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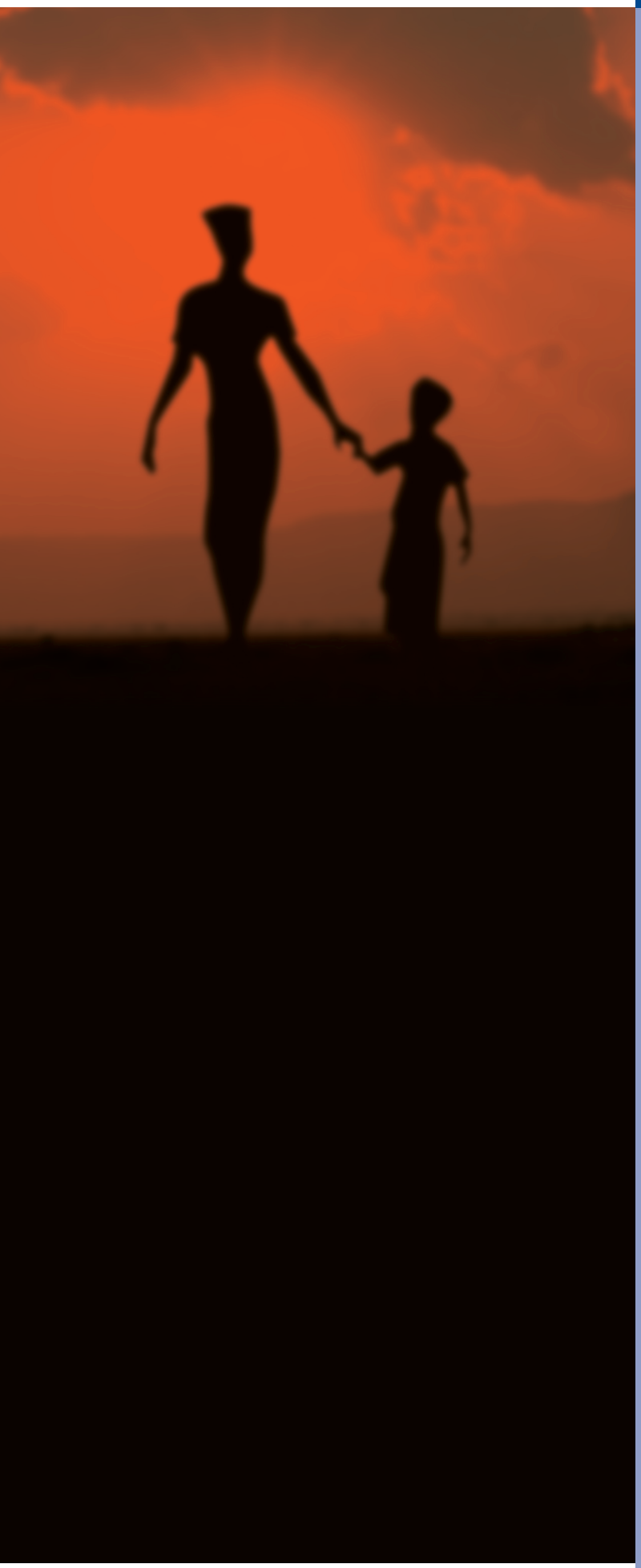

Female genital mutilation

An RCN educational resource for nursing and midwifery staff

Royal College of Nursing

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Contents

Foreword

We are all living and working in increasingly multi-racial, multicultural communities, which afford us many opportunities to learn about, and appreciate various customs and traditions. However, female genital mutilation (FGM) is one tradition that cannot be unquestionably regarded as acceptable. FGM is now considered as a harmful traditional practice, as well as a violation of the human rights of girls and women.

Health professionals, especially nurses and midwives, who may come into contact with girls and women who have undergone FGM, have a responsibility to provide them with the very best care. They will not be able to do this unless they know about and understand FGM. That is why I am so pleased to see that the Royal College of Nursing has taken the initiative to produce this guidance for its members.

The guidance provides a snapshot of the basic background information and the health consequences of FGM, and importantly the legislative, child protection and human rights dimensions of this practice.

It is critical that all nurses and midwives are clear in their minds that FGM is abuse, and that they have a responsibility to act to protect girls from this type of abuse. To fail to act because of labels of culture, tradition, religion or because of the fear of being labelled 'racist' is unacceptable!

It is FORWARD's hope that reading this guidance will challenge you, encourage you to read further, empower you to act when you need to, and motivate you to start raising FGM with practising communities – changing long-held beliefs, and resulting in positive, permanent, behaviour change.

Adwoa Kwateng-kluvitse
Director, FORWARD

Introduction

This publication has been written for nurses, midwives and specialist practitioners in public health. Some health care professionals work closely with communities who have practised female genital mutilation (FGM) for generations while many others may rarely come across this practice. FGM affects the lives and health of an estimated 100 million to 140 million girls and women around the world (WHO, 2000) and 86,000 in the UK (Powell et al., 2002). The World Health Organization (WHO) estimates that two million are cut every year.

In producing this document we want to ensure that all nurses, midwives and specialist practitioners in public health are informed about FGM, and understand the socio-cultural, legal and health issues that surround the practice. FGM is against the law in the UK and raises serious concerns and issues around the safeguarding of girls and young women. It is vital that practitioners who come into contact with women, children and their families from communities that practise FGM have adequate knowledge and understanding of the issues to be able to respond appropriately and meet their needs, and also to act within contemporary law and policy.

What is female genital mutilation?

WHO (2000) defines FGM as 'procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons'.

FGM is often called *female circumcision* implying that it is similar to male circumcision. However, the degree of cutting is far more extensive, often impairing a woman's sexual and reproductive functions and even the ability of girls and women to pass urine normally. This is why WHO refers to the practice as *female genital mutilation. Female genital cutting* is also used, particularly where the apparently judgemental phrase *female genital mutilation* might offend and lead to resistance to change.

The historical and cultural context of female genital mutilation and why it is performed

FGM is a deeply rooted practice with culture and tradition given as the main reasons for its continuation (Momoh, 2003). It may sometimes be seen as an act of love or as a rite of passage by the practising community, which may find it difficult to understand why the practice is condemned and may believe that they are doing the best for their daughters. Those that do not practise it generally view it as a form of abuse and a violation of human rights. This is the view taken by numerous international conventions, agencies and human rights groups, and by some women's groups and governments in areas where FGM is commonly practised.

It is not clear when and where FGM first started but it is known to have existed over two thousand years ago (El Dareer, 1982), and has been found in Egyptian mummies from 2000 BC. It is well documented that FGM was practised in Britain, Canada and the USA in the 18th century to prevent masturbation, cure hysteria and some psychiatric conditions (Ng, 2000).

There are many reasons for performing FGM and they vary between setting, communities and countries. They can be summarised as relating to control of women and their sexuality, religious motivations, rites of passage, ideas of hygiene, femininity and aesthetics, and social pressures and expectations.

FGM is often erroneously linked to Islam and is practised in some communities where Islam predominates. Some Muslims consider that Islam demands the practice to ensure spiritual purity, although many Islamic scholars disagree with this stating that FGM is not mentioned in the Qur'an. However, it is clearly a

Some views of people from African communities

"I cannot trust her if she is not circumcised"

"Female circumcision in our country has many beneficial aims like to keep the honour of the girl. But generally circumcision is not good because there is a different between circumcised women and uncircumcised women"

"Yes I am happy to marry uncircumcised woman"

"The right time to open my circumcision is at night-time of marriage"

"The type of circumcision I am going to circumcise my daughter is how the Islamic religion allows that is the sunnah"

"Allah doesn't accept to harm one organ of human being body, and is unlawful to cut human reproductive organs"

Quotes taken from interviews conducted by Comfort Momoh

ritual practice that predates the Prophet Mohammed and the Islamic religion. FGM transcends religious, racial and social boundaries (Webb, 1995). A minority of followers of other faiths, Christians, animists and Jews practise it (Maurad and Hassenein, 1994).

Performing FGM can be seen by some as an essential part of a culture that must be preserved (Momoh, 1999). FGM is often related to ideas about female chastity, hygiene and aesthetics, and is founded on deeply held cultural and traditional belief systems. Illiteracy, the low status of women, their lack of access to money and limited knowledge and power all help to perpetuate FGM.

In some societies FGM is believed to reduce the possibility of pre-marital and extra-marital sex, improving both the marriageability of 'circumcised' young women, and increasing their dowries. Hence, in many areas it is seen as a prerequisite for marriage, which may be the only secure future for women in these societies. FGM may also be considered to promote or maintain virginity and chastity by decreasing women's sexual enjoyment and desire for sex, as well as enhancing their partners' or husbands' pleasure. The closed introitus (the opening to the vagina) in infibulated (when the labia majora are sewn together) women is considered to provide evidence of virginity. Families, therefore, view FGM and virginity as important for maintaining their honour in society. The emphasis on 'tightness' may be so strong that women wish to be closed again after childbirth, or prior to remarrying if widowed or divorced. Carrying out closure is illegal in UK, and this is addressed in section five. FGM may be believed to improve fertility and often carries high social values (Giorgis, 1983).

FGM is also related to ideas of femininity and masculinity, particularly when the clitoris is likened to a penis. Some communities believe that children are born with the attributes of both sexes, and it is important to ensure that the child has been assigned to the appropriate sex and gender role after birth. Therefore, boys must have all feminine attributes removed – the foreskin, which is believed to be the remnants of the labia. Girls must have all masculine features removed – the clitoris, which is believed to be a diminutive penis. These acts ensure that each child has an assured and unambiguous place in the society.

Aesthetics and cleanliness are other reasons put forward for performing FGM. The female genitalia may be believed to be ritually unclean or polluted. It may be believed that a woman's clitoris 'poisons' the baby as it is born. Some cultures see uncircumcised women as bringing shame onto their families. In such societies uncircumcised women, and even girls, may be ostracised, so mothers have strong incentives to make sure their daughters undergo FGM. FGM is viewed as a positive and normal part of the heritage in many communities, which see the continuation of the practice as part of their identity as a group.

Finally, it is important to remember that the livelihood of those who carry out FGM for their communities depends on its continuance, so resistance to change may be strong. Such practitioners may also be highly respected members of society.

Parents who choose to refuse FGM for their daughters may come under considerable pressure from family members to conform. There is a very real fear that despite their objections, elders in the extended family will override their wishes and subject their daughters to FGM.

A case study

Comfort Momoh discovered how complex the issues around FGM are and why it remains a problem when she visited Somalia from where many of the women who attend her London clinic originate (2004). Although the Somali government supported the banning of FGM, such a change could no longer be sustained once civil conflict started in the early 1990s, and the number of women having undergone FGM is 98%. Mobile populations and strong ideas have made education slow to reach people and affect what they do. FGM is mainly performed by lay practitioners or family members. However, some qualified midwives and doctors still carry it out although awareness of the harm caused is increasing. Momoh describes the use of 'herbs, salt water, sugar, and camel dung' to stop bleeding, and also leg binding for several days (2004:631). She also found out some of the reasons for continuing the practice, and these affect those living in the UK too. For example, to:

- protect daughters from being raped
- ensure young women remain pure for marriage
- increase their eligibility for marriage
- increase the dowry
- maintain the family dignity.

Although more educated people and many urban dwellers are changing their ideas, Momoh discovered that lay practitioners believe that they provide a wanted service and also risk losing their livelihood.

Facts and figures about female genital mutilation

FGM is practised in about 28 African countries, the Middle East and South East Asia. Women and girls who have undergone FGM are also found in Europe, Canada, USA and Australia because of the increasing movement of communities and individuals between countries (WHO, 2000). Movements of people seeking refuge and asylum from the Horn of Africa has led to the situation now being taken more seriously in the UK than once was the case.

The situation worldwide:

- 100 million to 140 million girls and women have undergone some form of FGM, the majority from Africa (WHO, 2000)
- an estimated 2 million or more undergo some form of FGM every year worldwide, and 6,000 are at risk every day (WHO, 1997)
- many girls and women die from the short-term effects of FGM, such as haemorrhage, shock or infection
- many more suffer lifelong disability and may die from the long-term effects such as recurrent urinary or vaginal infections. Pain during intercourse and infertility are common consequences of FGM
- FGM increases the risk of women dying during childbirth and makes it more likely that the baby will be born dead. This increased risk can be as a result of severe bleeding and obstructed labour in places where safe and appropriate maternal health services are inadequate or inaccessible. In Somalia, where between 90% to 98% of women are infibulated, one in every 100 women giving birth dies as a result of this procedure.

In the UK:

- 86,000 women and female children, mostly first-generation immigrants, refugees and asylum seekers living in Britain, are estimated by FORWARD (Foundation for Women's Health, Research and Development) to have undergone FGM. Around 3,000 to 4,000 FGM acts may be performed each year (Powell et al., 2002). A further 7,000 children and adolescents under 16 are at risk annually. They are often taken to their countries of origin so that FGM can be carried out
- the majority of those living in UK who have experienced FGM, or are at risk of being cut, come from specific countries or have continuing links to them. The table below (figure 1) lists these and indicates the main type of FGM used (see figure 2 overleaf for explanations of types). Note that FGM is not necessarily practised in all areas and communities of these countries, and change is occurring almost everywhere.

Figure 1: Countries with which UK residents are most likely to have links and FGM classification

Country	Eritrea	Gambia	Ghana	Kenya	Nigeria	Sierra Leone	Somalia	Sudan	Yemen
Type	3	2	2	1, 2, 3	1, 2	2	3	3	3

Adapted from WHO, 1996

1

The practice of female genital mutilation

FGM may be performed between the age of a few days through to adolescence or young motherhood. Six to ten years is a commonly selected age. The procedure is often performed in poor light, without anaesthesia and using blades, knives, broken glass or non-surgical instruments that are often shared. Girls have to be forcibly restrained. Following more extensive forms of FGM, the legs may be tied together for many days to aid healing. Accidental damage, infection and haemorrhage are common, and long-term physical and mental health problems may follow even if the child survives. This is explored in more detail below. FGM offers no therapeutic benefit to women and girls, and is illegal in many countries, including the UK.

Types of FGM

FGM is practised in different ways by different communities, and some forms are much more extensive than others and cause greater health problems for girls and women. WHO has classified FGM into four types (see figure 2 below) as shown in the following diagrams.

Figure 2: Classification of FGM (WHO, 2000)

Type 1 excision of the prepuce (a retractable piece of skin covering part of the clitoris), with or without excision of part or all of the clitoris – see diagram 2

Type 2 excision of the clitoris with partial or total excision of the labia minora (may be known as sunna circumcision) – see diagram 3

Type 3 excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening, or infibulation (may be known as pharaonic circumcision of infibulation) – see diagram 4

Type 4 pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterisation by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding, or for the purpose of tightening or narrowing it – and any other procedure that falls under the definition given above – see diagram 5.

Diagram 1: Normal external female genitalia

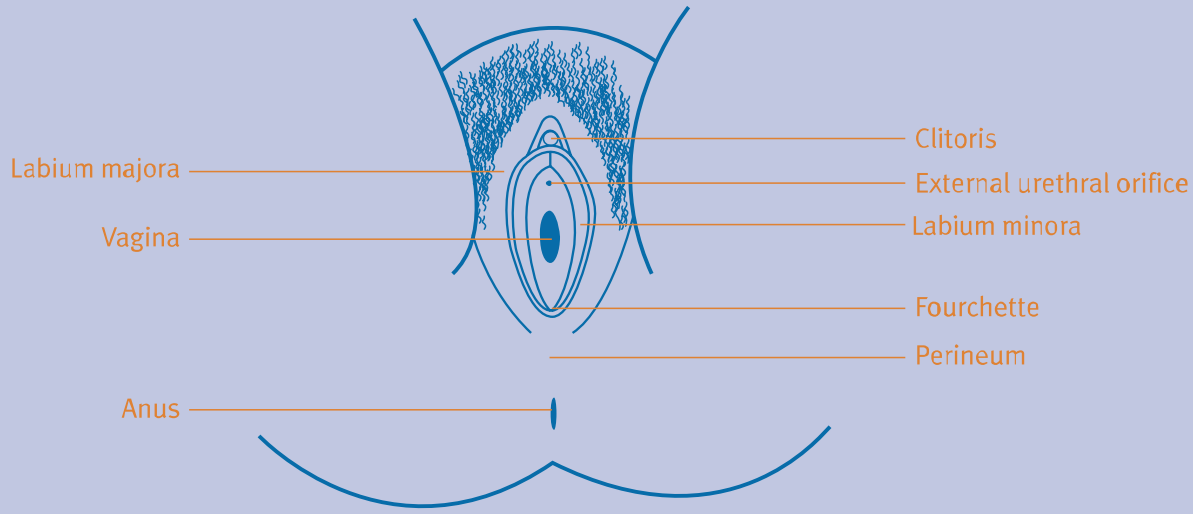


Diagram 2: Type 1 FGM

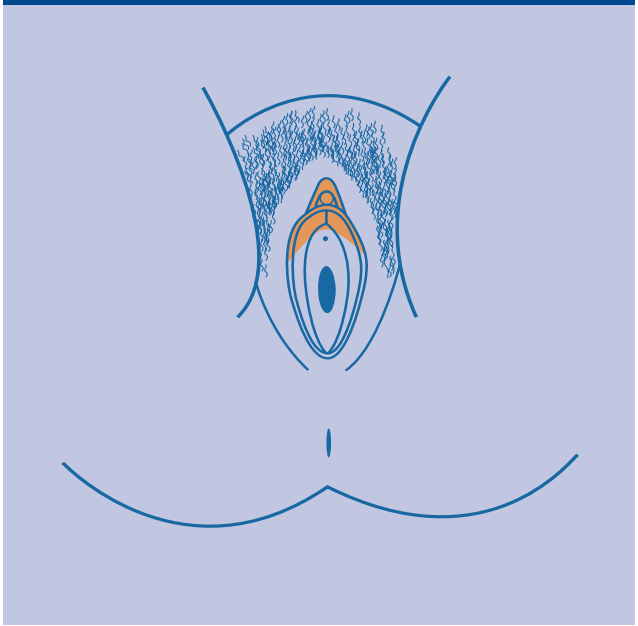


Diagram 3: Type 2 FGM

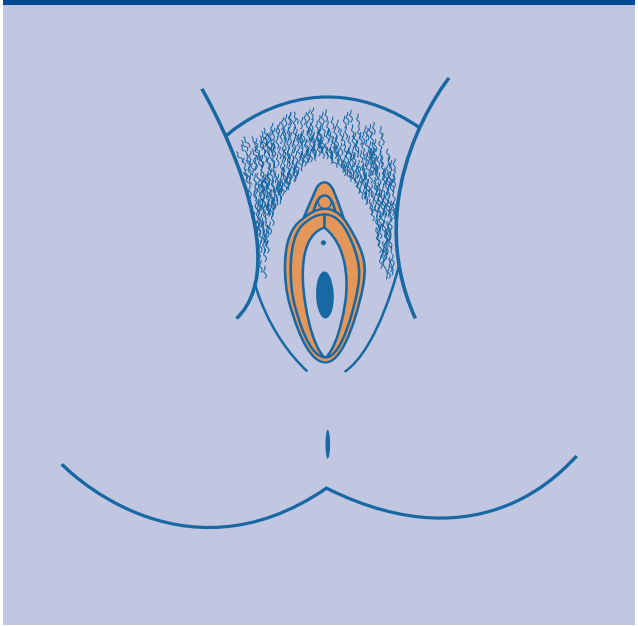


Diagram 4: Type 3 FGM

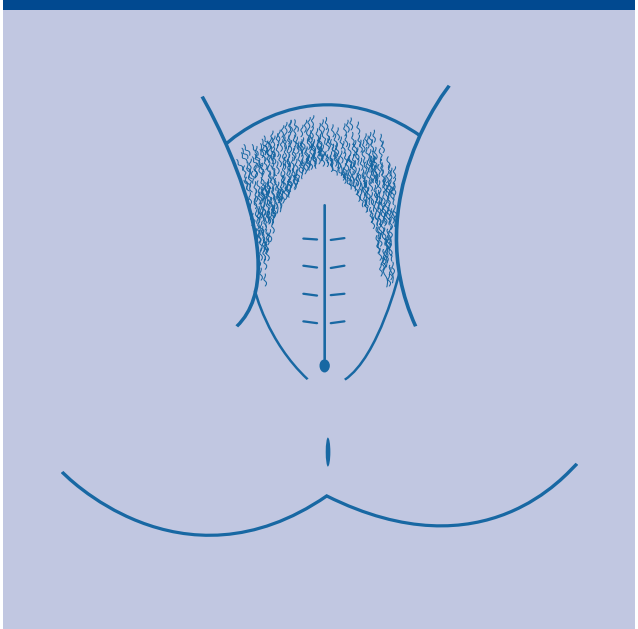
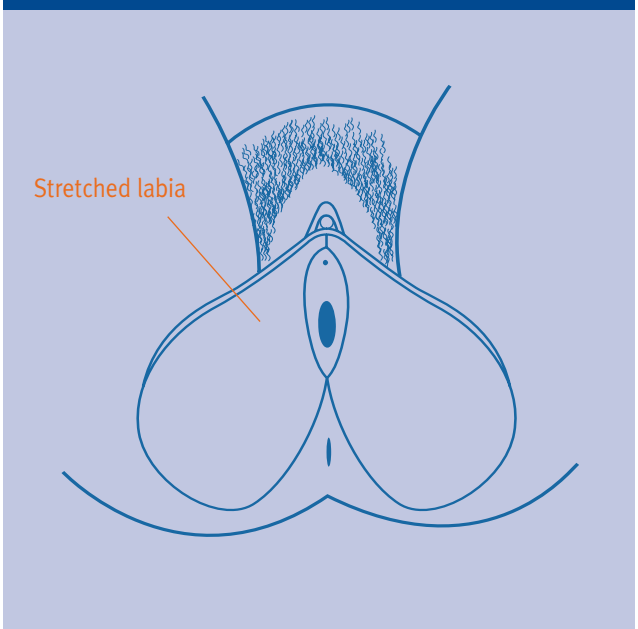


Diagram 5: An example of type 4 FGM



Health risks and complications of FGM

The complications that may occur following FGM will depend on the type and extent of the procedure carried out. They are generally classified as:

- immediate (figure 3)
- intermediate (figure 4)
- long-term complications (figure 5).

The health risks listed below must not be underestimated. Serious illness and death can occur even when FGM is carried out by health professionals, but who may be acting illegally and in unclean surroundings without sterilisation facilities for instruments. Even where the practitioner is skilled and cleanliness ensured, the long-term effects can ruin women's lives and relationships. Type 3 FGM inevitably causes more health problems and deaths. Momoh et al. (2001) found 86% of women suffered problems following type 3 FGM.

Most women with type 3 FGM tend to have problems with penetration following marriage. For some couples it can take several months to achieve this. Husbands who find penetration difficult at first intercourse may cut the introitus to make this easier, with pain, infection and bleeding as a consequence for the woman. In some cultures, the introitus will be opened surgically immediately before the first intercourse. The pinhole introitus left after FGM and lack of sexual response following type 3 FGM can cause significant problems for some women. The physical difficulties, ongoing dyspareunia, infection, scarring and psychological problems may lead to infertility and consequent rejection of women by their husbands. The problems can continue for years.

Type 3 FGM (infibulation) can cause particular dangers in childbirth. In addition to the problems listed above, prolonged or obstructed labour and perineal laceration occur due to tough, unyielding scar tissue. Clitoridectomy (type 1) does not usually cause obstruction unless there was infection at the time of mutilation.

Similarly, the neonatal problems occur mainly because of obstructed or prolonged labour which, if unchecked, can cause fetal distress, anoxia (lack of oxygen to the body's tissues) and fetal death.

Figure 3: Immediate complications

- haemorrhage, pain, shock
- wound infection, septicaemia, tetanus
- urine retention
- injury to other tissues, e.g. vaginal fistulae
- ulceration of genital region
- risk of bacterial or HIV infection due to instruments being re-used without sterilisation
- death.

Figure 4: Intermediate complications

- delayed healing
- abscesses
- scarring/keloid formation, dysmennorrhoea and haematocolpus – obstruction to menstrual flow
- pelvic infections
- obstruction to urinary flow
- urinary tract infection (bacteriuria is even more common than actual infection).

Figure 5: Long-term complications

- psychosocial trauma and flashbacks, post-traumatic stress disorder
- lack of trust in carers
- vaginal closure due to scarring
- epidermal cyst formation
- neuromata – cut nerve endings causing permanent pain
- pain and chronic infection from obstruction to menstrual flow
- recurrent urinary tract infection and renal damage
- painful intercourse (dyspareunia), lack of pleasurable sensations and orgasm, marital conflict
- infertility from pelvic inflammatory disease and obstructed genital tract
- risk of HIV through traumatic intercourse
- childbirth trauma – perineal tears and vaginal fistulae
- postnatal wound infection
- prolonged or obstructed labour from tough scarred perineum, uterine inertia or rupture, and death of infant and mother
- vaginal fistulae as consequence of obstructed labour.

2

Human rights, legal and professional responsibility issues

Human rights

FGM is clearly not just a matter of health problems. It also engages some fundamental human rights guaranteed by a variety of international agreements, the most significant of which, in terms of UK law, is the *European Convention for the Protection of Human Rights and Fundamental Freedoms*, drawn up by the Council of Europe in 1950. This has now been incorporated into domestic law through the Human Rights Act 2000. The Act affords citizens a variety of legal remedies in circumstances where their rights have been interfered with. Relevant rights in the context of FGM include:

- Article 3 – protection against inhuman or degrading treatment
- Article 8 – the right to respect for privacy and family life.

The requirements of the Convention reflect, very closely, existing good professional practice. Accordingly, for a health professional to act contrary to acceptable professional standards, is likely to be a breach of the Human Rights Act 2000. A failure of the state to fulfil its positive obligation to protect child and adult female rights in these circumstances, by prosecution or otherwise, will itself be open to challenge under the human rights legislation.

Various forms of mutilation, whether carried out for religious or social reasons, and conducted without the child's consent and for non-therapeutic purposes, infringe the child's right to bodily integrity. Although parents have rights to bring up their children according to their own beliefs, the rights of the child to protection come first and courts will inevitably weigh the balance more heavily in favour of child protection.

There is now a large body of international human rights law specifically to protect and promote the rights of children, for example, the UN Convention on the Rights of the Child (see page 10). Some of the other relevant international conventions such as the *Protocol to the African Charter* (Africa Union, 2003) are listed with the resources.

Legal aspects of FGM

FGM is now illegal in a number of countries even in those where it is customarily practised. Many countries where FGM is not normally carried out, such as the UK, also have legal provision to cover those who arrive from elsewhere especially if they are migrants from FGM-practising communities.

The UK legal framework

Two Acts of Parliament have made it a criminal offence for anyone to perform, aid, abet, or counsel to procure FGM in the United Kingdom. It is also illegal to take a child out of the country to perform FGM. The Acts are the Prohibition of Female Circumcision Act 1985 and the Female Genital Mutilation Act 2003. The 2003 Act applies to England, Wales and Northern Ireland. Scotland has passed the Prohibition of Female Genital Mutilation (Scotland) Act 2005. Doctors, nurses and midwives participating in FGM also face removal from their respective professional registers and would be prosecuted for taking part.

The 1985 Act states that it is an offence for any person to:

- 'excise, infibulate or otherwise mutilate the whole or any part of the labia majora or clitoris of another person'
- 'aid, abet, counsel or procure the performance by another person of any of those acts on that other person's own body.' This also means that following childbirth or de-infibulation, the anterior middle incision can only be over-sewn and not closed back to its original state.

However, because of a legal loophole concerning taking girls out of the country for FGM, and the consequent lack of prosecutions, it became necessary to amend the law and repeal the 1985 Act. The Female Genital Mutilation Act (2003) came into force in March 2004. It sends a strong message to communities practising FGM, and practitioners involved in aiding, abetting, counselling to procure and performing FGM, that the practice is no longer acceptable in the UK even if performed in another country. One important aspect to note is the change in terminology from *circumcision* to *mutilation*.

The main changes made are:

- it is now against the law for 'UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is now legal' (2003). This means that the law protects any girl who is a UK national or permanent resident from FGM anywhere in the world
- the penalty has been increased from 5 to 14 years' imprisonment
- *mutilation* is used instead of *circumcision*.

Practice points:

- 'aiding, abetting and counselling applies to those who assist or persuade a girl to perform FGM on herself even though it is not itself an offence for that child to carry it out on herself. Girl includes woman' (Female Genital Mutilation Act, 2003)
- although not an offence for a girl or young woman to perform FGM on herself, consideration should be given to whether such self-harm is a safeguarding issue where the action may be the result of adult pressure
- midwives need to note that it is illegal to reinfibulate a woman following the birth of her baby. This is crucial.

Although FGM is clearly illegal in UK, and it is against the law to take girls and young women out of the country to perform FGM, the law should be seen as only one aspect of tackling FGM. Safeguarding law provides the framework through which a girl or young woman's needs are assessed and her best interests considered. The welfare of the child is the paramount issue according to the Children Act (1989), and allows legal action to be taken. However, legal measures may not be appropriate if protection can be achieved without them. Judgemental attitudes are potentially harmful and bringing about change is more effective if people's long-held attitudes are addressed. It is important to promote understanding and to protect girls and women from the practice through a continuing programme of education and awareness-raising. This needs to include explaining the reason why FGM is considered to be a violation of human rights, and the connection between the procedures and the long-term effects on the body and the emotions.

Safeguarding children and young people

Professional responsibility for safeguarding children and young people

Health care professionals have a responsibility to ensure that their practice is performed within contemporary law and policy as well as related professional codes. While the overarching legal issue related to FGM is its illegality, practitioners must also ensure that they provide care and support that is consistent with safeguarding law and policy. Professionals should be familiar with *What to do if you are worried a child is being abused* (DH, 2003) and *Working together to safeguard children* (DH, 1999), and the appropriate sections of the Children Acts of 1989 and 2004 of England and Wales or Scottish legislation.

All areas have in place local procedures for safeguarding children, young people and vulnerable adults, and all practitioners must ensure that they are aware of and follow these procedures. Area-based procedures are produced by Area Child Protection Committees, which will soon become Local Children's Safeguarding Boards in England and Wales.

Also, practitioners must have in mind their responsibilities under Articles 3 and 19 of the UN Convention on the Rights of the Child, of which the UK is a signatory.

All nurses and midwives have a duty of care to girls and women who are at risk of having FGM performed, or who have already been cut in the past. The Nursing and Midwifery Council's (NMC) *Code of professional conduct* states that nurses and midwives in the UK must 'act to identify and minimise risk to patients and clients' (2002). There are clear child protection issues, as well as the practical and psycho-social care issues that are considered later. It is essential to collaborate with others such as teachers and social service colleagues. The police may also need to be involved in an emergency.

Safeguarding girls at risk of harm through FGM poses specific challenges because the families may give no other cause for concern such as parenting responsibilities or relationships with their children. Family members may indeed believe FGM is the loving thing to do and consider that it is in the child's best interest. Adults may find it difficult to understand why the authorities should intervene in what they may see as a cultural practice specific to their way of life. The family situation may be compounded by those who wish girls to be ritually cut when others disagree. Similarly there may be an inter-generational element, or husband and wife may have differing views about their daughters. The wish to carry out FGM is also not confined to individuals within particular levels of education or social class. The pressure to undertake this procedure may be embedded in family structures. At all times, however, it is important to 'think the unthinkable', and act with 'respectful uncertainty' (DH, 2003).

Four specific issues are important in this context:

1. an illegal act being performed on a female, regardless of age
2. the need to safeguard girls and young women at risk of FGM
3. the risk to girls and young women where a related adult has undergone FGM
4. situations where a girl child may be removed from the country to perform FGM.

1. An illegal act being performed on a female, regardless of age

Under Articles 19 and 36 of the UN Convention on the Rights of the Child any person below the age of 18 has the right to protection from activities or events that may cause them harm. These articles are enshrined in recent Human Rights legislation, as well as reflecting other laws including the Children Act 2004 (England and Wales), Protection of Children Act (Scotland) 2003 and Children (Northern Ireland) Order 1995. This requirement is in addition to other legislation that criminalises the practice of FGM.

2. The need to safeguard children and young people involved in FGM

Under the Children Act (1989) section 47, everyone who has information that a child is potentially or actually at risk of significant harm is required to inform social services or the police. Initially the practitioner will refer as a *child in need* and social services will assess the risk. This definition of harm has been extended in the Adoption and Children Act (2002), which includes where someone sees or hears the ill-treatment of another. Specifically, this relates to situations where there may not be direct disclosure of FGM being performed.

3. The risk to children and young people where a related adult has undergone FGM

Where practitioners believe that an adult has undergone FGM they must also consider the risks to any children or young people who may be related to or living with the woman. If this is an inter-generational practice then girls and young women may be at risk of harm. So, the requirements detailed above apply to all practitioners, as well as the public.

4. Situations where a child may be removed from the country for the purposes of performing FGM

As described, taking a girl abroad to perform FGM is illegal. However, there may be instances where the exact risk is not known but one parent may be concerned enough to alert professionals. In certain circumstances the Child Abduction and Custody Act (1985) can be used to prevent a girl being removed from the country. This legislation has a requirement for both (married) parents to agree to a child leaving the country. Normally however, a *prohibitive steps order* made by social services will suffice. Nonetheless, the potential risk must be considered under contemporary safeguarding policy as well as other legislation.

Ultimately there are wider legal and safeguarding concerns, as well as the practical and psycho-social care issues for all females which are considered later.

Health visitors, school and community children's nurses

Health visitors, school and community children's nurses (CCNs) have a responsibility to ensure families know this practice is illegal. They are in an ideal position to act if they consider a girl or young woman is at risk of having FGM performed. FGM may be carried out secretly in the UK, but it is more likely that she will be sent 'home' to her family's country of origin for FGM to be performed. This is inevitably, although not exclusively, likely to occur during school holidays or at the time in the child's life when it is customary for this to be done in her community. This will vary from one community or ethnic population to another. It demonstrates how essential it is for those who come into contact with girls and young women to have detailed knowledge of their client groups and understand what is important to them, as well as being aware of the processes for safeguarding them.

Health visitors, in particular, work closely with families in their homes, and have a key role in terms of health promotion and education from an early age in a girl's life. This may include helping and supporting families to explore ways of breaking the cycle of ritual abuse. Health visitors, school nurses and CCNs are also well placed to collaborate in support and referral as part of multi-professional teams. School nurses and CCNs, like teachers, may be in a position of trust and receive disclosures from girls and young women (or their friends) that lead them to suspect that they are at risk.

Practice points:

- behavioural changes that may indicate either that a girl or young woman is worried about being harmed, or that harm has already occurred. A simple change such as prolonged visits to the toilet may indicate that a child is experiencing difficulties urinating following type 3 FGM
- older girls and siblings may be very aware of the risk or purpose of a planned visit abroad but be unable to protect themselves unaided. They may have confided in the practitioner, who must know how to operate within the law and national and local safeguarding policies
- pressure may come from people other than the adult family members. It may be other children in the family who are pressurising one specific girl or young woman to undergo FGM
- while it is not the responsibility of individual practitioners to undertake investigations, they should be alert to these indicators and consider them in their overall analysis of the situation before taking action.

Midwives, community and practice nurses, neonatal nurses, children's nurses and others working in the acute sector

Midwives may become concerned about a girl being at risk while attending a family for the birth of a subsequent child. Similarly, community and practice nurses may note information leading them to think that girls may be at risk. Other nurses working across the full spectrum of acute services such as neonatal and child health, sexual health, accident and emergency, gynaecology, or other related areas should be aware of FGM. This includes being aware of the possible true purpose of a girl's visit to the family's country of origin. It is important to be able to respond appropriately in the best interests of any girl or young woman, while also being responsive to the needs of the client group. Child protection must, however, remain paramount.

Practitioners working in specialist units

Children and young people are cared for across a variety of specialisms including both paediatric and adult services. This will also include those cared for in children's hospitals and other institutions. Similarly, other care practitioners must be aware of FGM issues, and be able to recognise when girls or young women may be at risk or have been harmed.

Issues in safeguarding children and young people

FGM, like other safeguarding issues, is a key area where inter-agency collaboration and communication is vital. Where relevant, immigration officials and legal advisers may be involved because the risk of FGM has been successfully used for claiming asylum (Powell et al., 2002). Where a criminal act has been perpetrated the police must also be involved, either directly or through social services.

Whenever there is concern that a girl or young woman is at risk of harm through FGM, steps must be taken to safeguard them following national and local guidelines. If a girl or young woman has already had the procedure performed and there are other female siblings in the family, a *child in need* referral should be made following the steps outlined in *What to do if you are worried a child is being abused* (DH, 2003).

The referring practitioner should follow guidelines about working in partnership with the family by being honest where this is possible, and handling any disclosure sensitively. But, the practitioner must also be clear about the reasons why they are undertaking safeguarding actions. This partnership would be unacceptable where the child or young person may come to harm as a result of any evidence being given to parents, as it could cause the family to vanish with their daughter. There may be need to approach social services first with suspicions.

Identifying girls and young women at risk

This is difficult because:

- it happens only once
- parents may believe FGM is a good thing to do for their daughters
- the genitalia of girls are rarely examined
- it is not culturally acceptable for girls to talk openly about FGM.

There is a risk if:

- the girl's mother or her older sisters have been cut
- mother has limited contact with people outside of her family
- the paternal grandmother is very influential within the family
- mother has poor access to information about FGM
- no one talks to the mother about FGM
- health, social service and education staff fail to respond appropriately
- communities are given the impression that FGM is not taken seriously by the statutory sector.

Adapted from Foundation for Women's Health, Research and Development (FORWARD) training pack.

As well as health professionals having a role in providing information, it is the responsibility of social services to provide the family or parents with information about UK law and policy around FGM, safeguarding and support mechanisms. They should also alert families to their right to seek independent legal advice should they wish to appeal against any specific interventions.

Referral to appropriate agencies

To safeguard children and young people as required by UK law, it may be necessary to give information to people working in other parts of the health service or outside of it. For some practitioners this can pose dilemmas when it involves going beyond the normal boundaries of confidentiality. Nonetheless, both law and policy allow for disclosure where it is in the public interest or where a criminal act has been perpetrated. Guidance about disclosure is available in *What to do if you are worried a child is being abused* (DH, 2003). Parents are responsible for their children and they may fear having this responsibility (or even the child) taken away from them. There may also be the perception that passing on information can damage the relationship of trust built up with families and communities. However, it is crucial that the focus is kept on the best interests of the child as required by law.

The NMC (2002) gives clear guidance when a nurse or midwife can breach confidentiality. It is normally expected that information is shared with others only with the consent of the patient or client, but makes provision for when this is not possible 'if the patient or client withholds consent, or if consent cannot be obtained for whatever reason'. Disclosures may be made only where they:

- can be justified in the public interest (usually where disclosure is essential to protect the patient or client or someone else from the risk of significant harm)
- are required by law or order of court.

The NMC guidance also states: 'Where there is an issue of child protection, you must act at all times in accordance with national and local policies.'

Case studies

A young girl already subjected to FGM

Sahra was a 15-year-old asylum seeker who was very anxious and spoke very little English. She confided in a nurse that she was circumcised when she was five years old. She requested help and talked about the way she felt as well as the complications she was experiencing. If you found yourself in this situation:

- how would you help Sahra?
- what are the issues?
- are there any particular legal issues?
- what might you do?

A young girl is about to go on holiday to her country of origin

A six-year-old girl tells her teacher that she is going to her country of origin to see her family during the summer holidays. She was told by her mother that on her return she would be a woman. The teacher became concerned and suspected that the six-year-old would be circumcised:

- you are the school nurse. How might you become involved and what would you do?

A new baby girl

A woman delivered her first baby, a girl, a week previously. When the midwife visited her the woman asked her for information about where she could get a circumciser to circumcise her daughter because this is the culture in the area she came from.

- what do you believe a midwife should do in this circumstance?
- is this a child protection issue?
- who should be involved?

Knowledge about diverse ethnic populations

Acting in discriminatory ways or from racist motivations are other reasons why it may be difficult to deal with girls and young women who need safeguarding because of FGM. Lord Laming, writing in the report of the *Inquiry into the death of Victoria Climbié*, clearly notes the danger of making assumptions about cultural background that conflict with ensuring children's safety (DH, 2003). He notes that children's needs for protection are the same whatever their cultural background, saying 'a child is a child regardless of colour – if we are not careful we'll lose the whole emphasis on the child's welfare' (Cookey in DH, 2003).

Although the Laming inquiry concerned very different circumstances to FGM, there are other comments made in his report that are helpful. Counsel to the inquiry stated that: 'Fear of being accused of racism can stop people acting when otherwise they would.' The evidence of one witness indicated her expressed need 'to be sensitive to feelings of people of all races and backgrounds'. Lord Laming again noted that those involved in safeguarding 'should never feel inhibited from acting in a child's interests on the grounds that they are felt by others to have an insufficient grasp of the child's particular circumstances'.

Lord Laming makes another statement that is helpful to practitioners involved in protecting girls at risk of FGM:

'The basic requirement that children are kept safe is universal and cuts across cultural boundaries. Every child living in this country is entitled to be given the protection of the law, regardless of his or her background. Cultural heritage is important to many people, but it cannot take precedence over standards of care embodied in law.'

3

Diversity awareness and the provision of services

Women and children who have had FGM may need access to a variety of services such as:

- counselling and psychiatric support through statutory or voluntary services because of psychological trauma, relationship or psycho-sexual difficulties
- infertility
- uro-gynaecological services including surgical reversal of infibulation (known as *deinfibulation*)
- an easily accessible interpreter service with workers who appreciate the problems facing children and women who have been cut, and also those of refugees and asylum seekers. It is very important that women do not find themselves relying on family members for interpretation when dealing with health care professionals. Children should never be used for interpreting purposes.

Communication with women, even if interpreters are not required, needs to be clear, using straightforward language and explanations. Pictures or diagrams may help. It is important to listen without interruption, avoid rushing or providing too much information at once, and check that women have understood.

All services should be open with flexible access and collaboration between agencies. Women may be very unwilling to come forward for help, or may be unaware of what is available, or not know how to ask. They may find it difficult to raise the topic with health care staff because they know that practitioners may have limited awareness of FGM, and may respond in a negative manner. For this reason, nurses and midwives who come into contact with them should to be alert to this, and take opportunities to enquire sensitively and offer support and referral to specialist clinics. Generally, women are likely to prefer female carers to male.

Many of the UK's customary requirements for women's primary, sexual and reproductive health services, such as routine urinalysis, cervical screening, gynaecological and fertility services, may not be well-prepared to meet the needs of those who have been cut. It is important for women and girls to have access to specialist services. Currently there are few specialist clinics available countrywide. This is why it is important for nurses, particularly those already working with these women and children, their families and communities, to have the appropriate specialist learning and skills to work effectively with this client group.

It is important to note that health care professionals may not need to provide all services. Support groups and organisations have a very important role to play and have been prime movers in bringing about change. Some are listed in the resources section at the end of the publication.

4

Policies and protocols

A seamless service for women and adequate protection for girls at risk depends on integration and collaboration between services. Everyone who may come into contact with FGM-practising communities needs to understand their responsibilities, and have appropriate training and referral mechanisms. They need to know from whom they should seek help and advice, and the steps to take to provide appropriate support. This demands that clear policies, guidelines and protocols are in place. Powell et al. (2002) suggests this should be UK-wide. Guidance around child protection is available from the UK Home Office for those who work in communities where FGM is practiced (Home Office, circular 10/2004) and from the World Health Organization (see reference and resource lists).

Health care managers must be involved at a policy level by:

- providing clear guidance to employees
- providing education and training to staff
- having clear lines of communication with others such as education, social and law enforcement services.

A sample child protection procedure policy provided by FORWARD is included in the Appendix.

5

Clinical issues and procedures

Nurses and midwives need to be aware of how to care for women and girls, as well as being able to safeguard those at risk. They also need to be aware that accepting and respectful attitudes are vitally important to girls and women who have been cut. Health care professionals are most likely to need to provide support for women who have type 3 FGM in Britain because this is the most likely type to cause them difficulties. In Africa however, type 2 is the most common.

Women and girls who have suffered mutilation may be very reluctant to agree to a vaginal or rectal examination, and may refuse routine cervical smears and/or infection screening. It may be impossible to perform a vaginal examination at all, and be very difficult or impossible to pass a urinary catheter. Nurses and midwives need to deal with this in a sensitive manner, and be prepared sufficiently that they do not exhibit signs of shock, confusion, horror or revulsion on seeing the genitalia.

Even though sensitivity is needed, it is very important to ask women whether they have been 'cut' or 'circumcised'. Some seek help because they wish to have the FGM reversed before marrying, or may be experiencing problems conceiving because of difficulties with penetration. These women and girls need to be referred to appropriate clinics.

A deinfibulation service should be available, well advertised in women's groups, and easily accessible to those who may need it. Often known as 'reversal', deinfibulation involves opening the scar tissue that covers the vaginal introitus and the urethral meatus surgically. Although best performed when not pregnant, women may need reversal to be done as an emergency, for example, during a miscarriage. This is because products of conception, such as blood clots and fetal tissue, can be retained behind scar tissue and will lead to serious infection.

Figure 6 highlights some of the problems that require reversal in a woman with genital mutilation. It shows an examination of a woman who had undergone FGM as a child. The woman's labia majora and minora are absent, and the clitoris is not visible and may also be absent. There is a single narrow opening for the vagina and urethra. This is the passageway for both menstrual blood and urine.

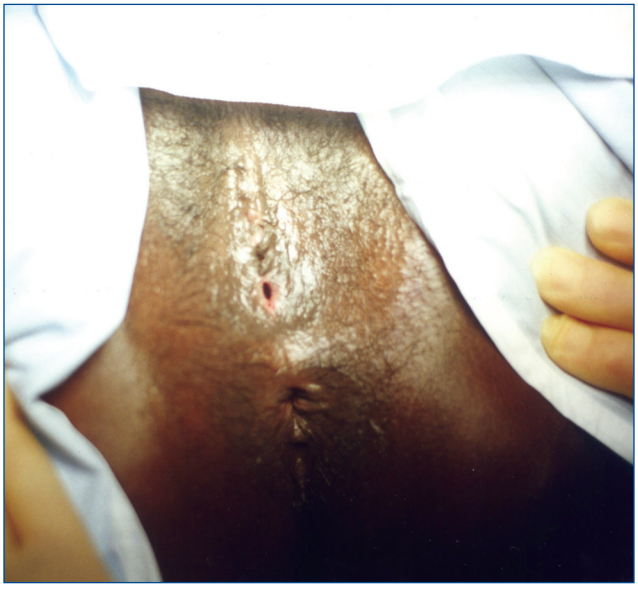


Figure 6: Examination of a woman with FGM type 3. A pinhole residual opening. Photograph courtesy of Mr Harry Gordon

Antenatal care and reversal of infibulation (deinfibulation)

It is important to identify women who have been cut when they first seek pregnancy care, and find out what type of FGM has been performed. It will probably be necessary to ask about FGM as they may not volunteer the information. Do this sensitively and non-judgementally.

Apart from the usual screening and antenatal care, it is important to provide pregnant women with support specific to their needs around FGM. They may need counselling, advice, information and social and psychological support. Under-age adolescents are likely to need extra support, and there may be safeguarding issues to be addressed.

Surgical reversal (deinfibulation) should be offered where appropriate. Partners should be involved in decision-making when the woman is willing for this. It is important to work out a care plan with the woman early in pregnancy, and to involve interpreters as necessary. Even fairly competent English speakers may have problems understanding medical terminology, and using a trained interpreter may be wise in order to avoid misunderstandings. Caesarean section is not indicated just because a woman has had FGM performed.

Reversal is best performed before pregnancy (commencing before the wedding night), or at least within the second trimester of pregnancy at around 20 weeks of gestation:

- this avoids the need to cut the scar tissue in labour
- reduces the possibility of extensive lacerations that can occur when the fetal head stretches the scarred or closed introitus and perineum. These may involve the urethra, bladder and rectum if uncontrolled and leave the woman with a fistula
- reduces the chances of fetal asphyxia or stillbirth if a woman progresses unaided to the second stage of labour
- it helps to reduce the incidence of bacterial vaginosis that is associated with pre-term labour.

It must be noted, however, that women may be reluctant to undergo reversal until labour commences because this may be normal practice in their country of origin. This reinforces the importance of careful and sensitive explanation in pregnancy of why antenatal reversal is preferable. It also underlines the importance of all midwives understanding what to do in this situation. It is also essential to inform women that they *may* still need a standard (posterior) medio-lateral episiotomy for fetal distress in the second stage of labour. This should be explained because women may be very disappointed if they have to have perineal suturing after the birth, despite having had a reversal in pregnancy.

The surgical procedure

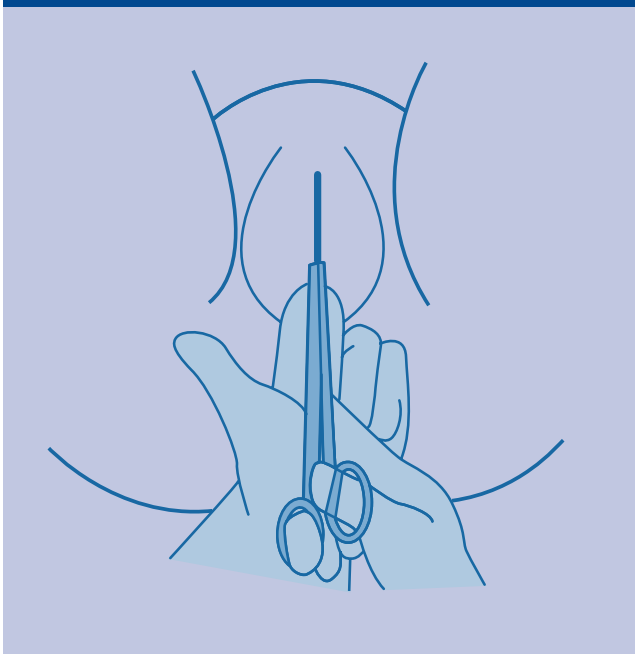
The aim of reversal is to restore normal anatomy as far as possible. The procedure is the same in principle whether it is carried out as an elective procedure before pregnancy, in the antenatal period, or in labour itself. It can be performed by a midwife if necessary during the second stage of labour once the presenting part is low:

- adequate pain relief (general, regional or local anaesthesia) is essential. Women may prefer to have general anaesthesia when reversal is performed before labour commences because the procedure can bring back very traumatic memories of when they were cut
- use aseptic techniques following cleansing of the vulval area, also pay careful attention to handwashing and wear gloves
- examine the vulval area carefully, infiltrate with local anaesthetic and then open the scar in the midline, exposing the underlying tissues which sometimes includes the clitoris. A midline incision along the scar is less likely to bleed heavily and will follow a line that may already have areas of weakness where the original healing of the edges was incomplete. It can be easier to do this if the tissue is carefully lifted along the midline with a finger or blunt instrument
- if the clitoris is present and can be palpated, an experienced practitioner can extend the incision to expose the clitoris and free any para-clitoral adhesions. If uncertain, cutting should stop when the urinary meatus is visible
- suture the raw edge on each side of the labia with fine dissolvable sutures to ensure haemostasis and an over-sewing stitch. This is important also to ensure the raw edges do not fuse together
- provide adequate analgesia following the deinfibulation
- if there is extensive fibrosis of the vaginal introitus, perhaps from the use of corrosive substances or angurya cuts, a large episiotomy may be needed
- provide advice on keeping the area clean
- couples should be advised to avoid intercourse until healing has occurred and to use a lubricant if necessary
- women need to be advised that urine and menstrual flow will appear heavier because of the removal of the scar-tissue barrier.

Note: WHO (2001) advises against cutting beyond the urethral opening because of the possibility of excessive and difficult-to-control bleeding. This is less relevant in UK hospitals than in resource-poor environments.

The reversal procedure is illustrated below.

Diagram 6: Cutting open the scar



Care in labour

Practice points:

- normal care is required during the first stage of labour
- sensitivity is essential at all times
- there is no need to pass a catheter unless the woman is unable to pass urine
- reversal may need to be carried out during the first stage of labour (see overleaf)
- midwives need to watch women who have undergone type 3 FGM closely during the second stage of labour even when the woman's introitus has previously been assessed as adequate for the birth. Unexpected problems may occur with descent of the fetal head or stretching of the perineum because the scar tissue around the vagina and perineum may be unstable
- a medio-lateral episiotomy should be performed in the second stage of labour only if unavoidable
- it is important to explain the requirements of the UK law. It is not permissible to reinfibulate or stitch the woman back closed after the birth.

Reversal in labour for type 3 FGM

If reversal of the infibulation has not already been performed, it needs to be carried out during the first stage of labour using adequate analgesia as in pregnancy. If the second stage has already been reached, a midline incision must be used.

Re-suturing or reinfibulation

Re-suturing, often known as reinfibulation, or closing, should never be done because it is illegal in UK. This may mean that careful discussions have to be held with the woman and family to explain the law and why reinfibulation has to be refused. Women may themselves request reinfibulation for social reasons or because they have known nothing else. It is necessary to follow up with the woman during the postnatal period as reinfibulation may be performed illegally at this point. Support, information and counselling continue to be very important.

Health care professionals who participate in FGM or reinfibulation may be removed from their respective professional registers.

The presence of infibulation should also be considered even when a woman has had previous vaginal births. This should be addressed during pregnancy or, if admitted in labour, it is important to check the state of the vulva in case the woman has been re-sutured.

The most important points to remember are to:

- arrange for reversal during the first stage of labour with adequate pain relief
- support the woman with sensitivity to her feelings
- notify her health visitor and other professionals if the baby born is a girl, with regard to safeguarding the child
- continue to provide postnatal support
- consider referring to an organisation that can offer support and information.

Case studies

Case study 1

A midwife helped a woman to give birth who had come from Africa and had undergone type 3 FGM. Following the birth, the midwife was confronted by the woman's husband asking that she reinfibulate his wife, and saying "put my wife back to how she was before she had the baby".

- what should the midwife have done?
- how should she have addressed the husband?
- what information is there to support midwives in persuading husbands to change their attitudes?

Case study 2

A young woman who had undergone type 3 FGM arrived on the labour ward in strong labour. As a midwife with no experience of caring for women who have experienced FGM:

- what would you do?
- how would you handle her care?
- what are the legal issues?

6

Professional learning requirements

Raising awareness about the socio-cultural, ethico-legal, sexual health and clinical care implications involved in FGM is essential. Education and training needs to be provided for all health and social care professionals who may work with affected women and girls and with their families. It is also important to consider the issues of ethnicity, custom, culture and religion in a sensitive manner. Professionals should explore ways of resolving problems about the continuation of this practice in ways that involve clients with their full participation.

Education of male partners and community leaders might reduce the number of children, young and older women who suffer in the future. However, as WHO clearly shows, cultural practices like FGM have been ingrained for many generations, and will require extensive cultural education to address the issues thoroughly and effectively (WHO, 1997).

Nurse training has not included FGM as part of the curriculum in the past, and midwifery programmes may not address the issues adequately either. The RCN recommends that FGM should be a part of sexual health education in all pre-registration and post-registration programmes for nurses, midwives and health visitors. It is equally essential to raise awareness and the seriousness of the issues among teachers, school nurses and social service staff.

The RCN believes that a programme of training around FGM should include the following:

Example training programme

- overview of FGM (what it is, when and where it is performed)
- socio-cultural context
- facts and figures
- UK FGM and child protection law
- FGM complications
- pregnancy, labour and postnatal periods
- safeguarding children – principles to follow when FGM is suspected or been performed
- roles of different professionals.

7

Conclusion

FGM has become a global issue that must be addressed if the aim is to put an end to the practice. Although the practice is illegal in the UK and much of the world, and it is now against UK law to remove a child to another country for FGM, it still happens. As Schroeder (1994) and Scherf (2000) clearly state, society has an obligation to protect children within the legal framework, regardless of where their parents come from or what the culturally accepted practice in their home countries might be.

Women and girls who have been cut need particular and sensitive support and facilities to help them deal with the physical, psychological and social consequences. Those who do not wish to continue the practice may need support to follow their wishes through. Change can only take place to keep women and girls safe if practising communities are involved at all stages of child protection and service provision. All professionals, the practising communities and the public have a role to play to make a difference.

8

References

Africa Union (2003) *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*, AU: Addis Ababa, Ethiopia. Available online at www.africa-union.org

Department of Health (1999) *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*, London: DH. Available online at www.dh.gov.uk

Department of Health (2003) *What to do if you are worried a child is being abused*, London: DH. Available online at www.dh.gov.uk

Department of Health (2003) *The Victoria Climbié inquiry: report of an inquiry by Lord Laming*, London: DH. Available online at www.dh.gov.uk or www.victoria-climbie-inquiry.org.uk

El Dareer A (1982) *Woman, why do you weep? Circumcision and its consequences*, London: Zed Books.

FORWARD (2004) *London child protection procedures in respect of FGM*, FORWARD: London. Unpublished document. See www.forwarduk.org.uk

Giorgis B (1983) Female circumcision in the Sudan, *Tropical Doctor*, 13, pp.131-133.

Home Office (2004) *Home Office circular 10/2004. The Female Genital Mutilation Act 2003*, London: Home Office. Available online at www.circulars.homeoffice.gov.uk

Maurad N and Hassenein O (1994) Female genital mutilation: three years experience of common complications in patients treated in Khartoum hospitals, *Journal of Obstetrics and Gynaecology*, 14, pp.40-41.

Momoh C (1999) Female genital mutilation: the struggle continues, *Practice Nursing*, 10 (2), pp.31-33.

Momoh C (2003) *Female genital mutilation: information for health care professionals* (2nd edition), London: African Well Woman Clinic.

Momoh C (2004) Attitudes to female genital mutilation, *British Journal of Midwifery*, 12 (10), pp.631-635.

Momoh C and Kaufman T (1998) Female genital mutilation (female circumcision), *RCM Midwives Journal*, 1(7) July, pp.216-217.

Momoh C, Ladhani S, Rymer J and Lochrie D (2001) Analysis of the first six months of a South East London specialist clinic, *British Journal of Obstetrics and Gynaecology*, February 108(2), Sexual Health supplement, pp.186-191.

Ng F (2000) Female genital mutilation: its implications for reproductive health. An overview, *British Journal of Family Planning*, 26(1), pp.47-51.

Nursing and Midwifery Council (2002) *Code of professional conduct - protecting the public through professional standards*, London: NMC.

Powell RA, Lawrence A, Mwangi-Powell FN and Morison L (2002) Female genital mutilation, asylum seekers and refugees: the need for an integrated UK policy agenda, *Forced Migration Review*, 14:35. Available online at www.fmreview.org

Scherf C (2000) Ending genital mutilation (letter), *British Medical Journal*, 321(7260), pp.570-571.

Schroeder P (1994) Female genital mutilation: A form of child abuse, *New England Journal of Medicine*, 331(11), pp.739-40.

Tomlinson J (1999) *ABC of sexual health*, Oxford: Blackwell Publishing. Reprinted 2004.

Webb E (1995) Female genital mutilation: Cultural knowledge is the key to understanding, *British Medical Journal*, 311(7012), pp.1088

World Health Organization (1996) *Female genital mutilation: information pack*, Geneva: WHO. Available online at www.who.int

World Health Organization (1997) *Female genital mutilation: a joint WHO/UNICEF/UNFPA statement*, WHO: Geneva. Available at www.who.int

World Health Organization (2000) *Female genital mutilation. Information fact sheet* (241), WHO: Geneva. Available at www.who.int

World Health Organization (2001) *Female genital mutilation: teacher's guide*, Geneva: WHO. Available online at www.who.int

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Further reading and resources

Adamson F (1992) *Female genital mutilation: a counselling guide for professionals*, London: FORWARD.

Dorkenoo E (1994) *Cutting the rose*, London: Minority Rights Publications.

Dorkenoo E and Elworthy S (1992) *Female genital mutilation: proposals for change* (information sheet), London: Minority Rights Group.

Department for Education and Skills (2004) *Female genital mutilation Act 2003: local authority social services letter* (LASSL 4), London: DfES. Available online at www.dfes.gov.uk

International Planned Parenthood Federation (2001) *Statement on FGM* [35(6)], New York: IPPF.

Lockat H (2004) *Female genital mutilation: treating the tears*, Enfield: Middlesex University Press.

Momoh C (2005) *Female genital mutilation*, Oxford: Radcliffe Publishing Group.

Royal College of Obstetricians and Gynaecologists (2003) *Female genital mutilation* (Statement no.3, May), London: RCOG. Available online at www.rcog.org.uk

World Health Organization (2001) *A systematic review of the health complications of female genital mutilation including sequelae in childbirth*, Geneva: WHO. Available online at www.who.int

World Health Organization (2001) *Female genital mutilation: student's guide*, Geneva: WHO. Available online at www.who.int

World Health Organization (2001) *Female genital mutilation: the prevention and the management of the health complications. Policy guidelines for nurses and midwives*, Geneva: WHO. Available online at www.who.int

World Health Organization (2001) *Management of pregnancy, childbirth and the postpartum period in the presence of female genital mutilation* (report of a WHO technical consultation Geneva, 15-17 October 1997), Geneva: WHO. Available online at www.who.int

International conventions on human rights

Africa Union (1986) *African (Banjul) Charter on Human and People's Rights*, AU: Addis Ababa, Ethiopia. Available online at www.africa-union.org

Africa Union (1999) *African Charter on the Rights and Welfare of the Child*, AU: Addis Ababa, Ethiopia. Available online at www.africa-union.org

Africa Union (2003) *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*, AU: Addis Ababa, Ethiopia. Available online at www.africa-union.org

Office of the United Nations High Commissioner for Human rights (1987 and 2003) *Convention against Torture and other Cruel, Inhuman or Degrading Treatment and Punishment*, UNHCR: Geneva.
Available online at www.ohchr.org

United Nations High Commissioner for Refugees (1981) *Convention on Elimination of all Forms of Discrimination against Women*, UNHCHR: Geneva. Available online at www.ohchr.org

United Nations High Commissioner for Refugees (1990) *Convention on the Rights of the Child*, UNHCHR: Geneva. Available online at www.ohchr.org

United Nations Population Fund (1994) *International conference on population and development (ICPD), Cairo and ICPD+5 New York, and ICPD+10 Beijing*, UNFPA: New York. Available online at www.unfpa.org

United Nations (1948) *Universal Declaration of Human Rights*, UN: New York. Available online at www.un.org

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4 Carol Street
London NW1 OHU
Tel 020 7482 2786
admin@women-and-health.org

African Women's Health Clinic
Whittington Hospital
Level 5
Highgate Hill
London N19 5NF
Tel 020 7288 3482
Women can self refer

Birmingham Heartlands Hospital
Princess of Wales Women's Unit
Labour Ward
Bordesley Green East
Birmingham
Tel 0121 424 3514

Central Liverpool PCT
FGM Advocacy Worker Rahima Farah
Kuumba Imani Millennium Centre
4 Princes Street
Liverpool L8 1TH
Tel 051 285 6370 (direct)

Chelsea and Westminster Hospital
Gynaecology and Midwifery Depts
369 Fulham Road
London SW10 9NH
Tel 020 746 8000

Drop-in Service
Central Health Clinic
1 Mulberry Street
Sheffield 51 2PJ
Tel 0114 271 8865

Global Consultant on Public Health
FGM & Surgical Reversal (GCPH)
10a Russell Gardens
London N20 0TR
Tel 0795 640 7063
comfort@fgmconsultancy.com
www.fgmconsultancy.com

Leytonstone Community Health Project
Kirkdale House
7 Kirkdale Road
Leytonstone
London E11 1HP
Tel 020 8928 2244

Liverpool Women's NHS Foundation Trust
Multi-Cultural Antenatal Clinic
Crown Street
Liverpool L8 7SS
Tel 0151 708 9988

St Mary's Hospital
Gynaecology and Midwifery Depts
Praed Street
London W2
Tel 020 7886 6666

Organisations and support groups

England

Agency for Culture & Change Management
The Old Corners Court
14/18 Nursery Street
Sheffield S3 8GG
Tel 0114 275 0193
www.accmsheffield.org

Black Women's Health and Family Support (BWHAFS)
82 Russia Lane
London E2 9LU
Tel 020 8980 3503
www.bwhafs.co.uk
bwhfs@btconnect.com

London Child Protection Committee
Association of London Government
59 1/2 Southwark Street
London SE1 0AL
Tel 020 7934 9999
www.alg.gov.uk

Midlands Refugee Council
5th Floor, Smithfield House
Digbeth
Birmingham B5 6BS
Tel 0121 242 2200

WoMan Being Concern International
K405 Tower Bridge Business Complex
100 Clements Road
London SE16 4DG
Tel 020 7740 1306
www.womanbeing.org

Northern Ireland

Multi-Cultural Resource Centre (Northern Ireland)
9 Lower Crescen
Belfast BT7 1NR
Tel 028 9024 4639
www.mcrc-ni.org

Northern Ireland Council for Ethnic Minorities (NICEM)
3rd Floor
Ascot House
24-31 Shaftesbury Square
Belfast
BT2 7DB
Tel 028 9023 8645 / 028 90319666
www.nicem.org.uk

Scotland

International Women's Centre
49 Lyon Street
Ground Floor Left
Dundee DD4 6RA
01382 462058
www.diwc.co.uk

Save the Children Scotland
Haymarket House
8 Clifton Terrace
Edinburgh EH12 5DR
Tel 0131 527 8200
www.savethechildren.org.uk/scotland

Scottish Refugee Council
5 Cadogan Square (170 Blythswood Court
Glasgow G2 7PH
Tel 0141 248 0799
www.scottishrefugeecouncil.org.uk

Wales

Central African Association
11 Richmond Road
Cardiff CF24 3AQ
Tel 029 2045 9945
www.centralafrican.org.uk

MEWN Cymru – Minority Ethnic Women's Network,
Wales 1st floor
Coal Exchange
Mount Start Square
Cardiff CF10 5EB
Tel 029 2046 4445
www.mewn-cymru.org.uk

SPA Somali Advice & Information Office
68 James Street
Cardiff Bay
Cardiff
Tel 029 2025 5526
www.switch-cymru.org.uk/html/SPA/contaus.htm

Welsh Refugee Council
Phoenix House
389 Newport Road
Cardiff CF24 1TP
Tel 029 2048 9800
www.welshrefugeecouncil.org
(site being developed)

National and international groups

FGM National Group
www.fgmnationalgroup.org (site being developed)

FORWARD (Foundation for Women's Health,
Research and Development)
Unit 4
765-767 Harrow Road
London NW10 5NY
Tel 020 8960 4000
www.forwarduk.org.uk
forward@forwarduk.org.uk

RAINBO (Research, Action and Information Network for the
Bodily Integrity of Women)
Queens Studios
121 Salusbury Road
London NW6 6RG
Tel 020 7625 3400
www.rainbo.org
info@rainbo.org

Waris Dirie Foundation
Verein zur Förderung von Hilfsaktionen für Afrika
Millenium Tower 24th Floor
Handelskai 94-96
1200 Vienna
Tel 0043 1 24 027 6351
Email waris@utanet.at
www.waris-dirie-foundation.com

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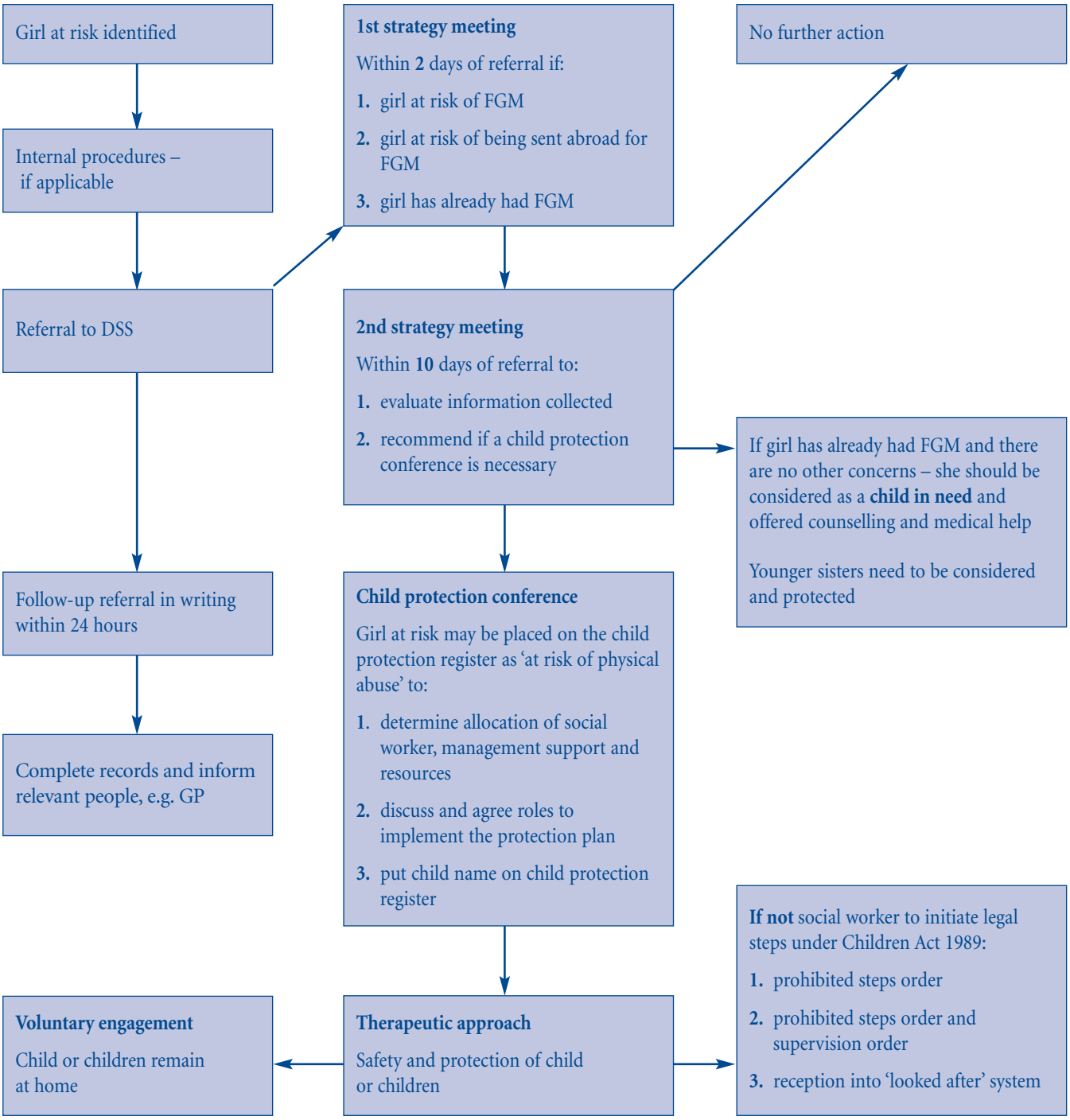
Appendix 1

Flow chart developed by FORWARD based on the *London Child Protection Procedures (2nd edition)* by the London Child Protection Committee.

London Child Protection Procedures in respect of FGM



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