Female genital mutilation: a dilemma in child protection

the Children Act, if the girl and her parents deny that she is to undergo female genital mutilation. Can we go to court to seek care proceedings solely on comments made to a teacher in school, or on the basis of playground conversations? Should we put all Somali girls on the ‘at risk’ register? If they were registered how could we ensure that they have not been mutilated, given the rights parents and children have under the Children Act to refuse consent to medical examination?

Even when we have evidence that a girl has been mutilated what kind of response is appropriate? Do we want to remove a child from the care of parents who believe that they have acted in her best interests and indeed may be model parents in all other aspects of her care? In such cases we believe the best approach is to request a police investigation to see if there are grounds for prosecution of the parents and/or others under the Prohibition of Circumcision Act. A subsequent approach, rather than set in motion child protection procedures after the event.

There have been several referrals made in the last two years but in no case was there enough evidence to proceed with the powers available under the Children Act 1989. One of these referrals involved a family with three girls who subsequently were taken to Ethiopia and may have been circumcised. This case has been referred by the police to the Criminal Prosecution Service.

Naive approaches such as ‘sensitive counselling in the child health clinics’ are unlikely to have any impact upon a custom thousands of years old. Such an approach, involving flagging up of female genital mutilation at health consultations for unrelated issues would only alienate clients and could amount to harassment. Female genital mutilation is only discussed during client/professional contact if that contact arises out of a formal referral regarding the practice or if the presenting complaint could result from, or interact adversely with, female genital mutilation.

Conclusion

A recent editorial recommended that ‘by working together local women and international organisations will be most effective in eliminating ... female genital mutilation’. We would add that local statutory and voluntary agencies and all members of the community, not just women, should be included in any initiative. However upsetting, we are mindful that despite our best endeavours some children in this area may suffer this mutilation. We believe that our approach, that is, one based on empowerment, will in the long term be the one that protects most children and helps the communities themselves to reject the practice.

With thanks to Maria Michael and Mina McElwain (South Glamorgan Social Services), Graham Anthony (South Wales Police), Dr Heather Payne (South Glamorgan Health Authority), and John Clark.


Commentary

Female genital mutilation has been illegal in the UK since 1985.1 No prosecutions have been brought in the UK (Guardian 22 Nov 93) but in November of 1993 a medical practitioner was brought before the General Medical Council charged with performing multiple female circumcisions, knowing the operation to be against the law. He was struck off.

It is estimated that in the UK 10 000 girls are currently at risk of genital mutilation, a traditional practice that is not based in religion but rather in concepts of fertility, female sexuality, and marriageability.2 Genital mutilation is widely practised by many ethnic groups from west, east, and north eastern parts of Africa. Hosken provided an estimate of the prevalence of genital mutilation from over 90% in Somalia to 50% in Egypt to 20% in Ghana.3 Over half the African nations do not practise female genital mutilation.4 The African Charter on the Rights and Welfare of the Child stresses that positive traditional values and cultures be preserved and strengthened, but requests in its Article 21, that, ‘appropriate measures be taken in order to eradicate traditional practices and customs which are prejudicial to the health of the child’. Currently 26 African countries have committees established after an initiative in 1984 to work towards eliminating female genital mutilation and other damaging customs (the Inter-African Committee Against Harmful Traditional Practices Affecting Women and Children).

The current debate extends from the United Nations, the Convention on the Rights of the Child advocates eradication of genital mutilation, to governments, but most important is the impact of women working at a local level.

The description of female mutilation and the possible physical and psychological sequelae are well known for the girl or woman but less well documented is the effect upon her partner and the consequences for their sexual relationship.

The way forward is difficult but much has already been achieved. There is legislation available in the UK, the 1985 Act, the Children Act 1989,6 and there is advice in Working Together 1991 as to how children might be protected.7 However, it is ‘through sensitive community education and social work intervention’ that progress is likely to be made.4 As a last resort a prohibitive steps order or a care order may be needed to ensure the girl’s protection (Children Act 1989).

From the 1989 First National Conference on Female Genital Mutilation in the UK guidelines as to management were agreed:

- Female genital mutilation is the preferred terminology

• It is a form of child abuse and a criminal offence
• Professional workers need education to understand the practice of genital mutilation
• Locally there should be a consultative body within social services departments incorporating black community members to set up bridges with the community
• Education is pivotal and funding for local groups is needed
• Counselling for parents should be available – it is difficult for loving parents to see their own behaviour as abusive, but rather will they compromise their daughter’s long term future by adversely affecting her marriage prospects?

Webb and Hartley describe their practice in Cardiff. In discussion with their local Somali community they have found diverse views from those who would wish to repeal the 1985 Act to those wanting to know the health risks and the law. They feel strongly that education in the context of a programme to improve the health and welfare of their population is likely to be most efficacious. But in addition they emphasise the need for all members of the community to become involved as well as voluntary and statutory agencies. Ultimately it is hoped that by empowering the community the practice will be rejected. They also feel that a campaigning style would alienate this already disadvantaged group and drive female genital circumcision underground (or abroad).

The Cardiff initiative is welcome, with programmes like fast track referral to a female gynaecologist to perform defibulation. They appear to have less success than others in a direct approach to families where children are thought to be at risk. There are child protection issues involved and a foreword in the latest document from Hedley and Dorkenoo, endorsed by the Minister of State for Health, says that a firm but sensitive approach is needed using legislation if necessary.

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