Female genital mutilation is a misunderstood and distressing issue. Nurses need to be aware of its impact to be able to offer or refer women for support.

Supporting women after genital mutilation

**In this article...**
- Different types of FGM
- How to identify women and girls with FGM
- Signposting support to women

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Female genital mutilation is a common practice in many cultures, and has a range of complications. Many women in the UK have undergone the procedure and many girls are at risk.

This article discusses the types of FGM and its complications, and explains how nurses can identify those who have had or are at risk of FGM and either offer support or specialist referral.

The World Health Organization estimates that today 100-140 million women have had female genital mutilation (FGM) performed (WHO, 2001), and two million girls are at risk from the practice each year worldwide.

Most females affected live in one of 28 African countries or parts of the Middle East and Asia such as Iran, Iraq, Yemen, Saudi Arabia and Malaysia. National FGM prevalence rates in the African region and Yemen vary from as low as 1% to 90% or more. The highest prevalence rates of 90% or more are found in Somalia, Sudan, Djibouti, Egypt, Guinea and Sierra Leone (WHO, 2014a).

Due to the increase in international migration, FGM is also practised among migrant communities in many countries. The estimated number of women resident in England and Wales who have been subjected to FGM is around 66,000 (Forward, 2007). Some 32,000 girls under the age of 15 from African communities are at risk of some form of FGM (FORWARD, 2007).

A more recent study on women accessing care from six specialist FGM clinics across the UK found that more than 1,700 had sought care for FGM within the past two years (Royal College of Midwives et al, 2013). The NSPCC runs a national FGM helpline. In 2013, over the course of three months, it received 102 calls relating to girls at risk of FGM; 38 of these were referred to the police for further investigation.

The scale of the problem in the UK may be even greater than estimated; FGM can be seen as a hidden phenomenon, because of the strong taboo associated with the practice and the cultural sensitivities involved in speaking out against it. The problem is also to a large extent hidden because it is under-reported in health and other information systems (RCM et al, 2013).

**What is female genital mutilation?**

The term “female genital mutilation” (also called female genital cutting and female circumcision) covers 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. There are four types of FGM (World Health Organization, 2008) outlined in Box 1.

Whatever the type of FGM performed, the procedure is often undertaken with a child being held down by female family members, without anaesthetic, using non-sterile equipment in a non-sterile environment such as a back yard. Some women retain clear, precise memories of this traumatic experience.

**5 key points**

1. Female genital mutilation covers all procedures that involve partial or total removal of or injury to the external female genitalia for non-medical reasons.

2. In the UK, around 66,000 women have undergone FGM.

3. FGM can be regarded as “hidden” because of the strong taboo around it and cultural sensitivities involved in speaking out against it.

4. Complications of FGM include haemorrhage, shock, urinary tract infections, menstrual problems, chronic pelvic infection, difficulties during childbirth and infertility.

5. Safeguarding daughters of women who have undergone FGM is vital.
Why is FGM performed?
The WHO has described FGM as a practice that “reflects a deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against women” (WHO, 2008).

The practice is related to the control of women's sexuality and gender-based social norms relating to “marriageability”. FGM is “culturally embedded”, as it is viewed as a form of cultural expression among those who support it, while it may be upheld as a religious obligation by some Muslim populations. However, the practice predates Islam and is practised by Muslims, Christians and followers of traditional African religions (RCM et al, 2013).

In the UK, reasons for practising FGM may have been adapted to fit their context. For example, it may be seen as a way of curbing sexuality and preserving cultural identity – the justification that having it carried out here protects girls from undergoing FGM in their country of origin is also gaining ground. Parents may also come under pressure from family and community members in the UK or overseas to have FGM performed on their daughters (RCM et al, 2013).

The type of FGM practised will depend on the reason it is performed; some women are unaware why it was done to them in the first place. The practice may be associated with witchcraft and black magic, or linked to religious issues. For example, meat cooked by a woman who has a clitoris may not be considered halal in some Muslim communities. Some women say their clitoris was removed due to fears it would grow like a penis and it would not be known whether they were a man or a woman. Type 3 FGM may be performed to prevent promiscuity or increase marriageability.

Effects of FGM
FGM can cause physical complications both in the long and short term (Box 2). It can affect women in different ways depending on the type of procedure they had. For example, type 3 FGM can cause problems with passing urine and menstrual fluid through the small opening that is left. This opening can sometimes be as small as a matchstick head, yet women are expected to pass urine, menstruate, have intercourse and give birth through it.

The length of time taken to pass menstrual fluid means some women do not have a blood-free day as one period is finishing when the next is starting. These women are very prone to urinary tract infections and can take up to 20 minutes to pass urine.

Women with FGM may also experience difficulties during childbirth; complications can include a ruptured uterus and the need for a Caesarean section. They may also have difficulty passing a foetus during miscarriage.

The effects of FGM are immense; it is both physically and psychologically damaging and scars women for life. Health professionals who have listened to the experiences of these women say their patients talk of the trauma of it and never forget the pain endured. All this needs to be acknowledged when caring for women with FGM.

Legal issues
In 2003, the Female Genital Mutilation Act made it an offence in the UK to excise, infibulate or otherwise mutilate the whole or any part of the labia majora or clitoris of another person; or to “aid, abet, counsel or procure” any of those acts on that person’s body. It is also illegal to take a child out of the UK for that purpose or to arrange such a trip. The penalty is up to 14 years’ imprisonment.

More recently, the Crown Prosecution Service published an action plan designed to improve prosecution rates by gathering more robust data on allegations, identifying what has hindered investigations in the past, and ensuring better working between police and prosecutors (Crown Prosecution Service, 2013.)

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Identifying and supporting women who have had FGM
Nurses should be aware of the countries where FGM is practised (the WHO provides a list at tinyurl.com/who-fgm-countries). When caring for women with
origins in a country where FGM is practised, nurses should try to establish whether they have had the procedure.

Nurses in all settings should establish whether female patients have undergone FGM, regardless of the woman’s country of origin – although awareness of the countries where it is practised will help them to recognise which women to pay particular attention to. This can be done during hospital admission or at an initial assessment. Routine questioning will act as a prompt to find out if a woman has had FGM; without this questioning, the information is unlikely to be forthcoming as it tends to be a taboo topic. The term FGM should be avoided, in favour of “circumcision” or “cutting”, which are more culturally appropriate to the communities where FGM is practised.

When examining a woman who has undergone FGM, it is important to take a sensitive, empathetic approach and avoid being judgemental; these women are victims and have not done anything wrong.

During examination, women may have flashbacks to their mutilation and experience psychological distress. However, in my clinical experience, some women had the procedure carried out as babies or very small children and therefore have no recollection of it; they may even be unaware that they have had FGM until they are informed by a health professional.

This highlights the importance of handling the situation with sensitivity and respect, being prepared for the outcome of unleashing these memories, and knowing where to refer women locally if necessary. Even those who are aware of their FGM may be afraid to seek help for any related problems. FORWARD offers advice and support for women with FGM (www.forwarduk.org.uk).

Type 3 FGM has the most serious health implications due to the nature of the mutilation. Cervical screening, a speculum examination or passing a urinary catheter on such women is impossible unless they undergo a deinfibulation (a procedure to “open” type 3 FGM).

**Specialist services**
A number of specialist clinics provide healthcare and assistance to girls and women affected by FGM, including clinics offering gynaecological and routine antenatal care.

The clinics are run by sensitive female staff who have an understanding of FGM and its effects on women, and translation services are available. Most clinics also offer deinfibulation services for women with FGM type 3 by opening up the seal and reforming the labia; the procedure is sometimes referred to as “reversal” but this is misleading as FGM is irreversible.

Specialist clinics are widely available in London but there are very few in other parts of the UK. Nurses therefore need designated professionals in specialist clinics to refer to and to be fully aware of guidance available both locally and nationally. The FORWARD website (tinyurl.com/forward-clinics) has a full list of specialist services available across the UK.

**Conclusion**
Nurses who have never seen a woman with FGM and lack knowledge about this issue may feel traumatised when faced with it.

Reading about the practice will help them to understand it and how to help women who have undergone it (Momoh, 2005). Raising awareness, educating staff and ensuring that FGM is a mandatory part of training for nurses and all health professionals, will help to ensure they are informed about these sensitive issues and are able to give patients the holistic approach and support they may need.

**References**