



Royal College  
of Nursing

# Female genital mutilation

An RCN resource for nursing and midwifery practice  
(Second edition)





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# Female genital mutilation

## An RCN resource for nursing and midwifery practice (Second edition)

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# Foreword

I am fortunate to have worked with many inspirational and dedicated people over many years towards our shared goal, the eradication of FGM. Many of those I have worked with are friends and colleagues from the health field who have dedicated their careers to this cause and it is those health professionals that have led the way in the movement to eradicate FGM, raising its profile as a high priority concern in our society. This momentum is growing and we are now seeing real, positive changes, not just nationally, but globally.

As Minister for Public Health, one of my personal priorities remains to ensure that all health professionals are supported to fully realise their crucial role in preventing this form of child abuse – and we do now agree that FGM is child abuse. This must be the starting point for the health service when responding to FGM, to put care, protection and prevention at the heart of our work.

So this guidance is especially welcome at a time when the way that we tackle FGM across the NHS is developing rapidly. For the first time ever we are collecting FGM patient information in the NHS. That means we can target the right resources in the places they are most needed to care for survivors. It also means we are supporting multi-agency work with partner agencies to protect girls at risk. The synergies between the work of the Royal Colleges, the NHS, FGM stakeholders, and Government departments show us why a joined-up approach is the best way to care for the wellbeing of girls and women affected by FGM.

For midwives and nurses, this guidance is a vital tool to raise awareness of what FGM is, why it happens and its legal background – an important framework upon which to build an effective response. The guidance supports health professionals in their response by illustrating good practice examples in the provision of specialised care as well as how to work effectively with other agencies and with the families affected.

Sharing our knowledge of FGM in this way empowers health professionals to start often difficult conversations, to make informed decisions, to effectively support women living with the consequences of FGM and to take preventive action to safeguard vulnerable girls.

No one epitomised the dedication of health professionals to eradicating FGM more than the late Efua Dorkenoo OBE, who trained as a nurse in the UK and went on to be a world expert on FGM. Her untimely death in October 2014 robbed the movement of one of its most inspiring figures, but we know what she expected of all of us. Efua would have welcomed this guidance but she would have also reminded us that issuing it is only half the battle. It must be used by everyone if we are to realise our shared vision of a country, and a world, free from FGM.



Jane Ellison MP  
Parliamentary Under-Secretary of  
State for Public Health

# Female genital mutilation (FGM)

## Introduction

Female genital mutilation (FGM), sometimes referred to as female circumcision, is a challenging subject to understand and manage.

FGM affects the lives and health of an estimated 125 million girls and women living in countries where the practice is prevalent (UNICEF, 2013). The World Health Organization (WHO, 2014) identifies FGM as a violation of the human rights of girls and women as the practice is usually carried out on young girls between infancy and the age of 15, commonly before puberty starts, and can have long-term negative effects on their health and wellbeing.

FGM is child abuse and the practice is illegal in the UK. The ‘hidden’ nature of the crime raises serious issues and concerns in relation to the safeguarding of girls and young women. It is vital that practitioners who come into contact with women, children and families from communities that practise FGM have an adequate knowledge and understanding of the issues in order to respond appropriately and act within contemporary legal frameworks.

The RCN guidance on this topic *Female genital mutilation: an RCN educational resource for nursing and midwifery staff* (RCN, 2006) has now been updated to take account of recent developments. It is important to acknowledge that while some health care professionals work closely with communities that have practised FGM for generations, others may rarely come across this practice. Nevertheless, it is important everyone has some understanding of FGM in order to provide the best quality care for the women and girls they come into contact with. This will need to be managed in the context of local safeguarding procedures, which all practitioners should be familiar with.

This publication aims to raise awareness among nurses, midwives and related health care personnel

about FGM, and to provide insight and understanding of the socio-cultural, legal and health issues surrounding the practice.

Alongside an overview of FGM and the potential harm and consequences it poses for young women, this guidance provides an outline of the context in which FGM is being managed across the UK. The guidance also provides:

- a consideration of legal and professional requirements, including safeguarding and the importance of multi-agency working
- clarification of individual nursing and midwifery roles, and a consideration of key service provision requirements
- a review of the practice issues nurses and midwives need to understand.

## What is FGM?

The WHO defines FGM as:

“...all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.”

WHO, 2014

The practice has no health benefits and can often lead to morbidity and mortality in girls and women. The lasting physical and psychological trauma caused by FGM can have lifelong complications for the health and wellbeing of women.

FGM is also referred to as female circumcision, an expression which implies the practice is similar to male circumcision. However, the degree of cutting is far more extensive and the procedure often impairs a woman’s sexual and reproductive functions and ability to pass urine normally.

Female genital cutting is another term used to describe the practice, and many traditional societies have different names for what is defined by WHO as FGM.

When discussing FGM, it is important to understand that many women may not be aware of what has happened to them, and because of the use of a variety of local cultural terms (which often refer to purification) may not comprehend what is meant or being referred to when using certain terminology.

## Historical and cultural context

Those who do not practise FGM generally view it as a form of abuse and violence and a clear violation of human rights. This attitude is enshrined in numerous international conventions, and agencies, human rights groups, women's groups and governments around the world are committed to eradicating the practice globally.

However, FGM remains deeply rooted within some cultures and traditions (Momoh, 2003), and it can be challenging to rationalise the beliefs that provide a vehicle for the practice to continue. Some communities view FGM as an act of love or a rite of passage and find it difficult to understand why the practice is condemned, believing they are doing the best for their daughters.

It is unclear when and where FGM first started, but reference to the procedure has been found on an Egyptian sarcophagus dating from around two thousand years ago. The practice of FGM was also documented in Britain, Canada and the USA during the 19th century when it was employed to prevent masturbation, cure hysteria and some psychiatric conditions in women (RCN, 2006).

The justifications for performing FGM are many and vary widely between individual communities, contexts and countries; in summary, motivations often relate to the control of women and their sexuality, religion, rites of passage, ideas of hygiene, femininity and aesthetics, as well as social pressures and expectations.

FGM is often erroneously linked to Islam, possibly because it is practised in communities where this religion predominates. Some Muslims believe Islam demands the practice to ensure spiritual purity, but many Islamic scholars disagree and state that there is no reference to FGM in the Qur'an or the Hadith.

In 2014, the Muslim Council of Britain (MCB), the country's largest Muslim organisation, condemned FGM and for the first time issued explicit guidance which criticises the practice and makes it clear it is not supported by any religious doctrine or linked to the teaching of Islam (MCB, 2014).

In reality, FGM transcends religious, racial and social boundaries; a minority of followers of a variety of faiths including Christians, Animists and Jews (the Falashe Jews of Ethiopia) practise it (RCN, 2006).

Performing FGM is seen by some as an essential part of their culture that must be preserved (Momoh, 2005). 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 premarital and extra-marital sex, improving both the marriageability of 'circumcised' young women and increasing their dowries. Hence, in many places it is viewed 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 suggestion is that a closed introitus (the opening to the vagina) – also known as infibulation – in which the labia majora and sometimes the labia minora may be sewn together, is considered to provide evidence of virginity. Families therefore view FGM – and by implication, 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. FGM may also be falsely believed to improve fertility. It should also be acknowledged that the procedure often carries high social values (Momoh, 2005).

### Figure 1 – Viewpoints on FGM 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 difference 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, MBE, 2006

In 2008, a global interagency statement condemned the practice of FGM, including its practice by health professionals:

“Trained health professionals who perform female genital mutilation are violating girls’ and women’s right to life, right to physical integrity, and right to health.”

WHO, 2012

Performing 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 that it is important to ensure that a child is 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 – while girls must have all masculine features removed – the clitoris, which is believed to be a diminutive penis. These acts are believed to ensure that each child has an 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 also be supposed 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. Many communities view FGM as a positive and normal part of their heritage and perceive continuation of the practice as an aspect of their group identity.

It is also important to recognise 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. Equally, it must be acknowledged that some health care professionals in the UK come from these communities and may have conflicting views and beliefs about FGM.

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.

## Prevalence

It is important to acknowledge that available data on FGM is estimated. Global statistics provided by the World Health Organization (WHO, 2011) suggest that



FGM is on the decline, however it remains a significant threat to many girls across the globe and is deeply rooted in regions of Africa, Asia and the Middle East (RCM et al., 2013). The movement of people seeking refuge and asylum from the Horn of Africa region has led to the situation now being taken seriously in the UK. [Appendix 1](#) maps the global prevalence of FGM.

In 2013, the United Nations International Children's Emergency Fund (UNICEF, 2013) estimated that 125 million girls and women in Africa and the Middle East, regions where FGM is primary concentrated, are living with the consequences of having had FGM performed on them. While not all women are negatively affected by FGM, research demonstrates that large numbers are physically and psychologically damaged by this mutilation (WHO, 2012). These numbers do not account for those who have died as a direct or indirect result of having FGM performed on them, or the babies that have died following a traumatic childbirth due to complications from FGM.

In African countries, more than 90 million girls and women over the age of 10 years are estimated to have undergone FGM; according to the World Health Organization, an estimated three million girls in Africa are at risk of undergoing female genital mutilation every year (WHO, 2010).

Many girls and women die from the short-term effects of FGM which include haemorrhage, shock or infection, whilst significantly more suffer lifelong disability and may die from long-term effects such as recurrent urinary or vaginal infections. Pain during intercourse and infertility are further 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 90-98 percent of women are infibulated, one in every 100 women giving birth dies as a result of this procedure (see Figure 2 for a short narrative that expands on this point).

## Figure 2 – FGM: a complex issue

Dr Comfort Momoh, MBE, discovered how complex the issues around FGM are and why it remains a problem when she visited Somalia in 2004, a location from which many of the women who attended her London clinic originate.

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 per cent.

The itinerant and highly mobile nature of the Somali populations, combined with strongly held beliefs and values, means education has been 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. She also uncovered some of the reasons why the practice continues: reasons that influence Somali populations now living.

For example, FGM is perceived 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 risked losing their livelihood if the practice was condemned.

The WHO, which heads up the global initiative against FGM, has recently published a strategy to counter the medicalisation of FGM entitled *Global strategy to stop health care providers from performing female genital mutilation* (WHO, 2014). The strategy was developed in



collaboration with other key UN agencies and international organisations following the adoption of a resolution to eliminate FGM by the UN General Assembly, which was passed in December 2012. This resolution resulted in greater engagement by global organisations such as WHO, UNICEF and the UNFPA, as well as the European Parliament and other national governments, in working to end this violation of the human rights of girls and women.

In 2009, END FGM, a European campaign led by Amnesty International Ireland, began working in partnership with a number of organisations in the European Union (EU) to highlight increasing concerns about the prevalence of FGM across the EU. The campaign focused on human rights issues and the need to lobby for a comprehensive and coherent approach towards ending FGM (END FGM, 2009). It has been suggested that 500,000 women living in the EU have undergone FGM and 180,000 girls are at risk of undergoing FGM every year, although it is unclear how this estimate was derived (European Parliament Resolution, 2008).

A recent study suggests that:

“... an estimated 103,000 women aged 15-49 with FGM, born in countries in which it is practised, were living in England and Wales in 2011, compared with the estimated 66,000 in 2001. In addition there were an estimated 24,000 women aged 50 and over with FGM born in FGM practising countries and nearly 10,000 girls aged 0-14 born in FGM practising countries who have undergone or are likely to undergo FGM. Combining the figures for the three age groups, an estimated 137,000 women and girls with FGM, born in countries where FGM is practised, were permanently resident in England and Wales in 2011.”

Macfarlane and Dorkenoo, 2014

## Tackling FGM in the UK

The recent increase in activity focused on the elimination of FGM because of the devastating consequences to women has been made possible, in

part, by the bravery of some girls and women who have been prepared to share their experiences and risk their own wellbeing in order to campaign against this practice.

A study of one such community-based project by Brown and Hemmings (2013), demonstrates how programmes which focus on community-orientated strategies can achieve significant outcomes by engaging with community members and leaders to change attitudes and deliver education on the risks associated with FGM. The evidence shows that understanding the community and providing access to specialist FGM services are vital steps for changing the existing culture.

Hussein's study (Hussein, 2010) also provides useful insights into women's experiences, perceptions and attitudes to FGM, and highlights key actions that can help eliminate FGM:

- engagement with the community and integration
- providing a safe space for dialogue and discussion
- raising awareness of FGM
- providing specialist health services which should incorporate female practitioners, interpreters, physical and psychological support, and sensitivity by staff in understanding FGM
- awareness of the law and balanced supportive safeguarding frameworks.

There are numerous examples of programmes across the UK, some initiated by women and others by professionals working across agencies who have invested in campaigns to raise consciousness and understanding of the consequences of FGM. These include community groups and the police, as well as education and health and social care practitioners. An example of one such initiative can be found in Bristol (see [appendix 2](#) for a synopsis of this work).

The education of male partners and community leaders may also reduce the number of children, and young and older women who suffer in the future. However, cultural practices such as FGM have been ingrained for many generations and require extensive education to address the issues thoroughly and effectively.

The establishment of an FGM Hotline (0800 028 3550 or [fgmhelp@nspcc.org.uk](mailto:fgmhelp@nspcc.org.uk)) in 2013 which is managed by the National Society for the Prevention of Cruelty to Children (NSPCC), has proved a useful source of support for women and professionals.

In 2013, the Royal College of Nursing, the Royal College of Midwives, the Royal College of Obstetrics and Gynaecology, the Community Practitioners and Health Visitors Association, in association with the human rights organisation Equality Now, created an intercollegiate FGM group (RCM et al., 2013) to develop recommendations towards tackling FGM across the UK, many of which are now being implemented.

The intercollegiate group's recommendations clearly assert the view that FGM is child abuse and a violation of human rights and provides an outline of areas for service improvement (see Figure 3). The report calls on health care professionals, together with the police and education and social work professionals, to consider their responsibilities on the safeguarding of the girls and women who may be affected by, or at risk of being mutilated.

### Figure 3 – Intercollegiate recommendations for tackling FGM in the UK

1. Treat it as child abuse.
  2. Document and collect information.
  3. Share that information systematically.
  4. Empower frontline professionals.
  5. Identify girls at risk and refer them as part of child safeguarding obligations.
  6. Report cases of FGM.
  7. Hold frontline professionals accountable.
  8. Empower and support affected girls and young women (both those at risk and survivors).
  9. Implement awareness campaign.
- RCM et al., 2013

There are a number of immediate challenges when it comes to tackling FGM; these are related to the education of the public and professional workers, and the need for more accurate data on actual prevalence. High quality information-sharing pathways across agencies and comprehensive evidence gathering to

support prosecutions, where a child has been put at risk or mutilated (RCM et al., 2013) is also essential.

Since the publication of these recommendations a wide range of initiatives have been enhanced or established with the intention of tackling FGM across the UK and the globe.

In July 2014, the UK government announced its intention to consult on the need for mandatory reporting of FGM. The consultation, due to report early in 2015 (Home Office, 2014b), has caused concern in some circles as it is unclear what the reporting requirement for health care practitioners will be: all cases of FGM; only those related to the direct treatment of complications; those at risk because they belong to a family where a woman had been mutilated; will all women who have FGM be considered at risk, if they give birth to a girl? At present the consultation is awaited, and current advice is that the contemporary local safeguarding procedures should be followed.

The situation, as it stood in January 2015, is as follows:

**Mandatory recording of data** is currently carried out by maternity services and on those women who seek advice or treatment in relation to complications from FGM. This data is anonymised, is reported on a country wide basis by the Health and Social Care Information Centre (HSCIC) and is invaluable for planning and commissioning services; especially in relation to identifying where services are most needed.

#### Effective use of data

While Macfarlane and Dorkenoo (2014) provide useful estimates on the prevalence of FGM in the UK, it is critically important to have accurate data on the actual numbers of women affected, by which types of FGM. In 2014 the Department of Health (ISB, 2014) set in place a requirement for better data collection across the health service and the first anonymised data report was published by the HSCIC in October 2014. Initial figures show that between April and September 2014, 1,279 female patients previously identified as having been subjected to FGM were receiving treatment. This data represents the first official figures published on FGM

cases seen in hospitals in England, and should be viewed critically as it will not provide a complete picture for some years to come.

The HSCIC acknowledged it has no figures indicating the population potentially at risk of FGM, or the number with a history of FGM not currently being treated for FGM-related or non-FGM related conditions (HSCIC, 2014). The full report shows that while 125 of the 160 acute trusts across England submitted data, this data does not take account of wider health and social care services. The intention is that this anonymous data will help to build a useful data set of the number affected by FGM across England.

**Mandatory reporting of individual cases** – the law has not changed in relation to safeguarding issues, however the Home Office is currently consulting on the introduction of mandatory reporting of FGM, and the results of this will be published in early 2015 (Home Office, 2014b). Until such time as there is a change in the law it is critically important for all health care professionals to be aware of local safeguarding procedures, and to be aware that there may be some variations to these across the UK. For this reason all health care professionals must seek local advice through safeguarding leads.

FGM is now widely recognised across the UK as a form of child abuse, and if a nurse or midwife is concerned that a woman or child is at risk, they should use local safeguarding procedures to sensitively manage the case, as they would with any suspected abuse. At present there is no requirement to refer women with FGM to social services or the police, however there should be opportunities to refer individuals to specialist health services where complications are identified. Health professionals need to be aware of which services are available locally to support women who have physical or psychological complications from having had FGM performed on them.

**Government initiatives** include the development of multi-agency guidelines to support best practice (HM Government, 2011) and in February 2014 the UK government published its declaration to end FGM on the International day of Zero Tolerance to Female

Genital Mutilation (6 February 2014). A national FGM prevention programme, initiated by the Department of Health in England, is well underway and [appendix 4](#) provides a diagrammatic overview of the government departments currently engaged in the campaign to end FGM across England.

The UK government is also in the process of amending the existing Female Genital Mutilation Act 2003 so that prosecutions can be made to prevent British citizens and residents living in this country from taking children overseas for the procedure. There are a series of amendments included in the Serious Crime Bill, which will strengthen the legal framework regarding FGM. The Serious Crime Bill is currently going through Parliament and is expected to become law in 2015. Should these changes become law, it will mean that the 2003 Act can capture offences of FGM committed abroad against UK residents, irrespective of immigration status. New laws will also allow for civil protection orders to be made where a girl or woman is identified at risk of FGM.

### Scotland

In Scotland, the FGM programme is managed under the Violence against women framework (further information, including fact sheets in a range of languages, can be found at [www.scotland.gov.uk](http://www.scotland.gov.uk)). A critical range of stakeholders are engaged in developing services, including data collection, learning about FGM and community engagement, as well as a recent initiative engaging head teachers (Scottish Government, 2014), where school education is seen as a key player in protecting girls who may be at risk. Further information on FGM in Scotland is also available from the Dignity Alert Research Forum (DARF) website ([www.darf.org.uk](http://www.darf.org.uk)).

### Wales

The Welsh government has an ongoing programme of work (WAG, 2013) developing a national training framework for key professionals across the public sector; as part of its work it is writing to all schools on the subject (WAG, 2014b). For health care professionals the work is led by the Chief Nursing Officer's office and supported by the Safeguarding Children Service, Public Health Wales.

### Northern Ireland

In Northern Ireland, the FGM programme of work is managed within safeguarding and the Department of Health, Social Services and Public Safety for Northern Ireland (DHSSPSNI) has recently published guidelines (DHSSPSNI, 2014). These guidelines provide a resource for contacts and specific guidance for Northern Ireland. There is growing expertise and understanding of the need to enhance services for women with FGM and key organisations are working to enhance service provision and awareness raising.

### International work

In 2014 the UK government's Department for International Development (DFID) appointed a consortium of leading anti-FGM campaigners to deliver a global campaign to end FGM within a generation. Known as the End FGM/C Social Change Campaign, the programme aspires to use a social change model that has a real impact on FGM practicing communities – and the consortium will also work across Africa to bring about a transformation in attitudes towards FGM and end the harmful practice.

## FGM procedures and health effects

Female genital mutilation (FGM) is a procedure that involves partial or total removal of the external female genitalia, or causes other injury to the female genital organs for non-medical reasons (WHO, 2014).

FGM may be conducted from shortly after birth to age 15 or young motherhood. The procedure may be performed in a clean, clinical setting but is often undertaken 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 and, following more extensive forms of FGM, their legs may be tied together for days to aid healing. Accidental damage, infection and haemorrhage are common, and long-term physical and mental health problems may follow if the child survives – death is not uncommon.

FGM offers no therapeutic benefit to women and girls, and is illegal in many countries including the UK. Some countries have legalised FGM on the assumption that it is safer if conducted within medical care, however this is contrary to WHO recommendations (WHO, 2008).

### Types of FGM

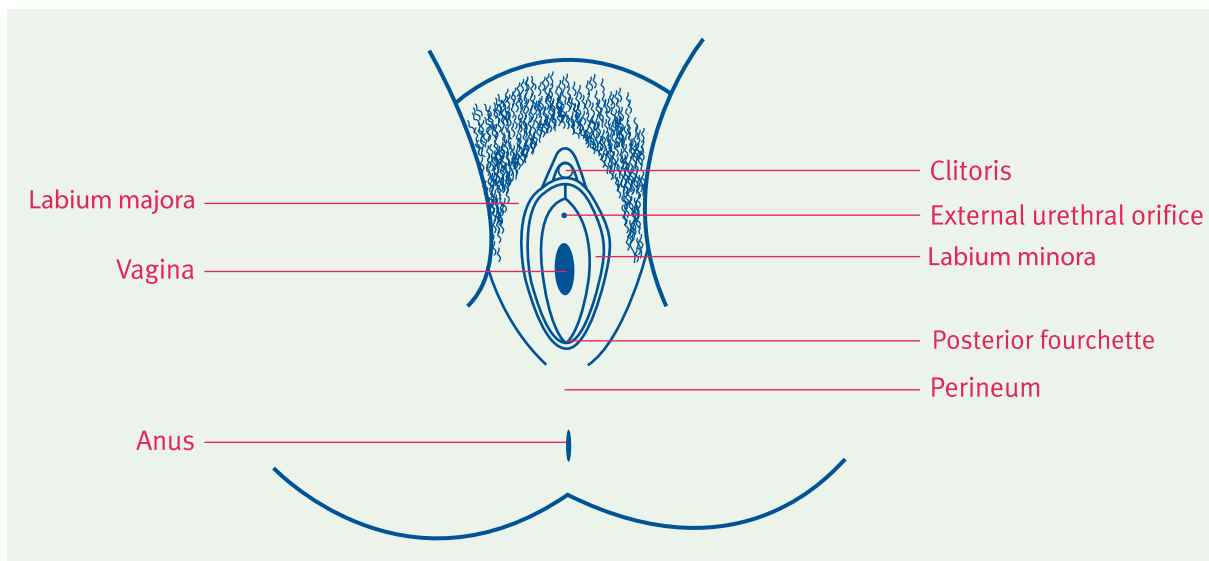
FGM is practised in different ways by different communities, and some forms are more extensive than others and cause greater health risks for girls and women. The WHO has categorised FGM into four types (see [figure 4](#)).

#### Figure 4 – WHO classifications: types 1-4

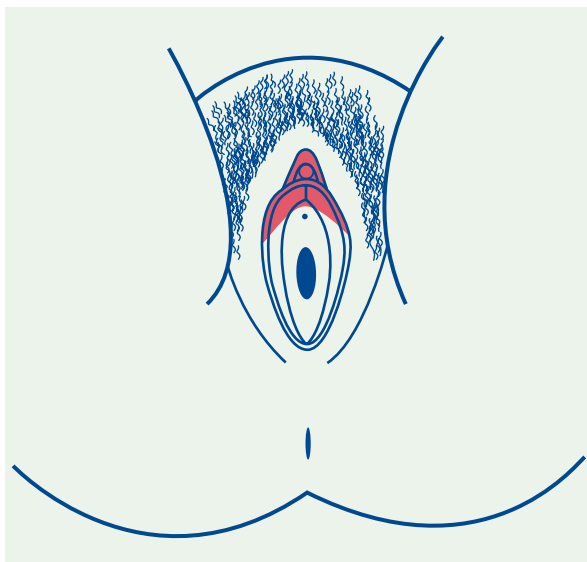
The WHO has developed four major FGM categories.

1. **Clitoridectomy:** the partial or total removal of the clitoris – a small, sensitive and erectile part of the female genitals – or the removal of the prepuce only – the fold of skin surrounding the clitoris, also known as the clitoral hood, rarely, if ever performed alone.
2. **Excision:** the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora – the labia are the ‘lips’ that surround the vagina). – see [diagram 2](#).
3. **Infibulation:** the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris – see [diagrams 3 and 4](#).
4. **Other:** all other harmful procedures to the female genitalia for non-medical purposes; for example pricking, piercing, incising, scraping and cauterising the genital area – see [diagram 5](#).

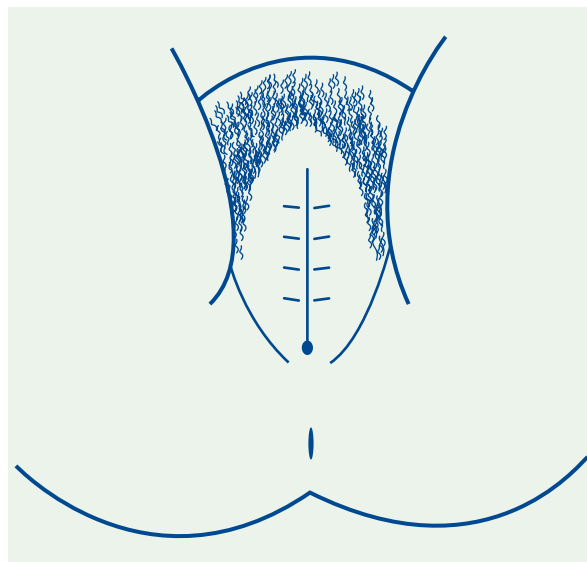
#### Diagram 1 – Normal external female genitalia



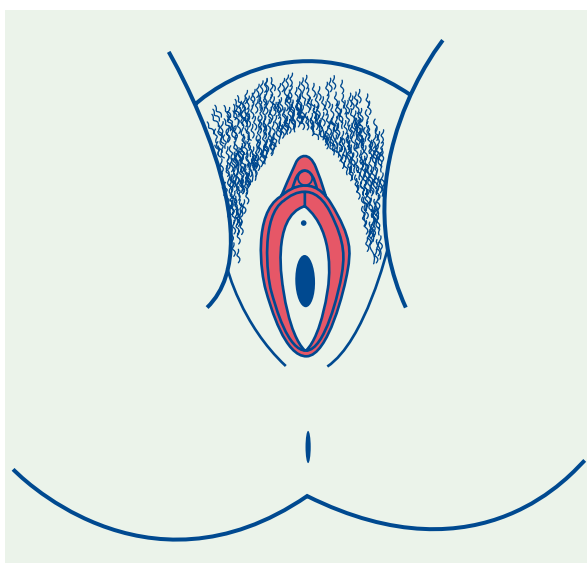
**Diagram 2 – Type 2 FGM**



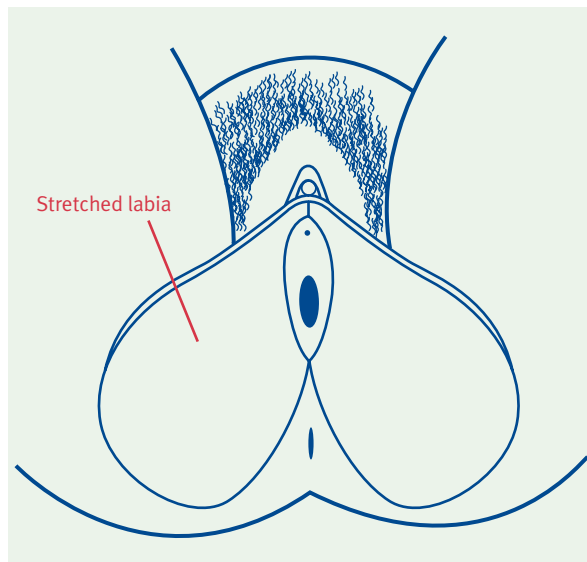
**Diagram 4 – Type 3 FGM**



**Diagram 3 – Type 3 FGM**



**Diagram 5 – An example of type 4 FGM stretched labia**





## Health risks and complications

The complications that may occur following FGM will depend on the type and extent of the procedure carried out and should not be underestimated. These are generally classified as:

- immediate (figure 5)
- intermediate (figure 6)
- long-term complications (figure 7).

### Figure 5 – Immediate complications

Immediate complications include:

- haemorrhage, pain, shock
- wound infection, septicaemia, tetanus
- urine retention
- injury to other tissues, for example, vaginal fistulae
- ulceration of the genital region
- bacterial or viral infections such as Hepatitis and HIV due to instruments being re-used without sterilisation
- death.

### Figure 6 – Intermediate complications

Intermediate complications include:

- delayed healing
- abscesses
- scarring/keloid formation, dysmenorrhoea and haematocolpus – obstruction to menstrual flow
- pelvic infections
- obstruction to urinary flow
- urinary tract infection.

### Figure 7 – Long-term complications

Long-term complications include:

- psychosocial trauma and flashbacks, post-traumatic stress disorder
- lack of trust in carers
- vaginal closure due to scarring
- epidermal cyst formation
- neuromata – benign tumours of nerve tissue that may arise from cut nerve endings and cause 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.

Serious illness and death can occur even when FGM is carried out by health professionals, 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. (2003) found 86 per cent 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 and their relationships. The physical difficulties, ongoing dyspareunia, infection, scarring and psychological problems may lead to infertility and consequent rejection of women by some husbands. The problems can continue for years.

Type 3 FGM 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 FGM) does not usually cause obstruction unless there was infection at the time of mutilation.

Neonatal problems occur primarily as a result of obstructed or prolonged labour which, if unchecked, can cause fetal distress, anoxia (lack of oxygen to the body's tissues) and fetal death.

The psychosocial trauma and post-traumatic stress caused by FGM cannot be underestimated; its impact is felt on the lives of women and their families. It is an area of practice that is increasingly becoming better understood and researched; a recent pilot study (Liao LM et al., 2013) demonstrated the critical need for further research in this area, in particular the requirement for psychological and psychosexual research to enhance service provision. It is also becoming more widely acknowledged that FGM has a detrimental impact on a woman's sexual pleasure, as well as her physical/sexual wellbeing.

The emergence of specialist clinics, such as those for children and those catering for the psycho-sexual needs of women affected by FGM, is a further demonstration of the advances being made in providing better services for women and girls. However, service provision should encompass a wide range of services required by women who have been traumatised by FGM – in particular, mental health, psycho-sexual services and counselling.

# Human rights, legal and professional responsibility

## A human rights issue

FGM is a violation of respect for, and the dignity of, girls and women subjected to this cruel practice; it is a clear form of violence against women and girls. The practice breaches fundamental human rights guaranteed by a multiplicity 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, the Convention has been incorporated into domestic UK 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 European Convention reflect, very closely, existing good professional practice. A failure of the state to fulfil its positive obligation to protect child and adult female rights in these circumstances, by prosecution or otherwise, could itself be open to challenge under 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 also 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* and the *Protocol to the African charter* (African Union, 2003).

## Legal aspects

FGM is illegal in a number of countries, even 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. This includes protection for those temporarily removed from the UK with the intention of inflicting harm on them.

### The UK legal framework

Two UK Acts of Parliament are relevant in respect to FGM:

- Prohibition of Female Circumcision Act (1985)
- Female Genital Mutilation Act (2003).

The 2003 Act applies to England, Wales and Northern Ireland; in Scotland, the Prohibition of Female Genital Mutilation (Scotland) Act 2005 applies. 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 concerns relating to girls being taken out of the country for FGM and the 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 re-enacted the above offences and created additional new offences, sending a strong message to communities practising FGM and practitioners involved in aiding, abetting, and/or counselling to procure, and performing FGM, that the practice is no longer acceptable in the UK even if performed in another country.

The main changes made were:

- it was 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, on a UK national or permanent UK resident, even in countries where the practice is now legal (Female Genital Mutilation Act, 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 was increased from five to 14 years’ imprisonment
- the term ‘mutilation’ is used instead of circumcision
- the term ‘girl’ includes ‘woman’
- 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 (although not an offence, consideration should be given to whether such self-harm is a safeguarding issue, especially where the action may be the result of adult pressure)
- it is now considered illegal to re-infibulate a woman following the birth of her baby, because this is seen as a form of FGM, within the WHO definition of FGM.

Despite this robust legislation, the intercollegiate report (RCM et al., 2013) considered the lack of prosecutions to date; there is evidence that the link between prosecutions and prevention is becoming increasingly recognised. There are renewed efforts among the police and others, including health professionals, to directly address the barriers to prosecution.

Following extensive evidence gathering, in July 2014 the Home Affairs Committee published its report on FGM (House of Commons Home Affairs Committee, 2014) which called for national action plan and highlighted a number of issues relating to:

- impediments to achieving prosecutions for offences against the law on FGM
- the need to revise the multi-agency guidelines on FGM to include the mandatory questioning on FGM for antenatal booking interviews and at GP registration, and a requirement for the personal child health record (also known as the PCHR or ‘red book’) to refer explicitly to FGM (House of Commons Home Affairs Committee, 2014)
- requiring all schools to provide training on FGM
- changes to the law on FGM, including the creation of FGM protection orders (similar to those for forced marriage).
- that the failure to report child abuse should become a criminal offence if other measures to increase the level of reporting are not effective in the next 12 months.
- better services for women and girls living with FGM.

This was contemporaneously published with a Ministry of Justice consultation on whether it was necessary to have a specific civil protection order, akin to the forced marriage protection order, that might provide an additional tool to prevent female genital mutilation and which could complement the existing criminal law (MoJ, 2014); this could also provide some anonymity for those giving evidence. In October 2014, the Ministry of Justice announced it would be implementing protection orders via the Serious Crime Bill currently going through Parliament.

This may have some impact on health professionals; for example, one of the questions asked is which ‘persons’ should be able to apply for an order to protect a potential victim of FGM.

The Serious Crime Bill (2014) seeks to extend the jurisdiction of the Female Genital Mutilation Act (2003). The changes mean the 2003 Act will capture FGM offences committed abroad by or against those habitually resident in the UK, irrespective of whether they are subject to immigration restrictions. Provided the offence is committed at a time when the accused person and/or the victim is resident in this country, it should not matter whether or not they intend to live here indefinitely or whether they also live elsewhere. These issues remain under discussion at the time of this document’s publication.

## Safeguarding now and for future generations

All health care professionals have a duty of care to girls and women at risk of having FGM performed, or who have been cut in the past. Their responsibilities include ensuring their practice is performed within the requirements of their regulators (for example, the NMC for nurses and midwives) and the overall legal framework of the country they practice in.

While the overarching legal issue related to FGM is its illegality, practitioners must also ensure they provide care and support that is consistent with safeguarding law and procedures. Professionals should be familiar with what to do if they are worried that a child is being abused, including the local child protection policies.

The current child protection policies in 2014 in UK countries are as follows:

- England – *Working together* (2013)
- Scotland – *National Guidance for Child Protection in Scotland* (2010) (refreshed in 2014)
- Northern Ireland – *Co-operating to safeguard children* (2003)
- Wales – *All Wales child protection procedures* (2008).

Safeguarding law provides the framework through which a girl or woman’s needs are assessed and her best interests considered. The welfare of the child is paramount, according to the Children Act (1989) which allows legal action to be taken. However, legal measures may not be appropriate if protection can be achieved without these; 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 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.

All regions and countries in the UK have in place procedures for safeguarding children, young people and vulnerable adults, and all practitioners must ensure they are confident in using them in their practice.

The NMC website ([www.nmc-uk.org](http://www.nmc-uk.org)) contains safeguarding guidance and information on how to raise and escalate concerns and apply safeguarding principles in nursing and midwifery practice. Similarly, the UK government’s Children’s Services provides online information and resources on safeguarding ([www.gov.uk](http://www.gov.uk)) and the RCN has produced guidelines for nurses around safeguarding children and young people (RCN, 2014).

Mather’s narrative in [appendix 2](#) demonstrates the importance of collaborating with teachers and social service colleagues, as well as working with affected community groups. The police may also need to be involved, especially in an emergency. Where relevant, immigration officials and legal advisers may be involved, because the risk of FGM has been successfully used for claiming asylum (FORWARD, 2014). Where a criminal act has been perpetrated the police must also be involved, either directly or through social services.

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 believe FGM is the right thing to do and consider it is in the child's best interest, and adults may find it difficult to understand why the authorities should intervene in what they 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 a husband and wife may have differing views about their daughters.

The desire 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 it is important to 'think the unthinkable', and act with 'respectful uncertainty' (DH, 2003).

Four specific issues are important in this context:

1. FGM is an illegal act; regardless of their age, a girl or woman has the right to protection from activities or events that may cause her harm. These rights (UN Convention on the Rights of the Child) are enshrined in UK human rights legislation and is reflected in other laws, including the Children Act 2004 (England and Wales), Protection of Children Act (Scotland) 2003 and the Children (Northern Ireland) Order 1995. These rights and protections are in addition to other legislation that criminalises the practice of FGM.
2. The need to safeguard children and young people involved in FGM.
3. The risk to girls where a related adult has undergone FGM.
4. Situations where a child may be removed from the country for the purposes of performing FGM. 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 a prohibitive steps order made by social services will suffice.

Whenever there is concern that a girl is at risk of harm through FGM, steps must be taken to safeguard them. If she 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're worried a child is being abused* (HM Government, 2006).

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 girl 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 a need to approach social services first with suspicions. 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. Social services should also alert families to their right to seek independent legal advice should they wish to appeal against any specific interventions.

The Department of Health has also announced that a new framework – developed in conjunction with professional bodies, Royal Colleges and the Department for Education – will be published to guide professionals dealing with girls at risk of FGM from birth onwards, so that NHS staff will know how to respond to FGM safeguarding concerns (DH, 2014).

All professionals coming into contact with children and young people have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about safeguarding issues,



including child protection. The publication *Safeguarding children and young people: roles and competences for health care staff* (RCPCH, 2014) provides extensive details on competences, skills and attitudes which should be embedded in all levels of practice and contact around safeguarding.

Across the UK, specialist safeguarding/child protection professionals provide expertise and have specific roles and responsibilities in safeguarding children. In England, Northern Ireland and Wales, named and designated professionals perform this function while in Scotland nurse consultants, child protection advisers and lead clinicians fulfil specialist roles (RCN, 2014). A sample child protection procedure provided by NHS England (London) is included at [appendix 3](#).

# Service provision and multi-agency working

## Communication

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. Some of these women may not have seen female genitalia which has not been mutilated therefore it may be useful to show diagrams of both for comparison.

Initiating the conversation can be challenging for many health care practitioners and so framing it in the context of “have you ever been cut or had any form of surgery or piercings?” may be a useful opening question to encourage further discussion.

## Multi-agency working

While raising awareness and creating cognisance of FGM are critical in the fight to eradicate the procedure, there also needs to be adequate and well considered services to support best practice; whether that is safeguarding, data collection, physical and psychological care, and training and education. A key characteristic of high quality safeguarding is multi-agency working and managing FGM similarly depends on this; work needs to reflect local need, and extend across health and social care, as well as education and the police forces.

This publication is focused on the needs of nurses and midwives, but providing the best care for women and girls affected by FGM must include working alongside other agencies involved in safeguarding. Safeguarding

is everybody's business and should not be left to those who may lead services in this crucial area of work.

FGM is an issue where multi-agency teamwork and communication is vital. All services should be open, offer flexible access and there should be cohesive collaboration between agencies. Women may be 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 may believe practitioners have limited awareness of FGM or may respond in a negative manner. Nurses and midwives should 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.

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.

## Service provision

A seamless service for women and adequate protection for girls at risk depends on integrated working 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 will need to know from whom they should seek help and advice and the steps to take to provide appropriate support. This means clear, well understood and rehearsed guidelines must be in place. 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.

Health care managers and commissioners should focus on access to and provision of:

- clear guidance to employees
- education and training for all, preferably across agencies, as well as specific to health care
- clear lines of communication with others such as education, social and law enforcement services.

Many of the 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 women and girls who have been subjected to FGM, and may need further support and changes to established service delivery.

Women and children who have been mutilated may need access to services such as:

- counselling, psycho-sexual 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
- access to an 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 essential that women are not reliant on family members for interpretation when dealing with health care professionals; children should never be used for interpreting purposes
- specialised maternity advice services.

It is also important for women and girls to have access to specialist services. A growing number of specialist clinics are becoming available across the UK and all nurses and midwives, particularly those working with women and children, families and communities, should have the appropriate specialist skills to work effectively with this client group.

## Health visitors, school and community children's nurses

Health visitors, school and community children's nurses (CCNs) have a responsibility to ensure families know that the practice of FGM is illegal and are in an ideal position to act if they consider a girl or young woman is at risk. FGM may be carried out secretly in the UK, but it is more likely that a girl or young woman 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 a school holiday, although approaches will vary from one community or ethnic population to another.

It is therefore essential that those coming into contact with girls and young women have detailed knowledge of local communities and social structures, whilst engaging with them to really understand what is important to them, as well as being aware of the safeguarding responsibility.

Health visitors work closely with families in their homes and have a key role to play in 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 and engage in support and referral as part of a multi-professional team. 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 individuals are at risk. 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.

Behavioural changes may indicate a risk of harm, 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.

This includes being aware of the possible true purpose of a girl's visit to the family's country of origin. Older girls and siblings may also 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 safeguarding and legislative procedures.

While it is not the responsibility of individual practitioners to undertake investigations, they should be alert to considering FGM among general assessments and know who to refer concerns to. The concept of making every contact count (RCN, 2014) has been expanded in recent years, and FGM is one of the issues that should be considered. Where suspicion has been established a risk assessment needs to take place, be actioned and then documented. Figure 8 provides questions which may help with the risk assessment process, although each local area should have such systems in place that are understood by all frontline personnel who are likely to come in contact with women or girls affected by FGM.

**Figure 8 – Questions to consider when undertaking a risk assessment**

- Do I need to consider FGM here?
- Where does the woman/girl come from originally?
- Has she ever been cut or had any form of surgery or piercings?
- Is the girl/woman a victim of FGM?
- Is the girl at risk of FGM?
- Does she have daughters under 18 years of age?
- In discussing attitudes to FGM, do you conclude that it is more likely or less likely that she will subject her daughter(s) to FGM?
- Are there any plans to travel to a country where FGM is prevalent with her daughter(s)?
- Does she have sisters/other female relatives who have undergone FGM?

## Community, practice and travel nurses

Community and practice nurses, who have access to women in the community or home setting may note information leading them to think that girls may be at risk, such as the behavioural changes identified above. It is equally important for nurses working in travel, clinics or who come into contact with women who are travelling abroad to be vigilant, for example around passport authorisation.

## Acute sector nurses

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. It is important to be able to respond appropriately in the best interests of any girl or young woman who may be at risk of abuse, or who may have already been mutilated.

## Midwives

Midwives are most likely to encounter women who have been mutilated, and it is important to ask the question during pregnancy to ensure a safe birth and postnatal care for both mother and baby. Maternity services, especially where there are known FGM practicing communities, will have specialist midwives who take the lead on supporting these women and their colleagues in better understanding the issues surrounding FGM.

Midwives may also be concerned where baby girls are born to women who have had FGM performed, and this will naturally require a sensitive approach. There are differing views at present on whether this puts the girl at risk, but child protection must remain paramount. Documentation of conversations and concerns are vital to ensure better continuity of care going forward. However, if there are any concerns then further action is essential and can be carried out via safeguarding leads. Equally, midwives may also become concerned about a girl being at risk while attending a family for the birth of a subsequent child.

## Figure 9 – Identifying girls 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
- the woman or girl has limited contact with people outside of her family
- the paternal grandmother is very influential within the family
- the woman 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
- the woman has strong links with country of origin, family remaining in country of origin/ frequent travel to country of origin.

Adapted from the Foundation for Women's Health, Research and Development (FORWARD) training pack, 2006

crucial that the focus is kept on the best interests of the child as required by law.

The NMC (NMC, 2010) is clear about professional responsibility, in particular around 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 these:

- 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 an order of court.

## Referral to appropriate agencies

Caring for girls and women affected by FGM is not the primary responsibility of one professional group; it requires multi-agency management and nurses and midwives need to be aware of local procedures for referral where safeguarding is a concern. It is also important to understand local structures and services which may benefit a woman or girl who has physical, psychological or psycho-sexual complications as a result of being mutilated.

Knowledge of local support groups or campaigns can be invaluable additions to the toolkit required to support best practice.

## Confidentiality

To safeguard children and young people 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, but both the law and policy allow for disclosure where it is in the public interest or where a criminal act has been perpetrated or a child is at risk. 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 a perception that passing on information can damage the relationship of trust built up with families and communities. Nonetheless, it is

## Education, raising awareness and conscious engagement to change

Raising awareness and consciousness about the practical, socio-cultural, ethico-legal, sexual health and practice care implications involved in FGM is essential, if real change is to happen.

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 women (and their communities) with their full participation.

The RCN believes that FGM should be a part of health education in all pre-registration and post-registration programmes for nurses, midwives and health visitors. It is also important for all registrants to ensure they are adequately prepared to provide effective practice in respect of FGM, in line with the NMC code (NMC, 2010). It is equally essential to raise awareness and the seriousness of the issues among teachers, school nurses and social service staff, as well as qualified nurses and midwives. There are increasing opportunities locally and nationally for access to appropriate education, dependant on the expected level of engagement in the subject by health professionals. A recent news report noted that nursery staff in London are being trained to spot the signs of female genital mutilation amid concerns that girls are being cut at increasingly younger ages to avoid detection (Evening Standard, October 2014).

The Department of Health has also commissioned Health Education England to produce six new e-learning training sessions. These will be provided on the national eLearning for Health platform, available free to all NHS trusts. The first of these was launched in December 2014 (available at [www.e-lfh.org.uk/programmes/female-genital-mutilation](http://www.e-lfh.org.uk/programmes/female-genital-mutilation)) and focuses on an introductory module for all health care staff.

As FGM is a safeguarding issue, it should be integral to all safeguarding training and annual updates to ensure all health care personnel have contemporary knowledge and a good understanding of identifying and referring any cases they come in contact with.

The case study scenarios contained in figure 10 may help with the initiation of professional conversations relating to FGM and may enable individual nurses and midwives to consider how they might manage situations that may arise.

### Figure 10 – Case study scenarios

1. A young girl who had already been 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?
2. A young girl is about to go on holiday to her country of origin. She has told 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 has become concerned and suspects that the six-year-old would be circumcised:
  - as the school nurse, how might you become involved and what would you do?
3. 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?



# Practice matters and procedures

## Professional curiosity and assessing need

Nurses and midwives need to be aware of how to sensitively 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. Equally, health professionals need to be curious about their local community to understand their needs and to actively engage with women to fully understand the community perspective on challenging issues such as FGM. Continuity of care and a holistic attitude to care provision will all support best practice.

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 can be very difficult or impossible to pass a urinary catheter. Nurses and midwives need to be compassionate and caring, exhibiting a sensitive manner, and be prepared sufficiently so that they do not exhibit signs of shock, confusion, horror or revulsion on seeing the genitalia.

*Making Every Contact Count* is a fairly recent programme, focused on improving the lives of all those who come in contact with health care professionals, and is an ideal opportunity to develop a relationship with women and their families and to gather information about issues such as FGM. It is intended to create opportunities within existing health consultations to make every contact with a health professional count towards increasing health and well being awareness. Further information on *Making Every Contact Count*, public health topics and nursing roles is available from the RCN website at [www.rcn.org.uk](http://www.rcn.org.uk).

Despite the need for sensitivity, it is important to ask women whether they have been cut or circumcised.

Some may seek help because they wish to have the FGM reversed before marrying, or may be experiencing problems conceiving because of difficulties with penetration and need to be referred to appropriate specialist clinics.

A deinfibulation service should be available, should be well-advertised via women's groups, and be 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 deinfibulation 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 could lead to serious infection.

## Knowledge about diversity

In our multi cultural and multi ethnic society, self-awareness and knowledge of diversity are essential skills for all health care professionals, enabling them to provide high quality individualised care. Concerns frequently articulated when giving reasons for why it may be difficult to engage with girls and women who need safeguarding because of FGM is not wishing to appear to act in discriminatory ways or from racist motivations.

FGM is mostly found in Africa, the Middle East and Asia, and while cultural sensitivity to the girl, woman and her family is always paramount, it should not override the safety or wellbeing of individuals. The inquiry report into the death of Victoria Climbié clearly notes the danger of making assumptions about cultural background that conflict with ensuring children's safety (House of Commons Health Committee, 2003). Lord Laming noted 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”

Health of Commons Health Committee, 2003

Although the Laming inquiry relates to very different circumstances to FGM, comments made in the report are useful to review and the 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’.”

Health of Commons Health Committee, 2003

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.”

Health of Commons Health Committee, 2003

On the subject of being accused of being prejudiced, and with reference to Lord Laming, Yana Richens OBE writes:

“Practice nurses, and all nurses and midwives who come in contact with women and girls in the community should take the opportunity to discuss with families who are requesting a passport for their female child to take them overseas to countries known to practice FGM. This should be recorded in the notes of the parent/guardian that they were informed regarding the legal consequences of FGM; it should also be recorded in the child’s health records. Nurses or midwives must not worry or be

concerned about being called racist due to stereotyping of certain cultures as this is clearly not the intent. I would rather be called racist and prevent this horrendous act being performed on one more child than to do nothing.”

Richens, 2014

## 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 be necessary to ask about FGM as they may not volunteer the information.

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. Teenagers may need extra support, and there may be safeguarding issues to be addressed.

Reversal or deinfibulation (which is considered a better term to describe this process, because it is not possible to reverse the consequences of FGM), is best performed before 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 and 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. It will also reduce the risk of fetal asphyxia or stillbirth if a woman progresses unaided to the second stage of labour.

Surgical deinfibulation should be offered where appropriate. Partners should be involved in decision making when the woman is willing for this to happen. It is important to work out an agreed 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; therefore 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. The midwife should always assess the need for an elective episiotomy in labour.

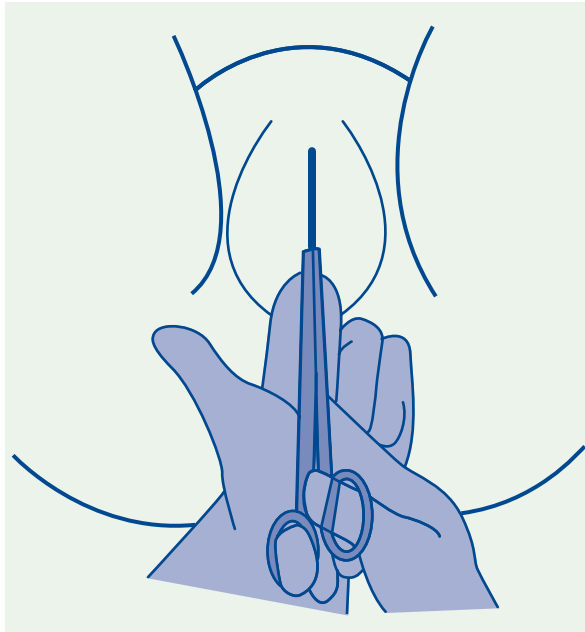
It must be noted, however, that women may be reluctant to undergo deinfibulation until labour commences, because this may be normal practice in their country of origin. This reinforces the importance of careful and sensitive explanation in pregnancy of why antenatal deinfibulation is preferable. It also 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 deinfibulation in pregnancy.

The aim of deinfibulation is to restore normal anatomy as far as possible, which may be very limited depending on the damage caused originally. 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 first stage of labour once the presenting part is low.

Principles of good practice include:

- adequate pain relief (general, regional or local anaesthesia) is essential; non pregnant women may prefer to have general anaesthesia because the procedure can bring back very traumatic memories of when they were cut
- using aseptic techniques following cleansing of the vulval area; also pay careful attention to hand washing 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 may include 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, an episiotomy may be needed
- provide advice on good personal hygiene, especially 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 may appear heavier because of the removal of the scar-tissue barrier.

The deinfibulation procedure is illustrated in [diagram 6](#).

**Diagram 6 – Cutting open the scar**

## Care in labour

Principles of good practice include:

- normal care is required during the first stage of labour; usual sensitivity is essential
- there is no need to pass a catheter unless the woman is unable to pass urine
- deinfibulation may need to be carried out during the first stage of labour
- 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 acceptable to reinfibulate or stitch the woman back closed after the birth.

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. If the second stage has already been reached, a midline incision must be used.

### Suturing a laceration or an episiotomy

It is of course important to repair a laceration or episiotomy, to stem the bleeding. If the woman did not have a deinfibulation during the antenatal period, midwives often perform an anterior episiotomy and this will require careful repair. The key is to ensure that both the urethra and introitus are able to be seen following repair.

Re-suturing or reinfibulation or closing should not be considered or offered. 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 (Momah, 2005).

It is necessary to follow up with the woman during the postnatal period. 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 most important points to remember are to:

- ensure early identification – during antenatal booking or first visit
- arrange for deinfibulation during the first stage of labour with adequate pain relief
- support the woman with sensitivity
- notify her health visitor, GP and other professionals if the baby born is a girl, with regard to safeguarding the child; this is also to provide ongoing information and support to the family
- continue to provide postnatal support
- consider referring to an organisation that can offer additional support and information.

Figure 11 contains case studies that may help with considering the issues which may arise in practice.

### **Figure 11 – Case studies**

#### **Case study 1**

A midwife helped a woman to give birth who had undergone type 3 FGM. Following the birth, the midwife is confronted by the woman's husband asking that she reinfibulate his wife, 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?

## Conclusion

FGM is a global and national issue, although significant progress has been achieved, there are many challenges ahead that must not be underestimated. In many cities across the UK there are pockets of good practice, support groups and professional expertise which is well established and accessible. Nevertheless, there is a continuing need to extend services and provide resources to accommodate the needs of women, girls, families and communities to support their health and wellbeing.

Education is a critical tool in the fight to change attitudes to FGM and eradicate this violence from society; teaching about FGM and its consequences should be imbedded in school education, as well as pre- and post-qualifying education for all those involved in caring for girls and women.

Women and girls who have been abused need particular and sensitive support, together with access to facilities to help them with the physical, psychological and social consequences of this potentially devastating abuse. All professionals, practising communities and the public have a role to play in this social change towards eradication. 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.

FGM also demands professional curiosity and awareness by those who come in contact with girls and women, including those health care professionals who may themselves have come from FGM practicing communities. A further challenge for many is to consider how awareness raising can be enhanced simply by voicing concerns, speaking to colleagues and engaging in the campaign to end this violation of basic human rights. This should also include being sensitive to how students or colleagues may react to learn that such mutilation takes place. Nurses and midwives have a role to play by being politically engaged in movements that impact on care, and this is particularly so with FGM.

FGM is a complex issue and requires vigilance, as well as continuing engagement with the changing scene of caring for girls and women who may be at risk or may have been mutilated by FGM.

Tackling FGM requires a multi-agency approach and response through a recognised pathway that supports quality, evidence-based care and safeguarding. It is the responsibility of all nurses and midwives, working both in city and rural locations, to recognise FGM as abuse and to know who their local contacts are for support, training and action should they have a concern.



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# FGM support services in the UK

Acton African Well Women Centre  
Acton Health Centre 35 – 61 Church Road  
London W3 8QE  
Tel: 0208 383 8716; 07730 970738

African Well Women Clinic  
McNair Centre  
Guy's and St Thomas' Hospital  
St Thomas Street  
London SE1 9RT  
Tel: 020 7955 2381

African Well Woman's Clinic  
Northwick Park and St Mark's Hospital  
Watford Road, Harrow  
Middlesex HA1 3UJ  
Tel: 020 8869 2870

African Women's Clinic University College Hospital  
Clinic 3, Elizabeth Garrett Anderson Unit  
Euston Rd  
London WC1E 6DH  
Tel: 020 7380 9300

African Women's Clinic  
4 Carol Street  
London NW1 OHU  
Tel 020 7482 2786  
[admin@women-and-health.org](mailto:admin@women-and-health.org)

African Women's Health Clinic  
Whittington Hospital, Level 5  
Highgate Hill, London N19 5NF  
Tel: 020 7288 3482

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

Bristol Community Rose Clinic  
Lawrence Hill Health Centre  
Hassell Drive  
Bristol BS2 0AN  
Email: [bristolrose.clinic@nhs.net](mailto:bristolrose.clinic@nhs.net)  
Tel: 07813 016911

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 Departments  
369 Fulham Road  
London SW10 9NH  
Tel: 020 8746 8000

Central Health Clinic  
1 Mulberry Street, Sheffield S1 2PJ  
Tel: 0114 271 8865

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 Departments  
Praed Street, London W2  
Tel: 020 7886 6666

## Organisations and support groups

### England

Agency Culture and Change Management  
The Old Corners Court  
14/18 Nursery Street  
Sheffield S3 8GG  
Tel: 0114 275 0193  
[www.accmuk.com](http://www.accmuk.com)

Black Women's Health and Family Support (BWHAFS)  
82 Russia Lane  
London E2 9LU  
Tel: 020 8980 3503  
[www.bwhafs.com](http://www.bwhafs.com)  
[bwhfs@btconnect.com](mailto:bwhfs@btconnect.com)

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

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](http://www.womanbeing.org)

### Northern Ireland

Bryson Intercultural Centre  
9 Lower Crescent  
Belfast BT7 1NR  
Tel: 028 9024 4639  
[www.mcrc-ni.org](http://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](http://www.nicem.org.uk)

### Scotland

International Women's Centre  
49 Lyon Street  
Dundee DD4 6RA  
Tel: 01382 462058  
[www.diwc.co.uk](http://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](http://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](http://www.scottishrefugeecouncil.org.uk)

Dignity Alert & Research Forum (DARF)  
UN House, 4 Hunter Square  
Edinburgh, EH1 1QW  
Tel: 07583 434602  
Email [dignityalert@hotmail.co.uk](mailto:dignityalert@hotmail.co.uk)

Saheliya  
125 McDonald Road  
Edinburgh EH7 4NW  
Tel: 0131 556 9302  
Email: [info@saheliya.co.uk](mailto:info@saheliya.co.uk)



## Wales

Bawso  
9 Cathedral Road  
Cardiff CF11 9HA  
Tel: 029 20 644633 or 24 hour helpline 0800 7318147  
[www.bawso.org.uk](http://www.bawso.org.uk)

Central African Association  
11 Richmond Road  
Cardiff CF24 3AQ  
Tel: 029 2045 9945

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](http://www.mewn-cymru.org.uk)

SPA Somali Advice and Information Office  
68 James Street  
Cardiff Bay  
Cardiff  
Tel: 029 2049 9916

Welsh Refugee Council  
Phoenix House  
389 Newport Road  
Cardiff CF24 1TP  
Tel: 029 2048 9800  
[www.welshrefugeecouncil.org](http://www.welshrefugeecouncil.org)

## National and international groups

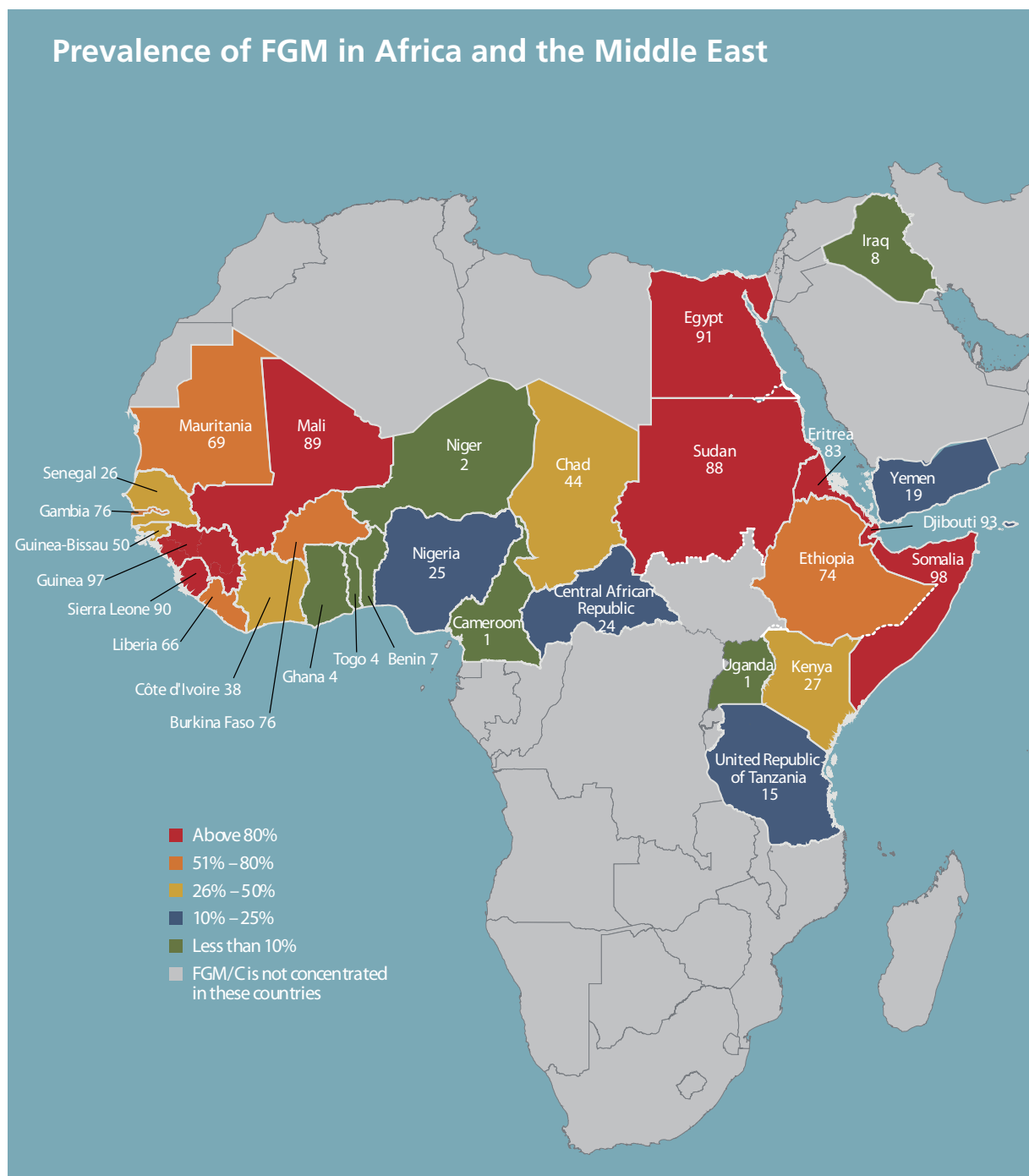
FGM National Group  
[www.fgmnationalgroup.org](http://www.fgmnationalgroup.org)

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](http://www.forwarduk.org.uk)  
[forward@forwarduk.org.uk](mailto:forward@forwarduk.org.uk)

# Appendices

## Appendix 1

### Map showing the global distribution of FGM



UNICEF global databases, 2014, based on DHS, MICS and other nationally representative surveys, 2004-2013

## Appendix 2

### The Bristol story

The Bristol model for FGM has its roots in many different areas. The main focus started when a school nurse and teacher began working in partnership to consider the needs of their school community. In 2006, they attended training which explored faith and cultural issues and the impact of these on the child protection agenda. The event marked a turning point for the professionals, who began to ask questions to see if they could identify if FGM had taken place or a child was at risk of having FGM. They found that the more they asked, the more they discovered – and the more cases they identified.

Some parents were considering FGM for their daughters but were unaware of UK law or the related health implications associated with FGM. The teacher and nurse began to refer cases to social care and the police, and soon realised they were becoming to be seen as local experts.

The school nurse realised she was picking up health concerns in girls who had FGM. These girls and their families had been seeking health care; however, the health departments were not always aware of the associated issues. For example, one indicator was recurrent urinary tract infections. No one was asking the question; ‘Have you been cut, circumcised or had FGM?’

There were also pockets of professionals and some community members working locally to end FGM, but there was no co-ordinated city-wide approach.

The school health nurse and teacher approached the Local Safeguarding Children’s Board for support and to increase the co-ordination of work related to FGM. A multi-agency group developed guidelines to support professionals in recognising and managing suspected or known cases of FGM. These guidelines examined the risk to women and girls from FGM, the need to develop a health promotion strategy and how to effectively safeguard those at risk.

Midwives also developed guidance to ensure a consistent approach that was fair and recognised the cultural needs of the women. The guidance was endorsed by women who were campaigning to raise awareness within their community that FGM is illegal, is not a religious requirement and can be harmful to the woman and her unborn baby.

Both these guidelines referenced professional guidance provided by Royal Colleges such as the RCN, RCM and BMA. Multi-agency and single-agency training was set up and priority groups were identified – considered key in educating families about the risks of FGM and highlighting the legal and child protection issues. The groups identified included midwives, health visitors, GPs, school health nurses, practice nurses, emergency departments, and obstetrics and gynaecology staff.

Systems were set up for effective information sharing which evidenced families had been given information and to ensure other professionals continued the health promotion work by reinforcing the message at major consultations. These include maternity care, immunisations, foreign travel, health checks, cervical cytology, sexual health counselling and support, family planning and PSHE training within school.

Working together with communities affected by FGM and other agencies, health professionals can raise awareness and end FGM. The Bristol model is a way of working in partnership; listening to the needs of those affected, developing services to meet their needs and always responding to the wider safeguarding issues, by recognising the risk to the child being seen while considering the risk to their siblings and their wider family network.

The main areas of learning from the Bristol model are to engage the community, listen to the voice of young people, ensure adequate training; how to recognise FGM and respond appropriately to safeguard girls at risk. Partnership working with other agencies helps

embed understanding of FGM in all practices, so it is sustained and is not the responsibility of one or two who may move on or leave. Key to success is raising awareness in affected communities so they understand the health professionals' duty to safeguard and protect.

Jacalyn Mathers, Designated nurse safeguarding children, Bristol CCG

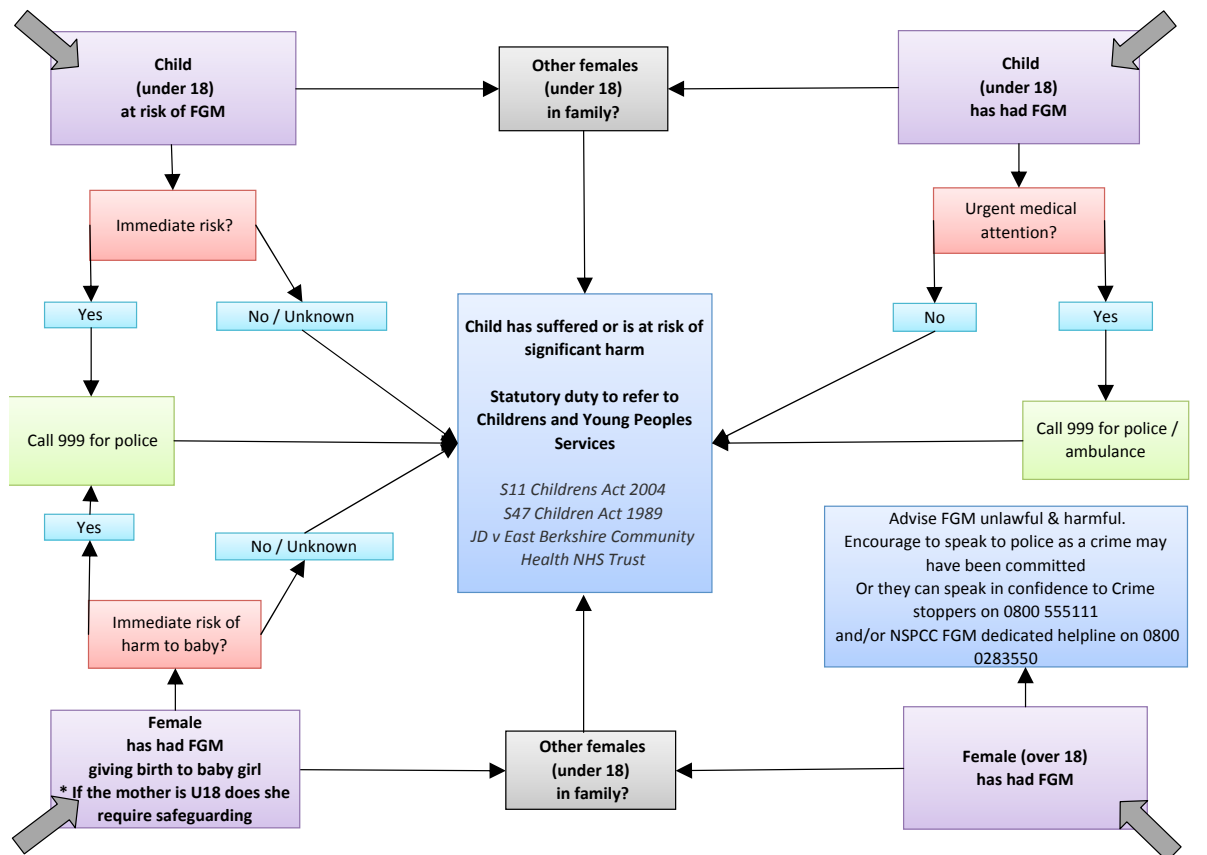
Further information on the Bristol model is available at [www.bava.org.uk](http://www.bava.org.uk)

## Appendix 3

### An example of safeguarding and protection procedures – London

#### Safeguarding Girls at Risk of Female Genital Mutilation (FGM)

"All procedures involving partial or total removal of outer genitalia or any injury to female genital organs for cultural or non-medical reasons" (World Health Organisation)



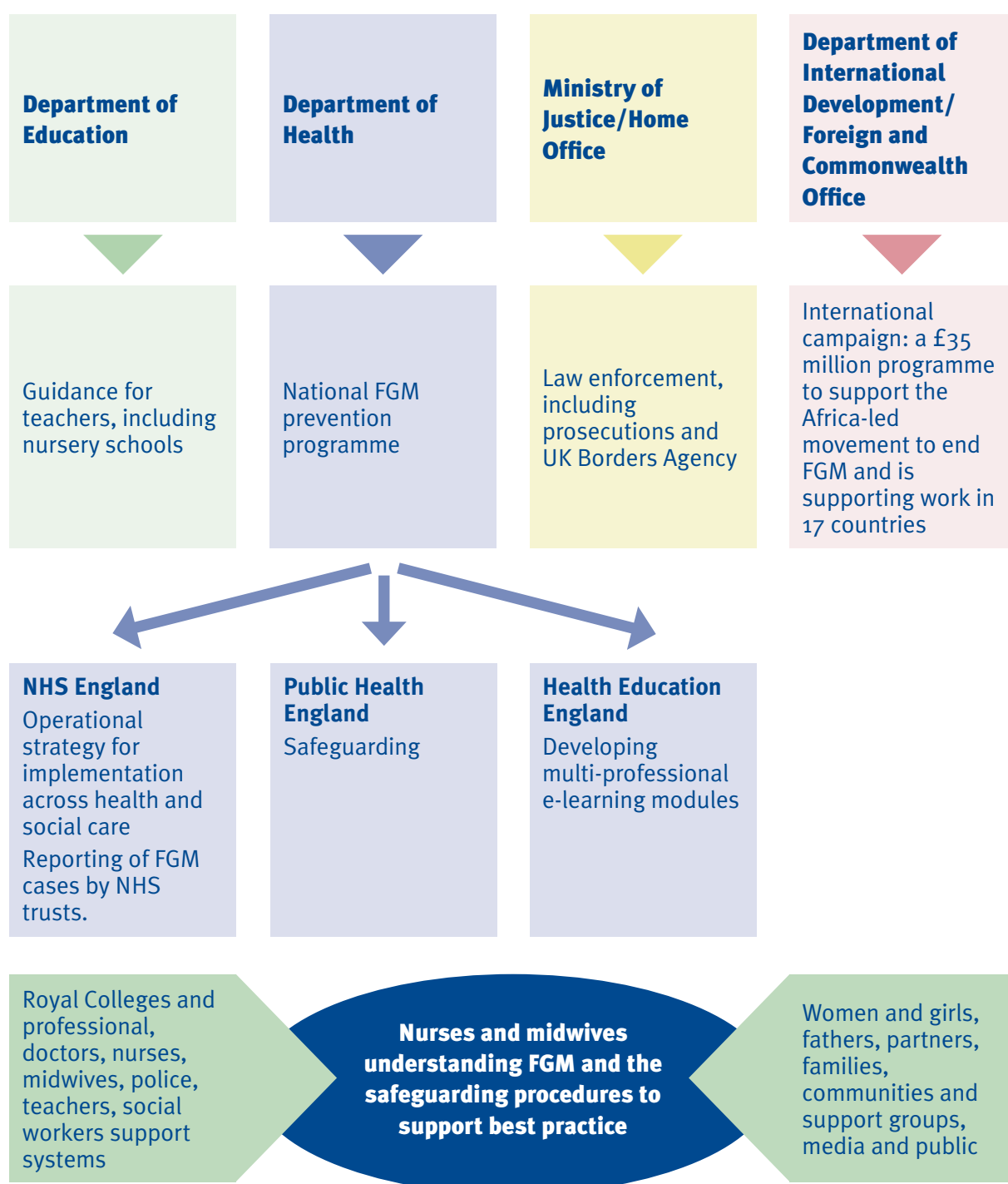
*If a colleague is suspected you must contact the medical director immediately*



Significant harm is any physical, sexual or emotional abuse, neglect, accident or injury that is sufficiently serious to adversely affect progress and enjoyment of life.

## Appendix 4 Tackling FGM in England

Diagrammatic representation of how government departments and NHS in England work working together to ensure all nurses and midwives understand their role, and work collaboratively across different agencies to best support women and girls affected by FGM.





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