



## **Female Genital Mutilation: A clinical approach for GPs**

### **Introduction**

1. Female Genital Mutilation (FGM) is a brutal crime that affects women and girls within the UK and worldwide. It is generally performed on pre-pubescent children and can lead to severe short and long term physical and psychological conditions. In some cases FGM can lead to the death of the child.
2. The RCGP views FGM as child abuse, as the child has been subjected to irreparable physical harm, and is committed to its eradication. If it is suspected by a GP that a child has undergone FGM then the parent(s) or guardian(s) should be referred to social services who should have the means to deal with the offence accordingly.
3. Adult women who are victims of FGM will also require the support of their GP for the long term medical and psychological complications they may experience.
4. GPs are very important to the recognition and response to FGM. The unique position of a GP, as the expert medical generalist at the heart of the community, means that they are in a strong position to identify FGM, provide support to the affected patient, and refer the case onto the relevant authorities.
5. However, in order to ensure a safe and proper referral that would see the victim properly supported, there needs to be sufficient provision of culturally sensitive support services for victims. The College has concerns that a lack of consistent provision of specialised FGM services may leave victims without adequate support.
6. Moreover, if GPs are to help to ensure that the perpetrator is convicted based in part on the information they have provided, they must be given detailed guidance as to what kind of information the police may require. Currently the RCGP has concerns that there is not enough information available on the volume or kind of information needed to ensure a conviction.
7. This paper contains a breakdown of the role of the GP in combatting FGM, an analysis of the possible barriers to identification and referral as well as possible improvements to the way in which FGM is addressed within the UK.

### **Background**

8. **Definition.** 'Female Genital Mutilation' (FGM) refers to all procedures involving partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons. There are four different types of FGM:
  - Type 1: Prepuce removal only or partial or total removal of the clitoris (clitoridectomy)
  - Type 2: Removal of the clitoris plus part or all of the labia minora (excision)
  - Type 3: Removal of part or all of the labia minora with the labia majora either being sewn together covering the urethra and vagina leaving only a small opening for urine and menstrual fluid (infibulation)
  - 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
9. FGM is a global issue, with victims numbering in the millions every year. Most affected women live in 28 African countries, as well as parts of the Middle East and Asia. National FGM prevalence rates in the African region and Yemen vary from as low as 1% to 90% or more. FGM is usually

performed on pre-pubertal girls but even infants and adult women have been targeted. A map from UNICEF gives the number and percentage of women and children that have been affected<sup>1</sup>.

10. Increased international migration means FGM is a problem in countries such as the UK: data from 2001 suggested that 66,000 women resident in England and Wales may have undergone FGM, and that 23,000 girls from African communities under the age of 15 were at risk or may have already undergone FGM<sup>2</sup>.
11. FGM is not a religious issue. The World Health Organisation (WHO) has described FGM as a practice that “*reflects a deep-rooted inequality between the sexes*”. In the UK, family members and the wider community, both here and abroad, play a role in pressurising parents to put their children through FGM. Even where prevention is making headway in countries of origin, FGM can be used within UK migrant communities to curb sexuality and preserve the cultural identity of a minority.

### **Policy and political background**

12. FGM is a crime. The prohibition of Female Circumcision Act (1985) was replaced by the Female Genital Mutilation Act (2003) in England, Wales and Northern Ireland and similar terms were ratified in the Prohibition of Female Genital Mutilation Act (2005) in Scotland. It is a crime to conduct FGM and to aid, abet, counsel or procure FGM either within or outside the UK, whether by a UK or non-UK national or the girl herself. In March 2014 the first prosecutions under the Acts(s) were announced, including one doctor.
13. FGM is a form of child abuse, as it usually affects girls under the age of 18 years. Multi-agency practice guidelines were produced by the DH in 2011<sup>3</sup>, but “Working Together to Safeguard Children 2013” only mentions it once and this is in an appendix<sup>4</sup>. FGM differs in signs and symptoms from other forms of abuse (although the signs one sees in terms of the consequence of emotional/psychological damage may overlap). Children subjected to FGM may be unknown to social services and concerns may be below current referral thresholds.
14. Nationally and internationally there has been much recent discussion about FGM. END FGM is a European campaign, led by Amnesty International Ireland, working in partnership with a number of organisations in EU member states (<http://www.endfgm.eu/en/>). Within the UK an all-party parliamentary group on FGM was set up in 2011, with Jane Ellison MP as its chair. In November 2013 the Royal College of Midwives, Royal College of Gynaecologists, Royal College of Nursing and Equality Now produced “Tackling FGM in the UK: Intercollegiate recommendations for identifying, recording and reporting” were published<sup>5</sup>.
15. The Coalition Government announced in February 2014 that from September 2014, all hospitals in England will be required to record if a patient has had FGM, if there is a family history of the practice or whether deinfibulation has been carried out on a woman<sup>6</sup>. This will include community midwives. The prevalence data will then be reported to the Department of Health every month. Other health professionals (including GPs) may wish to support the standard and provide an FGM Prevalence Dataset. A national programme of education for communities affected and professionals is also taking place.

### **The role of the GP in combating FGM**

16. GPs play a unique role within the community as not only the first point of contact for the vast majority of patients in the health service, but also as an expert medical generalist trained to see the whole patient. As such GPs have a very important role to play in combating FGM within the UK.

<sup>1</sup> United Nations Children’s Fund, *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, UNICEF, New York, 2013. [http://www.unicef.org/media/files/FGCM\\_Lo\\_res.pdf](http://www.unicef.org/media/files/FGCM_Lo_res.pdf)

<sup>2</sup> Dorkenoo, E, Morison, L, Macfarlane, A, (2007) *A Statistical Study To Estimate the Prevalence of FGM in England and Wales*, FORWARD, London.

<sup>3</sup> Department of Health/HMG. *Multi-agency practice guidelines: Female Genital Mutilation 2011* [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216669/dh\\_124588.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216669/dh_124588.pdf)

<sup>4</sup> Department of Education. *Working Together to Safeguard Children 2013* <http://www.workingtogetheronline.co.uk/index.html>

<sup>5</sup> *Tackling FGM in the UK: Intercollegiate recommendations for identifying, recording and reporting* [http://www.rcog.org.uk/files/rcog-corp/FGM\\_Report%20v10%20a-final%20forwebsite.pdf](http://www.rcog.org.uk/files/rcog-corp/FGM_Report%20v10%20a-final%20forwebsite.pdf)

<sup>6</sup> NHS England. *The ISB 1610 Standard Title Female Genital Mutilation Prevalence Dataset* <http://www.isb.nhs.uk/library/standard/280>

## Identification

17. The most prominent role that GPs can play is one of identification. However, in order to do this they must be provided with the resources to do so.

18. The most significant risk factors that indicate that patients may be at risk of FGM are:

- Coming from a community known to practice FGM
- Having a mother or sister that has been affected

If patients present within surgery and either of these factors are known it should enable a diagnosis of FGM

19. There are a number of clinical situations when GPs and practice nurses may be able to identify patients who have been affected by FGM. These include:

- The registration of new patients from affected communities.
- At the start of pregnancy in women from affected communities. This can be achieved by asking a direct question.
- Patients presenting with symptoms that may suggest they have been affected by FGM, such as UTIs or vaginal soreness.
- Instances when patients from affected communities refuse cervical cytology or experience pain or distress during the test.
- When immunisations are requested for an extended break overseas to countries where the procedure is practiced.

20. There are also a number of immediate and long term effects of FGM that if encountered in a patient from an affected community could indicate that FGM had been performed.

- Immediate effects:
  - I. Severe pain
  - II. Shock
  - III. Bleeding
  - IV. Wound infections
  - V. Retention of urine
  - VI. Injury to vulval tissues surrounding the entrance to the vagina
  - VII. Damage to other organs nearby, such as the urethra and the bowel
- Long-term consequences
  - I. Chronic vaginal and pelvic infections
  - II. Blood-borne virus infections such as HIV, hepatitis B and hepatitis C
  - III. Abnormal and painful periods
  - IV. Difficulties passing urine and persistent urine infections
  - V. Renal impairment and possible renal failure
  - VI. Damage to the reproductive system, including infertility
  - VII. Complications in pregnancy and newborn deaths
  - VIII. Pain during sex and lack of pleasurable sensation
  - IX. Psychological damage, including low libido, feelings of betrayal by parents, depression and anxiety, PTSD
  - X. The need for later surgery to open the lower vagina for sexual intercourse and childbirth

21. However, there are a number of possible barriers to identification by GPs, such as:

- A lack of awareness of the risk factors that suggest a patient may be affected by FGM. Unfortunately there is a lack of adequate data on communities and individuals who are affected by FGM within the UK. It is likely that this is impacting on the ability of GPs to judge which of their patients may be at risk.
- Cultural sensitivity issues. GPs may feel unable to raise the issue sensitively with members of affected communities.

- FGM may not be clinically apparent to a GP who does not often conduct intimate examinations, especially if it is Type 1 (clitorectomy) in a pre-pubertal girl. Less extensive surgery may still be as serious in terms of infection (including HIV and other blood borne viruses), pain and subsequent mental health problems.
- Difficulty asking questions sensitively, but directly. Particularly in the case of women and children who are accompanied by a family member.
- Difficulty obtaining consent to an examination.
- Language and communication problems. There has been less access to translation services in recent years due to cut-backs within the health service.

22. In France routine examinations of the genitalia of young girls has led to a higher rate of prosecution. While the RCGP appreciates that routine screening can have positive outcomes, we have concerns that a screening programme of this type could alienate hard to reach individuals and communities, and could in itself be a traumatic experience.

## Recording

23. GP systems have a specific code to record FGM as detailed below. This has the potential to be a valuable tool in combating FGM by increasing the level to which it is recorded and therefore understood. In addition, by gathering local prevalence data, it may be possible to make a better case to gather funding for additional resources such as specialist services and language services.

Read coding the diagnosis:

Diagnosis	Read v2
Family History of Female Genital Mutilation	12b..
History of Female Genital Mutilation	15K..
Female Genital Mutilation Type 1	K5780
Female Genital Mutilation Type 2	K5781
Female Genital Mutilation Type 3	K5782
Female Genital Mutilation Type 4	K5783
Deinfibulation of vulva	7D045

## Referring, Safeguarding and Child Protection

24. FGM is a form of child abuse and if it is suspected that it has occurred or that there is a high risk that it is about to occur, a GP should refer the case to social services under Local Safeguarding Children Board (LSCB) procedures. There need to be clear pathways of care and thresholds for referral. The RCGP/NSPCC Safeguarding children toolkit contains further information<sup>7</sup>.
25. As the main point of entry into the health service for the majority of patients, GPs have a duty to refer patients to relevant secondary bodies. However, in order to do this for patients affected by FGM there need to be clear pathways of care and thresholds for referral to police, social and other relevant services, including mental health. Local Safeguarding Boards (LSGB) need to be encouraged to develop their local multi-agency procedures to clarify these. In addition some women and children will need specialist FGM support services, for the physical and/or psychological consequences of their trauma. The RCGP does not think adequate support services currently exist, except in small pockets within some large cities.

<sup>7</sup> RCGP/NSPCC. *Safeguarding Children & Young People: A Toolkit for General Practice 2011*. <http://www.rcgp.org.uk/~media/Files/CIRC/Safeguarding%20Children%20Module%20One/Safeguarding-Children-and-Young-People-Toolkit.ashx>

26. The RCGP opposes the introduction of mandatory reporting for FGM (the legal requirement to report all instances of FGM encountered) when the victim is an adult. Automatic disclosure in every instance of FGM would fail to take into account the unique circumstances of each patient and therefore may not be in their best interests. The College believes that GPs should be trusted to make the decision about when it is the right time to refer an adult victim to the relevant authorities and any move towards mandatory reporting would undermine the safeguarding role of the GP. In addition, its use risks further isolating the communities which FGM affects.

### Raising awareness

27. The RCGP has helped to produce a number of documents aimed at GPs which contain advice on how to address FGM (detailed in paragraph 29 below). In addition, GPs should feel free to display posters and have leaflets in their surgeries, especially if they are in an area with a high prevalence of FGM.

### Working with the wider health service

28. In addition, GPs also have a role in supporting other health care professionals who may be closer to the victim or the mother of the victim, such as midwives or health workers, to identify and refer any cases of FGM they may encounter.

### Training

29. GPs should understand their responsibilities in terms of cultural sensitivity, legal issues, multi-agency working and safeguarding and develop the necessary skills for working with women and children who have suffered from FGM. Most GPs will probably need to address some learning needs in this area and find out about local referral pathways.
30. The RCGP curriculum highlights the need for GPs to be able to communicate sensitively with women about sexuality and intimate issues (particularly in recognising the impact of past sexual abuse and the illegal procedure of female genital mutilation) and local GP training programmes should ensure appropriate training is provided to GP trainees on this issue.

### Information regarding FGM for GPs

31. Readily available information on FGM and how it should be addressed is essential to support diagnosis in general practice and the referral of the victim and perpetrator to the relevant services.
32. There are a number of resources currently available for GPs:
- Department of Health (2011) *Female genital mutilation: multi-agency practice guidelines*<sup>8</sup>
  - BMA Ethics: *Female Genital Mutilation: Caring for patients and safeguarding children 2011*.<sup>9</sup> and *Tackling FGM in the UK: Intercollegiate recommendations for identifying, recording and reporting*<sup>10</sup> The RCGP welcomes and supports these guidelines. However, in common with a recent article in the BMJ<sup>11</sup> the RCGP feels that the document fails to grasp how the actions needed to deliver the outcomes may be achieved in every day practice.
  - The RCGP has also helped to draw up a number of resources on FGM for use within primary care:
    - I. The Primary Care Child Safeguarding Forum (PCCSF) is a Primary Care Society affiliated to the RCGP and has recently produced a Statement on Female Genital Mutilation.

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<sup>8</sup> Department of Health, *Female Genital Mutilation: Multiagency guidelines* <https://www.gov.uk/government/publications/female-genital-mutilation-multi-agency-practice-guidelines>

<sup>9</sup>BMA, *Female Genital Mutilation: Caring for patients and safeguarding children 2011* <http://bma.org.uk/-/media/Files/PDFs/Practical%20advice%20at%20work/Ethics/femalegenitalmutilation.pdf>.

<sup>10</sup> Royal College of Obstetrician and Gynaecologists, *Intercollegiate Group draws up ground-breaking recommendations for tackling Female Genital Mutilation* <http://www.rcog.org.uk/news/intercollegiate-group-draws-ground-breaking-recommendations-tackling-female-genital-mutilation>

<sup>11</sup> Creighton S, M Liao L-M. *Tackling female genital mutilation in the UK*. *BMJ* 2013;347:f7150

- II. The RCGP has been involved in a major piece of work on FGM, led by our colleagues at the Royal Colleges of Midwives and Obstetricians and Gynaecologists, amongst others. This is focused on helping to raise clinician awareness of this problem, which affects some of the most vulnerable girls and women in our society. The report *Tackling FGM in the UK* looks at the role that all health and social care professionals - including GPs - have in identifying and reporting cases of FGM.
- III. The RCGP in conjunction with the NSPCC had previously developed a toolkit for health professionals on safeguarding children and young people, including advice of relevance to cases of FGM.<sup>12</sup>
- IV. The RCGP 'Violence Against Women and Children' online course, developed in partnership with the Department of Health (England) VAWC team, which includes information on FGM and on identifying and responding to other forms of violence. As of April 2014, this course has been accessed by over 3600 practitioners: <http://elearning.rcgp.org.uk/course/info.php?id=88>

33. However, the RCGP has concerns that insufficient information has been made available from Government on this issue. The March 2013 Department for Education publication of "Working together to safeguard children"<sup>13</sup> does not mention FGM in any meaningful detail. This reinforces the feeling that child protection and combating FGM are not properly strategically aligned.

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<sup>12</sup> RCGP and NSPCC, *Safeguarding Children and Young People A Toolkit for General Practice*, 2011  
<http://www.rcgp.org.uk/~media/Files/CIRC/Safeguarding%20Children%20Module%20One/Safeguarding-Children-and-Young-People-Toolkit.ashx>

<sup>13</sup> Department for Education, *Working together to safeguard children*, 2013  
<http://www.education.gov.uk/aboutdfe/statutory/q00213160/working-together-to-safeguard-children>.

## **Useful Contacts and Organisations**

NSPCC FGM helpline. Helpline offering advice, information and support to anyone concerned that a child's welfare is at risk because of female genital mutilation.

Tel: 0800 028 3550. Email: [fgmhelp@nspcc.org.uk](mailto:fgmhelp@nspcc.org.uk)

NHS Specialist Services for Female Genital Mutilation in England

List of contact details for specialist services. Last updated March 2014

<http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Documents/List%20of%20FGM%20Clinics%20Mar%2014%20FINAL.pdf>

The Primary Care Child Safeguarding Forum (PCCSF) is a Primary Care Society affiliated to the RCGP.

<http://pccsf.blogspot.co.uk/> or [rcgp.org.uk](http://rcgp.org.uk) under “safeguarding children”.

RCGP/NSPCC Safeguarding Children & Young People: A Toolkit for General Practice 2011

<http://www.rcgp.org.uk/clinical-and-research/clinical-resources/child-and-adolescent-health/safeguarding-children-toolkit.aspx>

(in the process of being updated)

**Daughters of Eve:** A campaigning and support organisation. <http://www.dofeve.org/>

**Forward UK:** A campaigning and educational organisation. <http://www.forwarduk.org.uk/>

**Equality Now:** A campaigning organisation. <http://www.equalitynow.org/>