GPs at the Deep End

Pioneer Scheme Day-release programme

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Horselethill Road, Glasgow

Female Genital Mutilation

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Background

Most communities in the world have had practices throughout history which were believed to be beneficial but are now understood not to be. There are also ongoing traditional practices which are known to be harmful e.g. heavy drinking, child marriage, honour crimes, selective abortion, FGM. Most of the examples show male dominance and power over women.

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

The term has been changed from female circumcision as male and female circumcision are not comparable. There are no health benefits to female circumcision and the main aim of the procedure is to reduce the enjoyment of sex for the female. Type 1 FGM would be the equivalent of cutting off the glans penis, type 3 would equivalate to cutting off the whole penis.

Type 1 - Clitoroidectomy: partial or total removal of the clitoris and in very rare cases, only the prepuce (fold of skin surrounding clitoris)

Type 2 - Excision: partial or total removal of the clitoris and labia minora, with or without excision of the labia majora

Type 3- Infibulation: narrowing of the vaginal opening through creation of a covering seal. The seal is formed by cutting and repositioning the inner or outer labia, with or without removal of the clitoris

Type 4 - Other: all other harmful procedures to the female genitalia for non-medical purposes e.g. pricking, piercing, incising, scraping and cauterising the genital area

TYPES OF FGM (www.who.int/mediacentre/factsheets/fs241/en/

De-infibulation (aka defibulation or FGM reversal): the surgical procedure to open up the closed vagina of FGM type 3. Avoid using the term "reversal" as this is not an accurate description of procedure.

Re-infibulation (aka re-suturing): re-stitching of FGM type 3 to re-close the vagina again after childbirth. This is illegal in the UK as it constitutes FGM.

Causes/motivations

There is no religious body that promotes FGM and there is a theory that the practice predates Christianity or Islam. Different groups have various justifications for the practice of FGM including:

- Preservation of virginity and chastity
- Religion, in the mistaken belief that it is a religious requirement
- Fear of social exclusion
- To ensure the girl is marriageable or to improve the marriage prospect
- Hygiene and cleanliness
- Increasing sexual pleasure for the male
- Enhancing fertility
- Family honour
- Social acceptance

I.e. there are no health benefits and none of the above reasons are for the benefit of the female, but rather to increase/enforce male power.

The age at which FGM happens is different in different communities and area and is linked to the reasons for carrying it out. The most common age is between 4 and 10 (particularly around 5 years old), although reports suggest that the average age is falling in some areas.

Communities potentially at risk

Countries where the prevalence of FGM is *more than 80%:*

- Egypt
- Somalia
- Sudan
- Mali
- Guinea
- Sierra Leone
- Eritrea
- Djibouti

The prevalence is likely to be higher as it is not always documented. The prevalence appears to be increasing in e.g. Malaysia and Columbia but is this due to increased awareness?

Some countries e.g. Nigeria have a low average but have certain communities with a very high prevalence.

The procedure is usually carried out by a woman/birth attendant who will have a high status within the community and will be paid for doing it. In Egypt FGM is more medicalised and so the FGM tends to be more severe.

The total number of people (men, women and children) born in one of the 29 FGM practising countries identified by UNICEF and living in Scotland in 2011 was 23,979. In 2012, 363 girls were born in Scotland to mothers from an FGM practising country. We can approximate a minimum additional 700 children/year born into communities in Scotland potentially affected by FGM. (*Tackling female genital mutilation in Scotland*. A Scottish model of intervention, 2014)

Health impact

Not every woman will experience severe health problems as a result of FGM and some women may not be aware of any health problems associated with it.

Immediate and long-term health impacts will vary depending on the type of FGM. Other than the physical impacts remember to consider psycho-sexual and psychological issues as well as social consequences such as estrangement from parents and/or family and relationship or marriage breakdown.

Issues which may arise:

- Shock at realisation of what has happened
- Anger that the procedure is not reversible
- Relationship with parents – anger/betrayal/protective
- Flashbacks
- Reluctance to attend for smears/sexual health for fear of reactions (?could use smears/travel vaccines as screening for FGM
- Possible difficulties with being examined by a woman
- Not knowing what is “normal” in terms of menstruation/dyspareunia
- Difficulties in sexual relationships
- Concerns about girls at risk
- Unable to trust family with their daughters

The Law

FGM has been an offence in the UK since 1985 and the law was strengthened in 2005 – Prohibition of Female Genital Mutilation (Scotland) Act. It is also a crime for a person to carry out, assist or arrange the FGM of another person, even if the actual mutilation occurs outside Scotland.

Child protection and risk assessment

Use the usual child protection routes if you are concerned. Unfortunately, there is a lack of information from secondary care regarding antenatal care (with or without SNIPs involvement) and delivery. Antenatal clinics are encouraged to refer to social work if the mother is known to have FGM.

The issue was raised about how much information we can/should give the home office.

Risk factors for FGM:

- **One or both parents come from an ethnic group that traditionally practices FGM**
- **Her mother has had FGM**
- An older sister or cousins of similar age have undergone FGM
- Mother and/or father has requested re-infibulation following delivery
- Parents express views that they value the practice

The risk obviously reduces if the reason for seeking asylum is fleeing from FGM for the daughter.

Remember to code FGM in daughter's notes.

Discussion about census - Are asylum seekers included in the census? Should the census ask about FGM?

Resources

- www.fgmaware.org – multiple documents
- FGM Scottish government multiagency guidance November 2017 http://www.gov.scot/Resource/0052/00528145.pdf (most relevant pages Pg31 Guidance for GP's, Pg19 Good practice when raising subject of FGM, Pg23 Potential Risk Factors)
- Traditional and local terms for FGM

Local services and contacts

- One stop clinic at Stobhill
- Rape Crisis Glasgow, Ruby Project – support and help for BME women and girls (13+). 08088 00 00 14, info@rubyproject.co.uk
- Saheliya – specialist MH services, well-being support and advocacy for BME women and girls (12+)

Owen Fenn (manager at Govan Community Project): owen@govancommunityproject.org.uk

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