Female genital mutilation, asylum seekers and refugees: the need for an integrated UK policy agenda

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Asylum seekers and refugees in the UK often receive inadequate or culturally insensitive care.

A group at particular risk, especially in largely monocultural areas outside London to which refugees are being dispersed, are girls and women who have undergone, or are at risk of undergoing, female genital mutilation (FGM).

FGM is the range of procedures (performed for cultural rather than therapeutic reasons) involving partial or complete removal of female genital organs. As a result of migration and refugee flows, the practice of FGM has now extended beyond the 28 African countries in which it is traditionally practised and affects as many as 140 million women and girls worldwide.

The degree of physical and psychological health problems associated with FGM vary according to its type.[1] Immediate effects can include pain, injury to adjacent tissue, shock, infection, urinary retention, and haemorrhaging resulting in death. Long-term morbidity consequences can be severe and include: urinary incontinence, recurrent urinary tract infection, pelvic infections resulting in infertility, menstruation difficulties, fistulae of the bladder or rectum, sexual dysfunction and problematic pregnancy and childbirth.

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Although FGM was made illegal in the UK under the 1985 Prohibition of Female Circumcision Act, evidence suggests that it still takes place. While estimations of FGM prevalence are essentially speculative, researchers estimate that there are 3,000-4,000 new FGM cases in the UK every year. FORWARD, an FGM-focused NGO, estimates there are 86,000 first generation immigrant refugee/asylum-seeking women and girls in the UK who have undergone FGM. Numbers are increasing with the influx of asylum seekers from Somalia, Sudan and Sierra Leone. There have been no prosecutions of FGM practitioners.

Despite commendable work, existing UK FGM programmes lack the rigour, multi-agency coherence and funding needed to address asylum seekers' and refugees' needs satisfactorily. What is required is an integrated policy agenda capable of meeting these girls' and women's needs. This agenda should cover the training of professionals, research, community education and the development of culturally sensitive health services.

The problem of caring for those affected by the practice increasingly falls on UK health, education and social services professionals and on the police, who, for the most part, are poorly trained and ill-equipped to deal with such cases. Much more needs to be done to research the extent of FGM, train professionals, educate communities and develop culturally sensitive health services.

The psychological consequences of FGM require investigation. They are likely to be worse for girls and women living in a society that regards circumcision as abnormal rather than a means of enhancing social status. The opinions and attitudes of FGM-practising communities must be heard and understood if professionals are to appreciate why the practice continues.

In a number of cases in the UK, avoidance of FGM has been one of the reasons for a successful asylum claim. To evaluate these claims compassionately and fairly, immigration officials, barristers and solicitors need to receive adequate and appropriate FGM education to make informed judgements and represent their clients effectively in court.

Specific child protection guidance should be made available to all professionals potentially involved in identifying the risk of FGM. All referrals of suspected or actual FGM from health personnel, teachers, friends or relatives should be treated seriously, irrespective of how vague the suspicion. FGM specialists should be appointed in every health authority and referral and information exchange systems established. Asylum seekers arriving from countries where FGM is practised should be given leaflets in relevant languages with information on how to access available services. Female interpreters need to be available to translate medical terms in a form understandable to FGM victims.

The increased number of asylum seekers and refugees from FGM-practising countries arriving in the UK means the practice will not disappear gradually. More professionals will encounter women and girls who have either been, or are at risk of being, mutilated. Using rigorous evidence-based research, these professionals must be educated about FGM and feel technically equipped to provide suitable support to meet existing health needs.

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1 There are four types, ranging from the pricking, piercing, stretching or incision of the clitoris and/or labia to the excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).