Female Genital Mutilation: Caring for patients and safeguarding children

Guidance from the British Medical Association

July 2011

The guidance is currently under review to take into account recent legislative and policy developments. An updated version of the guidance will be available following the publication of new statutory FGM guidance, which is expected shortly in England and Wales. Meanwhile:

- **Guidance on the implementation of a new statutory duty to report known FGM in under 18-year-olds (from the 31 October 2015, England and Wales only) can be found at: www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information**
- **Updated clinical guidance "Female Genital Mutilation and its Management, Green-top Guideline No.53" can be found on the Royal College of Obstetricians and Gynaecologists (RCOG) website at: www.rcog.org.uk**
- **Guidance on the new FGM Enhanced Dataset (England only) can be found at: www.hscic.gov.uk/fgm**
- **A comprehensive e-learning package on FGM can be found on the e-learning for healthcare website at: www.e-lfh.org.uk/programmes/female-genital-mutilation/**
- **Further guidance on FGM can be found on the NHS Choices website at: www.nhs.uk/Conditions/female-genital-mutilation/Pages/Introduction.aspx**

* World Health Organization. *Regional Plan of Action to Accelerate the Elimination of Female Genital Mutilation in Africa.* Brazzaville: WHO, 1997.

UK-wide guidance

BMA

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1. Basic principles

- Female Genital Mutilation (FGM) is a form of child abuse and is against the law.
- The BMA supports the effective enforcement of the Female Genital Mutilation (England, Wales and Northern Ireland) Act 2003 and the Prohibition of Female Genital Mutilation (Scotland) Act 2005.
- If a child is identified as being at risk of female genital mutilation, urgent action must be taken to safeguard the child.
- Matters of female genital mutilation should be handled sensitively, but a child's welfare is paramount.
- Medical personnel should be trained in how to meet the needs of girls and women who have undergone female genital mutilation. Care should be taken to ensure that affected girls and women do not feel stigmatised.
- There is a need to raise awareness about the health and legal issues, and about support services and sources of information that are available amongst communities that practise female genital mutilation.
- Risk of female genital mutilation should be recognised as legitimate grounds for refugee and asylum status.

2. Background and introduction

2.1 Definitions

Female genital mutilation (often referred to as "FGM") is a collective term used for a range of practices involving the removal or alteration of parts of healthy female genitalia for non therapeutic reasons. Different degrees of mutilation are practised by a variety of cultural groups in the UK. The two most common forms of mutilation are *excision* and *clitorecdectomy. Circumcision* involves the removal of the hood of the clitoris, with the body of the clitoris left intact, although this term is often euphemistically used to cover a range of forms of mutilation. *Excision* involves total or partial removal of the prepuce, clitoris and/or labia minora. *Infibulation* is the total amputation of all of the external genitalia together with the stitching together of the remainder of the labia majora leaving only a matchstick-sized opening for the passage of urine and of menstrual blood. Other mutilations include pricking, piercing or stretching of the clitoris and/or labia, cauterisation by burning of the clitoris and surrounding tissues, scraping of the vaginal orifice or cutting of the vagina, and introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing it. The age at which such procedures are carried out varies from a few days old to just before marriage.

All forms are mutilating and carry serious health risks.

World Health Organization (WHO) classification of female genital mutilation:[1]

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing,[2] incising, scraping and cauterization.

2.2 Prevalence

The number of girls and women world-wide who have undergone genital mutilation is estimated at between 100 and 140 million, with 3 million young girls undergoing it each year.[3] It is found in 28 African countries, and also in South East Asia and the Middle East. The highest prevalence rates, of 90% or more, are found in Djibouti, Egypt, Guinea, Sierra Leone, Somalia and Sudan. Eritrea and Mali both also have very high prevalence rates, around 80%.[4] It is also found in Europe and elsewhere amongst communities originating from these parts of the world.

In Britain, female genital mutilation is seen in some ethnic groups that have migrated to this country. The majority are refugees. The main groups in the UK are from Egypt, Eritrea, Ethiopia, Gambia, Iraq, Kenya, Kurdistan, Liberia, Mali, Nigeria, Northern Sudan, Sierra Leone and Somalia. Dispersal of asylum seekers across the UK makes increasing numbers of doctors likely to come into contact with girls and women who have been mutilated and girls who might be.

It is important that all health professionals are aware of which groups are potentially at risk, so that when caring for a girl and her family who have racial or cultural links with countries where female genital mutilation is endemic, they are alert to the possibility of mutilation. In Britain the most common age for a girl to be mutilated is between 7 and 9 years. It is most likely to occur over the summer holidays with the girl being taken overseas, although there have been media reports of an increasing number being carried out in the UK.[5]

Precise figures for the number of girls and women who have undergone, or who are at risk of genital mutilation, in the UK, are hard to establish due to the secrecy surrounding the practice. A Department of Health funded study found that, in England and Wales:[6]

- In 2001, 65,790 women had undergone genital mutilation with the highest numbers in women from Kenya and Somalia. The study noted that "their numbers are likely to have increased since then".
- In 2004, there were 9,032 pregnant women, and women who had just had a baby, with genital mutilation.
- In 2005, over 21,000 girls under the age of 15, in England and Wales, were at high risk of genital mutilation.

Although government guidance notes that "it is possible that, due to population growth and immigration from practising countries…FGM is significantly more prevalent than these figures suggest."[7]

2.3 Health risks

Mutilation has immediate risks, including severe pain, haemorrhage, tetanus and other infections, septicaemia or even death. These consequences are worsened when traditional "circumcisers" work in unsterile conditions without anaesthesia. They may use knives, scissors, scalpels, pieces of glass or razor blades to carry out the practice. Girls who are infibulated often have their legs bound together for several days or weeks after the mutilation.[8]

In the longer term, girls and women may experience problems with their sexual, reproductive and general health. Girls and women with type III genital mutilation may have difficulty with voiding or menstruating, and will be prone to recurrent urinary tract infections and pelvic infections. These may leave women infertile and others who do conceive are likely to experience difficulties with childbirth due to a scarred birth canal. This increases the risk of stillbirth or haemorrhage from internal tearing which may lead to maternal death. The health risks are higher with type III genital mutilation.

One of the most comprehensive studies into FGM and obstetric outcomes was published in June 2006 by the World Health Organization (WHO). The research shows a causal relation between obstetric complications and the type of mutilation suffered – the more extensive the mutilation, the worse the complication. According to the research, women who have undergone FGM are more likely to have a Caesarean delivery, have up to 66 per cent chance of having a baby that requires resuscitation and, with type III genital mutilation, are 55 per cent more likely to have a child who dies before or shortly after birth.[10] Girls and women who have undergone FGM are prone to cysts and keloid formations. The struggling that occurs during the procedure can lead to unintended cuts into the urethra and rectum which may cause fistulas.

Little is documented about the psychosexual and psychological sequelae of female genital mutilation. Sexual sensitivity may be reduced after mutilations that remove the clitoris or leave large areas of tough scar tissue in place of sensitive genitalia. Narrowing of the vaginal opening can make intercourse painful for both partners. Long term consequences might also include behavioural disturbances as a result of the childhood trauma and possible loss of trust and confidence in carers who have permitted, or been involved in, a painful and distressing procedure. In many cases young girls are pinned down by their female relatives to carry out the genital mutilation. It is also reported that women may have feelings of incompleteness, anxiety and depression, and suffer chronic irritability, frigidity, marital conflicts, or even psychosis.[10]

Many health professionals in the UK will not be familiar with the sequelae of female genital mutilation. Specialist medical procedures, obstetric care, counselling and psychotherapy may all be required – see notes 3.10 and 3.11 for sources of practical advice and information.

2.4 Motivation

The reasons given to justify female genital mutilation are numerous and it has not been possible to determine when or where it originated. The reasons cited generally relate to tradition, power inequalities and the ensuing compliance of girls and women to the dictates of their communities. In sociological studies, WHO reports that the following reasons have been given for female genital mutilation: custom and tradition; religious demand; purification; family honour; hygiene (cleanliness); aesthetic reasons; protection of virginity and prevention of promiscuity; increasing sexual pleasure for the husband; giving a sense of belonging to a group; enhancing fertility; and increasing matrimonial opportunities.[11] The belief amongst some of the practising groups that female genital mutilation is demanded by some religions, for example Islam, is erroneous.

FGM is frequently condoned by family members in order to conform to social norms. There are often multiple decision makers involved in a decision to perform FGM on a girl. Many women believe that their circumcision, excision or infibulation is necessary to ensure marriageability and acceptance by their community. Attitudes are gradually changing in communities that practice it. Some members of the communities in the UK affected by female genital mutilation are strongly opposed to the continuation of the practice and have expressed serious concerns about the welfare of women and girls living in the UK who are likely to be mutilated. Doctors practising in multicultural environments can offer valuable support to those members of ethnic communities who seek to eliminate female genital mutilation.

2.5 Regulation

As well as being unethical, female genital mutilation is illegal in England, Wales and Northern Ireland under the Female Genital Mutilation Act 2003 and in Scotland under the Prohibition of Female Genital Mutilation Act 2005. Both Acts make it an offence for any person:

(a) to excise, infibulate or otherwise mutilate the whole or any part of a person's labia majora, labia minora or clitoris; or
(b) to aid, abet, counsel or procure the performance by another person of any of those acts on that other person's own body, or
(c) to aid, abet, counsel or procure a person to excise, infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris.

Both Acts also make it a criminal offence in certain circumstances to carry out female genital mutilation abroad, and to aid, abet counsel or procure the carrying out of female genital mutilation abroad, including in countries where the practice is legal.

These prohibitions are not absolute, and both Acts permit surgical and obstetric procedures that may fall within these categories if they are carried out by an appropriately registered practitioner either during childbirth or for the physical or mental health of the patient. There has been limited clarification of the circumstances in which procedures falling within this definition might be necessary. Valid exceptions to the prohibition on FGM are listed in the Explanatory Notes of both Acts and include surgery for gender reassignment, cosmetic surgery resulting from perceived abnormality, and operations to remove malignant tumours.[12,13] There has been little clarification of the circumstances in which FGM might be necessary for mental health purposes. It is clear, however, that in determining whether an operation is necessary for the mental health of a person, "it is immaterial whether she or any other person believes that the operation is required as a matter of custom or ritual".[14,15]

In many communities, including those based in the UK, custom demands that a woman be re-infibulated after each childbirth. Re-infibulation is illegal. The Royal College of Obstetricians and Gynaecologists clinical guidelines state that:

> "Any repair carried out after birth, whether following spontaneous laceration or deliberate defibulation, should be sufficient to appose raw edges and control bleeding, but must not result in a vaginal opening that makes intercourse difficult or impossible."[16]

A person found guilty of an offence under either Act could be imprisoned for up to fourteen years. At the time of writing, there have been no prosecutions under the Acts.

Two doctors have been found guilty of serious professional misconduct before the General Medical Council. The first of these, in 1993, involved a doctor who had performed female genital mutilation while knowing that it was illegal. The doctor was struck off the medical register but the police refused to prosecute. In 2000, another doctor was struck off for offering to carry out female genital mutilation.

Research indicates that the law has discouraged some from the practice of female genital mutilation.[17]

3. Guidance for UK doctors

In 2011, the government issued comprehensive multi-agency guidelines[18] on female genital mutilation, for England and Wales. The aim of the guidance is to support frontline practitioners from health, education and social care to:

- identify and prevent further incidents of female genital mutilation;
- ensure that victims and potential victims receive the response and support they need; and
- provide step-by-step practical guidance to sensitively handle cases of FGM.

Although the guidance is England and Wales focused, much of the guidance can also be applied to Scotland[19] and Northern Ireland.

Key points for doctors from *Multi-Agency Practice Guidelines: Female Genital Mutilation*:

Doctors should:

- Deal with FGM in a sensitive and professional manner, and be sufficiently prepared so that they do not exhibit signs of shock, confusion, horror or revulsion when treating an individual affected by FGM.
- Always consider other girls and women in the family who may be at risk of FGM when dealing with a particular case.
- Ensure that mental health issues are considered when supporting girls and women affected by FGM.
- Health professionals, particularly nurses and midwives, need to be aware of how to care for women and girls who have undergone FGM, particularly when giving birth.
- All girls and women who have undergone FGM should be offered counselling to address how things will be different for them after de-infibulation procedures. Parents, boyfriends, partners and husbands should also be offered counselling.

Where a medical examination is required of a child suspected of having undergone female genital mutilation, the examination of a child or young person should be in accordance with safeguarding children procedures and should normally be carried out by a consultant paediatrician, preferably with experience of dealing with cases of FGM.[20]

GPs are encouraged to consider a number of actions:

- A question about FGM should be asked when a routine patient history is being taken from girls and women from communities that traditionally practise FGM.
- Information about FGM could be made part of any 'welcome pack' given to a practice's new patients.
- Consider the risk of FGM being performed on girls and women overseas when vaccinations are requested for an extended break.

In addition, the organisation FORWARD suggests that leaflets that women can collect discreetly, especially at GP surgeries, should be provided.[21]

Comprehensive clinical guidance on female genital mutilation is also available from the Royal College of Obstetricians and Gynaecologists – *Female genital mutilation and its management; green-top guideline No. 53* (available at www.rcog.org.uk). In addition, the knowledge and skills needed to identify and manage female genital mutilation are now part of the advance training modules required for paediatric and adolescent gynaecology, advanced antenatal practice and genitourinary medicine, and community sexual and reproductive health, amongst others.[22] The National Institute for Health and Clinical Excellence (NICE) also notes that healthcare professionals routinely involved in the care of pregnant women should be given training on "the specific health needs of women who are recent migrants, asylum seekers or refugees, such as needs arising from female genital mutilation…"[23]. The psychosocial needs of patients affected by FGM should be recognised and appropriate support given. Due to the multiple needs of refugees and asylum seekers, those affected by FGM maybe less willing to seek help in relation to FGM.

Women and girls who have been affected by FGM require culturally competent and compassionate care and medical professionals should recognise that the term female genital mutilation may not be considered respectful or appropriate. It is best to use more neutral terms such as female genital cutting or circumcision.

3.1. Child protection

3.1.1 Girls at risk of female genital mutilation

Female genital mutilation is perceived in the UK as a form of child abuse, it is illegal, performed on a minor who is unable to resist, medically unnecessary, extremely painful and poses severe health risks. Although members of communities that practice female genital mutilation do so with best intentions for the future welfare of their child and do not intend it as an act of abuse; it is abuse.

If it becomes apparent that a girl is at risk of female genital mutilation, the GP or other doctor caring for her, for example the community paediatrician, must ensure that there is discussion with the family about the health and legal issues.

Doctors are unlikely to be able to initiate all of this work as individuals and should seek help, for example, from social services, counsellors and other health professionals – such as, child protection leads or other clinicians with experience of working with communities that have a tradition of female genital mutilation. In initial enquiries to seek general help, advice and information, it is unlikely to be necessary to identify the child or family. See note 3.1.3 on confidentiality.

Risk factors that a girl or woman might be subjected to FGM: [24]

- If female genital mutilation is practised in the girl or woman's country of origin.[25]
- The family is not integrated into UK society.
- The girl's mother has had FGM.
- If the girl has a sister who has already undergone FGM, or if other children in the extended family have been subjected to FGM.

It is important that there is follow up to make sure that younger girls in the family are not subjected to FGM.

Where a doctor has a reasonable belief that a child is at serious risk of immediate harm of FGM, he or she should act immediately to protect the interests of the child, and this will involve contacting one of the three statutory bodies with responsibilities in this area: the police, the local authority social services or the National Society for the Prevention of Cruelty to Children (NSPCC), and make a full report of concerns. The precise action taken should be governed by the safeguarding children procedures. For example in England and Wales, set out by the Local Safeguarding Children's Board (LSCB). While professionals should ordinarily seek to involve the family in discussions relating to these concerns and to seek their agreement to the course of action, this should only be done where it will not place the child at an increased risk of significant harm.

The steps that should be taken to initiate child protection proceedings where there is concern about the welfare of a child are set out in Government guidance *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*.[26]

The guidance states that a local authority "may exercise its powers under s.47 of the Children Act 1989 if it has reason to believe that a child is likely to suffer or has suffered FGM. Despite the very severe health consequences, parents and others who have this done to their daughters do not intend it as an act of abuse. They genuinely believe that it is in the girl's best interests to conform with their prevailing custom. Where a child has been identified as at risk of significant harm, it may not be appropriate to consider removing the child from an otherwise loving family environment. Where a child appears to be in immediate danger of mutilation, consideration should be given to getting a prohibited steps order. If a child has already undergone FGM, particular attention should be paid to the potential risk of harm to other female children in the same family".[27] Section 47 requires local authorities to make or initiate enquiries to establish whether action is needed to protect a child's welfare, and to take such action as necessary.[28] A prohibited steps order is a court order prohibiting the person or persons specified in that order from taking certain actions; in this case, to prevent parents from subjecting their daughter to genital mutilation either in the UK or abroad.

Guidance for doctors involved in child protection proceedings is published by the BMA,[29] Royal Colleges[30] and the Department of Health.[31] Other useful sources of information are given in sections 3.10 and 3.11 below.

3.1.2 Girls being taken abroad for genital mutilation

Where there are fears that a girl may be taken abroad for genital mutilation, doctors should counsel the parents, explain the health and legal issues, and, as above, follow local safeguarding children procedures. As noted above (see section 2.5) it is an offence under both the Female Genital Mutilation (England, Wales and Northern Ireland) Act 2003 and the Prohibition of Female Genital Mutilation (Scotland) Act 2005 to take a child out of the country to procure female genital mutilation. Under the Children Act 1989 the local authorities can also apply to the court for various orders to prevent a child being taken abroad for mutilation.[32]

Suspicions may arise that a child is being prepared to be taken abroad for genital mutilation, if the family belongs to a community that practises female genital mutilation, and preparations are being made to take the girl overseas. For example:

- Arranging vaccinations
- Planning absences from school
- The child is talking about a "special procedure" taking place.[33]

3.1.3 Confidentiality

Parents' rights to control information about their young children may be overridden where this is necessary to protect the child from serious harm, although wherever possible, their permission for disclosure of information to social services or another appropriate agency should be sought. If permission is not given, relevant information can still be disclosed to the appropriate authority to prevent serious harm to the child. In judging how to broach the issue with parents, doctors must bear in mind the likely attitude of parents in such circumstances and the risk that the child may simply disappear by being concealed within the community or sent to relatives abroad. This can be extremely difficult and doctors must take great care to ensure that their reactions are supportive of the child's overall welfare.

In the context of child protection generally, the GMC notes that:

> "Your first concern must be the safety of children and young people. You must inform an appropriate person or authority promptly of any reasonable concern that children or young people are at risk of abuse or neglect, when that is in a child's best interests or necessary to protect other children or young people."

And if a doctor decides not to disclose information:

> "You must be able to justify a decision not to share such a concern, having taken advice from a named or designated doctor for child protection or an experienced colleague, or a defence or professional body. You should record your concerns, discussions and reasons for not sharing information in these circumstances."[34]

3.2 Indications that genital mutilation has already taken place

It is important for doctors to identify if a girl or woman has undergone genital mutilation in order to provide follow-up care and to identify if any other children are at risk of genital mutilation.

Doctors might identify that a girl or woman has undergone genital mutilation by the following:[35]

- difficulty walking, sitting or standing;
- longer than normal time in the bathroom or toilet due to difficulties urinating;
- frequent urinary or menstrual problems; and
- a reluctance to undergo normal medical examinations – for example, smears.

A girl or woman may ask for help, but may not be explicit about the problem due to embarrassment or fear.

3.3 Requests for female genital mutilation

It is rare that doctors are asked to perform female genital mutilation on young girls. Instead families might seek a traditional circumciser or other member of their own community to do it. Requests are more likely to be faced from women asking to be re-infibulated after childbirth, although it is not known how common such requests are. As is explained above (see section 2.5), re-infibulation is illegal under the Female Genital Mutilation Acts, with certain exceptions, including during childbirth if necessary for the physical or mental health of the patient. This must be explained to the woman. If she agrees, it may also be important to explain to her husband the reasons why re-infibulation, which is not medically necessary, cannot be carried out. This may be particularly important if there is pressure from him for the procedure, although the main impetus for mutilation often comes from female members of the community.

3.4 Reversal/de-infibulation

In some communities, it is traditional for infibulation to be reversed immediately after marriage. This is carried out by a midwife or birth attendant and facilitates consummation of the marriage. Many women living in the UK find it difficult to obtain this service, or erroneously believe that it is not available to them. Experiences with de-infibulation at the African Well Woman Clinic at Northwick Park Hospital lead to the conclusion that encouraging women to have infibulation reversed before pregnancy is to be encouraged.[36] The clinic found support for this from both women and their husbands.

The WHO recommends that "defibulation should be offered as soon as possible (not only during childbirth) since it may reduce several health complications of infibulations, as well as providing impetus for change."[37]

3.5 Services for patients

It is essential that communities likely to practice female genital mutilation are given information about what support services are available and how to access them. This should include information about reversal procedures. Information and attempts to raise awareness need to focus on the health and well being of all girls and women who are affected, including expectant mothers.

Information about specialist services is included in section 3.10 below.

3.6 An inter-agency approach

The approach to eradicating female genital mutilation amongst UK residents involves the health care team, counsellors, social services, educators and members and leaders of communities that practice female genital mutilation. Doctors should co-operate with local initiatives providing information and advice. As well as making efforts within communities to stop mutilation, doctors must work with individual patients. This requires an awareness of who may be at risk, either of being mutilated at a future date, or of suffering health complications as a result of mutilation.

It is essential that doctors work closely with appropriate statutory and other organisations, obtaining advice where necessary, when faced with an individual case. Initial approaches for general advice should normally be made on an anonymous basis, without identifying the child or family concerned.

For example in England and Wales, Local Safeguarding Children Boards (LSCBs) have responsibility for developing inter-agency policies and procedures safeguarding and promoting the welfare of children. The LSCB's policy should focus on a preventive strategy involving community education and be alert to the fact that the practice may also take place in this country.[38]

3.7 Medicalisation

It is sometimes argued that, as it would minimise some of the health risks, female genital mutilation should be done by doctors, in sterile conditions with anaesthesia. Most international organisations and national medical associations, including the BMA, agree that health professionals should not carry out female genital mutilation and that the practice constitutes a clear breach of human rights. The WHO considers that "the medicalisation of the procedure does not eliminate this harm and is inappropriate for two major reasons: genital mutilation runs against basic ethics of health care whereby unnecessary bodily mutilation cannot be condoned by health providers; and, its medicalisation seems to legitimise the harmful practice".

3.8 Support for the prevention and ending of the practice

The urgent and unqualified need to prevent and end all forms of female genital mutilation is being pursued at all levels, from campaigns by international organisations, to groups of women refusing to have their daughters mutilated.

Individual doctors have an important role to play in efforts to support communities to abandon female genital mutilation. In addition to identifying girls who may be at risk of genital mutilation, they can work as part of inter-agency teams to change opinion amongst communities where it is practised. Doctors can also raise awareness of the harmful effects of female genital mutilation, within their practice, amongst the public, medical professionals,

decision-makers, governments, political, religious and village leaders, as well as traditional healers and birth attendants. They can also speak at community events on the health risks of female genital mutilation.

3.9 Asylum seekers

UNHCR and other agencies of the United Nations have stated that refugee and asylum status should be granted to women and girls fleeing their country to escape genital mutilation. The BMA supports this position.

World-wide only a very small number of women have been granted refugee status on the grounds that they would be at risk of female genital mutilation if they returned to their country. In a 1998 publication, Amnesty International noted a case in Canada, one in the US and two in Sweden.[39] A second application was successful in the US in 1999.[40] No statistics are available for the UK, but the Home Office reports that there have been successful asylum claims in the UK based on the threat of female genital mutilation, where removing the applicant could be contrary to Article 3 of the European Convention on Human Rights that protects the right to be free from torture, inhuman or degrading treatment.[41]

Guidance on the rights of asylum seekers to health care in the UK is available from the BMA.[42]

3.10 Sources of practical advice and information

It is clear that female genital mutilation has serious physical and mental health consequences for women. It is rare for women to survive mutilation without complications, be they short or long term, physical or psychological. Doctors must give their patients help and support, and provide psycho-sexual and gynaecological advice as appropriate. This section identifies sources of information and advice for doctors.

All key professionals working with communities which practise female genital mutilation should, where possible, receive specific training on the subject.

One valuable source of advice and information, for health professionals and patients, is people working at clinics with experience of caring for women who have been mutilated. The government *Multi-Agency Practice Guidelines on female genital mutilation* includes information and contact details of FGM specialist health services in England and Wales (available at **www.fco.gov.uk/fgm)**.

The Foundation for Women's Health, Research and Development (FORWARD) provides contact details for clinics on its website at **www.forwarduk.org.uk**. At the time of writing, there are 15 hospitals and clinics in the UK which specialise in FGM health services, many of which women can self-refer or drop-in to.

The following organisations provide help and advice, and may be able to put enquirers in contact with local women's groups.

Equality Now
5th floor, 6 Buckingham Street, London WC2N 6BU
Tel: 020 7839 5456
Fax: 020 7839 4012
Email: **ukinfo@equalitynow.org**
Internet: **www.equalitynow.org**

Foundation for Women's Research and Development (FORWARD)
Suite 2.1 Chandelier Building, 2nd Floor, 8 Scrubs Lane, London NW10 6RB
Tel: 020 8960 4000
Fax: 020 8960 4014
Email: **forward@forwarduk.org.uk**
Internet: **www.forwarduk.org.uk**

International Planned Parenthood Federation
Newhams Row, London SE1 3UZ
Tel: 020 7939 8200
Fax: 020 7939 8300
Email: **info@ippf.org**
Internet: **www.ippf.org**

Black Women's Health and Family Support (BWHAFS)
82 Russia Lane, London E2 9LU
Tel: 020 8980 3503
Fax: 020 8980 6314
Email: **bwhafs@btconnect.com**
Internet: **www.bwhafs.com**

3.11 Resources for health professionals

- British Medical Association. *Child protection – a toolkit for doctors*, 2009. Available at **www.bma.org.uk/ethics**
- HM Government. *Multi-Agency Practice Guidelines: Female Genital Mutilation*, 2011. Available at **www.dh.gov.uk** or **www.fco.gov.uk/fgm**
- Royal College of Nursing. *Female genital mutilation: An RCN educational resource for nursing and midwifery staff*, 2006. Available at **www.rcn.org.uk**
- Royal College of Obstetricians and Gynaecologists. *Female Genital Mutilation and its management, Green-top guideline No. 53*, 2009. Available at **www.rcog.org.uk**
- Department of Health. Female Genital Mutilation DVD, 2006. This Department of Health DVD gives a general introduction to female genital mutilation and its health implications. It also includes interviews with women who have undergone genital mutilation and how health care professionals should respond if they come into contact with a woman who has undergone the practice. To request a copy, email: **violence@dh.gsi.gov.uk**
- FORWARD offer a bespoke training service to health professionals on the issues surrounding FGM. For more information contact FORWARD (details above) or visit: **www.forwarduk.org.uk/what-we-do/uk-programmes/child-protection-training**
- Equality Now promotes policy to further the prevention of FGM globally and with grassroots partners on FGM programmes in more than 22 African countries. It offers direct technical support to health professionals on request. For more information contact **ukinfo@equalitynow.org**

• PHAROS – the national Dutch knowledge and information centre on migrants, refugees and health care issues – has published *Conversation Protocol Female Genital Cutting* (2005) which offers some useful guidance on how to ask patients about female genital mutilation in section 4 of the document. The document is available in Dutch on the PHAROS website **www.pharos.nl**. At the time of writing, the guidance had been translated into English and it was anticipated that an English translation would also be available on the PHAROS website.

Requests for further information and all enquiries about these guidelines should be directed to:

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female genital mutilation of young girls is child abuse



FGM is illegal in the UK.

It is also an offence for UK nationals or permanent UK residents to carry out FGM abroad or to assist the carrying out of FGM abroad. The maximum penalty for an offence is 14 years' imprisonment.

No religious doctrine supports FGM.

FGM has serious long-term health consequences for the girls and woman affected.

Be informed, be aware and be ready to flag a concern.

SAY NO TO FEMALE GENITAL MUTILATION

Don't let it damage another generation.

www.fco.gov.uk/fgm

Foreign & Commonwealth Office

Home Office

DH Department of Health

Department for Education