Combating female genital mutilation

Saul Beeson, Holly Vincent and Joe Frankland discuss addressing educational needs to combat female genital mutilation

Female genital mutilation is the cutting or changing of the female genital organs for non-medical purposes. It is a form of child abuse and violence against women and girls; it is a violation of human rights that perpetuates gender inequality and denies women control over their bodies and lives. The consequences of female genital mutilation are severe and long-lasting, including physical complications, such as bleeding, infections, pain and childbirth complications, as well as psychological trauma and a sense of violation (World Health Organization (WHO), 2023). It is a deeply ingrained social practice that inflicts physical and psychological suffering on millions of girls and women. The justifications for practising female genital mutilation vary, but are often based on misconceptions and misinformation that must be challenged.

Despite global efforts, female genital mutilation remains a prevalent issue affecting over 200 million girls and women, with approximately 3 million girls being at risk annually (WHO, 2023). Urgent action is necessary to eliminate female genital mutilation, which is typically performed by untrained individuals using unsterile instruments, amplifying the risks of infection and complications (HM Government, 2020). This article aims to shed light on the multifaceted aspects of female genital mutilation, raise awareness and promote dialogue among individuals, communities and policymakers. By understanding the complexities and consequences of female genital mutilation, we can strive for a future where girls and women are free from this violation of their rights.

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Prevalence and risk factors

Female genital mutilation can be practised anywhere, but according to UNICEF (2023) data, the highest risk groups are from Africa and Indonesia. Data from the Somali health and demographic survey indicate that almost every Somali-born woman in the UK has undergone female genital mutilation, putting children under their care at risk (Directorate of National Statistics and Federal Government of Somalia, 2020). Female genital mutilation is most prevalent in countries such as Somalia, Mali, Egypt, Sudan, Guinea, Sierra Leone, Burkina Faso, Ethiopia, Eritrea and Djibouti (UNICEF, 2023).

In the UK, female genital mutilation is illegal and considered a form of child abuse and violence against women and girls. It falls under the duty of mandatory reporting, which means that healthcare professionals and teachers are legally obligated to report cases of female genital mutilation in girls under 18 years old. However, this duty does not extend to those over 18 years old or at risk of female genital mutilation, and most cases encountered in maternity services are handled under local safeguarding procedures (Home Office, 2015).

Family history of female genital mutilation practice is a significant risk factor for female genital mutilation in children (HM Government, 2020). This leads to referrals of female infants born to mothers who have experienced female genital mutilation, as well as any female children the mother may already have, to local children's safeguarding teams (HM Government, 2020). This focus on safeguarding the neonate can present challenges in building a relationship with the mother and providing holistic, woman-centred care (Turner and Tancred, 2023). Preventing disengagement from health services because of issues related to female genital mutilation is vital in ensuring that patients continue to receive any physical or mental healthcare that they require. It has been previously found that over half of children believed to have been cut had not been subject to female genital mutilation, while families were subject to invasive police and social services investigations (Creighton et al, 2019).

Data from the UK

An NHS England (2023) dataset showed that there were 760 new patients with female genital mutilation identified in the first quarter of 2023. It also highlighted that female genital mutilation is often undetectable until much later in a patient's life; the average age of a patient on first attendance with a female genital mutilation-related issue was 32 years old. For those where female genital mutilation was performed when under the age of 18 years old, they reported that it occurred at least 10 years ago in 99% of cases.

Additionally, the type of female genital mutilation was on average only recorded in 60% of cases. Recording the type is important, as it indicates the severity of female genital mutilation (WHO, 2023). In England, midwifery services were the primary identifier of female genital mutilation (NHS England, 2023). However, midwives themselves have reported challenges with identification of categories of female genital mutilation and inadequate provision of female genital

mutilation-specific training (Turner and Tancred, 2023).

Reporting and UK law

In the UK, all women, regardless of country of origin, are asked if they have experienced female genital mutilation at their initial antenatal consultation with a midwife (Royal College of Obstetricians and Gynaecologists (RCOG), 2015). The language used by those asking such a sensitive question is paramount; midwives must be professional, non-judgemental and use interpreters if required (RCOG, 2015). The choice of words is important to not only aid understanding but also to prevent offence. For example, using the word 'cutting' may be preferable to describing what may be a culturally normal procedure as 'mutilation'.

Just as infibulation is illegal in the UK, so too is re-infibulation (the process of re-closing the opened introitus after childbirth) (HM Government, 2020). As such, women and their partners require counselling on the procedure and adapting to the changes in their bodies. Despite the well-documented negative physical (Banks et al, 2006; Berg and Underland, 2013; Berg et al, 2014) and psychological (Mulongo et al, 2014; Knipscheer et al, 2015) implications of female genital mutilation, the practice is culturally related to purity and faithfulness, and is considered a rite of passage for girls.

All women who disclose female genital mutilation are referred to consultant-led care (RCOG, 2015). The interventions required during (or before) the intrapartum period are dependent on the severity of cutting; therefore, specialist counselling is imperative (RCOG 2015). Where vaginal examinations, urinary catheterisation or other intrapartum per vaginal procedures would not be possible, de-infibulation (the process of surgically opening the vaginal introitus) is recommended (RCOG, 2015). De-infibulation has been shown to improve maternal and obstetric outcomes, reducing the risk of caesarean section, postpartum haemorrhage, infection and urinary retention (Gupta and Latthe, 2018).

Specialist services

The RCOG (2015) recommend that all acute trusts should have access to a consultant and specialist midwife responsible for caring for women who have undergone female genital mutilation (RCOG, 2015). There are currently 25 specialist female genital mutilation clinics in England (NHS, 2022), with some of these clinics providing services specifically to pregnant or non-pregnant patients, while some serve both groups. However, access to female genital mutilation clinics varies geographically, with most services being London-centric (n=16). Outside of London, only six cities currently host clinics: two in the north of England, two in the Midlands and two in the south of England (NHS, 2022).

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Barriers to accessing care

As well as potential issues accessing specialist services, women may face additional barriers when disclosing or seeking support for female genital mutilation. Women accessing maternity services in the UK may not have the language needed to understand conversations around female genital mutilation, or to enable them to disclose having had the procedure. Although the National Institute for Health and Care Excellence (2021) recommends that interpreting services should be available in these circumstances, they acknowledge that women find services to be 'unreliable and inconsistent'. There is also the risk that even when interpreters are available, if these are from the woman's own community (and therefore possibly pro-female genital mutilation), this may inhibit disclosure.

Women may have experienced previous stigmatisation or negative reactions from healthcare professionals regarding female genital mutilation (Vloeberghs et al, 2011; Vissandjée et al, 2014). However, a positive relationship with a midwife can encourage women to have open conversations surrounding female genital mutilation. Karlsen et al (2019) discussed how women of Somalian heritage in Bristol reported a lack of confidence in healthcare workers, after experiencing discrimination and stigmatisation in appointments. They described a heavy focus being placed on female genital mutilation, even when attending appointments for unrelated issues, and felt perceived to be unable to protect their children. This led to some families disengaging from health services and seeking non-medical or unregulated services (Karlsen et al, 2019).

The role of different healthcare professionals

In addition to female genital mutilation clinics, midwives and paramedics play a crucial role in identifying and supporting girls and women who have undergone female genital mutilation. These healthcare professionals are often the first point of contact for individuals seeking medical assistance or reproductive healthcare services. According to the Royal College of Midwives (2019), 'midwives are one of the key frontline healthcare professionals who can identify and prevent female genital mutilation'. Recognising, referring and working as part of a multidiscplinary team to support women who have undergone female genital mutilation and safeguard children is cited in the Nursing and Midwifery Council (2019) standards of proficiency. By sensitively and compassionately discussing female genital mutilation with women, midwives can create a safe space for disclosure, provide information about available support services and facilitate referrals to specialised clinics and healthcare professionals.

Paramedics, on the other hand, are trained to respond to emergency medical situations and provide immediate care. When encountering patients who have

undergone female genital mutilation, paramedics can assess an individual's immediate physical and psychological needs, provide necessary emergency treatment and initiate the referral process to appropriate healthcare services. They can also offer guidance and support to the patient and their family, emphasising the importance of seeking comprehensive medical care and counselling (College of Paramedics, 2021).

The importance of education

Education plays a crucial role in preventing female genital mutilation and protecting the wellbeing of girls and women. It raises awareness about the negative impacts of female genital mutilation on health, rights and wellbeing, empowering individuals to make informed decisions (WHO, 2023). Education also influences the attitudes and behaviours of men and boys, who are key in supporting abandonment of female genital mutilation. Studies have shown that education is associated with lower rates of female genital mutilation. Van Bavel (2022) found that women with secondary education in Kenya were 50% less likely to have undergone female genital mutilation than those without education. In Egypt, women who completed primary education were more likely to oppose female genital mutilation (Hassan, 2022).

Education also provides alternative opportunities for social and economic advancement, reducing dependence on marriage (WHO, 2023). To end female genital mutilation and promote gender equality, investments in education are crucial. Various channels, such as formal schooling, community-based programs, media campaigns and peer networks, can be used to deliver education (WHO, 2023). The target audience should include girls, women, boys, men, religious leaders, health workers, teachers and policymakers. Education should be culturally sensitive, participatory and evidence-based, integrated with interventions addressing the root causes of female genital mutilation, including poverty, discrimination and violence against girls and women. A holistic and multi-sectoral approach is needed to eliminate female genital mutilation (WHO, 2023).

Conclusions

Education is imperative in ending the practice of female genital mutilation globally. This educational approach must be sensitive, sympathetic and non-judgemental. For it to succeed, it must reach not only women and girls but also men and boys, as well as educational, religious, social and community figures and groups. Greater training and awareness are required for healthcare staff, particularly in determining the type of female genital mutilation. More training is needed for paramedics in identifying patients at risk and also in how to approach the subject and where to refer patients for further care and support.

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Reporting female genital mutilation and making safeguarding referrals is an important method of protecting the vulnerable. More resources need to be used to identify girls and young women who have suffered female genital mutilation but have not yet required midwifery or obstetric services. This will enable services to treat and, if possible, reverse the damage done by female genital mutilation to prevent further issues during labour and childbirth. This also has the potential to reduce risks of urinary tract and sexually transmitted infections as these women become sexually active. Education is key in reaching out to these patients and encouraging them to seek help and support. **BJM**

Banks E, Meirik O, Farley T, Akande O, Bathija H, Ali M. Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. Lancet. 2006;367(9525):1835–1841. https://doi.org/10.1016/s0140-6736(06)68805-3

Berg R, Underland V. The obstetric consequences of female genital mutilation/cutting: a systematic review and meta-analysis. Obstet Gynecol Int. 2013;2013:496564. https://doi.org/10.1155/2013/496564

Berg R, Underland V, Odgaard-Jensen J, Fretheim A, Vist G. Effects of female genital cutting on physical health outcomes: a systematic review and meta-analysis. BMJ Open. 2014;4(11):e006316. https://doi.org/10.1136/bmjopen-2014-006316

College of Paramedics. Scope of practice. 2021. https://collegeofparamedics.co.uk/COP/ProfessionalDevelopment/Scope_of_Practice.aspx (accessed 4 December 2023)

Creighton S, Zimran S, Otoo-Oyortey N, Hodes D. Tackling female genital mutilation in the UK. BMJ. 2019;364:l15 https://doi.org/10.1136/bmj.l15

The Directorate of National Statistics, Federal Government of Somalia. The Somali health and demographic survey 2020. 2020. https://somalia.unfpa.org/sites/default/files/pub-pdf/FINAL%20SHDS%20Report%202020_V7_0.pdf (accessed 4 December 2023)

Gupta S, Latthe P. Female genital mutilation de-infibulation: antenatal or intrapartum? Obstet Gynaecol Reprod Med. 2018;28(3):92–94. https://doi.org/10.1016/j.ogrm.2017.12.002

Hassan HE. Study females attitude toward female genital mutilation. J Gynecol Womens Health. 2022;24(3). https://doi.org/10.19080/jgwh.2022.24.556137

HM Government. Multi-agency statutory guidance on female genital mutilation. London: HM Government; 2020

Home Office. Mandatory reporting of female genital mutilation – procedural information. 2015. https://assets.publishing.service.gov.uk/media/5a8086f2ed915d74e33faefc/FGM_Mandatory_Reporting_-_procedural_information_nov16_FINAL.pdf (accessed 10 July 2023)

Karlsen S, Carver N, Mogilnicka M, Pantazis C. When safeguarding becomes stigmatising: a report on the impact of FGM-safeguarding procedures on people with a Somali heritage living in Bristol. 2019. https://research-information.bris.ac.uk/ws/portalfiles/portal/187177083/Karlsen_et_al_2019_When_Safeguarding_become_Stigmatising_Final_Report.pdf (accessed 10 July 2023)

Knipscheer J, Vloeberghs E, Van der Kwaak A, Van den Muijsenbergh M. Mental health problems associated with female genital mutilation. BJPsych Bulletin. 2015;39(6):273–277.

https://doi.org/10.1192%2Fpb.bp.114.047944
Mulongo P, Martin C, McAndre S. The psychological impact of female genital mutilation/cutting (FGM/C) on girls/women's mental health: a narrative literature review. J Reprod Infant Psychol. 2014;32(5):469–485. https://doi.org/10.1080/02646838.2014.949641
National Institute for Health and Care Excellence. Antenatal care. 2021. https://www.nice.org.uk/guidance/ng201 (accessed 10 July 2023)
NHS. National FGM support clinics. 2022. https://www.nhs.uk/conditions/female-genital-mutilation-fgm/national-fgm-support-clinics/ (accessed 10 July 2023)
NHS England. Female genital mutilation (FGM) enhanced dataset January 2023 to March 2023, England, experimental statistics. 2023. https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/january-2023--march-2023#:~:text=There%20were%201%2C675%20individual1,practices%20where%20FGM%20was%20identified. (accessed 4 December 2023)
Nursing and Midwifery Council. Standards of proficiency for midwives. 2019. https://www.nmc.org.uk/globalassets/sitedocuments/standards/standards-of-proficiency-for-midwives.pdf (accessed 10 July 2023)
Royal College of Midwives. Media release: 'midwives key frontline professionals who can identify FGM says RCM. 2019 https://www.rcm.org.uk/media-releases/2019/november/midwives-key-frontline-professionals-who-can-identify-fgm-says-rcm/#:~:text=%E2%80%9CMidwives%20are%20one%20of%20the,in%20identifying%20girls%20at%20risk. (accessed 10 July 2023)
Royal College of Obstetricians and Gynaecologists. Female genital mutilation and its management. 2015 https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/female-genital-mutilation-and-its-management-green-top-guideline-no-53/ (accessed 10 July 2023)
Turner J, Tancred T. Maternity care provision for women living with female genital mutilation/cutting: a qualitative study from a high asylum-seeking dispersal context in the UK. Int J Health Plan Manage. 2023;38(3):790–804. https://doi.org/10.1002/hpm.3625
UNICEF. Female genital mutilation (FGM). 2023. https://data.unicef.org/topic/child-protection/female-genital-mutilation/ (accessed 25 June 2023)
Van Bavel H. Education, class, and female genital cutting among the samburu of northern kenya: challenging the reproduction of the "ignorant pastoralist" narrative in anticutting campaigns. Violence Against Women. 2022;28(15–16):3742–3761. https://doi.org/10.1177/10778012221079376
Vissandjée B, Denetto S, Migliardi P, Proctor J. Female genital cutting (FGC) and the ethics of care: community engagement and cultural sensitivity at the interface of migration experiences. BMC Int Health Human Rights. 2014;14:13. https://doi.org/10.1186/1472-698X-14-13
Vloeberghs E, Knipscheer J, van der Kwaak A, Naleie Z, van den Muijsenbergh M. Veiled pain: study in the Netherlands on the psychological, social and relational consequences of female genital mutilation. Utrecht: Pharos; 2011
World Health Organization. Integrating female genital mutilation content into nursing and midwifery curricula: a practical guide. 2023. https://www.who.int/publications/i/item/9789240042025 (accessed 23 June 2023)