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PRACTICE REPORT

Survey of UK physiotherapists treating female genital mutilation

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Abstract
Since many of the long-term effects of female genital mutilation (FGM) are within the scope of practice of women's health physiotherapists, the International Organization of Physical Therapists in Women's Health conducted a survey of its member countries in 2010 to determine if women who have undergone FGM are receiving physiotherapy, and to identify any current research or the level of interest in such research. Survey Monkey was the tool used. This survey showed that approximately 13% of 423 respondents had treated women with FGM, mostly in small numbers of up to four per year, with some treating 20 or more. Urinary incontinence, perineal trauma/tears in childbirth, dyspareunia, postpartum urinary problems and chronic pain were the conditions for which treatment was most often sought. A synopsis of this survey has been communicated to the World Health Organization. Because the world-wide survey showed that the UK was the country in which the most women were treated by physiotherapists, a further survey was conducted in this country during March–April 2015, and the results are reported below.

Keywords: female genital mutilation, physiotherapy, UK.

Background

Despite growing awareness of the dangers to health and the infringement of human rights, the practice of female genital mutilation (FGM) persists, in declining numbers, but with some changing trends. The two most disturbing are a lowering of the average age at which girls are subjected to the practice, and the medicalization of the procedure (WHO 2011). Younger girls are less likely to resist, and by having a healthcare professional perform the cutting, some parents believe that the procedure is safer, thus mitigating the risk of adverse health effects. In the same report, the World Health Organization (WHO) reports that 18% of all women who have undergone FGM have done so at the hands of healthcare providers, with this trend increasing in all practising countries (WHO 2011). Dr Marleen Temmerman, director of the WHO Department of Reproductive Health and Research, suggests that education about the health risks of FGM has resulted in many families choosing a clinical environment rather than the traditional context (Morgan 2015). She also warns of the danger of practising milder cuts in the knowledge that the majority of health risks come from type III FGM (infibulation). Dr Temmerman states that it is imperative the practice in all its forms is abandoned.

Tradition is often quoted as the reason for the persistence of FGM, just as slavery, foot binding and other inhumane practices were once defended (Mackie 1996). The convention model (Mackie 1996) is credited with ending the practice of foot binding in China in the early 1900s. And it is this model, using collective change and public declarations, that is reported by non-government organizations such as Tostan (2016) to have had the most success in achieving the abandonment of the practice in parts of Africa (WHO 2008).

Female genital mutilation is defined as procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.

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Box 1. The 2007 World Health Organization classification of female genital mutilation (WHO 2008)

Type I: (clitoridectomy) partial or total removal of the clitoris and/or the prepuce.
Type II: (excision) partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.
Type III: (infibulation) narrowing of the vaginal orifice with the creation of a covering seal by cutting and apposition of the labia minora and/or the labia majora, with or without excision of the clitoris leaving a pencil-sized common orifice for menstruation and urination. This may lead to slow and painful menstruation, or bladder emptying drop by drop. Another consequence of infibulation is the difficulty of initiating sexual intercourse by penetration, which may only be possible surgically by defibulation.
Type IV: unclassified (all other harmful procedures to the female genitalia for non-medical purposes; e.g. pricking, piercing, incising, scraping and cauterization).

A classification of FGM was first drawn up by WHO in 1995, and then modified in 2007 (WHO 2008) (Box 1), noting that there is inevitably simplification because of the difficulties in reflecting vast variations in the practice from traditional cutters in villages with young girls held down by female relatives as part of a traditional ceremony, to the sterile conditions of an operating theatre run by a health professional.

2015 UK survey

Overall numbers

This survey, with a total of 109 respondents, showed that 21% had treated women or girls for the effects of FGM, concurring with the percentage result in the first survey.

Numbers treated in practice

Of those respondents treating women or girls with FGM, 73% treated numbers ranging from one to four, 11% treated five to nine, 4% treated 10–14, and 11% treated 20 or more. Unfortunately, this question did not specify the time frame; the first survey had asked approximately how many women were treated per year.

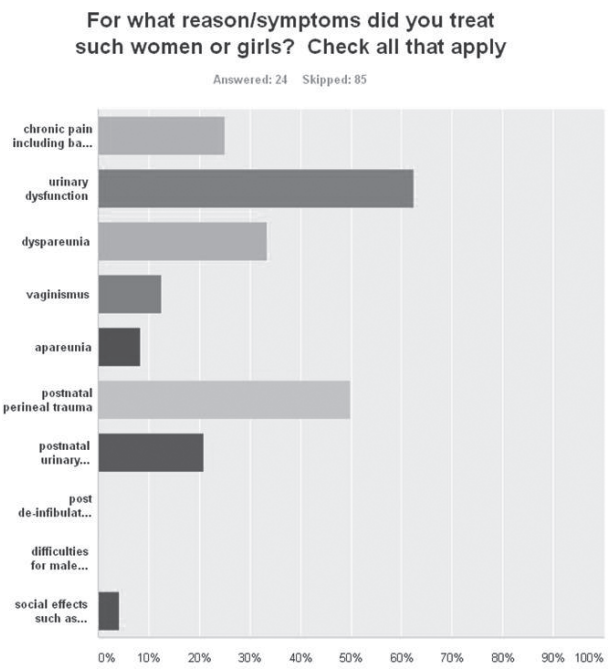

Figure 1. For what reason/symptoms did you treat such women or girls? Check all that apply.

Reasons/symptoms treated

Urinary dysfunction and postnatal perineal trauma were the reasons for most referrals, followed by dyspareunia, chronic pain and postnatal urinary dysfunction (Fig. 1). These results are almost identical to the world-wide membership survey, the only difference being that, in the UK, chronic pain was treated with a higher frequency than postnatal urinary dysfunction. Other reasons included functional bowel disorder, faecal incontinence and pelvic organ prolapse.

Referrals

Sixty-four per cent of referrals were from specialist obstetricians and gynaecologists, followed by family doctors (28%) and then midwives (24%). One comment mentioned a new service for specialist midwives enabling them to refer women and girls directly to physiotherapists for symptoms relating to the practice of FGM.

Treatments

Pelvic floor muscle (PFM) exercises were included in 96% of treatments, followed by biofeedback (32%), myofascial release and trigger-point pressures (28% each), facilitation techniques (24%), and muscle energy techniques (16%) (Fig. 2). Additional treatments in the

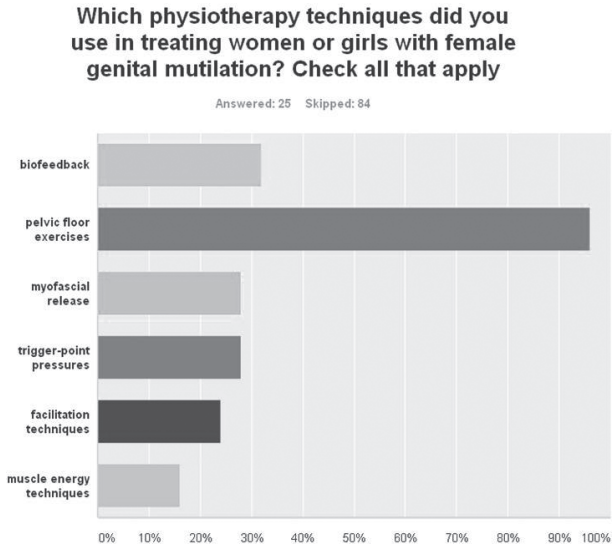

Figure 2. Which physiotherapy techniques did you use in treating women or girls with female genital mutilation? Check all that apply.

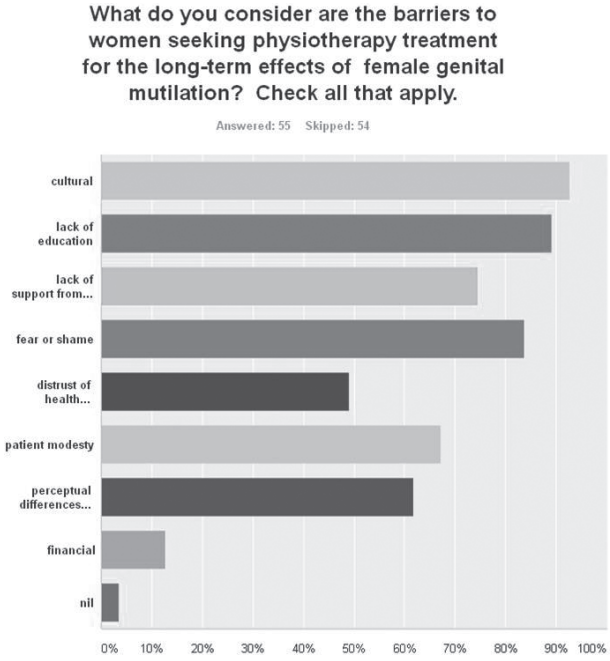

Figure 3. What do you consider are the barriers to women seeking physiotherapy treatment for the long-term effects of female genital mutilation? Check all that apply.

comments box included anal biofeedback, perineal massage, scar management, bladder training and electrical stimulation.

Episodes of care

This question related to the different reasons for treatment of the same women (e.g. urinary incontinence and postnatal perineal trauma), and 55% of those treating women with FGM responded that three or more episodes of care were required.

Education of therapists

Forty-five per cent of the UK respondents had attended lectures on the subject, but not specifically on physical therapy and FGM. Such sessions were reported as having the effect of increasing knowledge and awareness, as well as understanding of legislation against the practice of FGM in the UK. This included raising awareness of the responsibility of reporting any knowledge of the practice being carried out in the UK to the appropriate authorities.

Perceived barriers to treatment

Many barriers to treatment were identified (Fig. 3). One comment suggested a reluctance to acknowledge and refer to physiotherapy by other health professionals.

Survey summary

There is a paucity of research concerning the effectiveness of physiotherapy for women with symptoms relating to FGM. Currently, best practice is extrapolated from evidence-based research data for the efficacy of PFM training and other modalities for urinary dysfunction not related to FGM. In the first survey of the International Organization of Physical Therapists in Women's Health's (IOPTWH's) world-wide membership in 2008, only one person reported being actively involved in research. However, a large number of therapists did express an interest in such research.

There are now case reports documenting the use of biofeedback and PFM exercises. Writing in the *BMJ*, Abdulcadir & Dällenbach (2013) reported the use of biofeedback re-educative therapy in a case report on overactive bladder after female genital mutilation/cutting type III. Dr Abdulcadir states, in correspondence, that in her hospital in Geneva, Switzerland, midwives trained by physiotherapists carry out the therapy. The same author, in her paper on research gaps in the care of women with female genital mutilation (Abdulcadir *et al.* 2015, p. 300), stated that "[f]urther studies could evaluate long-term postpartum complications, such as prevalence of incontinence postpartum, or the effectiveness of treatments [. . .] (e.g. biofeedback or Kegel exercises)". She suggests that perineal re-education could improve not only the lower urinary tract symptoms and dyspareunia, but also a woman's self-knowledge. Research into evidence-based physiotherapy care for women and girls with FGM, and validated outcome measures are needed.

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Ruth Broom is a retired New Zealand physiotherapist who has worked in all areas of women's health. With a special interest in high-risk pregnancy, her primary clinical involvement was with multidisciplinary teams of obstetricians and gynaecologists in the public sector. From 2005 to 2015, she chaired the Practice Committee of the IOPTWH. In this capacity, she led the writing of a position paper against the practice of FGM, which she presented at the 2007 World Confederation for Physical Therapy (WCPT) Congress in Vancouver, Canada. This paper became the background document for a statement developed by the WCPT that was put to a vote and unanimously endorsed by the 101 member nations at the business meeting at this forum. This position, against the practice of FGM, was subsequently communicated to WHO. At the 2011 WCPT Congress in Amsterdam, the Netherlands, Ruth presented the results of an international survey to determine the extent to which physiotherapy is used for the treatment of women who have undergone FGM. She presented the results of a further survey of physiotherapists working in women's health in the UK at the 2014 WCPT Congress in Singapore. At a national level, Ruth has been an active committee member of her country's Continence, Women's and Men's Health Special Interest Group and the New Zealand delegate to the IOPTWH.

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