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Guest Editorial

The role of nurses in tackling female genital mutilation

> The details are carved in my memory. I do not remember how old I was exactly, but I remember what happened to me after. I started bleeding intensely and the midwife had to use ice and cotton with oil to stop the bleeding. It did, but it was a painful process that I still vividly remember.
>
> Anonymous (Daily News Egypt, 6 February 2013)

In June 2013, a child aged 13 died during a surgical operation in a village near Cairo. The cause of death was not recorded; Suhair al Bata was not a hospital patient, but a victim of backstreet female genital mutilation (FGM). Despite being illegal since 2008 in Egypt, this practice remains widespread (*BBC News*, 19 June 2013a). In Somalia, 98% of women have been circumcised (House of Commons International Development Committee, 2013). The World Health Organisation (2013) estimates that 120–140 million women and girls have experienced FGM, mostly in Africa but also in the Middle East and elsewhere in Asia. Potentially causing lasting physical and psychological harm, there is a professional and political consensus that FGM is unethical and an abuse of human rights.

In recent years, FGM has become a major issue in the UK. The Female Genital Mutilation Act 2003 made taking a child for FGM anywhere in the world illegal, and increased the maximum period of imprisonment to 14 years (Home Office, 2004). Based on 2001 census data, the Foundation for Women's Health Research and Development (FORWARD, 2007) estimated that 66,000 women in the UK had experienced FGM, with over 20,000 girls at risk. However, these figures are likely to have increased substantially due to mass immigration from countries where FGM is widely practised, including a large Somali diaspora. Measuring the extent of FGM is restricted by personal and cultural privacy. There is no routine examination of schoolgirls to detect this practice, and it is unlikely to be reported by women and girls fearful of implicating their parents in crime.

FGM covers various procedures. In the typology of the World Health Organisation (2008), excision of the prepuce of the clitoris is the mildest form; most severe is infibulation, which entails removal of the clitoris and tying back of the labia, leaving only a small opening to the vagina. A systematic review of empirical studies of the consequences of FGM (Obermeyer, 2006) showed evidence of short-term and long-term harm, including haemorrhage, pain, pelvic and urinary infections, renal impairment, cysts, sexual dysfunction, complications in pregnancy and childbirth, and psychological trauma. However, the research has methodological limitations; despite statistical correlations, there is no robust evidence of a causative relationship between FGM and health problems (Simpson et al., 2012). Researchers should classify the type of FGM; inevitably the more radical the procedure, the greater the physical and psychological risk. In its action plan (Home Office, 2013), the British government has commissioned further research on the health effects of FGM.

In 2010, marking the International Day for the Elimination of Violence Against Women, the UK Government launched its programme *Ending Violence Against Women and Girls in the UK* (Home Office, 2010). One of the objectives is to eradicate FGM. A *Daily Telegraph* editorial (25 November 2009) argued that while the more widespread crimes of rape and domestic violence are included, this generic strategy was a smokescreen for confronting the culturally-specific problems of forced marriage, 'honour' killings and genital mutilation. While this view may be refuted, there is a tendency for the political establishments in Britain and Europe to tolerate cultural practices at odds with Western mores, partly to celebrate diversity, but also as defensive stance. In a recent series of cases of sex-grooming of vulnerable white English girls by men mostly of Indo-Pakistani Muslim background, local authorities were accused of failing to act due to the ethnicity of the abusers (Hargey, 2013). No sections of society should be stigmatised, but sometimes a nonjudgmental approach is negligent. In the notorious Victoria Climbie case, a black schoolgirl was killed by her parents after many years of opportunities for health and social care practitioners to intervene; in the enquiry report, Lord Laming (Department of Health and Home Office, 2003)

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warned of services subverting their priority of protecting vulnerable members of society with cultural sensitivity.

In 2013 the UK Government pledged £35million to tackle FGM, mostly for countries where it is traditionally practised (House of Commons International Development Committee, 2013). However, Britain is not setting a good role model in preventing FGM. Despite multi-agency guidelines devised within the broader policy of tackling violence against women and girls (Home Office, 2010), and increasing public and professional awareness of the issue, little action has been taken. Teachers are failing in their duty to report predicted or suspected cases, and when they do, social services are not placing girls on the Child Protection Register (*Evening Standard*, 5th March 2013). Not a single prosecution has reached a British court. Meanwhile, incidence of FGM may be increasing. The *Independent on Sunday* (20th December 2009) reported that 'cutters' are being flown to the UK to perform the procedure at 'parties' involving up to 20 girls. As acknowledged by the House of Commons International Development Committee (2013: 24), 'the UK's credibility in calling to end the practice overseas is undermined by the failure to tackle the problem at home'.

Undoubtedly, cultural sensitivity is a major challenge in dealing with FGM. While performed as a rite of passage, female circumcision is not merely ritual: it signifies chastity and an honourable marriage. Within communities that practise FGM, there is pressure for parents to conform, and possible loss of livelihood should the child and family be socially tainted. Although common in many Muslim countries, it predates Islam, and it appears to be more of a regional than a religious phenomenon. According to the Ahmadiyya Muslim Community (accessed 20 June 2013), the Shafi'i and Hanbali schools of jurisprudence consider male and female circumcision as obligatory, but such *Hadiths* (interpretation of the prophecy of Mohammed) are not generally accepted as Islamic ruling. The *Koran* does not mention circumcision. In 2006 the International Council of Nurses (*Nursing Ethics*, 2007) applauded a group of Muslim scholars for opposing female genital mutilation on the basis that Islam forbids inflicting harm.

Most professional literature and policy documents deny any relationship between FGM and Islam, but this overlooks the power of religious patriarchy. Clerics in Egypt have argued that the law prohibiting female circumcision should be rescinded, as this procedure tames women's sexual impulses (*BBC News*, 19 June 2013b). One of the most influential figures to speak out against FGM is Somali feminist writer Ayaan Hirsi Ali, an apostate and staunch critic of Islam. Having had a clitoridectomy at five years of age, Hirsi Ali regards FGM as cruelty. During her time as a member of the Dutch parliament she proposed mandatory annual examination of girls with a background in countries with a tradition of this practice, with suspected cases to be investigated by the police. While this level of surveillance was not enacted, the Netherlands recently tightened legislation against FGM, allegedly leading to many of its Somali residents moving to the UK (Cameron, 2013). Many Muslims believe that for spiritual purity the prepuce should be removed from the clitoris, just as the foreskin is removed from the penis; some argue that minor clitoral excision (which accounts for the majority of female cases) should not be classed as FGM.

We would like to draw attention here to the neglected issue of circumcision of boys. Widely practised in the past, male circumcision was based on exaggerated belief in health benefit, but there are very few medical circumstances today justifying this operation, which can cause infection and copious bleeding. The British NHS displays double-standards on circumcision, in some areas continuing to operate on boys for religious reasons NHS (2010). Local decision-making is promoted in the NHS, and without a clear national policy for male circumcision, commissioning bodies in catchments of particular demography are supporting this cultural tradition. This highlights the need for a child-specific rather than gender-specific policy. It is absurd that FGM is denounced as an appalling crime, while male genital mutilation is performed in the British NHS at taxpayers' expense. The same principle is at stake: part of a child's anatomy is removed without consent, inflicting pain without clinical purpose. A proposed ban by the German government fell to Jewish opposition; however, at least a stand was made, unlike in Britain where policy-makers do not see any equivalence between male and female circumcision. In pursuit of equality, this anomaly must end.

Despite the law against FGM, in practice there is lack of clarity on who would be prosecuted. A policy titled *Ending Violence Against Women and Girls* obfuscates perpetration and victimhood, because mothers may be complicit or actively involved in FGM. Royal College of Nursing guidelines (RCN, 2006) make the same mistake of assuming woman/mother and girl/daughter are on the same side. Although misogynist oppression may be a strong underlying force, female circumcision is regarded as 'strictly women's business' (Cameron, 2013), and genitalia are most likely to be severed by a woman. Hirsi Ali (2010) described how her father opposed FGM, but while he was imprisoned as a political dissident in Somalia, her grandmother took her to be cut. Blunt gender stereotypes, therefore, may not reflect the reality of FGM, and there is a danger of infantilising women from traditional ethnic backgrounds. A nurse from Bristol Safeguarding Children Board (*Independent on Sunday*, 20th December 2009) argued that parents commit their child to FGM through love, and that only the cutters should be prosecuted. Irrespective of culture, parents are responsible for their children's welfare. In a landmark case in Spain (*Daily Telegraph*, 13 May 2013), both Gambian parents of a schoolgirl were jailed for six years, despite claiming no knowledge of their daughter's clitoridectomy. Physical violence against a child would not be accepted, so should genital destruction be excused? Furthermore, is it realistic to haul nameless, veiled operators from the hinterlands of Sudan or Yemen to a British court?

Although FGM is a crime, it cannot be stopped by criminal proceedings alone. The law does not make exceptions on cultural grounds, but an absolutist approach may be counterproductive, as there is a danger of ostracising communities, potentially leading to refusal to