Female genital mutilation and reporting duties for all clinical personnel

Female genital mutilation is illegal. It is now mandatory for health-care professionals to report female genital mutilation to the police. Professionals caring for women and girls of all ages must understand how female genital mutilation presents, and what action to take.

Female genital mutilation describes all procedures which partially or totally remove or injure the external female genitalia for non-medical reasons. These involve removal of normal healthy tissue, carried out on girls ranging in age from infancy to 15 years old, and in rare cases on adults (World Health Organization et al, 1997). Female genital mutilation has been performed for thousands of years but, following greater understanding of its impact, groups such as the World Health Organization and the United Nations Children's Fund have been working to abolish it as it is a human rights violation, with the United Nations General Assembly adopting a resolution on the elimination of female genital mutilation in December 2012 (United Nations Children's Fund, 2013). There are no health benefits to female genital mutilation, while removing normal tissue leads to an extensive list of consequences including sepsis, haemorrhage and infertility.

Female genital mutilation is illegal in over 30 countries, including the UK and many countries where it was widely practised (United Nations Children's Fund, 2013). It is important to note that just as practising female genital mutilation is illegal in the UK, it is also illegal to take girls outside of the UK in order to perform female genital mutilation, and this still needs to be reported and acted upon. This legislation is specified in the Female Genital Mutilation Act 2003.

From October 2015 the Serious Crime Act 2015 specifies that health-care professionals in England and Wales have a mandatory duty to report female genital mutilation in those under 18 years of age to the police. Failure to do so may incur an investigation of fitness to practise (Department of Health, 2015).

Classification of female genital mutilation

Female genital mutilation is not frequently seen by all health-care professionals in the UK, so the classification system provided by the World Health Organization (OHCHR et al, 2008) can be a useful descriptor. In practice, defining the category of female genital mutilation can be difficult, and a more important task will be signposting women or girls to support organizations, arranging management of side effects, and discussion with police and social care where applicable. The classification system is:

1. Type 1 female genital mutilation – 'clitoridectomy' – removal of the hood of the clitoris or removal of the clitoris and hood together
2. Type 2 – 'excision' – partial or total excision of the clitoris and labia minora, with or without excision of the labia majora
3. Type 3 – 'infibulation' – cutting or repositioning the inner or outer labia, with or without removal of the clitoris, and narrowing the vaginal opening by stitching the cut edges of the opposing labia together to form a covering
4. Type 4 includes all other harmful procedures to female genitalia such as piercing or pricking (genital piercings or tattoos are included as female genital mutilation, and are illegal in girls under 18 years).

Origins and continuation of female genital mutilation

Female genital mutilation is usually performed by traditional circumcisers, sometimes called cutters, typically without anaesthesia in non-sterile conditions; often women will forcibly restrain the girl, and a range of instruments may be used (Foundation for Women's Health, Research and Development, 2012).

Female genital mutilation is usually performed on girls from birth to 15 years old; however, it has been reported that in half of the more frequently-practising countries with available data most girls were cut before 5 years of age. Increasing awareness of the illegality of female genital mutilation may have lead to it being performed at earlier ages to evade repercussions (United Nations Children's Fund, 2013).

Explained by some as a religious practice, female genital mutilation is in fact not related to any major religion, and is practised in countries of different faiths. In one study of

Dr Gabrielle Cropp is Community Paediatric Registrar, Birmingham Community Healthcare Trust, Child Development Centre, Birmingham Heartlands Hospital, Bordesley Green East, Birmingham B9 5SS

Dr Jane Armstrong is Consultant Community Paediatrician, Birmingham Community Healthcare Trust and Designated Doctor, Birmingham South Central Clinical Commissioning Group

Correspondence to: Dr G Cropp (gabrielle.cropp@nhs.net)

© 2016 MA Healthcare Ltd

Table 1. Countries with a high prevalence of female genital mutilation

Countries in which female genital mutilation is concentrated	Benin Burkina Faso Cameroon Central African Republic Chad Cote d'Ivoire Ethiopia Gambia Ghana Guinea-Bissau Iraq	Kenya Liberia Mauritania Niger Nigeria Senegal Togo Uganda United Republic of Tanzania Yemen
Countries in which the prevalence of female genital mutilation is >80%	Djibouti Egypt Eritrea Guinea	Mali Sierra Leone Somalia Sudan

From United Nations Children's Fund (2013)

1920 women seen at a clinic in Burkina Faso, where 40% were recorded as Catholic and 46% as Muslim, 93% had been cut (Jones et al, 1999). There is no basis for female genital mutilation in any religious text (World Health Organization et al, 1997).

The United Nations Children's Fund reported on female genital mutilation in 2013, looking at eradication efforts. The report cites 29 countries where female genital mutilation is concentrated (*Table 1*) and estimates that, alongside the more than 125 million girls and women alive today who have had female genital mutilation, up to a further 30 million girls are at risk in the next decade (United Nations Children's Fund, 2013). Initial campaigns against female genital mutilation stressed the health implications, but it is feared this lead to 'medicalization' of the procedure, with health-care professionals including midwives and doctors now performing female genital mutilation. More than 18% of all female genital mutilation is performed by health-care providers (UNAIDS et al, 2010) and participation by medical professionals may help to continue the custom.

Female genital mutilation is increasingly seen in countries where it had previously been uncommon, such as the UK, as a result of communities continuing traditional practices from their country of origin. Health-care providers may have felt concern that reporting female genital mutilation interfered with patients' religious beliefs, but legislation has been brought in to remove this uncertainty. The female genital mutilation enhanced dataset report for July to September 2015 (Health and Social Care Information Centre, 2015b) shows acute trusts in England reported 1385 newly recorded cases of female genital mutilation; however, that does not identify when the procedure took place and as it is a new dataset the numbers have varied considerably each quarter. Of these 1385 cases, 17 included girls under the age of 18 years. Although the most frequently documented country of birth was Somalia, the UK was the birthplace of eight of the women and children.

Reasons cited for female genital mutilation continuing include pressure to conform, a way to prepare for marriage and adulthood, or a way to help limit a woman's libido and prevent her from becoming promiscuous (World Health Organization et al, 1997). Some believe that if left un-cut the clitoris will continue to grow and that female genital mutilation 'facilitates childbirth by widening the birth canal' (Reymond et al, 1997). Female genital mutilation is considered relevant to modesty or cleanliness, and the absence of female genital mutilation may impair a girl's chances of marriage into a culture where female genital mutilation is the norm (OHCHR et al, 2008). In some cultures female genital mutilation is practised to ensure a girl's virginity, and increase the chance of obtaining a good dowry (Foundation for Women's Health, Research and Development, 2012). Many women feel it is a requirement of their society (UNAIDS et al, 2008) hence the continuation of the practice in their daughters, even when they may have found it traumatic.

In some countries where female genital mutilation is common, the number of women who support its continuation is less than the number who have had female genital mutilation. This is true of some countries where female genital mutilation is almost universal, for example Burkina Faso, 'where 76% of girls and women have been cut, but only 9% favour the continuation of FGM [female genital mutilation]' (United Nations Children's Fund, 2013).

Consequences of female genital mutilation

Articles regarding female genital mutilation reflect growing recognition that it is unacceptable, and highlight the negative health and psychological implications documented in *Table 2*.

'De-infibulation' describes the operative re-opening of scar tissue, to allow vaginal delivery of infants or simply to reverse some effects of type 3 female genital mutilation. Patients can experience flashbacks of the original female genital mutilation event during de-infibulation. Occasionally following de-infibulation families may request that the woman be infibulated again, but this is also illegal. When de-infibulation had been performed to permanently reverse type 3 female genital mutilation some women felt their appearance and sexual function had improved (Nour et al, 2006). Women having de-infibulation may need to be advised that urinary flow will be quicker and often noisier following the procedure.

One major concern regarding female genital mutilation is effects on pregnancy and childbirth, with an estimated increase of 1–2 perinatal deaths per 100 deliveries (WHO study group on female genital mutilation and obstetric outcome et al, 2006). It is thought some difficulties around delivery may not be directly related to scar tissue (many women who have had female genital mutilation will undergo de-infibulation or episiotomy as needed during labour) and that other factors such as delayed consent to caesarean section (for fetal distress) and language barriers may also have been at fault (Essen et al, 2002).

© 2016 MA Healthcare Ltd

Jones et al (1999) found that the type of female genital mutilation (i.e. type 1 *vs* type 3) affected the likelihood of gynaecological complications: women with type 3 were 2.5 times more likely to have observable complications. Likelihood of complications during childbirth was also affected, with 5% risk in women who had not had female genital mutilation, 18% risk in women with type 1, 30% in type 2 and 36% in women with type 3. Almroth et al (2005) in Sudan showed a positive association between anatomical extent of female genital mutilation and risk of primary infertility. The WHO study group on female genital mutilation and obstetric outcome et al (2006) study reported that for women with female genital mutilation, 'Risks seem to be greater with more extensive FGM.'

Jones et al (1999) caution that describing less extensive forms of female genital mutilation as creating fewer side effects could promote or validate increased use of the less extensive forms (e.g. type 1 female genital mutilation) over other types. Among other risks, type 1 carries risks of significant bleeding should there be any damage to the clitoral arterial supply. Ultimately, this is still female genital mutilation because it involves unnecessary procedures permanently damaging normal anatomy. The 'type' or extent of female genital mutilation does not necessarily indicate the severity for the girl, and it is important not to underestimate the impact all types of female genital mutilation may have.

Asibiani and Rouzi (2010) showed that sexual function is also adversely affected by female genital mutilation while Dirie and Lindmark (1992) in Somalia found that 88% of the women questioned who had undergone infibulation (type 3 female genital mutilation) needed de-infibulation by some means to allow sexual intercourse and childbirth. They found that 87% of married women had been de-infibulated 'naturally' by their husbands (a process which could take weeks). The rest had required de-infibulation with the use of 'knives, razor blades and scissors' either by their husband or a female relative of their husband.

Psychological impact is an important consideration: Behrendt and Moritz (2005) performed neuropsychiatric interviews with a small number of Senegalese women including a group who had experienced female genital mutilation and a similar group who had not. Of those who had experienced female genital mutilation more than 90% expressed intense fear, helplessness, horror and severe pain, and over 80% still had intrusive re-experiences of the event. Researchers felt the prevalence of affective or anxiety disorders in the group of women who had undergone female genital mutilation indicated that despite it being a cultural norm in Senegal, this did not protect the women from suffering psychiatric disorders as a result of female genital mutilation.

Female genital mutilation risk factors and symptoms

A number of factors may indicate the risk that a girl could be subjected to female genital mutilation; these include originating from a community which is more likely to practise female genital mutilation and having a mother or sister who has had female genital mutilation, because the chance of a girl having female genital mutilation 'increases significantly if her mother has been cut' (United Nations Children's Fund, 2013). Professionals may recognize indicators of imminent female genital mutilation which include a girl talking about a special occasion to 'become a woman', a child going to her country of origin, where female genital mutilation is prevalent, a girl confiding that she believes that female genital mutilation will be performed or knowledge that a female elder is visiting the family (HM Government, 2014; National Society for the Prevention of Cruelty to Children, 2016).

Table 2. Immediate and long-term consequences of female genital mutilation

Immediate consequences	Severe pain Shock Haemorrhage Tetanus Sepsis Urine retention Open sores Injury to nearby genital tissue
Long-term consequences	Recurrent urinary tract infections and cystitis Difficult or slow passage of urine Cyst formation Infertility Increased risk of childbirth complications Increased risk of newborn deaths Increased risk of stillbirths and newborn resuscitation Increased risk of low birth weight babies Haematocolpos and prolonged menstruation Intrusive re-experiences of female genital mutilation procedure Increased prevalence of affective or anxiety disorders

From World Health Organization et al (1997), Behrendt and Moritz (2005), WHO study group on female genital mutilation and obstetric outcome (2006), Foundation for Women's Health, Research and Development (2012)

Professionals need to take a sensitive approach, as some women and girls may be unaware of female genital mutilation, and having risk factors does not mean female genital mutilation will take place. Indicators that a girl has already undergone female genital mutilation include discomfort on sitting or standing, difficulties with urination or menstruation, behaviour change following prolonged absence, reluctance to undergo medical examination or actually confiding in a professional (HM Government, 2014). It is believed that school holidays are a time when girls may be taken abroad for the procedure to allow healing of physical injuries before returning to school.

Implications for health-care professionals

It is important for health-care professionals to consider female genital mutilation, and to ask girls and women about it where relevant. One point when this can be effective is at booking appointments for pregnancy. Women may be noted as taking a long time to provide a urine sample which could be because of the slow urinary flow rate created by female genital mutilation (HM Government, 2014).

© 2016 MA Healthcare Ltd

Many different terms are used to describe female genital mutilation, and it is helpful to think of how questions relating to it might be phrased as the girl or woman may never have heard of female genital mutilation. There may be a more common term used in her community, or she may be more familiar with terms such as 'circumcision' or 'cutting' (*Table 3*). In cases where it was performed when the girl was very young she may not remember it distinctly (United Nations Children's Fund, 2013).

It is recommended that female interpreters, with knowledge of female genital mutilation and not known to the individual or having influence in the local community, be used to avoid situations where a woman or girl feels embarrassed or potentially threatened by speaking about her experiences (HM Government, 2014).

Sometimes female genital mutilation may only be identified at the time of childbirth and the woman may require de-infibulation to allow vaginal delivery. Some women request re-infibulation afterwards, and will require help with explanation and support – particularly around the legal status of female genital mutilation and re-infibulation.

Women who have had female genital mutilation may present late in pregnancy and may be afraid that they will be judged by professionals treating them (HM Government, 2014). In all cases of female genital mutilation those affected need reassurance and professionals need to be aware of their own reactions to what they may see, and avoid creating fear or anxiety in their patient. If female genital mutilation is identified during pregnancy it is possible to discuss de-infibulation, and there are specialist centres where women may be referred – see *Table 4*.

Table 3. Terms used to describe female genital mutilation (not an exhaustive list)

Cut	Sunna	Halalays	Megrez
Circumcised	Gudniin	Tahur	Khitan

From Department of Health (2015)

Table 4. Sources of further information

Specialist FGM clinics – NHS Choices website www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Pages/fgm-health-services-for-women.aspx
Royal College of Paediatrics and Child Health www.rcpch.ac.uk/improving-child-health/child-protection/female-genital-mutilation-fgm/female-genital-mutilation-fgm
Health Education England has produced an e-learning tool: www.e-lfh.org.uk/programmes/female-genital-mutilation
NSPCC FGM Helpline telephone 0800 028 3550 or email fgmhelp@nspcc.org.uk
FORWARD (Foundation for Women's Health, Research and Development) www.forwarduk.org.uk
Department of Health (2006) Female Genital Mutilation DVD. Order from fgm@dh.gsi.gov.uk

Mandatory reporting duties

When caring for a woman who has had female genital mutilation, it is important to discuss with her that it is illegal, and that if she has daughters this will be considered a safeguarding issue, and information will be passed on to their health visitor.

Guidance from NHS England and the Department of Health (2015) sets out actions to take when a professional is made aware of female genital mutilation. If a child or young woman (under the age of 18 years) either discloses that she has had female genital mutilation, or in the course of practice physical signs of female genital mutilation are observed, the professional has a statutory duty to call the police on 101 to make a report. A formal diagnosis may be made later following examination as part of a multidisciplinary response, if deemed necessary. It is not necessary for a practitioner to examine a girl's genitalia unless this is already part of the practitioner's role during that consultation. This reporting duty also applies in cases of girls under 18 years who have had genital piercings or tattoos. If there is believed to be an imminent risk of a girl having female genital mutilation, or she has been very recently cut, it may be necessary to act urgently and call 999.

This is a mandatory reporting duty for all health, social care and education professionals, and it is the individual's responsibility to make the report (Department of Health, 2015). It is best practice to report concerns at least before close of practice the following day. When calling the police practitioners will need to provide their own contact details, details of the safeguarding lead in their organization, and information regarding the young woman. The practitioner also needs to update the local safeguarding lead, and document decisions and actions taken. Complying with this duty is not a breach of confidentiality or data protection issue as it constitutes necessary information sharing when safeguarding issues are present, and is supported by General Medical Council (2012) and Nursing and Midwifery Council (2015) guidance.

Alternatively, in cases where a parent or guardian discloses that a girl has had female genital mutilation, or a girl is considered to be at risk of female genital mutilation, or it is believed she may have had female genital mutilation but there are no signs or symptoms, or she has made no disclosure, it is necessary to follow local safeguarding procedures and refer to children's social care (Department of Health, 2015). In the case of referrals to social care or the police, it is best to discuss this with the girl and her family, unless it is felt this may place the girl at risk, in which case it is better to discuss this with the local trust safeguarding lead in the first instance.

Once reported, there may need to be a response for the child and other girls in the family and police and social care will convene a multi-agency meeting. A health professional with relevant experience may be involved, to lead on the girl's health needs and perform general health assessment (as well as possible genital exam), and the team will consider safeguarding needs (Department of Health, 2015).

© 2016 MA Healthcare Ltd

For young women over 18 years old, this mandatory reporting duty does not apply, but they should be signposted to local services. Other female members of their household or family who may be at risk need to be considered, especially girls under 18 years.

From October 2015 GP surgeries, mental health trusts and acute trusts in England have been required to record information in the clinical record and also report to the female genital mutilation enhanced dataset regarding women attending with female genital mutilation, whether found through examination or self-reporting (Health and Social Care Information Centre, 2015a; Royal College of Paediatrics and Child Health, 2015). Each trust has a member of staff with access to an online portal where episodes are submitted on a case-by-case basis. The data are collected on behalf of NHS England and the Department of Health to support prevention of female genital mutilation.

A female genital mutilation risk indication system is due to be implemented in 2016 where clinicians can record that a girl may be at risk of female genital mutilation on the NHS Summary Care Record application, allowing other health-care professionals to see this information and consider risk and the need for any safeguarding action (Royal College of Paediatrics and Child Health, 2015).

Conclusions

Female genital mutilation is a human rights violation, and across the world there are efforts to eradicate the practice. It is imperative that health-care professionals are aware of female genital mutilation and the need to report it to the police and/or social care as appropriate. Women who have undergone female genital mutilation need support from doctors, and girls at risk of female genital mutilation need doctors' protection. BJHM

Conflict of interest: none.

KEY POINTS

- Female genital mutilation is illegal, and professionals have a duty of care to report female genital mutilation in those under 18 years old.
- It is illegal to take girls outside the UK to have female genital mutilation performed.
- More than 125 million girls and women worldwide have had female genital mutilation.
- Female genital mutilation can be described using many terms.
- Female genital mutilation does not form part of any religion, but is present in many cultures.

Almroth L, Elmusharaf S, El Hadi N, Obeid A, El Sheikh M, Elfadil SM, Bergstrom S (2005) Primary infertility after genital mutilation in girlhood in Sudan: a case control study. *Lancet* **366**(9483): 385–91 (DOI: doi: 10.1016/S0140-6736(05)67023-7)

Asibiani SA, Rouzi AA (2010) Sexual function in women with FGM. *Fertil Steril* **93**(3): 722–4 (doi: 10.1016/j.fertnstert.2008.10.035.)

Behrendt A, Moritz S (2005) Posttraumatic stress disorder and memory problems after female genital mutilation. *Am J Psychiatry* **162**(5): 1000–2 (doi: 10.1176/appi.ajp.162.5.1000)

Department of Health (2015) FGM: mandatory reporting in healthcare. www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare (accessed 10 January 2016)

Dirie MA, Lindmark G (1992) Risk of medical complications after female circumcision. *East Afr Med J* **69**(9): 479–82

Essen B, Bodker B, Sjoberg N-O, Gudmundsson S, Ostergren P-O, Langhoff-Roos J (2002) Is there an association between female circumcision and perinatal death? *Bull World Health Organ* **80**(8): 629–32

Foundation for Women's Health, Research and Development (2012) Female Genital Mutilation: Frequently Asked Questions: A Campaigner's Guide for Young People. www.forwarduk.org.uk/wp-content/uploads/2014/12/Forward_-FGM-FAQ.pdf (accessed 30 December 2015)

General Medical Council (2012) Protecting Children and Young People – The Responsibilities of all Doctors. www.gmc-uk.org/Protecting_children_and_young_people___English_1015.pdf_48978248.pdf (accessed 20 January 2016)

Health and Social Care Information Centre (2015a) Female Genital Mutilation Enhanced Dataset: Frequently Asked Questions. www.hscic.gov.uk/media/16204/FGM-Frequently-Asked-Questions-Enhanced-Dataset/pdf/FGM_Frequently_Asked_Questions_Enhanced_Dataset_v2.6.pdf (accessed 10 January 2016)

Health and Social Care Information Centre (2015b) Female Genital Mutilation (FGM) - July 2015 to September 2015, Experimental Statistics. www.hscic.gov.uk/searchcatalogue?productid=19408&q=%22female+genital+mutilation%22&sort=Relevance&size=10&page=1#top (accessed 10 January 2016)

HM Government (2014) Multi-Agency Practice Guidelines: Female Genital Mutilation. www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf (accessed 21 January 2016)

Jones H, Diop N, Askew I, Kabore I (1999) Female genital cutting practices in Burkina Faso and Mali and their negative health outcomes. *Stud Fam Plann* **30**(3): 219–30 (doi: 10.1111/j.1728-4465.1999.00219.x)

National Society for the Prevention of Cruelty to Children (2016) Female Genital Mutilation (FGM) Signs, symptoms and Effects. www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/female-genital-mutilation-fgm/signs-symptoms-and-effects/ (accessed 19 January 2016)

Nour NM, Michels KB, Bryant AE (2006) Defibulation to treat female genital cutting: Effect on symptoms and sexual function. *Obstet Gynecol* **108**(1): 55–60 (doi: 10.1097/01.aog.0000224613.72892.77)

Nursing and Midwifery Council (2015) Standards: The Code for Nurses and Midwives. www.nmc.org.uk/standards/code/read-the-code-online/ (accessed 20 January 2016)

OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNICEF, UNIFEM, WHO (2008) Eliminating female genital mutilation: an interagency statement. www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf (accessed 12 January 2016)

Reymond L, Mohamud A, Ali N (1997) Female Genital Mutilation, The Facts. www.path.org/publications/files/path_the_facts_fgm.pdf (accessed 11 January 2016)

Royal College of Paediatrics and Child Health (2015) Female Genital Mutilation. www.rcpch.ac.uk/improving-child-health/child-protection/female-genital-mutilation-fgm/female-genital-mutilation-fgm (accessed 12 January 2016)

UNAIDS, UNDP, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, FIGO, ICN, IOM, MWIA, WCPT, WMA (2010) Global strategy to stop health-care providers from performing female genital mutilation. http://apps.who.int/iris/bitstream/10665/70264/1/WHO_RHR_10.9_eng.pdf (accessed 12 January 2016)

United Nations Children's Fund (2013) Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change. www.unicef.org/publications/index_69875.html (accessed 12 January 2016)

World Health Organization, United Nations Children's Fund, United Nations Population Fund (1997) Female genital mutilation. A joint WHO/UNICEF/UNFPA statement. http://apps.who.int/iris/bitstream/10665/41903/1/9241561866.pdf (accessed 15 January 2016)

WHO study group on female genital mutilation and obstetric outcome, Banks E, Meirik O, Farley T, Akande O, Bathija H, Ali M (2006) Female Genital Mutilation and Obstetric outcome: WHO collaborative prospective study in six African countries. *Lancet* **367**(9525): 1835–41 (doi: 10.1016/s0140-6736(06)68805-3)

© 2016 MA Healthcare Ltd