sexually responsive. Some even report 'rich sexual lives, including desire, arousal, orgasm, and satisfaction'. This is true among women who have experienced clitoral reductions and undergone infibulation, and women who've undergone less severe forms of FGM.

This point was recently confirmed by anthropologist [Fuambai Ahmadu](#), who specialises in female health and sexuality. She reported that women who have been circumcised can lead healthy sex lives and achieve orgasm. She also speaks from personal experience. Despite growing up and studying in the U.S., Ahmadu chose to be circumcised at age 21 in her home country of Sierra Leone. She was already sexually active at the time and the traditional initiation ceremony, in which her clitoris and labia were cut, did not negatively impact her sexuality. 'I was surprised to find out that there was absolutely no difference in terms of my sexual experience, sexual feeling, ability to achieve orgasm. There was absolutely no change at all.'

- Health complications of genital cutting 'represent the exception rather than the rule'. Reports frequently include lists of acute and long-term negative medical consequences of FGM, and while these

may feel intuitively true, evidence suggests that health problems are, for the most part, no more common in cut than uncut women: 'from a public health point of view, the vast majority of genital surgeries in Africa are safe, even with current procedures and under current conditions'.

Campaigners ignore this aspect because health justifications for opposing FGM are considered more acceptable to practising communities.

- Girls are not generally cut in response to the influence of cruel patriarchy. Most societies that cut girls also cut boys; some groups that engage in cutting have relatively permissive sexual rules for women, some do not; and female genital cutting practices are typically controlled and organised by women. (Correspondingly, men control male genital surgeries.)
- Western-led efforts to eliminate FGM are largely ineffective and sometimes backfire. Unsurprisingly, people don't appreciate being told that they are barbaric, ignorant of their own bodies, or cruel to their children. Benevolent strangers who try to stop cutting in communities, as well as top-down laws instituted by politicians (often in response to Western pressure) are very rarely successful. The most impressive interventions have involved communities being given resources to achieve their desired goals and then getting out of the way.

Some recent examples illustrate the last point. Although banned in Kenya, 3,000 [Maasai](#) women demanded that the government should allow them to practise FGM, arguing it constituted a vital part of their culture and one they didn't want to lose. In [Ethiopia](#), criminalisation of FGM has led to it being carried out clandestinely, in less than desirable conditions. And in [Egypt](#) - where 90 per cent of women are reported to undergo FGM, despite it being illegal there since 2008 - a 13-year-old died in 2013 from an antibiotic reaction following FGM by a medical doctor. Now standing trial, villagers continue to support him.

Some positive changes have been wrought in relation to the practice of [circumcision](#) and girls in Kenya now undergo new [rites of passage](#) that mimic the old ways. Girls experience all the elements of the ceremony, but are not cut.

Even in Somalia, a life-long, experienced ‘cutter’ [explained](#): ‘I use a blade, some material to stop the bleeding and some local anaesthetic. I go to the local health centre to get them. Before I used to remove all the clitoris and all the labia, major and minor, and sew them. Now I only remove the clitoris. I changed about 10 years ago.’

People’s views change

Contrary to some campaigners’ beliefs, there is objective evidence, albeit limited, that people who immigrate are willing to reconsider their views on FGM. Assuming they won’t without the ‘help’ of a plethora of professionals, campaigners, charities and organisations smacks of low horizons, determinism and racism.

This view is supported by Matthew Smith who wrote: ‘there is also a danger of falling into racism by assuming that all girls from any country where FGM happens are at risk (they are not), by assuming that the cultures involved will not change unless given the big stick by “civilised” whites, by branding a cultural norm which is not done for anyone’s gratification “child abuse”, by throwing around words like “barbarity” as if insulting a minority community with a different culture who consider themselves perfectly civilised will bring them on side.’

A good example of the potential for change is provided in regard to the Somali community, where 90 per cent traditionally have had FGM performed in their home country. A 2004 [study](#) among young Somalis in London describes how experiences and attitudes relating to FGM vary according to age on arrival in Britain. The authors conclude: ‘Living in Britain from a younger age appears to be associated with abandonment of female circumcision and with changes in the underlying beliefs on sexuality, marriage and religion that underpin it. Groups identified with more traditional views towards female circumcision include males, older generations, new arrivals and those who show few signs of social assimilation’.

Written [evidence to the Commons Select Committee](#) (P104) by the Victoria Climbié Foundation also confirmed that: ‘FGM is not a taboo topic; it is widely discussed within relevant communities and people are open to talking about it and discussing its effects on women and the family. One thing people feel united against however is the aggressive tactics used by

some campaigners and the media. A lot of people feel that their culture is being held hostage by outsiders who judge their cultural norms without understanding why they exist.'

[Matthew Johnson](#) has suggested that calling FGM barbaric and heretical transforms what is a complex and varied issue into a simplistic condemnation of parents who sincerely believe they are doing the right thing for their children. By extension, their children are also condemned as barbarian heretics and stigmatised as mutilated, compounding emotionally the physical injury inflicted by the cut.

Is FGM abuse?

I understand completely that FGM is illegal in Britain because it represents an assault on a child – therefore, it is considered to be child abuse. But what's not being acknowledged is that what's considered abuse by some isn't by others and context is important. For example, child labour and male circumcision are viewed as abuse by some societies but not where they're normal practices. Chinese foot-binding did not die out until the twentieth century, partly due to changing social conditions and partly as a result of anti-foot-binding campaigns.

Consequently, how 'abuse' is dealt with warrants consideration of the sensitivities involved. This should be factored into determining how we respond should we encounter 'at risk' girls or young women, or actual instances of FGM. Unfortunately, multi-agency practice [guidelines](#) (soon to be updated) and Multi Agency Safeguarding Hub ([MASH](#)) resources and procedures leave little opportunity for professionals to exercise judgement, driven as they are by an obsession with the 'safeguarding landscape' and tick box approaches to practice.

[Jay Kamara-Frederick](#), who had been sexually abused before having FGM at 15 years of age, disagrees vehemently with calling FGM abuse: 'I have a problem with that because I don't believe that a child who undergoes FGM comes from a family that is abusing them. Most come from a loving home. When you've been abused yourself you know what abuse looks like.' She also refuses to let herself be defined as mutilated, saying 'I am not FGM'.

Intent to cause harm must surely be a consideration also. There is no indication of such intent in regard to FGM. It's done as a one-off act, is done from a loving intent and is rarely repeated.

But mandatory reporting is now being encouraged for all types of suspected abuse, including FGM, and is considered a very good thing by organisations like the NSPCC. However, this removes and overrides professionals' responsibility to assess and form a judgement about specific circumstances and within specific relationships, as sociologist Frank Furedi notes in an article titled 'NSPCC: not in the best interests of the child'. Furedi draws our attention to the classic text, *The Best Interests of The Child*. The authors - Joseph Goldstein, Albert Solnit, Sonja Goldstein and Anna Freud - advised: 'Put yourself in a child's skin as you try to decide what guiding principles would best serve the child's interests.' From this perspective, what matters is not a procedural imperative.

Furedi continued: 'Sometimes, after careful reflection, many social workers, child professionals and teachers decide that if the disruption of a child's life, or the dissolution of an important bond and relationship, is judged on balance to be harmful, then it is morally wrong to involve the law. They rightly take the view that in certain specific instances, a child's interests are best served through some form of informal and low-profile intervention. They know that a child is not an abstract legal entity, hence they act on their suspicion in ways focused on the needs and interests of a particular child. Mandatory reporting removes the possibility of exercising judgement according to the specific needs of the child; it negates distinctions and offers administrative and technocratic solutions to what are existential problems confronting children.'

Is FGM a human-rights violation?

One of the commonest arguments proffered by campaigners against FGM is the claim that FGM is contrary to a child's human rights and therefore something that always has to be outlawed. But this argument assumes the issue that needs to be questioned - namely, is it necessarily always right to prosecute in cases of FGM? Those who claim that the issue has already been resolved by human-rights law are telling us more about their views of human rights - as an unquestionable set of laws that should be applied widely, regardless of the nuances involved - than about their views of FGM. Opposing FGM with pleas to human rights does not engage with the issue of FGM but does much to put the issue beyond debate by claiming that lawyers have already determined that the issue must be outlawed.

Strengthening the law

Alison Saunders, the DPP, [told](#) the select committee on FGM that there were a number of loopholes in the current legislation that she wanted to see closed, but added that the lack of prosecutions had stemmed from a dearth of evidence, rather than flaws in the legislation.

The committee has suggested that there is a strong case for strengthening the law on FGM, principally to ensure the safeguarding of at-risk girls, but also to increase the likelihood of achieving successful prosecutions. It also wants re-infibulation to be made a crime. That this denies an adult a very important right – that of bodily autonomy, seems to be irrelevant.

Presumably nobody thought it was important, even if they noticed, that there is a particular weakness in the [current legislation](#) (section 6 (1)), which states specifically 'girl includes woman' - thus treating an adult woman's capacity to consent as no different from that of a child. This denies a woman the right to bodily autonomy, namely to have her genitals altered in the absence of medical need. The law is framed to criminalise surgery that an adult woman has freely consented to.

Official responses

In Britain, referrals to social care and the police are encouraged when FGM is seen or suspected and both services recognise the importance of dealing sensitively with those referred.

According to the FGM committee's [case for a national action plan](#) 'Healthcare professionals have a vital role in breaking the generational cycle of FGM'. It would be a real shame, however, if a statutory service like the NHS, traditionally trusted by immigrants, was turned into a coercive arm of the state by making staff 'police' people's practices, escalate referrals of potentially 'at risk' people to social services and collude in introducing divisions between families.

The Victoria Climbié Foundation also drew the select committee's attention to this aspect: "There is an ongoing conflict between health professionals, trying to support the health and wellbeing needs of those being treated, and the police, who are proactively seeking referrals. The background of such cases is that the practice is viewed positively by those [family] who still support the practice, and thus is difficult for a young person to speak

out against one's family or community; not difficult out of fear, rather difficult because these are people that they love.'

Juliet Albert, Specialist FGM Midwife at Queen Charlotte's and Chelsea Hospital also [addressed](#) this in her submission to the committee: 'If we are going to refer all women with FGM to social services then we must ensure that the women do not feel persecuted, and that a social care referral results in an appropriate response. Otherwise there is a real risk that when women are asked whether they have FGM, that they will say "no". My personal experience is that women from vulnerable and refugee communities are fearful that social services will take their children away and this issue must be addressed and not simply ignored. My experience of social care referrals is that families are immediately treated as if they are criminals by social workers that are not knowledgeable about the causes and complexities of FGM.'

Dr Erskine [said](#): 'I have yet to see anyone born in the UK who has had FGM. I know it happens, but it is rare. All the women I have seen with FGM were born outside the UK and were cut before they arrived here.'

Dr Erskine also made the point that women need sensitive care which is what the [Specialist NHS Clinics](#) have been doing well and unobtrusively for years. Services available include de-infibulation or reversal of Type III FGM. It would indeed be a cruel irony if the first prosecution in Britain made the care of such women worse, not better.

I also agree with Jay Kamara who [said](#) that 'making FGM a child protection issue is not a good idea. Ripping children apart from loving families under false circumstance, calling it abuse... people think of abuse as sex abuse, violence, malnourished, neglect etc. No, it's part of a cultural system which the campaign is trying to stop. Call a thing something that's what it is. Mutilation is horrific – disfiguring.'

The police are also determined to do their bit. [Detective Chief Inspector Pook](#) has taken the lead on FGM cases in Avon and Somerset and has helped formulate the influential [Bristol FGM Model](#) which is now shared with other forces.

As part of '[Operation Limelight](#)' which began in May 2014, the police are focusing on 'hotspot' airports to identify and question potential FGM victims/supporters. And they are using anti-FGM campaigners like [Sarian Karim Kamara](#) to help educate and identify likely suspects. The operation is supported by the UK Border Force and the National Crime Agency, as well

as officers from the Met, Essex, Avon and Somerset, Greater Manchester, West Yorkshire, Sussex and West Midlands police forces.

The [Border Force](#), operating as 'Operation Eris', has an 80-strong team of specialist child-protection officers at Heathrow and teams of 65 at Gatwick (the Gatwick Angels) and 21 at Manchester. A new team also operates at the port of Harwich in Essex. Similar is planned at the ports of Calais and Dunkirk, and at Birmingham, Stansted and London City airports.

Greater Manchester was recently identified as one of six 'hotspots' in the UK. Based on intelligence from community members, officers recently stopped specific families at Manchester Airport returning on flights from countries such as Somalia. Detective Inspector Jeremy Pidd said: 'We simply say to them, "have you had this procedure done, how are things, you've been out in a risk area with a risk child for an awfully long time, have you had any problems, have you had this done?'"

That sensitive and tactful approach will surely have 'victims' confessing in droves!

Lawyers are now advising girls who've undergone the practice since it became illegal in Britain in 1985 that they may have a case against the state for failing in its duty of care to them. The implication is that we may see a flurry of litigation, the effect of which will be to encourage those who have had FGM to see themselves as 'victims' – which may, in the long run, be unhelpful to them, even if there is financial compensation as a result. The mayor of London, Boris Johnson, wants authorities to explore whether special provision could be made for FGM 'victims' bringing a case that doesn't involve her having to go to court. He wants perpetrators brought to justice based on evidence from health and other professionals.

Pester power: using girls to front campaigns

A successful tactic being used by anti-FGM campaigners is to project 'victim' campaigners into the limelight, and to use young women from the diaspora to front FGM campaigns that pressurise organisations and politicians to act: pester power with a difference. Some, like Bristol's [Fahma Mohamed](#), come from communities where FGM is still practiced. Others like [Malala Yousafzai](#), now a Nobel Peace Prize winner and famous for campaigning for Pakistani girls' rights to education, is also a supporter. She sees the lack of access to education and FGM as symptomatic of women's oppression.

Fahma, now a junior trustee of [Integrate Bristol](#), is credited with gathering 234,374 supporters via an online petition which led to Michael Gove, the then education secretary, writing to all school head teachers in England and Wales, asking them to support and protect young girls in the lead up to the 'cutting season' as the summer approached.

But Eritrean [Tsedal Tesfamariam](#) is highly critical of this approach suggesting that it is 'at best a waste of schools' time and at worst is a condescending and patronising initiative that echoes the 'let's save these savages from themselves' attitude that informed the Victorians who colonised our nations in Africa a hundred-plus years ago.'

At the Girl Summit in July 2014, Malala [called](#) on practising communities to change tradition, saying: 'We should not be followers of those traditions that go against human rights. We are the human beings and we make the traditions. Traditions are not sent from God. We have the right to change cultures and we should change it.'

That these different campaigners are granted such a sympathetic hearing in our morally disoriented times, where politicians have abdicated responsibility for political leadership and are constantly searching out new ways of connecting with the electorate, could perhaps be interpreted as using young people and campaigners so that they too can be seen as caring and interested in immigrant's well-being.

In that vein, the UK prime minister, David Cameron - the arch-representative of a desperate political class trying to find a way of connecting with a population it feels completely cut off from - [announced](#) at the Girl Summit that his government would legally oblige teachers, healthcare workers and social workers to report FGM, train professionals and criminalise parents if they failed to protect their children.

How should we deal with FGM?

Coercion isn't progressive, insensitivity scares people and pejorative labelling is alienating and unwelcome. That the practice is being challenged by many within their communities, despite all of this, is a credit to them. Some are realising that FGM is no longer necessary and that young women can aspire to more than they used to be able to. So what more should be done? And who should do it?

As 'Sharmini' wrote in response to my article on [Nursing Blog](#): 'The worst thing we could do in the developed world, where the practice is already a crime, is to embark on a moral crusade against the practice. This could only

be interpreted as an attack on their culture and make them more determined to hang onto outdated traditions. We need instead to tolerate difference, introduce them to our values and encourage their assimilation rather than frightening them into defending the outdated values they left behind in societies that are worlds away from ours.'

The onus therefore is on us to make immigrants feel welcome and not to assume their views are backward, fixed and impossible to change. People, if encouraged to assimilate, are influenced by new ideas, sometimes even welcoming them.

But we should be wary of penalising immigrants for holding on to old ideas. When people have a social norm they think is good, they'll get angry if told it's bad. Progressive change may not happen overnight or as rapidly as we'd like it to, but it's surely better that change comes about willingly, over time, rather than coercively. Supportive, sensitive work needs to continue within relevant communities by people and organisations who are trusted and who deserve that trust, and not foisting agendas they don't consider important onto them.

The Black Women's Health and Family Support ([BWHAFS](#)) recognises the importance of this: 'We recognise that the issue of FGM is not the most important concern within the affected communities. Many of the practising communities living in Britain are refugees still undergoing enormous cultural and environmental shock. This is why BWHAFS aims to build up the trust of these communities through supporting them with the issues affecting them in their daily lives, and not simply highlighting the problem of FGM. To do this would alienate us as an organisation from the very communities we are seeking to help.'

So, if organisations and campaigners who purport to represent immigrants' interest are seen as aligned to coercive state organisation and representatives, they may withdraw, become more alienated and less willing to engage. If the drive to seek prosecutions becomes paramount, it may foster suspicion about and unwillingness to access preventive services or health care provision until crisis point is reached. Campaigns that feel threatening, as some anti-FGM ones surely must, may even be counterproductive and a deterrent to encouraging progressive change.

If campaigners really want to help challenge the problems they believe FGM represents - such as patriarchy, women's second class status and oppression - it's worth remembering, as Furedi [said](#), that throughout history, the best antidote to cruelty was the cultural and educational

development of society. We need fewer laws and more opportunities for children and their parents to realise their potential.

What about girls who might be ‘mutilated’ before that change comes about, I hear you ask? While FGM is not desirable or necessary, neither is it the end of the world as many women have lived to testify. But if we continually tell children and young people that it is, it may well become that for them, with all of the associated psycho-social, confidence and self-esteem problems they’re told they will acquire. So until a girl is old enough to make decisions, her parents must be allowed to make them on her behalf.

Nor do I think a girl’s value is solely determined by what happens between her legs. As Jay Kamara [said](#): ‘How a woman looks underneath her clothes is for her to know. No one else. Degrading a woman by that terminology is horrible’.

Criminalising people’s behaviour in regard to FGM has already gathered far too much support and momentum. Just because our morally disoriented society finds it difficult to trust people to make judgement calls and behave in a responsible manner, it does not mean we should criminalise immigrants for their outdated traditional practices.

Nor is it in the child’s best interests. If that is our priority, we should rethink the crusading, zealous, negative thrust of anti-FGM campaigning. Children don’t need saving from their parents. The child protection industry is far more damaging. Consequently, strategies should be based on fact, not speculation and guesstimates.

The good work already being done by some campaigns that have a close relationship with the people they support, as well as the specialist health services, needs to be allowed to continue without any more pressure on staff to ‘escalate’ concerns. If not, women in need of those services may avoid them and communities may feel even more cut off, and become more inclined to re-embrace their traditions.

Professionals like nurses, doctors, teachers, nursery workers and the organisations who represent them should also question their support for and roles in these campaigns. Their professional autonomy and ability to exercise professional judgement is being over-ridden and undermined by agendas that they don’t necessarily subscribe to and are divisive. The resultant intrusion into the private lives of families that’s being encouraged exploits the trusting relationship that should exist between them and professionals. It also prevents professionals from offering a supportive service to families/clients/patients/customers. Barriers will go up if

immigrants feel that they are viewed primarily as mutilators – potential or actual, and guilty until proven innocent.

Nor should we support parents losing their freedom to bring up their children as they see fit. There's a developing trajectory towards overriding parent's rights when it comes to looking after what are considered 'vulnerable' children. The family of [Ashya King](#) discovered this recently when their child with a brain tumour was forcibly removed from them and they were imprisoned. Nobody loves children more than their families and we should reject measures that interfere with that and trust them do their best by them.

The anti-FGM campaign is a sledgehammer being used to crack a nut. A more subtle and sensitive approach to the issue has more chance of success in the long run and will avoid enormous harm.