

Female genital mutilation:

everyone's problem

Female genital mutilation (FGM), euphemistically called female circumcision, is defined by the World Health Organization (WHO) as 'all procedures involving partial or total removal of the external female genitals, or injury to the female genital organs for non-therapeutic reasons'. Globally, as many as 3 million girls are at risk of having it performed every year. Over 20 000 girls aged <15 years are at high risk of FGM in the UK each year and 66 000 women in the UK are living with its consequences, although its true extent is unknown because of the hidden nature of the crime.¹ In the UK there is still an attitude that this is a problem of 'elsewhere' and this violent abuse of non-consenting girls is somehow distant and not our problem. This attitude must change.

The reasons behind the practice are complex. In some communities, for example, it is believed that the process of mutilation means the victim will preserve her virginity until marriage and keep her sexual organs clean. The traditional aspect of FGM in some families means it can be perceived as being beneficial and secures the girl's status.¹ The tradition is mainly perpetuated by women; men do have some influence but their knowledge about the procedure is poor. A recent study of 1000 Gambian men showed that 77% did not realise that FGM has a negative impact on women's health and 60% thought it was equivalent to male circumcision.²

The physical consequences of FGM are significant and include: bleeding, infection, damage to local structures, infertility, and death. The psychological consequences are also severe and include high levels of mood and anxiety disorders as well as post-traumatic stress disorder. Sexual function is adversely affected and women who have undergone FGM have a significantly lower sexual quality-of-life score than those who have not.³ A meta-analysis of obstetric consequences showed that women who have undergone FGM were over three times more likely to have a difficult labour, obstetric haemorrhage was twice as high,⁴ and perinatal deaths could be increased by one or two in every 100 deliveries.⁵ The newborns of FGM women are four times more likely to have adverse health consequences.⁶

INTERNATIONAL RESPONSE TO FGM

FGM is an accepted cultural tradition in many communities (Figure 1) so change has

to involve the entire community.¹ Religious leaders are open to listening to health professionals about the detrimental effects of FGM on women. As a result, fatwas have been issued in Egypt, Mauritania, and West Africa and these have made significant differences to Islamic communities where it is believed that FGM had a religious basis. Younger men with increased knowledge are less supportive of the practice and are receptive to banning it.² Alternative rites ceremonies where girls are able to celebrate their coming of age, and alternative income for the 'cutters', need to be developed. In Kenya this has been successful in many communities, where a 2-day ceremony celebrates coming of age without mutilation. Community buy-in is the major key to making these changes successful.⁷

The response to FGM in Indonesia is illustrative of the difficulties where a lesser form of mutilation is proposed. In Indonesia in 2006 the Ministry of Health banned doctors from doing FGM because it was recognised to be harmful. However this was not enforced and hospitals still offered the procedure. In 2011 parliament reversed their decision and issued guidelines on how

to carry out FGM, endorsing this by saying it would 'safeguard the reproductive system'. Nahdlatul Ulama (the largest, but mostly moderate Muslim organisation in Indonesia) has stated that it approves of FGM but that doctors 'should not cut too much'. As recently as 2010 the American Academy of Paediatricians suggested that a lesser form of genital mutilation would be acceptable in a drive to ban the more radical mutilations, but this was subsequently reversed after a professional and public uproar.⁸

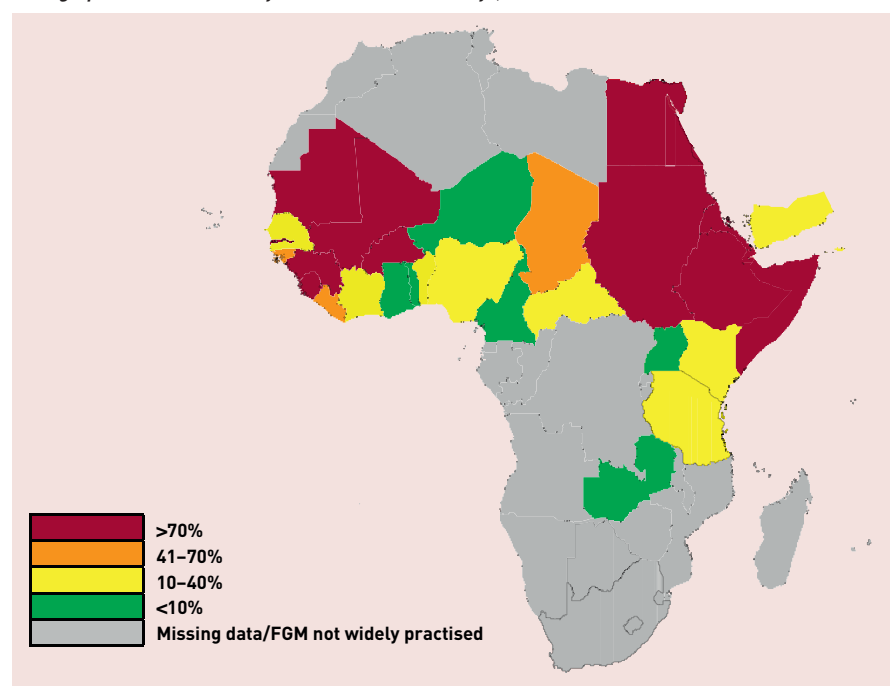
FGM IN THE UK

FGM is being practised in this country and UK citizens are being taken overseas to have the procedure performed despite the fact that FGM has been illegal in the UK since 2003. It is illegal to take a British national or permanent resident abroad for FGM or to help someone trying to do this. The maximum sentence for carrying out FGM or helping it to be carried out is 14 years in prison (Female Genital Mutilation Act, 2003).

Keir Starmer, Director of Public Prosecutions, has recently convened two meetings of government ministers, police officers, healthcare professionals, social services, and other interested parties with

Figure 1. Prevalence of female genital mutilation among women aged 15–49 in Africa.¹

Data Source: UNICEF (October 2010), global databases based on data from Multiple Indicator Cluster Survey, Demographic and Health Survey and other national surveys, 1997–2009.



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the aim of eliminating this violence against women. The Metropolitan Police have made considerable efforts to record cases of FGM, and are actively asking people to come forward anonymously to say who are the cutters, but there has been a poor response.

Children are frightened to speak out because if they report their parents or their friends' parents they will be put into care. An anonymous helpline was launched by NSPCC 3 months ago to enable anyone who is worried about a child being a victim of FGM to obtain advice, information and support. There were 80 referrals in the first week but the number has dramatically decreased since then.

Education is likely to be the key to change but the Department of Education appears unlikely to assist in an education programme and girls have been told by their parents not to discuss FGM at school.

PRIMARY CARE RESPONSE TO FGM

The Department of Health multi-agency practice guidelines on FGM state that it is a form of child abuse and violence against women and should be dealt with as part of existing child and adult protection structures, policies, and procedures.¹ GPs, practice nurses, and their community colleagues need to be alert to the practice of FGM and to girls who may be at risk. Factors thought to increase risk to a child include: the level of integration of her community within UK society; whether her mother or older sisters have been subject to FGM; and girls withdrawn from school. FGM can be carried out from newborn to first pregnancy but the commonest age is thought to be between 5 and 8 years. Girls may be taken abroad during school holidays or for longer periods for the procedure to be carried out.

There are a number of ways in which GPs and primary care teams can help. Leaflets in consulting rooms may increase awareness and provide information about referral to the police and to helplines. GPs working in communities where the practice is more common might develop links with community leaders and educational institutions. Sensitive questioning and discussion with women who attend for

advice about contraception, smears, and pregnancy-related issues may be appropriate. Health visitors should consider discussing FGM at new birth visits or when carrying out developmental checks. Families attending for travel advice and immunisations could also be targeted. The guidance is clear that the safety and welfare of the child is paramount and that fears of being branded 'racist' or 'discriminatory' should not diminish the protection provided to vulnerable girls and women. Professionals have a responsibility to ensure that families are aware that the practice is illegal and are protected by both law and policy in reporting to other agencies if they have suspicion of abuse or criminal act. There is a role for those involved in education and training of doctors, nurses, and social workers to ensure attention is given to raise awareness of FGM and to provide professionals with the skills to talk to young girls and women about these practices and to intervene where appropriate.

THE FUTURE

The media have raised awareness of FGM in recent years, and many groups and campaigners are making significant headway. Lynne Featherstone MP has said that we should aim to end FGM within a generation and £35 million has been committed to this objective by the Department for International Development. Research is still needed to determine the most cost-effective methods to combat FGM and to supporting the diaspora in the UK. However, we all have a responsibility to be trained and to train others so that this abuse of women can be brought to an end.

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