

Female genital mutilation: the role of health professionals in prevention, assessment, and management

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Female genital mutilation (FGM), also known as female circumcision or cutting, is thought to affect 100-140 million women worldwide.¹ It describes a range of procedures, often involving partial or total excision of the external female genitalia, that are carried out for non-medical reasons (box 1; figs 1-4).² FGM breaches international human rights law, in particular the United Nations Convention on the Rights of the Child,³ and has been criminalised in much of the world, including many African countries in which it is traditionally practised. The United Kingdom is one of several Western countries that have enacted specific legislation in response to international migration (box 2).⁴

An estimated 66 000 women who have undergone FGM

live in England and Wales, with a further 20 000 children at risk.⁶ Minority ethnic communities are highly concentrated geographically in the UK, and these women live mainly in London and other large cities. The estimated proportion of maternities (pregnancies resulting in one or more registered births) in women with FGM in inner London was 6.3% in 2004 compared with a national average of 1.48%.⁶

Despite legislation and the thousands of girls thought to be at risk, no prosecutions have been made for FGM in the UK, and there is little published evidence about FGM as a health problem. The limited knowledge and attitudes of professionals might contribute to the under-reporting of cases and poor collection of evidence.⁴ A drive

SOURCES AND SELECTION CRITERIA

The multiagency guideline published by the UK government in 2011 was a key source for this article. We also searched the literature and the databases of international organisations for other clinical guidelines, reviews, and articles relevant to the topic. This published material was then supplemented by clinical experience and personal communications with the Metropolitan Police and community workers. We also performed Medline and Google searches using the search terms female genital mutilation, female genital cutting, female circumcision, and FGM along with guidelines and management. Particular areas of interest were then investigated with more specific searches.

Box 1 | Classification of female genital mutilation⁵

Type 1: Partial or total removal of the clitoris or prepuce, or both
Type 2: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora
Type 3 (infibulation): Narrowing of the vaginal orifice with creation of a covering seal by cutting and opposing the labia minora or majora (or both), with or without excision of the clitoris
Type 4: All other harmful procedures to the female genitalia for non-medical purposes—for example, pricking, piercing, or cutting

Box 2 | UK law and female genital mutilation (FGM)

Since 1985, a person who performs FGM or aids, abets, counsels, or procures FGM has committed an offence under UK law (Female Circumcision Prohibition Act 1985). In 2003, the law was amended so that anybody who aids, abets, counsels, or procures FGM outside the UK on any UK national or permanent resident is also guilty of a criminal offence (Female Genital Mutilation Act 2003). This revision attempted to close the loophole whereby children were being taken overseas by their families for the purposes of FGM. It also raised the maximum penalty for conviction from five to 14 years in prison.

A select committee report in 2010 documented that the Metropolitan Police Service had been involved with 46 so called incidents of concern relating to FGM during the financial year 2008-9 and 58 in 2009-10 (www.mpa.gov.uk/committees/cep/2010/101104/08/); in 2010-1 this number was 31. Most of these were early intervention cases involving girls thought to be at risk. In particular, midwives and health visitors caring for affected women have made referrals when they thought that girls in the family were at risk. There has been most success with increased reporting in London boroughs where Project Azure has been involved in multiagency training.

In the few cases where a criminal investigation has taken place the police have been unable to proceed to formal charges or prosecution. Reasons for this include:*

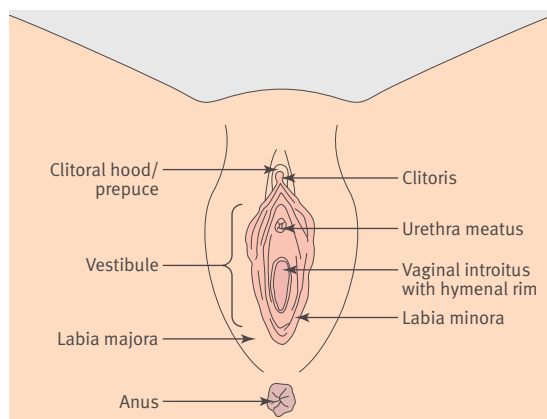
- The girl was unwilling to testify
- Diplomatic immunity in the case of a child of a foreign consular worker
- The girl or her family alleged that FGM took place before they were UK nationals or permanent residents
- In a provincial force, a lack of knowledge about FGM by a paediatrician and a Crown Prosecution Service lawyer who considered that the pursuit of a case was not in the public interest as it was a "cultural issue"

*Thanks to the partnership team on the Child Abuse Investigation Command Unit at the Metropolitan Police for providing this information.

SUMMARY POINTS

Female genital mutilation (FGM) is a form of child abuse and is illegal in the UK. It is also a criminal offence to arrange (or try to arrange) FGM overseas for a UK national or permanent UK resident. FGM is prevalent in certain UK minority and ethnic communities, and health professionals should be aware of its likelihood within their patient populations. Health professionals must identify the local services available for women seeking help and children at risk. Training is essential so that health professionals can raise the matter with women sensitively and advise families on the UK legal position. All pregnant women from practising communities must be asked about FGM at routine antenatal booking; systems should be in place for this information to feed back to the community team.

Fig 1 | Unaltered female genitalia



for increased awareness was kick started by the publication of comprehensive multiagency practice guidelines on FGM by the UK government in February 2011.⁷ Health professionals, particularly those in primary care, must be better informed for practice to improve. This article provides health professionals with a practical approach to the assessment and management of women and girls with FGM, coupled with strategies aimed at prevention.

Why is FGM performed?

Women surveyed cite tradition as the primary reason for performing FGM.⁸ Other reasons relate to virginity (by preserving chastity and preventing promiscuity), religious requirements, cleanliness, and marriage prospects. It is an ancient practice that is not unique to any one religion. FGM

is not advocated in the Koran or any other holy text and has been widely condemned by Muslim clerics.⁹

More broadly, FGM can be seen as a manifestation of sexual inequality and a form of gender based violence. We must acknowledge the West's own history of female circumcision—as late as 1936 medical professionals advocated cauterisation or removal of the clitoris as a cure for masturbation,¹⁰ and today some would argue that cosmetic genitoplasty constitutes a form of FGM.^{11 12}

Parents, more often mothers, arrange for daughters to have FGM in the belief that it is in the girl's best interests; this distinguishes it from most other forms of child abuse.

How is FGM performed?

FGM is practised in more than 26 African countries, and in a few populations in Asia and the Middle East. The type of mutilation practised varies geographically. Infibulation (see box 1) is largely confined to northeast Africa: Ethiopia, Eritrea, Somalia, and Sudan have prevalence rates of 74%, 88%, 88%, and 89%, respectively.¹³

Most women and girls with FGM in the UK are immigrants who have undergone the procedure before their arrival. It is also suspected that some UK girls undergo FGM in the UK or during holidays overseas to the family's country of origin.⁷

The age at circumcision varies between countries. In Ethiopia, Eritrea, and the Yemen, most girls will have been cut before their first birthday, whereas in Egypt 90% of girls are circumcised between 5 and 15 years of age.⁸ Very few women undergo FGM as adults.⁸

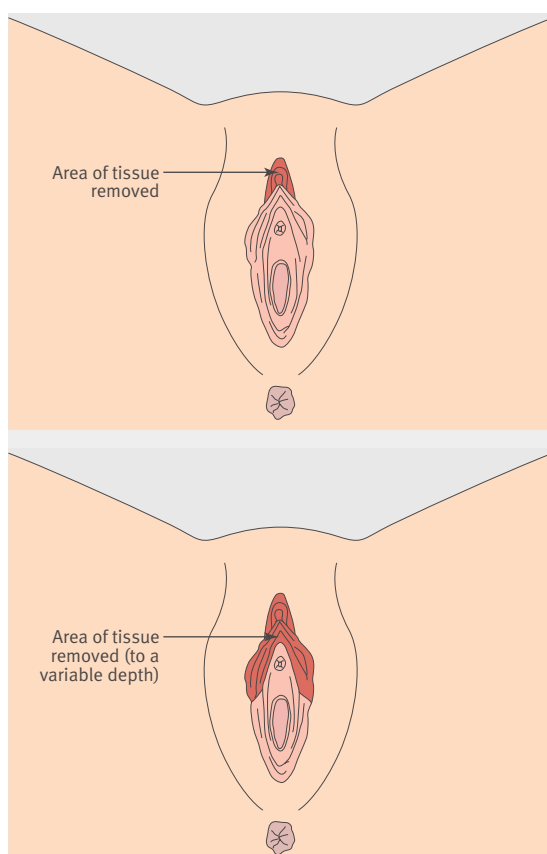


Fig 2 | Tissue removed in type 1 female genital mutilation (top) and type 2 female genital mutilation (bottom)

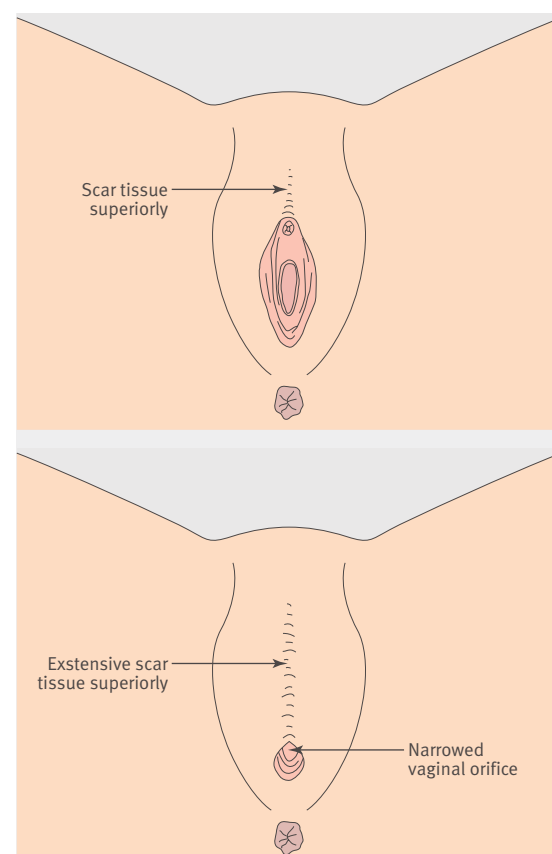


Fig 3 | Appearance of type 2 female genital mutilation (top) and type 3 female genital mutilation (bottom)



Fig 4 | Clinical appearance of type 2 female genital mutilation. The large arrow indicates scar tissue superior to the vagina and the smaller arrow indicates the vestibule with no narrowing of the vaginal orifice

FGM is mostly performed by traditional practitioners, often older women considered to be specialists. Instruments are crude and conditions unhygienic. Despite widespread professional condemnation,² the involvement of medical personnel to mitigate complications is increasing.¹⁴ This is particularly true in Egypt, where 61% of circumcised women report that they have participated in such procedures.⁸

What are the health consequences of FGM?

FGM has no known health benefits and is widely recognised to have undesirable consequences. Robust evidence to support this is limited because research into FGM is complicated by difficulty in defining variable surgical procedures and conducting research in resource poor environments.¹⁵ The reliability of self reports of FGM in women and girls has also been questioned.¹⁶

Broadly speaking, the negative effects of FGM follow a dose-response association: the more extensive the FGM and the more traumatic the circumstances, the higher the risk of complications.^{15 17} Box 3 lists short term and long term health consequences of FGM as described by the World Health Organization in 2008,⁵ and it is largely based on cross sectional studies, case series, and a notable prospective cohort study.¹⁷

How can we talk about FGM with our patients?

FGM is a sensitive and complex matter, and talking about it can make health professionals feel uncomfortable. Our reluctance to engage with women about FGM may be caused by embarrassment, uncertainty about how to frame the questions, or anxiety about being perceived as culturally insensitive.¹⁸

It is essential that we are able to raise the issue of FGM with our patients. Certain steps can be taken to make these conversations easier and more successful.

Optimise the environment

Ensure privacy and adequate time for the discussion and offer the presence of a female professional. Consider the need for an appropriately trained interpreter—a family member, friend, or an interpreter from the same community would be inappropriate.

Use appropriate and value neutral terminology

An opening line might be, “Many women from your community have been circumcised as a child. Did this happen to you?” Other useful phrases include, “Have you been cut or closed?” or “Have you been circumcised?”

Ensure a professional and sympathetic response

Women and girls with FGM must be treated with respect and a thorough assessment made of their health needs. Girls do not choose to undergo FGM.

Recognise that the law creates a barrier to open communication

FGM is a crime committed by close family members. Women may not seek help for fear that disclosure will cause trouble for their family. Women with FGM who are recent immigrants to the UK and lack a confirmed immigration status may be afraid that involvement with any statutory agency will lead to deportation.

How can we identify those affected or at risk?

Presentation to healthcare services provides opportunities for education and prevention of FGM. It is crucial to be aware of the matter and of which communities are affected.

Identifying FGM in symptomatic women

The national guidelines suggest that general practitioners should contemplate asking about FGM when taking any medical history from a woman or girl who comes from a practising community.⁷ Others may present openly with complications relating to FGM or seek help for these problems without disclosure. Health professionals should therefore consider FGM as an underlying cause of symptoms such as dyspareunia or chronic urinary tract infections.

Box 3 | Health consequences of female genital mutilation

Immediate risks

Pain, shock (caused by pain or haemorrhage, or both), excessive bleeding, difficulty passing urine or faeces, infection (including tetanus inoculation and the transmission of bloodborne viruses such as HIV, hepatitis B, and hepatitis C), psychological consequences (as a result of pain, shock, or physical restraint), unintended labial fusion, death (caused by haemorrhage or infection).

Long term risks

Pain (chronic neuropathic pain), keloid scarring, infections (including chronic pelvic infections, recurrent urinary tract infections, and an increased incidence of certain genital infections), birth complications (caesarean section, postpartum haemorrhage, and episiotomy), danger to the newborn (including death), decreased quality of sexual life, psychological consequences (including post-traumatic stress disorder, depression, and anxiety).

Long term risks particular to type 3 FGM

Need for later surgery (deinfibulation), urinary and menstrual problems, painful sexual intercourse, and infertility.

Identifying FGM on routine genital examination

Women aged 25–64 years should present for regular cervical screening. Health professionals involved must be trained to identify FGM during the examination of the female external genitalia that should form part of this assessment.

Clues in children

Health and education professionals must be alert to subtle indicators that FGM may be about to happen. These include reports of extended holidays, preparations for special ceremonies, and requests for travel vaccinations or antimalarials. Indicators that FGM may have already taken place include genitourinary symptoms, prolonged visits to the toilet at school, the avoidance of sports, and abrupt behavioural changes after a holiday.

Identifying FGM during pregnancy

Routine direct questioning at booking and its documentation in the antenatal notes are essential. Otherwise, midwives or obstetricians should be trained to look for and identify the various types of FGM at delivery.

Identifying infants at risk of FGM

The daughters of women with FGM are at particular risk. When FGM is identified during pregnancy, health professionals must explain its health risks and the UK legal status. If detected at delivery, these discussions should take place postnatally. Never assume that a circumcised mother will want FGM for her daughters or that she can resist external family pressure.

When a female child is born to a woman with FGM, all discussions about the subject must be documented in the discharge summary and child health record held by the parents (red book). The health visitor and general practitioner can then reinforce the message on education, ensure that appropriate care and support are provided, and safeguard the child.

Identifying relatives with FGM

Once a woman or girl is found to have undergone FGM, health professionals must consider the risk to her female children, siblings, and extended family members.

How should we care for women with FGM?**Offer referral for specialist care**

London and other cities have African well women's clinics that can offer specialist advice, support, counselling, and deinfibulation if needed (www.forwarduk.org.uk/)

A PATIENT'S PERSPECTIVE

I had the experience at the age of 5 or 6 years. When you are a child you usually don't remember things at that age but I remember. I remember being at a party and the people holding me down. My legs. My hands. My knees. And then I remember the practitioner with the knife. I don't remember any anaesthetic. I just remember crying, crying, and pleading. I was completely shattered—emotionally and physically.

Hagir Ahmed (Bint Al-Sultan), spokesperson for the Manor Gardens health advocacy project (for further details contact Hekate Papadaki, Manor Gardens advocacy project manager (+44(0)2072817694; hekate@manorgardenscentre.org).

resources/support/well-woman-clinics). Most clinics will take referrals from health professionals and directly from women themselves.

Deinfibulation

This minor surgical procedure to divide the fused labia in infibulated women can be performed in clinic under local anaesthetic, ideally before conception. In pregnancy it can be performed from the mid-trimester until term, or during the first stage of labour. Deinfibulation facilitates vaginal examination and catheterisation in labour and reduces perineal trauma at delivery. Inform women, and their husbands, that reinfibulation after childbirth is illegal in the UK.

How should we care for girls with FGM and those thought to be at risk?**Child safeguarding**

Health professionals who are worried that a child is at risk or has been subject to FGM must always discuss their concerns with social care and make a referral.¹⁹ Disclosure of confidential information to third parties is justified if a child is thought to be at risk of serious harm.²⁰ It can also be made in the public interest or when a serious crime is suspected.²¹

On receipt of a referral, social care will convene a strategy meeting of representatives from social care, the police, education, and health within 48 hours. The police service may have experienced officers who can provide help and advice (for example, Project Azure—a designated team of officers within child abuse investigation command at the Metropolitan Police).

The strategy meeting must first ascertain whether the family understands the harmful consequences of FGM and the law on FGM. Most girls identified as at risk are not in immediate danger. A typical outcome might be a home visit by social workers and community advocates to discuss the problem. The family may then sign a contract stipulating that they will not procure FGM for their child. Legal injunctions such as a Prohibitive Steps Order that restricts the parents' right to take a child abroad will be considered only once advice and counselling have failed.

If a child is thought to be in immediate danger of FGM—for example, by being taken abroad, an Emergency Protection Order will be sought so that the girl can be taken to a place of safety. Removal of the child from the parental home is considered only as a last resort.^{4 7}

If a child is thought to have already undergone FGM then the strategy meeting must establish how, where, and when the procedure took place. If there is evidence that the law has been broken the police will consider criminal investigation. A child protection conference is needed only if other safeguarding concerns emerge.

Specialist paediatric care

If a child is suspected to have undergone FGM, social care will seek confirmation of the diagnosis. The genital examination of children is not routine practice for most general practitioners or even paediatricians, and subtler types of FGM can be difficult or impossible to identify. A paediatrician with a special interest can confirm and act

ADDITIONAL EDUCATIONAL RESOURCES

Resources for healthcare professionals

Foreign and Commonwealth Office. Multi-agency practice guidelines: female genital mutilation. 2011. www.fco.gov.uk/fgm

Royal College of Obstetricians and Gynaecologists. Female genital mutilation and its management. Green top guideline 53. 2009. www.rcog.org.uk/female-genital-mutilation-and-its-management-green-top-53

BMA. Female genital mutilation: caring for patients and safeguarding children. 2011. www.bma.org.uk/images/femalegenitalmutilation_tcm41-207836.pdf

Unicef. Coordinated strategy to abandon female genital mutilation/cutting in one generation. 2007. www.childinfo.org/files/fgmc_Coordinated_Strategy_to_Abandon_FGMC_in_One_Generation_eng.pdf. Provides a comprehensive understanding of female genital mutilation as a social convention and details of successful community led interventions

Equality Now (www.equalitynow.org)—Charity aimed at ending violence and discrimination against women worldwide that has produced a film documenting the grassroots movement to end female genital mutilation across Africa (to purchase a copy contact ukinfo@equalitynow.org)

FGM National Clinical Group (www.fgmnationalgroup.org)—Information and access to a training DVD

Resources for women with FGM or girls at risk

FORWARD (www.forwarduk.org)—Organisation that campaigns against FGM while supporting affected women and providing resources for professionals, including bespoke training

Daughters of Eve (www.dofeve.org)—Aims to protect girls and young women who are at risk from female genital mutilation; this website is particularly aimed at young people

Kids Taskforce (www.kidstaskforce.com)—An educational video targeted at schools on female genital mutilation co-produced by the Metropolitan Police (*CUT: some wounds never heal*) can be found under “watch over me”

QUESTIONS FOR FUTURE RESEARCH

What is the prevalence of female genital mutilation (FGM) in the UK?

What is the actual risk of FGM in children born in the UK within practising communities?

What are the gynaecological, sexual, and psychological outcomes of FGM?

Are FGM and female genital cosmetic surgery related?

What are the barriers for healthcare professionals in identifying and managing FGM?

What are the attitudes of communities in the UK to FGM?

What are the most effective interventions aimed at stopping the practice?

Would a coming of age ceremony like that now practised in some African countries be an alternative in the UK among practising communities?

on the diagnosis. The next steps may include testing for bloodborne viruses, offering vaccinations for hepatitis B and tetanus, identifying and managing any complications, and referring the girl to child and adolescent mental health services. Examination may be refused, but if FGM is strongly suspected, engagement with health and social care must continue without a confirmed diagnosis.

Aims for the future

The international medical establishment has called for the complete abandonment of FGM.⁵ Global efforts to eradicate FGM are encouraging: the prevalence of FGM seems to be falling,¹⁴ with several community led initiatives—often containing an element of public pledge or an alternative rite of passage—²² showing success when combined with legislation.

In the UK, mainstream healthcare must embrace the problem of FGM so that it becomes core learning for all health professionals. This should be supported by multiagency training provided by local child safeguarding boards.

Health professionals have a difficult role in encouraging women to access services while dealing with safeguarding concerns. Women may not want to seek help

because of the legal consequences for themselves and their families. Practising communities must be engaged with by health professionals so that high quality care can be provided and accessed. Even more importantly, health professionals must support strategies for prevention, with the aim of reducing the prevalence of FGM in the UK.

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Patient consent obtained.

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