

Female Genital Mutilation (FGM)

A handbook for Health Care Professionals

Edited by

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Female Genital Mutilation: A Framework

Introduction

Having worked as a midwife for over twenty years, both in the hospital setting and in the community, I was inspired to explore the knowledge around Female Genital Mutilation (FGM) amongst health care professionals in primary care by one incident: my first, vivid experience of having to deal with FGM. A woman in labour presented herself in the delivery ward, ready to have her baby; she had undergone the most severe form of female circumcision, had very little antenatal care and needed a reversal in order to be able to give birth. I had never done a reversal before, nor had I ever received training on FGM.

As Brent and Harrow are culturally diverse communities, health care professionals in both primary and secondary care need to understand the needs and beliefs of our patients, including those women who have undergone FGM. This requires great sensitivity and awareness. It is our role as health care professionals to provide a service that is equitable and meets the needs of the communities we serve.

However, where a traditional practice represents a hazard to health it becomes obvious that health professionals need to be aware of the implications for both secondary and primary care, enabling them to support, manage and refer appropriately. Clinical guidelines for managing women who have undergone FGM are essential in providing such appropriate and culturally competent care (Nour 2004).

Health care professionals need to understand both the physical consequences of these procedures and the cultural issues surrounding them in order to provide the sensitive care required to meet these women's needs (Daley 2004). Such a framework would enable practitioners to recognise the type of circumcision; ensure cultural competency and provide the appropriate clinical care. Current guidance from the ethics department of The British Medical Association (BMA) supports the basic principles of raising awareness surrounding health and legal issues, and the services and sources of information that is available to communities that practice female genital mutilation .

Seeking to establish a framework for the identification of those women at risk, and referral procedures for those who have already undergone such a procedure, the issues surrounding FGM were explored through a field study of general practitioners and practice nurses, aimed at ascertaining their level of knowledge regarding FGM and providing clear referral pathways. Three FGM seminars were organised over two years in Brent and Harrow, with distinguished speakers, including Mr. Harry Gordon, Comfort Momoh and Adwoa Kluitse who shared their expertise: this

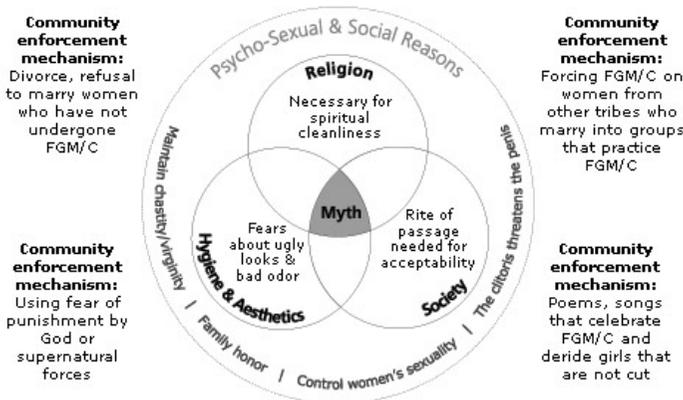
evolved from this exercise whilst writing dissertation for my MSc in 2003 and a runner up for Mary Seacole Award.

In the first section I provide an overview of the historical and Socio-Cultural Context of FGM showing how the practise is embedded within communities, before going on to detail its occurrence today; in the second I examine what FGM actually is, and provide the World Health Organisation's (WHO) classificatory schema and some facts and figures regarding rates of occurrence. In section three I outline the main health consequences of FGM. Next I examine how FGM has shifted from being regarded primarily as a health issue to that of being a Human Rights issue, before looking at the position of FGM within UK law. Finally, I examine the role of the health professional in the recognition of those at risk of FGM and providing clear referral procedures and guidelines.

Part One: The Historical and Socio-Cultural Context of FGM

The precise origins of FGM are unknown, but the practice of FGM dates back 200 B.C(El Dareer 1983) although in many parts of West Africa, the practice began in the 19th or 20th century (Duncan & Hernland 2000). Some scholars claim that it originated in the Nile Valley during the Pharaonic era and dates back to 400 years (Gilbert 1993).

Irrespective of how, where or when the practice began, those who practice it share similar beliefs, or 'mental maps', that present compelling reasons for why the clitoris and other external genitalia should be removed (Mohumad 1997). However, the details of these mental maps vary across countries so it is important for health care workers to understand these differences in order to be able to deliver a culturally sensitive and refer- support ral sys-



Source: adapted from: Asha Mohamud, Nancy Ali, Nancy Yinger, World Health Organization and Program for Appropriate Technology in Health (WHO/PATH), FGM Programs to Date: What Works and What Doesn't (Geneva: WHO, 1999): 7.

Diagram one: a conceptual framework for understanding the role of FGM for those communities in which it is found.

FGM is deeply embedded in local traditional belief systems for various reasons (Koso-Thomas 1987):

- Faithfulness: to ensure that women are virgins at marriage and remain faithful to their husbands .
- Chastity: to suppress female sexuality and to ensure chaste or monogamous behaviour (predominantly type 3, see below).
- Amongst herders, as a protection against rape for the young girls who pasture

- Health: belief that it promotes cleanliness, improves fertility, and prevents both infant and maternal mortality.
- Religion: some practicing communities believe that FGM is a religious obligation, but there is no doctrinal basis for FGM .

The practise of FGM is widespread; there are approximately 6,000 new cases everyday, or five girls every minute (WHO 1997a). It is generally performed on girls aged between 4 and 12, although in some cultures it is practiced as early as a few days after birth; as late as just prior to marriage; during pregnancy or after the first birth (Toubia 1995; WHO 1996).

Girls may be cut alone, or with a group of peers from their community or village. The excisor can be a traditional birth attendant, a traditional practitioner or a health professional; typically, traditional elders (male barbers or female excisors) carry out the procedure, sometimes for pay. In some cases, it is not the remuneration but the prestige and power of the position that compels practitioners to continue. The practitioner may or may not have had health training, use anaesthesia, or sterilize the cutting instruments. Instruments used for the procedure include razor blades, glass, kitchen knives, sharp rocks, scissors, and scalpels (Al-Krenawi & Wiesel-Lev 1999).

A discouraging trend is the use of medical professionals (physicians, nurses, and midwives) in some countries (including Egypt, Kenya, Mali, and Sudan) to perform the procedure; this trend is probably due to growing recognition of the health risks associated with FGM and heightened concern regarding its possible role in the transmission of HIV (Brady 1999).

Part Two: What is FGM? The Four Main Types

Female Genital Mutilation (FGM) - also known as Female Circumcision (FC) or Female Genital Cutting (FGC) - involves the cutting or alteration of the female genitalia for social, rather than medical, reasons. The term FC was widely used for many years to describe the practice; however, it has been largely abandoned as it implies a false analogy with male circumcision (Toubia & Rahman 2004) though various communities still use the term as a literal translation of their own languages.

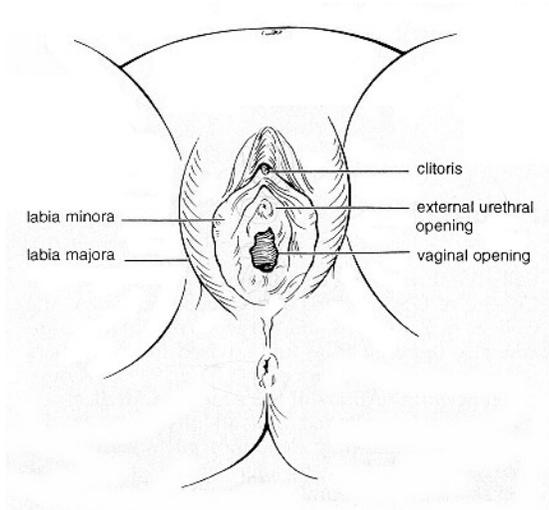


Diagram two: A normal vagina

FGM 'comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female organs, whether for cultural or other non therapeutic reasons' (WHO 1997b). Female Genital Mutilation or Cutting is therefore far more damaging and invasive than male circumcision. Furthermore, while male circumcision is seen as affirming manhood, FGM is often perceived primarily as a means to curtail premarital sex and preserve virginity.

The World Health Organisation has classified four types of FGM:

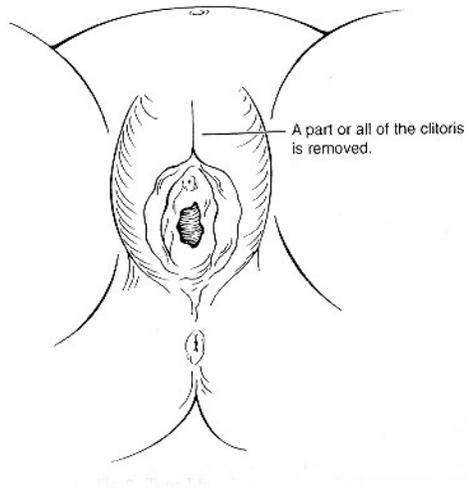


Diagram three: Type 1

Type 1: Making cuts to the hood of the clitoris, often called 'sunna', this involves the removal of the clitoris prepuce, with or without excision of part or the entire clitoris. This is the least severe form of FGM.

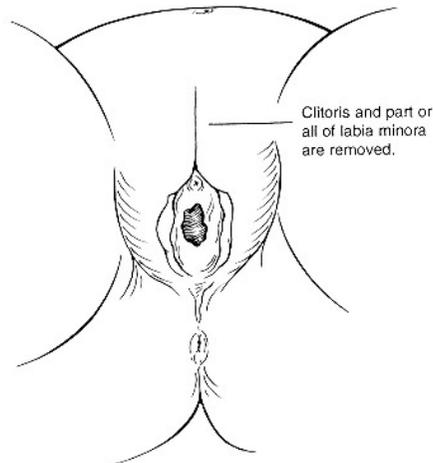


Diagram
Type 2

f o u r :

Type 2: Excision of the clitoris with partial or total excision of the labia minora.

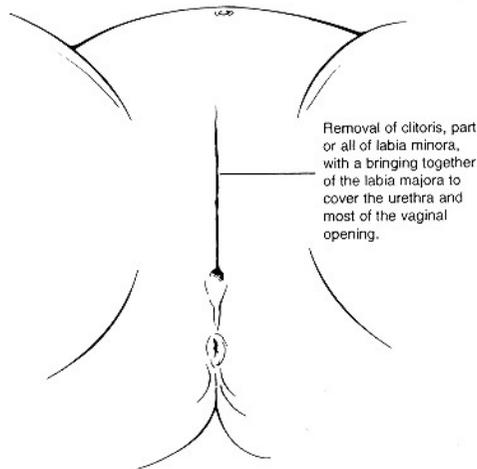


Diagram five: Type 3

Type 3: The most severe form of FGM, known as ‘infibulations’; involves the removal of the clitoris and the inner and outer labia, the sides are then sutured together using thorns, silk, catgut sutures or thread. Often a tiny piece of wood or reed is inserted to leave a small opening for the flow of blood and urine.

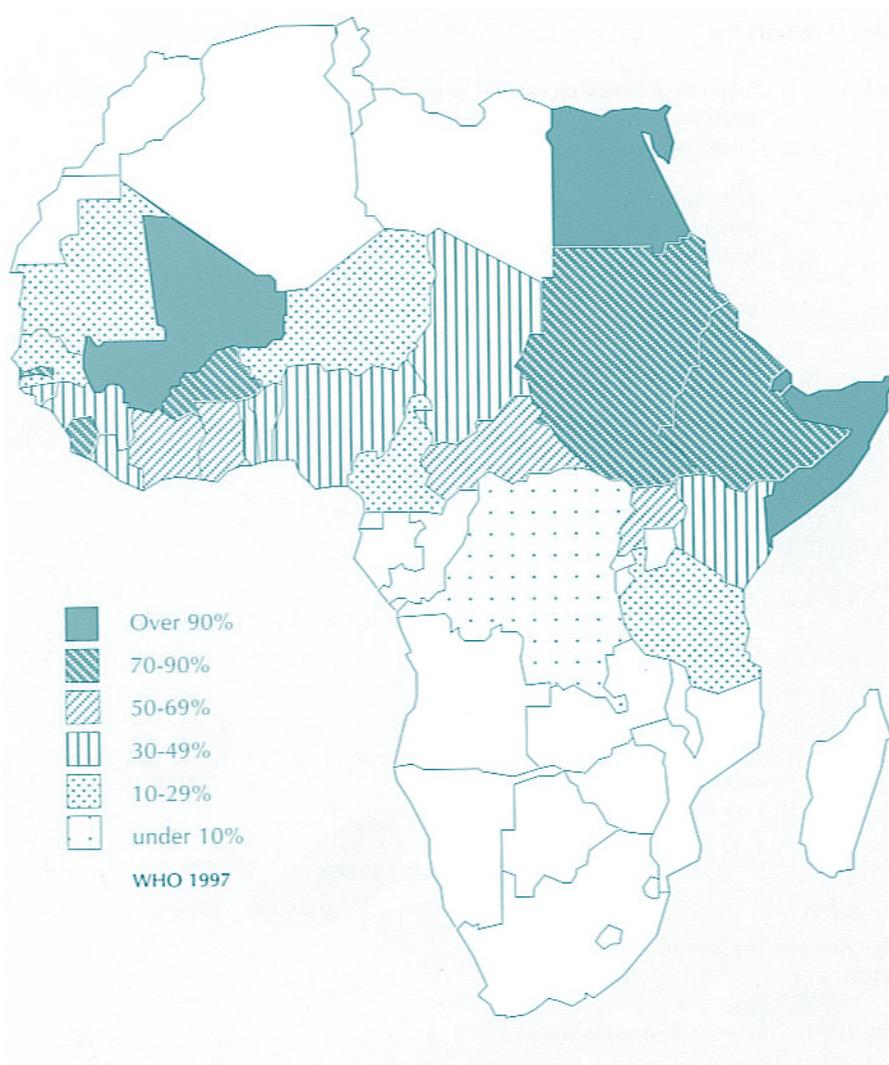
Type 4: Unclassified, includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting into the vagina (gishri cuts); the introduction of corrosive substances or herbs into the vagina to cause bleeding, or for the purposes of tightening or narrowing it, and any other procedure that falls under the definition of female circumcision given above (WHO 1997c).

FGM is practiced in at least 28 countries in sub-Saharan and north-eastern Africa, but not in southern Africa or the Arabic-speaking nations of North Africa, with the exception of Egypt. It is practiced at all educational levels, in all social classes and occurs among many religious groups (Muslims, Christians and animists), although no religion mandates it (Althus 1997). In the United Kingdom, it is often seen among immigrant from Somalia, Eritrea, Mali, Sudan, Ethiopia, Sierra Leone and Nigeria (McCaffery 1995)

While it is difficult to determine either the number of women who have undergone FGM or how many have undergone each type, about 2 million or more girls undergo the practice each year; there are approximately 6,000 new cases each day or five girls

every minute (Women's Health: WHO 1994). The WHO has estimated that clitoridectomy (Type 1) is the most common procedure, accounting for up to 80 percent of all cases. Fifteen percent of all affected women have been infibulated (Type 3) the most severe form of cutting (WHO 1996).

Estimated prevalence of female genital mutilation in Africa



Estimates of the extent of FGM in Africa by country

(Sources: Hosken1993; Toubia 1993; World Health Organisation 1998)

Country	Characteristics of FGM in the country	% of women affected	Number of women affected
North-East Africa			
1. Somalia	Infibulation almost universal Operations performed between 5-8yrs by traditional midwife.	98%	5034,260
2. Djibouti	Infibulation almost universal. Operation performed between 5-8yrs by traditional midwife.	98%	248,920
3. Sudan	89% of women infibulated. 82% of circumcised women infibulated. Performed on children by traditional and trained midwives.	89%	12,816,000
4. Egypt	Clitoridectomy practiced by both Christians and Muslims except for urban upper class. Some estimate the proportion affected 90% of rural areas and 75% for urban. Performed by traditional midwives or barbers.	97%	27,905,930
5. Ethiopia and Eritrea	Clitoridectomy among both Muslims and Christians. Infibulation near borders with Sudan and Somalia.	90%	26,323,250
East and Central Africa			
7. Kenya	Excision decreasing in urban areas, primarily around Rift Valley. Performed on girls between 8 and 13.	50%	6,967,500
	Clitoridectomy reported amongst	10%	1,552,000

9. Central African Republic	Excision reported.	43%	759,810
10. Uganda	Excision reported in one group.		513,050
11. Zaire	Excision reported	5%	945,000
West Africa		5%	
12. Nigeria	Symbolic circumcision, clitoridectomy, excision, infibulation and Gishiri cuts found among Christians, Muslims and Animists.	40%	25,601,200
13. Sierra Leone	All ethnic groups except Creoles practice clitoridectomy and	90%	2,167,200
14. Mauritania	Excision reported.	25%	295,250
15. Benin	Excision reported mainly in the northern region.	50%	1,365,000
16. Burkina Faso	Excision reported.	70%	3,656,800
17. Cameroon	Excision reported.	20%	1,336,800
18. Chad	Excision reported.	60%	1,932,000
19. Ivory Coast	Excision reported.	60%	3,750,000
20. Gambia	Excision reported.	80%	396,800
21. Ghana	Excision practiced in Northern region.	30%	2,635,200
22. Guinea	Excision reported.	60%	1,999,800
23. Guinea Bissau	Excision reported.	50%	272,500
24. Liberia	Excision reported.	60%	902,400
25. Mali	Excision with some infibulation.	99%	5,155,900
26. Niger	Excision reported among Peul, southern part of the country	20%	921,200
27. Senegal	Excision predominantly in the North and South East.	20%	838,000

Part Three: The Health Consequences of FGM

There is ample clinical documentation of the health consequences of FGM. However, there are few quantitative, community based case reports on the frequency and patterns of these consequences.

The clinical documentation strongly suggests that the more severe forms of mutilations are likely to result in serious and long-lasting complications; which can be summarised as follows:

Short-term physical complications:

- Severe pain
- Injury to the adjacent tissue of the urethra and vagina
- Haemorrhage
- Shock
- Acute urine retention
- Infection
- Failure to heal
- Death (especially young girls)

Long-term physical complications:

- Difficulty in passing urine
- Recurrent urinary tract infection
- Pelvic infection
- Infertility
- Cysts and abscess on the vulva
- Difficulties in menstrual flow
- Calculus formation in the vagina
- Vesico-vaginal fistula (VVF) or recto-vaginal fistula (RVF)
- Keloid scar

The risks associated with pregnancy are increased according to the severity of the procedure (WHO 2006). The evidence also suggests that FGM is associated with increased rates of genital and urinary tract infection, which could also have repercussions for obstetric outcomes.

Unassisted Labour and Delivery of Women with Type 3 FGM (or with severe scarring due to FGM)

- Prolonged or obstructed labour: this occurs due to tough, unyielding scar tissue associated with type 3; type 1 & 2 do not usually cause such obstruction;
- Perineal laceration and uterine inertia;

There is a dearth of information on the sexual and mental health effects of FGM or on the mortality rates associated with the procedure:

Neonatal Problems

These occur mainly due to obstructed or prolonged labour, which if unchecked can cause foetal distress, anoxia and foetal death.

Sexual Complications

Women who have undergone genital mutilation may suffer painful sexual intercourse (dyspareunia) due to the scarring and narrowing of the vaginal opening. With severe forms of FGM, vaginal penetration may be difficult or even impossible without tearing or re-cutting the scar tissue.

Vaginismus may result from injury to the vulval area, repeated vigorous sexual acts or as a result of flashbacks of the original mutilation.

Psychosexual Consequences

For many women, their experience of FGM is a vivid 'landmark' in their mental development: a memory that never leaves them. Some women are able to express the humiliation, inhibition and fear that have become part of their lives as a result of enduring genital mutilation. Others find it difficult to talk about their personal experience, but their anxiety and sometimes tearfulness reflect the depth of their emotional pain.

Women have expressed feelings of betrayal, bitterness and anger at being subjected to such an ordeal, even if they received support from their families following the procedure. These feelings may cause a crisis of confidence and trust in the family that may have long-term implications; it may affect the relationship between the girl and her parents or her ability to form intimate relationships in the future, even with her own children. Some young women have expressed feelings of incompleteness, loss of self-esteem, and depression as a result of having undergone FGM.

Part Four: FGM, Human Rights and UK Law

Internationally, there has been a shift from thinking about FGM primarily as a cultural and health issue, toward considering it as an issue of human rights; the United Nations Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) promotes the rights of women and specifically addresses discriminatory traditional practices. The United Nations Convention on the Rights of the Child (CRC) protects children's equal rights (irrespective of sex) to the highest attainable standards of health; to freedom from all forms of mental and physical violence; to freedom from torture, or cruel, inhuman or degrading treatment.

Prohibition of Female Circumcision Act 1985 made genital mutilation illegal in the U.K although it allowed girls to be taken abroad and circumcised. A Private Members Bill was introduced by Ann Clwyd MP in 2003, and came into force in March 2004. (Mohammad 2005)

The Female Genital Mutilation Act 2003 makes it an offence for UK national or permanent UK resident to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice may be legal. It also increases the maximum penalty for performing and procuring FGM from 5 to 14 years imprisonment. (Gordon 2005)

The Children's Act (1989) states that every professional has a duty and responsibility to protect children, and that the welfare of children is PARAMOUNT.

Social Services Departments (SSD) have a statutory duty to protect children, including responsibility to investigate and respond to children suffering, or likely to suffer, significant harm and to take appropriate action to safeguard or promote children's welfare. FGM is a risk of significant harm.

These duties and responsibilities apply to all children, regardless of their sex, race, colour culture or ethnicity and health professionals have a duty to report any concerns.

Part Five: Health Professionals, Recognition of Risk and Referral Procedures

Any medical provision for a woman who has been the subject of FGM provides the opportunity for recognition and preventative work with parents and carers.

A girl may be considered to be at risk if it is known that older girls in the family have been subjected to the procedure. Pre-pubescent girls of seven to ten are most at risk, though the practice has been reported amongst babies.

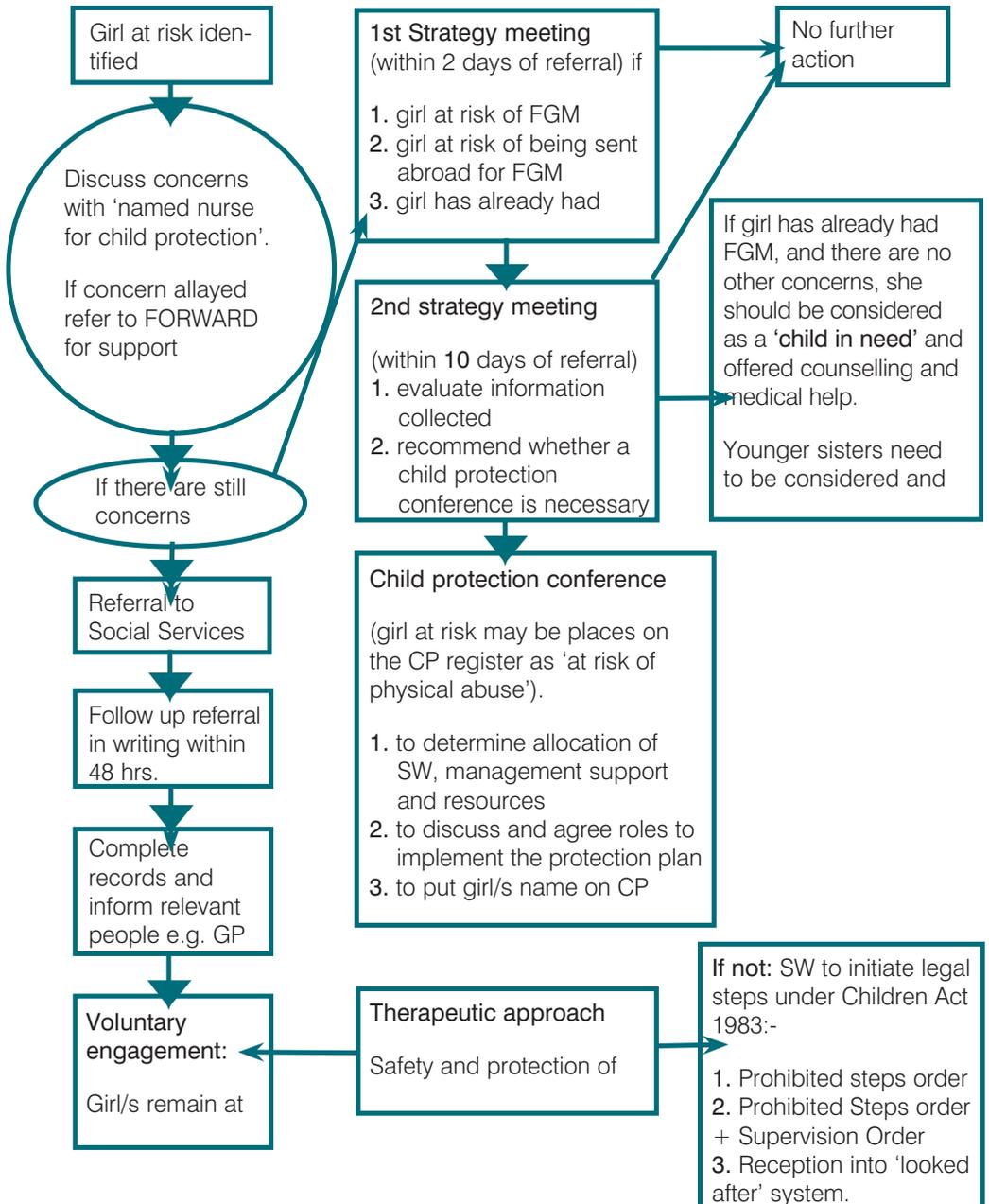
What to do if you have concerns regarding possible or actual FGM:

If you have any concerns that a girl might be at risk, discuss your concern with your [Named health professional for child protection](#). Following this discussion, if the practitioner no longer has concerns that the female child/young girl is at risk of FGM, a referral should still be considered to ensure that supportive services are provided to prevent future risk. If the practitioner has concerns that the FGM has been, or is likely to be, carried out a referral should be made to social services immediately, as the procedure is illegal within the UK. Any other female children or young girls in the household should also be considered as they are also at risk. Any referrals should be made by telephone at the earliest opportunity and followed up in writing within 48 hours.

Following a Social Services Referral:

The social worker and manager should acknowledge receipt of the referral and decide on the next course of action within one working day. The Social Service Department must inform the Police Child Protection Unit at the earliest opportunity, as they are responsible for any criminal investigation. If the child or young girl has already undergone FGM, and there are no other concerns about her welfare, she should be designated a 'child in need' and a social work assessment will look at what support services are required.

London Child Protection Procedure for FGM



Child Protection Conference

A child protection conference must be convened as it is only at such a conference that any girls believed to be in danger of FGM can be placed on the child protection register, under the category of risk of 'physical abuse'.

The main emphasis of work in cases of actual, or threatened, FGM should be through education and prevention; this approach will be reflected in the child protection action plan resulting from the child protection conference.

The Role and Responsibilities of Health Care Professionals

The health care professional has the responsibility to:

- Recognize the sensitivity and complexity of issues relating to FGM;
- Provide support, information and advice for the communities that practice FGM in the context of the UK legislation, human rights and health outcomes;
- Identify, refer and provide sensitive and appropriate care to women and girls who are at risk of FGM, or who have undergone FGM;
- Form networking links and work in partnership with local communities, and local statutory and voluntary organizations to share and disseminate information.

Women with FGM will seek medical help at some time, so health professionals need to be sensitive to the signs and respond to them non-judgementally and without stereotyping. Some women are under pressure to remain silent about FGM, so health professionals need to be aware of the following issues:

- Not to make assumptions about a woman's needs based on unhelpful stereotypes;
- To recognise the effects of racism on a woman's life experiences and which may her decision not to seek external help;
- To recognise that there may be family, religious and cultural pressures on women to choose not to disclose FGM;
- Many women wish to see someone from their own or similar background, but that this is not always the case;
- A woman may require language support and sensitive interpreters;
- A woman may need you to make initial contact with support services on her behalf.

It is important for midwives, nurses and GP's to identify women with FGM at the

Once identified, they should be referred to Central Middlesex Hospital Northwick Park Hospital or to The African Well Woman Clinic at Guy's and St. Thomas' Hospital Trust.

Brent and Harrow Specialist Services: the African Well Woman Clinic at Guy's and St. Thomas' Hospital Trust

Established in September 1997, in response to the increasing numbers of pregnant and non-pregnant women with FGM presenting at delivery, gynaecology or family planning clinics, the clinic is run by a full-time specialist midwife, supported by a consultant (obstetrics and gynaecology), and provides counselling, advice, information and support to women with female circumcision. The clinic offers surgical de-infibulation, where appropriate, to both pregnant and non-pregnant women. It is based in the McNair centre, located on the ground floor of Thomas Guy House (Guy's Hospital) at London Bridge.

Based in the Brent Birthing Unit, ACAD

Midwifery Staff: Hugette Comesary and Anna Phil-Ebosie.
Administration: Beth Kiarie: 02084532409.

The specialist Midwife at Guys - Comfort Momoh - 0207 955 2381(ext 2381)

Clinics: Wednesday pm (no translator), Thursday am Services available

Full medical based consultant/ midwife care:

Rapid access for advice
Experienced interpreter
Excellent links with core medical services
Psychosexual counsellor

The main reasons for attending clinic:

Interpreter
Problems with circumcision
Medical Problems: Psychosexual, Family planning

Once a woman is referred to the service, the professional at the initial assessment will ask leading questions using the following checklist:

Checklist for Specialist Service around Female Genital Mutilation (FGM):

- Name of client
- Address
- Date of Birth
- Telephone Number
- GP's Name
- GP's address
- GP's Telephone Number
- Referral Agency

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> GP	Practice Nurse	<input type="checkbox"/> Health Visitor	<input type="checkbox"/> Midwife
Community Organisation		Other	Self
Referred			

- Show a picture of the types of FGM from page 5-8.
- Ask the women to point to the type that she has undergone.
(She may not know, professionals need to be very aware)

Ask the women

- Do you have problems with passing urine or menstruation?
- How many minutes does it take to pass urine?
- At what age did you have the cut or operation? (This may be useful question to ask
woman experiencing flashbacks or trauma).

Women should be helped to make an informed choice regarding surgical options and other healthcare matters relating to FGM.

Referral Procedure

Both pregnant and non-pregnant women can be referred to the clinic by all health Care professionals, women's groups or can self-refer. The clinic is very flexible; the midwife arranges suitable and convenient appointments for each woman and each woman is treated as an individual. The clinic also provides educational support for staff and outreach work for communities that practice FGM.

The clinic aims to perform de-infibulation (reversal) antenatally, under adequate

Some women prefer to have this procedure performed during labour, or the 2nd stage, as they do not want to suffer the two separate pains of de-infibulation and labour.

The aim in labour is that of a normal delivery, with caesarean section reserved for the usual obstetric indications. De-infibulation can be performed during first stage if not done antenatally, this is achieved by performing an anterior midline incision and giving adequate pain relief; such pain relief is key in avoiding unwanted flash-backs for some women.

Give an anterior midline incision to expose the urethra and the clitoris which is sometimes buried under the scar tissue. All infibulated women should have an anterior midline incision during labour (medico-lateral only if necessary). As with all procedures informed consent is essential.

Following delivery, assessment should be made regarding suturing and this should occur promptly. Re-infibulation (stitching back to the previous state) is an illegal practice in the UK so must not be carried out; the Anterior midline incision SHOULD ONLY entail 'over sewing' of the edges of the labia with very fine Dexon 2.0.

Postnatal Care and Post-Reversal Care

During the postnatal period, the aim is to continue support for the woman and her baby. If she had a reversal, a 4-6 week appointment should be made for a post-reversal check at the African Well Woman Clinic, for advice and counselling on physical and other changes that the woman may experience such as micturition, menstruation, sexual health and intercourse.

Useful Contacts

African Well Woman's Clinic.

Central Middlesex Hospital,
Acton Lane,
Park Royal,
London.

NW10 7NS

Tel: 0208 965 5733

Clinic every Thursday Morning in the Brent Birth Centre.

African Women's Clinic,

Women and Health,
4 Carol Street,
Camden,
London.

NW1 0UH

Tel 0207 482 2786

Women can self refer for services.

African Well Women's Clinic,

Northwick Park & St.Mark's Hospitals,
Watford Road,
Harrow,
Middlesex.

HAI 3UJ

Tel 0208 869 2880

Contact: Jeanette Carlsson.

The African Well Woman's Clinic,

St.Thomas' Hospital Trust,
c/o Admin Office,
10th Floor North Wing,
London.

SE1 9EH

Tel 0207188 6872

Mobile-0756542576

Contact: Comfort Momoh at Comfort.momoh@gstt.sthames.nhs.uk
or cmomoh@hotmail.com

African Women's Health Clinic,

Whittington Hospital,
Level 5,
Highgate Hill,
London.
N19 5NF
Tel 0207 288 3482

Open last Wednesday of each month (afternoons only)
Home visits, or women can attend the hospital clinic.
Contacts: Joy Clarke or Shamse Ahmed.

Lydia Moore Multi-Cultural Antenatal Clinic,

Liverpool Women's Hospital,
Crown Street,
Liverpool.
L8 755
Tel-01517 089988
Contact: Dorcas Akeju.

Chelsea & Westminster Hospital,

Gynaecology and Midwifery Departments,
369 Fulham Road,
London.
SW10 3NH
Tel-0208 8746 8000
Ms. Gubby Ayida(Consultant Obstetrician)

St.Mary's NHS Hospital Trust,

Gynaecology and Midwifery Departments,
Praed Street,
London.
W2 1NY
Tel 0207 886 6666

Women's Clinic,

The Elizabeth Garret Anderson & Obstetric Hospital,
Huntley Street,
London.
WC1E 6DH
Tel 0207 380 9773

Women's & Young People's Service,
Sylvia Parkhurst Health Centre,
Mile End Hospital,
Bancroft Road,
London.
E1 4DG

Open Monday-Friday 9am-5pm
Contact: Tammy Porter.

Acton African Well Woman Centre,
Mill Hill Surgery,
111 Avenue Road,
Acton W3
Tel-0208 383 8712
Opening Hours-Every Tuesday 2.30-5pm

Voluntary and Community Groups

African Women's Health Project,
Talbot House,
204-226 Imperial Drive,
Harrow,
Middlesex.
HA2 7HH
Tel 0208 429 5949
Email:info@developmentsupport.org
Website: www.developmentsupport.org

Foundation for Women's Health Research & Development (FORWARD),
465-467 Harrow Road,
London.
NW10 5NY
Tel-0208 960 4000
Email:forward@forwarduk.org.uk

Rainbo,
Suite 5A,
121 Salisbury Road,
London.
NW6 6RG
Tel:0207 635 3400
Email:info@rainbo.org

London Black Women's Health Action Project (LBWHAP),
82 Russia Lane,
Bethnal Green,
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References

- Althus F (1997) Female Circumcision: Rite of passage or violation of rights, *International Family Planning Perspectives* 23 (3)130
- Brady M (1999) Female Genital Mutilation: Complications and Risk of HIV Transmission, *AIDS Patient Care and STDs* 12 (12), 709-716
- Daley A (2004) Caring for women who have undergone female genital mutilation, *Nursing Times* 100 (26), 32-35
- El Dareer A (1983) Epidemiology of female circumcision in the Sudan. *Tropical Doctor*.(13) 41-5
- Gilbert D (1993) For the sake of purity (and control).Female Genital Mutilation, *Links* 9(5): 6-8
- Gordon H (2005) A clinician's experience. In: Momoh C, *Female genital mutilation*: Radcliffe. UK. p. 29-42
- Hosken F P (1995) *The Universal Childbirth Picture Book*.(pictures by Marcia L.Williams) Lexington. 2nd edition.
- Koso-Thomas O (1987) *The Circumcision of Women: A Strategy for Education*. Zed Press: London: p. 40-61
- Al-Krenawi A & Wiesel-Lev R (1999) *Attitudes toward and Perceived Psychological Impact of Female Circumcision as Practiced among the Bedouin-Arabs of the Negev*. Family Process. 38 (4) p. 31
- McCaffery M & Gordon H et al (1995) Management of Female Genital Mutilation: the Northwick Park Hospital experience. *British Journal of Obstetric and Gynaecology*. (102) p787-790
- Mohammed S (2005) Legislative action to eradicate FGM in the UK. In:Momoh C (ed) *Female Genital mutilation*. Radcliffe p.129-145
- Mohamud A (1997) *Strategies to Abandon FGM: The Role of Youth and Youth-Serving Organizations*, paper presented at the African Adolescent Forum, Program for Appropriate Technology in Health (PATH), Addis Ababa, Ethiopia, January 20.
- Nour N M (2004) *Female Genital Cutting: Clinical and cultural guidelines*, Obstetric and Gynaecology survey 2004. 59(4):272-9.

Shell-Duncan B & Hernlund Y (2000) *Female Circumcision in Africa: Culture Controversy and Change*. Boulder Co: Lynne Rienner.

Toubia N (1993) *Female Genital Mutilation: A call for Global Action*. Rainbow, New York. p.24-25

Toubia N (1995) *Female Genital Mutilation. A call for Global Action*. New York, Rainbow p.24-25

Toubia N & Rahman A (2004) *Female Genital Mutilation: A Guide to Laws and Policies Worldwide*. London and New York: Zed Books.

World Health Organisation (1996), *Female Genital Mutilation: Report of a WHO technical working group meeting: Geneva:17-19 July 1995*.

World Health Organisation (1992, 1997a, 1997b, 1997c), *Female Genital Mutilation*. A joint WHO/UNICEF/UNFPA statement WHO, Geneva.

World Health Organisation (1998) *Female Genital Mutilation: an overview*, WHO Geneva.

World Health Organisation (2006) Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African Countries. *Lancet*, 367 p.1835-41



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