

Men and women living with Female Genital Cutting are experiencing Health Care Poverty

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In the UK, 37,615 individual women and girls have been identified as having experienced Female Genital Cutting or Circumcision (hereafter FGC)¹. FGC has been associated with long-term physical, sexual, reproductive and psychological complications².

About the research

In 2015 the UK Government raised the profile of FGC in health policy. Pursuing a dual strategy of prevention and care, the new policy measures encompassed the active promotion of safeguarding in health encounters – including a Mandatory Reporting Duty for professionals working in regulated settings – as well as the establishment of the FGM Enhanced Dataset to collect epidemiological data on patients, and the creation National FGM Support Clinics to provide a confidential and safe space for women seeking healthcare and information.

Despite these measures, both the access to and quality of healthcare received by women living with FGC in the UK, has been described as sub-optimal and requiring improvement. Our research finds the main reasons for this care poverty are that:

- The requirements on health professionals to take a primary role in reporting potential future criminal activity and the demands of data collection for the FGM Enhanced Dataset have altered the nature of interactions in healthcare settings. Women with lived experience of FGC feel that their own health needs are being marginalised as a consequence of these policies and many report feeling profiled and stigmatised in healthcare settings.
- The specialist services offered are limited in scope (with a focus on surgical interventions) and reach (offered to women only) and are not widely known about.

1. In recognition of the stigmatising nature of the term 'Female Genital Mutilation' or FGM, we are using 'FGC' as an alternative. The WHO categorise FGM in to four different types which are associated with varying health consequences: Data on FGC in the UK can be found at: [Female Genital Mutilation, Annual Report - April 2023 to March 2024 - NHS England Digital](#).

2. "The most severe type, Type III, has serious obstetric risks including infant resuscitation, stillbirth, and neonatal death; while Types I and II carry risks of caesarean section and postpartum bleeding" (Farouki, et al., 2020: 3-4). Type IV – which includes genital piercing, pricking etc – is typically associated with little, if any, physical long-term consequences.

Recommendations

To address FGC health care poverty, the NHS should:

- 1. Urgently reprioritise female patient care needs and ensure trauma-informed approaches in healthcare encounters.** Women who have FGC are too often treated as potential perpetrators rather than victims or survivors. Policies relating to mandatory reporting and FGM NHS Dataset requirements should be revised according to the principles of trauma-informed health and care interventions.
- 2. Review and revise training and guidance for healthcare professionals.** Policy should take a holistic and compassionate approach to the healthcare of women living with FGC. Discourses and language which suggest that women who have FGC are abnormal, incomplete, and/or dysfunctional – including use of the term ‘mutilated’ – should be challenged and abandoned.
- 3. Offer specialist services to men as well as women.** Men are typically excluded from FGC healthcare provision despite being impacted. FGC can result in physical injury to men during intercourse, impact erectile functioning, and entail psychological trauma. In many cases, physical aggression is required for penetration to be achieved, something which can have profound consequences for relationships. Men with lived experience need to be part of the development of services, alongside explicit services addressing their needs and knowledge.
- 4. Expand specialised sex and relationships counselling services.** Current services offered to women living with FGC, focus on anatomical solutions (such as deinfibulation) and there are [currently calls for the NHS to offer reconstruction surgery](#). Surgical interventions for FGC can address issues relating to pain and discomfort as well as appearance, but are liable to further damage nerve endings and thus decrease sensitivity. Priority should be given to services which address psycho-sexual functioning, trauma and relationship counselling.
- 5. Provide greater transparency around service provision and funding.** It remains unclear what has changed as a result of data gathered through the NHS Enhanced Dataset. Information should be published about what services are being offered, how those services have been advertised to target communities, and how well those services are being utilised.
- 6. Resource and develop Community Health Advocates to raise awareness about existing health care services and increase trust in those services.** Knowledge of existing services among those with lived experience was exceptionally poor. In addition, trust in NHS services, especially first points of contact (e.g. GPs) was also extremely low. Community health advocates can play a vital role in tackling both these issues.

Key findings

Research Study One

In a collaborative project with Caafi Health, a grass-roots health organisation based in Bristol, the Bristol Research on Female Genital Modifications (BRFGMo) group, conducted seven focus groups involving 41 participants including both women (n=26) and men (n=15) and 14 semi-structured interviews (with nine women and five men) from 10 different nationality backgrounds.

After analysing the data, we brought our participants together with other members of affected communities, healthcare providers and professionals from Bristol in July 2023 and held reflective discussions to verify the key findings and prioritise recommendations.

Study One finds that those affected by FGC have particular healthcare needs which are not currently being met. This is despite the existence of a specialist FGC NHS service for women based in East Bristol and a weekly drop-in service run by Refugee Women of Bristol.

This is due to the combined effects of a lack of awareness of existing services, barriers to accessing existing services including perceptions of culturally inappropriate services and previous negative healthcare experiences due to the requirements of the FGM Enhanced Dataset, and a lack of provision of certain kinds of service to address the psycho-physiological needs arising from FGC.

We find many of the unmet care needs relate to sexual functioning and its impact on spousal/ partner relationships and families more broadly. The powerful social messaging around FGC as foreclosing sexual pleasure was perceived by both women and men to be as significant to poor sexual functioning as any physiological or post-trauma consequences of FGC.

Research Study Two

A subsequent research study was designed to explore in more depth the issues raised by participants regarding sexual functioning and the powerful social messaging around FGC.

Together with Caafi Health and The Bridge, an organisation that specialises in sexual trauma and counselling in Bristol, and a puppetry expert from Royal Central School of Speech and Drama, we worked with a group of nine women and a group of six men with lived experience to devise scripts which captured and overcame the difficulty of having conversations with partners about sexual intimacy and FGC. We also explored what an approachable health service might look like and what services it might offer.

In the course of developing these scripts, women and men expressed the enormous challenges they had in talking to their sexual partners about what was re-traumatising and what they enjoyed. Women told us that many men, including for some their own otherwise loving partners, presumed that FGC meant they were unable to experience sexual pleasure, and therefore made no attempt to find out their triggers or their desires. Some reported being abandoned by partners because of perceived sexual inadequacy relating to their status as having FGC, whilst others reported being rejected by potential suitors because they had FGC. They also told us that they were reluctant to approach health practitioners to ask for help given their previous experiences with the health services and their perception that health professionals were as equally ill-informed about FGC and its impact on sexual functioning as many men.

Further information

The final report of Study One, can be found here: Care Poverty: [The unmet needs of those living with Female Genital Cutting/Mutilation in the UK](#).

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A video of Study Two can be found here: <https://youtu.be/qBBU3UxVVgA>

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For further research carried out by the team see: [Bristol Research on Female Genital Modification | Supporting needs and experiences of women living with FC in the UK](#)

