

# Understanding Female Genital Cutting in the United Kingdom within Immigrant Communities

Christelle N. Onwu

*The age-old tradition of Female Genital Cutting (FGC), most commonly known as Female Genital Mutilation (FGM), is a coming-of-age ritual practiced in some countries in Africa, the Middle East, Asia, and Latin America. It is also practiced in the immigrant communities that migrate from these regions to Western countries. There are a multitude of physical and mental health issues associated with FGC, including chronic infections, infertility, anxiety and depression, complications during childbirth, and death. In 1985, the United Kingdom criminalized the practice of FGC in order to eliminate it. However, evidence suggests that criminalization has been ineffective and that immigrant communities continue to practice FGC without proper medical training and equipment. This paper proposes that replacing criminalization with harm reduction programs will allow policy makers to obtain accurate data on FGC in the UK in order to inform the development of future programs that will ultimately eradicate the practice.*

## Introduction

The United Nations, the World Health Organization, and other advocacy groups declare that Female Genital Cutting (FGC) is a human rights violation and an act of gender-based violence (World Health Organization, 2015). Many countries support the eradication of FGC, including countries where it is commonly practiced, such as the Central African Republic, Egypt, Eritrea, Ethiopia, Kenya, and Uganda. Furthermore, eighteen African countries and several Western countries, including the United Kingdom, France, and Canada, criminalize the procedure (Human Rights Watch, 2010). Seeking to eliminate a culture's intergenerational practice can be challenging, especially when it is deeply rooted in the culture's traditions.

The criminalization of FGC in the UK has been ineffective for two primary reasons. First, when FGC is performed in the UK, the procedure is done in private locations without medical personnel, so there is no official documentation (NHS Choices, 2014). Second, young girls are frequently transported back to their country of origin to have the procedure completed in order to bypass the UK's criminalization laws (NHS Choices, 2014). As a result, evidence of FGC is lacking, making it difficult to prosecute those involved and to obtain accurate numbers of the prevalence of FGC in the UK.

Over the past decade, an increasing number of Africans have fled their countries to seek asylum in the UK, and it is likely that the incidence of FGC will rise accordingly (Topping, Laville, & Carson, 2014). In order to fully protect young girls from the physical and psychological ramifications of FGC, it is essential that the UK government reexamines the criminalization of FGC and establishes a more effective policy. To successfully eliminate FGC in the UK, it is necessary for the government to first accurately measure the scope of the issue. This may be achieved by implementing a harm reduction approach that decriminalizes FGC for girls under the age of sixteen. Decriminalization will reduce avoidable negative health outcomes associated with the practice and allow victims and those involved in FGC to feel safer discussing their experience without fear of prosecution. Obtaining this data will allow researchers and policy makers to collect adequate information and be better equipped to create programs and policies that more effectively address FGC.

## Background Information

There are three types of FGC that are frequently practiced. Type I is a clitoridectomy, during which the clitoris is partially or fully removed; Type II is partial or complete removal of the clitoris and inner labia and may include removal of the labia majora; and Type III is the removal of the external genitalia and the narrowing of the vaginal opening (NHS Choices, 2014). While all types of FGC are harmful, Types I and II

are considered least invasive. Women who undergo Type III are especially at risk of developing health issues (Desert Flower Foundation, 2015).

It is estimated that over 20,000 girls in the UK under the age of 15 are at risk of FGC every year (United Kingdom Government, n.d). Girls considered “at risk” are members of communities that practice FGC and are therefore more likely to undergo the procedure. However, these numbers are approximations, as researchers are unable to measure the exact number of women who have undergone FGC in the UK. Regardless of the fact that FGC is considered a human rights violation, many cultures continue to perform FGC on girls before they begin menstruation as a symbolic ritual for the entrance into adulthood (Chalabi, 2013; Althaus, 1997).

In the UK, FGC is primarily performed by first generation immigrants and asylum and refugee seekers (NHS Choices, 2014). Some African immigrants perform FGC to culturally define themselves in contrast to Western norms. In certain communities, un-cut women are considered “unclean” and not fit to marry (Althaus, 1997). This is a common belief in communities that practice Type III circumcision because a woman is able to demonstrate her virginity (Althaus, 1997). Moreover, many communities perform FGC to reduce a female’s sexual desire by removing what is considered the most masculine part of female genitalia (the clitoris and labia), which, in turn, is meant to enhance obedience and fertility (Althaus, 1997).

Traditionally, a midwife who has little or no medical training performs FGC. Anesthetics and antiseptic treatments are not generally used, and the practice is often carried out with knives, scissors, scalpels, and pieces of glass or razor blades (NHS Choices, 2014). All three types of FGC may lead to infections post-surgery, pain during sex, and, in some cases, death (Toubia, 1994). Type III can cause chronic pelvic and urinary tract infections that could potentially result in kidney damage, small and large tumors forming along scar tissue, infertility, painful menstruation, and complications during and after childbirth (Toubia, 1994). Additionally, health problems frequently result from the unsanitary conditions and lack of mental and physical health information provided to women before and after the procedure, as well as from the nature of the procedure itself (Toubia, 1994).

### **Criminalization of FGC in the United Kingdom: Has Criminalization Been Effective?**

Although the aim of criminalizing FGC is to protect young girls and ultimately eliminate the practice, the UK has yet to make a conviction despite evidence suggesting that the practice still occurs. One study conducted in September 2014 found that 467 women sought medical treatment in the UK due to complications originating from FGC procedures within a one-month period (Vissandjée, Denetto, Migliardi, & Proctor, 2014). Over the past decade, the UK has increased its efforts to arrest individuals involved in FGC, including offering a £20,000 reward for information on FGC, hosting FGC helplines, and performing airport searches during summer “cutting seasons” (Ridley, 2015). While efforts have been effective in identifying cases for inquiry – with investigations occurring for 41 cases in 2013, compared with 25 in 2012, and 8 in 2011 – the cases lacked evidence for trial (Ridley, 2015). Mak Chishty, the national police commander in charge of investigating FGM in the UK, acknowledged the difficulty in prosecuting FGM cases: “If you haven’t got a compliant victim, or when and where the offence occurred, or any of the complexities we need to prove beyond reasonable doubt, there can be difficulties” (Ridley, 2015, p.2). The low conviction rate of those who perform FGC is due in part to the lack of reporting from those who have undergone the procedure, as FGC is frequently performed by friends or relatives of the victims (Kern, 2013). The lack of FGC-related arrests and convictions, despite the glaring evidence that FGC is being performed in the UK, suggests that the criminalization of FGC has not been effective.

### **Harm Reduction as an Alternative to Criminalization**

Harm reduction is an approach that decreases the health risks associated with certain behaviors by promoting safer options if complete abstinence is unattainable (Shell-Duncan, 2001). Over the last decade, harm reduction has gained increasing popularity in the field of public health, especially as a substance abuse intervention. The effectiveness of the harm reduction approach is evident in the needle exchange and drug education programs that emerged in response to the AIDS epidemic (Shell-Duncan, 2001). As discussed in Strathdee and Vlahov (2001), an international comparative study found that cities with needle exchange programs had a 5.8% decrease per year in the incidence of HIV in contrast with a 5.9% yearly increase in the incidence of HIV in cities that did not have established needle exchange programs.

Similarly, rather than criminalizing FGC, using a less punitive approach to eliminate the practice could prove beneficial. Harm reduction and educational outreach programs that are culturally appropriate would likely be more acceptable and influential within immigrant communities. Shell-Duncan (2001) argues that using medicalization as a harm reduction approach is a more effective way to improve women's health in instances where eliminating the procedure entirely might not be possible. A harm reduction strategy could reduce risk of medical complications by improving hygienic conditions, providing preventive medical measures, and the skill level of the cutter, subsequently lowering the amount of cutting, and presumably, risk of complications (Shell-Duncan, 2001).

Although decriminalization does not align with the zero tolerance policy of FGC adopted by many countries, studies have found that when medical services-using sterilized instruments, anti-tetanus injections, and prophylactic antibiotics-are used during the FGC procedure, negative health outcomes, such as infections, are effectively reduced by as much as 70% (Shell-Duncan, 2001, p.1019). Additionally, research by Ruderman (2013) supports the assertion made by Shell-Duncan (2001) that harm reduction is significant – if not essential – in decreasing medical complications that result from FGC. Reducing medical complications saves money and other resources that would otherwise be used on medical treatments incurred by complications from undergoing FGC (Ruderman, 2013). Thus, decriminalizing the procedure might both increase the safety of women at risk of FGC and save government funds (Ruderman, 2013).

In addition to helping women at risk of FGC, adopting a harm reduction approach may also reduce the harm experienced by women who have undergone the procedure, as they would be more likely to seek medical treatment when complications arise. Studies have shown that women in some regions of Sudan hide FGC complications for fear of legal repercussions (Shell-Duncan, 2001). Furthermore, as a result of a rise in infection and health-related complications, Indonesia overturned the 2006 ban on FGC, as it forced individuals to perform the procedure in secret, unhygienic conditions (Ruderman, 2013). Evidence from these case studies suggests that decriminalizing FGC for consenting adults over the age of sixteen in the UK would allow women with complications to seek treatment without fear of punishment. This would both reduce the overall harm experienced by victims of FGC and simultaneously help researchers obtain accurate data on the prevalence of the practice in the UK.

### **A Culturally Sensitive Approach**

A policy that aims to ultimately eliminate FGC within immigrant communities in the UK must consider culture and tradition. In addition to decriminalizing FGC, the UK should implement educational outreach campaigns to reduce the demand for FGC procedures (Vissandjee et al., 2014). In Kenya, for example, forums that educate on the risks FGC and encourage collaboration to create alternative coming-of-age rituals proved effective when led by village members (Tenoï, 2014). The success of these campaigns relies heavily on ensuring that outreach agents come from within the community and understand the history and cultural meaning of the practice. A similar approach to educational outreach might be effective in immigrant communities in the United Kingdom as well.

A Kenyan woman, Sarah Tenoi, successfully reduced FGC in her community by 20% through the introduction of a new alternative to FGC as a rite of passage (Tenoi, 2014). Although Kenya outlawed FGC, some still practice the procedure, as it is deeply rooted in their cultural values. Having been a victim of female circumcision herself, Tenoi understood the needs of her village and collaborated with the community to educate them about the dangers of the practice. Tenoi's message was not to change the culture of her fellow men and women, but to alter one aspect of the culture that resulted in negative outcomes for women. She stated:

Circumcision in Maasai culture marks the transition from girlhood to womanhood ... to move away from female genital cutting we have developed an alternative rite of passage, in which the girl experiences all the elements of the ceremony but is not cut. (Tenoi, 2014, p.2)

Utilizing Tenoi's success as a model, the UK government could collaborate with women who have undergone FGC to reach out to their communities within the UK.

## Conclusion

While it is well documented that serious physical and mental health issues originate from FGC, the practice cannot be eradicated overnight. Because the criminalization of FGC in the UK has not been effective and data is not available to accurately analyze the scope of the issue, policy makers must take a different approach. Such alternatives include a harm reduction approach that decriminalizes Types I and II while developing outreach programs with members from the community. Advocating for decriminalization does not, in principle, align with many human rights documents that condemn gender-based violence and have a zero tolerance policy for FGC. Yet with decriminalization and harm reduction, researchers and policy makers will be able to gather accurate information on the prevalence of FGC in the UK, allowing for the creation of policies and programs that utilize actual data as evidence. Additionally, to work toward eventual elimination, the UK must establish a culturally sensitive outreach campaign that educates immigrant and refugee communities on the risks of FGC and possible alternatives to the practice.

## References

- Althaus, F. A. (1997). Female circumcision: Rite of passage or violation of rights? *International Family Planning Perspectives*, 23(3), 130-133. Retrieved from <http://www.guttmacher.org/pubs/journals/2313097.html>
- Chalabi, M. (2013, June 24). Female genital mutilation: How prevalent is it? *The Guardian*. Retrieved from <http://www.theguardian.com/news/datablog/2013/jun/24/female-genital-mutilation-prevalence-uk>
- Desert Flower Foundation. (2015). What is FGC? Retrieved from <http://www.desertflowerfoundation.org/en/what-is-fgm/>
- Human Rights Watch. (2010). Q&A on female genital mutilation. Retrieved from <http://www.hrw.org/news/2010/06/10/qa-female-genital-mutilation>
- Kern, S. (2013, May 9). UK: *The crisis of female genital mutilation*. Retrieved from <http://www.gatestoneinstitute.org/3705/uk-female-genital-mutilation>
- NHS Choices. (2014). Female genital mutilation. Retrieved from <http://www.nhs.uk/conditions/female-genital-mutilation/pages/introduction.aspx>
- Ruderman, R. (2013). Female circumcision: The effects of harm reduction policies. *Michigan Journal of Public Affairs*, 10. Retrieved from <http://mjpa.umich.edu/files/2014/08/2013-Ruderman-FemaleCircumcision.pdf>
- Ridley, L. (2014, February 9). FGM trial: Why has no-one ever been convicted in Britain despite the practice been illegal for 30 years. *The Huffington Post*. Retrieved from [http://www.huffingtonpost.co.uk/2015/02/04/fgm-police-lead-mak-chisty-convictions-charges-evidence-illegal\\_n\\_5747672.html](http://www.huffingtonpost.co.uk/2015/02/04/fgm-police-lead-mak-chisty-convictions-charges-evidence-illegal_n_5747672.html)
- Shell-Duncan, B. (2001). The medicalization of female 'circumcision': Harm reduction or promotion of a dangerous practice? *Social Science & Medicine*, 52(7), 1013-1028. doi:10.1016/S0277-9536(00)00208-2
- Strathdee, S., & Vlahov, D. (2001). The effectiveness of needle exchange program: A review of the science and policy. *AIDS Science*, 1(16). Retrieved from <http://aidsscience.org/Articles/aidsscience013.asp>
- Toubia, N. (1994). Female circumcision as a public health issue. *New England Journal of Medicine*, 331(11), 712-716. doi:10.1056/NEJM199409153311106
- Tenoi, S. (2014, February 6). An alternative to female genital mutilation that prevents girls suffering. *The Guardian*. Retrieved from <http://www.theguardian.com/commentisfree/2014/feb/06/alternative-to-circumcision-prevents-girls-suffering-kenya>
- Topping, A., Laville, S., & Carson, M. (2014, February 6). FGM is banned but very much alive in the UK. *The Guardian*. Retrieved from <http://www.theguardian.com/society/2014/feb/06/female-genital-mutilation-foreign-crime-common-uk>
- United Kingdom Government. (n.d.). Female genital mutilation: The facts. Retrieved from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/300167/FGM\\_leaflet\\_v4.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300167/FGM_leaflet_v4.pdf)

© 2015 Onwu. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits the user to copy, distribute, and transmit the work provided that the original author(s) and source are credited

Vissandjée, B., Denetto, S., Migliardi, P., & Proctor, J. (2014). Female genital cutting (FGC) and the ethics of care: Community engagement and cultural sensitivity at the interface of migration experiences." *BMC International Health and Human Rights*, 14(13). doi:10.1186/1472-698X-14-13.

World Health Organization. (2015). Classification of female genital mutilation. Retrieved from <http://www.who.int/reproductivehealth/topics/fgm/overview/en/>

**Christelle N. Onwu** is a second year student at Columbia University School of Social Work with a concentration in Policy and field of practice in International Social Welfare for Services to Refugees and Immigrants. She is currently interning at Safe Passage Project at New York Law School.