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Search Pack L29

Female genital mutilation

Female genital mutilation (FGM) and cutting worldwide and their effects on pregnancy, labour and women's health. Contains articles from 2010 to present. For older records see L29A.

Date created: 02/04/2026

L29 - Female genital mutilation

(683)

2025-15025

Family Court Statistics Quarterly: July to September 2025. Ministry of Justice (2025), 18 December 2018

This report presents the latest statistics on type and volume of cases that are received and processed through the family court system of England and Wales in the third quarter of 2025 (July to September).
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Full URL: https://www.gov.uk/government/statistics/family-court-statistics-quarterly-july-to-september-2025?utm_medium=email&utm_campaign=govuk-notifications-single-page&utm_source=24583362-c4b1-4e34-9d1a-652d81b737e4&utm_content=immediately

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2025-14658

Anti-FGM programmes axed in UK aid cuts: 'There will be more victims'. Schraer R (2025), Independent 11 December 2025

Efforts to tackle female genital mutilation have been hit, but the Foreign, Commonwealth and Development Office claims it is 'steadfast' in tackling the 'scourge' of FGM. (© Author)

Full URL: https://www.independent.co.uk/news/world/africa/uk-aid-cuts-fgm-labour-b2880849.html

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2025-14604

Family Court Statistics Quarterly: April to June 2025. Ministry of Justice (2025), 25 September 2025

This report presents the latest statistics on type and volume of cases that are received and processed through the family court system of England and Wales in the second quarter of 2025 (April to June). (© Crown copyright)

Full URL: https://www.gov.uk/government/statistics/family-court-statistics-quarterly-april-to-june-2025

2025-14603

Family Court Statistics Quarterly: January to March 2025. Ministry of Justice (2025), 26 June 2025

This report presents the latest statistics on type and volume of cases that are received and processed through the family court system of England and Wales in the first quarter of 2025 (January to March). (© Crown copyright)

Full URL: https://www.gov.uk/government/statistics/family-court-statistics-quarterly-january-to-march-2025

2025-14397

Female Genital Mutilation, Annual Report - April 2024 to March 2025. NHS England (2025), 4 December 2025

This publication includes analysis of data for the year April 2024 to March 2025 from the Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) which is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices. The report includes data on the type of FGM, age at which FGM was undertaken and in which country, the age of the woman or girl at her latest attendance and if she was advised of the health implications and illegalities of FGM and various other analyses. Some data for earlier years are reported. (© Crown copyright)

Full URL: https://www.gov.uk/government/statistics/female-genital-mutilation-annual-report-april-2024-to-march-2025

2025-14299

Female genital mutilation: Government Response. Seventh Special Report of Session 2024–26. HC 714. House of Commons, Women and Equalities Committee (2025), 2 December 2025

Presents the government's response to recommendations from the Women and Equalities Committee Seventh Special Report of Session 2024–26 on Female genital mutilation (HC 714), which was published on 12 September 2025. (MB)

Full URL: https://committees.parliament.uk/publications/50483/documents/274112/default/

2025-13744

Legal reform and female genital mutilation in Sierra Leone. Evaborhene NA, Jiba D, Oga J, et al (2025), The Lancet Obstetrics, Gynaecology, & Women's Health vol 1, no 3, November 2025, pp E157-E158

Reports on the Economic Community of West African States (ECOWAS) Court of Justice ruling that Sierra Leone's failure to ban female genital mutilation (FGM) violates human rights, calling the practice a form of torture. FGM is

widespread in Sierra Leone, deeply tied to cultural traditions, and causes severe health and social harm, yet the country lacks a legal ban despite international obligations. The ruling creates a historic chance for Sierra Leone to enact laws, support survivors, and promote cultural alternatives to end FGM. (MB)

Full URL: https://doi.org/10.1016/j.lanogw.2025.09.006

2025-13118

Determinants of traditional uvulectomy practice among mothers of Ungogo Local Government, Kano State. Saleh AS (2024), Journal of Community & Public Health Nursing vol 10, no 6, 2024, 539

Traditional uvulectomy is a surgical procedure in which the total or partial part of the uvula is removed by traditional surgeons. Traditional uvulectomy is widely practiced in some African countries such as Nigeria, in northern part of Nigeria particularly the hausa speaking areas, traditional uvulectomy is widely practice especially with the vulnerable children mostly neonates, such practice usually take place at first week of life, which may be associated with life threatening complications. The objectives of the study is to assess the level of knowledge and awareness of traditional uvulectomy, to assess the complications arising from the procedure and where they are managed and to find out possible ways of preventing the traditional uvulectomy practice. a cross sectional study was conducted to assess the determinants of traditional uvulectomy among 150 mothers selected by multi stage sampling from 25 March to 1 April at Ungogo Local Government Kano State. A set of administered questionnaire with translation into hausa by the researcher and assistants was used to collect data on research variables. The data was analysed using frequency and percentages. Most of the respondents were Hausa 60%, Married 70%, Housewife 60% aged range from 26-35 years. Majority of the respondents have idea about uvula 80%, Majority of the respondents believed bleeding is one of the complications of traditional uvulectomy practice 90%, fever 70%, nasal regurgitation 70% they don\'t know and most of the respondents seek their management at health facilities 90%, home 90% and traditional uvulectomist 67% and 70% of the respondents strongly agreed that traditional uvuluvulectomy practice can be prevented through health education 70% agreed can be prevented through Community participation and 70% also through community engagement and involvement and 50% of the respondents agreed that using setting controlling mechanisms for the health care delivery system can be used to prevents traditional uvulectomy practice. This study revealed that there is so many complications arising as a result of traditional uvulectomy practice, and possible ways are found to prevents the procedure mostly through health education and community mobilizations. The government should organizes massive campaigns aimed at discouraging the practice of traditional uvulectomy to the community through media, at home visits and should assist with funding of programs in training and provides the barbers with cleansing agents for disinfecting their equipments. (© 2024 Abubakar SS.)

Full URL: https://www.omicsonline.org/open-access/determinants-of-traditional-uvulectomy-practice-among-mothers-of-ungogo-local-government-kano-state-131277.html

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2025-13064

Assessment of Knowledge, Attitude and Practice towards Female Genital Mutilation Among community of Agarfa Town, Southeast Ethiopia. Mohammed AY, Ermeko T, Wodera AL (2021), Journal of Community & Public Health Nursing vol 7, no 3, 2021, 273

Background: Above one hundred million girls and women worldwide have undergone the practice of female genital mutilation and more than three million girls mainly in Africa are estimated to be circumcised each year. In Ethiopia, the prevalence rate is 74% in women of reproductive age group (15-49 years).

Objective: The aim of this study was to assess knowledge, attitude and practice of the community towards female genital mutilation in Agarfa town, southeast Ethiopia.

Methods: A Community based cross-sectional house to house interviews on knowledge, attitude and practice of the community on female genital mutilation was conducted among 272 respondents in Agarfa town, Bale zone, Oromia, Southeast Ethiopia from May 01-05, 2013. Systematic sampling method was used to identify the respondents and data were collected using structured questionnaire on different aspects of FGM. The data were organized in percentage and frequency, and presented in table and graph.

Result: In this study around 86.1% of females were circumcised. Female genital mutilation was reported to be known by 93% of the participants and as to the attitude of the community towards the practice, 81.6% of the participants rejects its continuation. From these males and females were 82.4% and 81.6%, respectively. One fourths of them stated that FGM is currently being practiced in their village. About twenty percent were sure that there is no female circumcision currently. Majority reported that traditional circumcisers (83.3%) are the main operator of the practice.

The main reasons for the practice were to respect culture (75.3%) and for religion (15.6%).

Conclusion and recommendation: The prevalence of Female genital mutilation was high. The study participants had good knowledge and negative attitude towards the practice of FGM. Majority of them had high degree of awareness about the complications of the practice. The main circumcisers were found to be traditional circumcisers. Thus, an effort should be made to change the knowledge, attitude and practice of traditional circumcisers by participating the community as whole. (© 2021 Mohammed AY, et al)

Full URL: https://doi.org/10.4172/2471-9846.1000273

2025-12697

Ending female genital mutilation: A global call to action from FIGO. Sridhar A, Koch M, En-Nosse M, et al (2025), International Journal of Gynecology & Obstetrics vol 171, no 3, December 2025, pp 924-927

Female Genital Mutilation (FGM) affects over 230 million women and girls in more than 90 countries. Despite global condemnation and recognition of FGM as a violation of fundamental human rights, the practice persists, alongside an alarming rise of medicalization – with over 52 million procedures now performed by healthcare professionals. FGM causes severe short- and long-term consequences, including obstetric complications, chronic pain, infertility, sexual dysfunction, and significant mental health burdens. Ending FGM is a medical responsibility and a moral imperative. FIGO unequivocally condemns all forms of FGM, including medicalization, and calls for unified global action. FIGO urges its member societies and healthcare providers to strengthen capacity-building, enforce ethical guidelines, raise community awareness, provide reconstructive care and mental health care, and advance research in this field. (© 2025 International Federation of Gynecology and Obstetrics.)

Full URL: https://doi.org/10.1002/ijgo.70544

2025-10322

Female Genital Mutilation: What's in a Name?. Bradley L (2025), The Practising Midwife vol 28, no 3, May 2025, pp 8-11

This article reflects on the author's experiences as a midwife in a super-diverse inner-city team, providing care to women affected by female genital mutilation (FGM). Since qualifying in 2008, the author has learned to navigate the sensitive and complex subject of FGM through personal reflection, education and improved communication. FGM, deeply rooted in cultural traditions, is illegal in the UK but continues in many countries. The article explores the legal context, the cultural significance of FGM, and the challenges healthcare providers face in addressing it. It emphasises the need for culturally sensitive, empathetic care, and highlights the benefits of continuity of care to ensure safer outcomes for affected women and their children. (© Copyright 2025 All4Maternity)

2025-09805

Factors associated with female genital mutilation/cutting in Tanzania: insights from Tanzania demographic and health survey 2022. Nyamhanga T, Kapinga O, Muro BA, et al (2025), BMC Women's Health vol 25, no 1, 30 August 2025, 415

Background: Globally, female genital mutilation (FGM) remains a significant public health concern. The practice is disproportionately high in African countries. In Tanzania, FGM poses serious health risks to both women, girls and children. However, there is limited empirical literature on the factors associated with FGM in Tanzania. This study intended to fill the gap.

Methods: In this study, we analysed secondary data from a cross-sectional survey, involving a weighted sample of 7,678 women aged 15-49 from the 2022 Tanzania Demographic and Health Survey (TDHS). In this study, the binary dependent variable indicates whether the respondent is mutilated or not mutilated while the independent variables include various demographic characteristics of women, such as age, education level, socioeconomic status, and region of residence. Bivariate and multivariable logistic regression analyses were conducted. A threshold of p-value < 0.05 at 95% Confidence Interval (CI) was used to determine a statistically significant association.

Results: The prevalence of FGM in Tanzania is 8.2% and types I and II (a cut with or without removal of flesh) were the dominant types of FGM practice by 89.2%. After controlling for other variables, higher odds of being mutilated was reported in; older ages 45-49 years (adjusted Odds Ratio(aOR));3.09, 95%CI: 1.72, 5.54), in rural areas (aOR;2.30, 95%CI:1.4,3.6), in women in unions (aOR;1.60, 95%CI:1.20,2.10), in Northern zone (aOR;9.10, 95%CI: 4.60, 17.80), those who ever heard about FGM had 2.27 times (aOR; 2.27, 95%CI: 0.82, 6.29), those who said FGM required by religion had 8.3 times (aOR; 8.30, 95%CI: 4.30,16.03), those who supported FGM had 5.29 times (aOR; 5.29, 95%CI: 2.69, 10.40) higher odds of reporting having undergone FGM compared to those who said the practice should be stopped. Conversely,

lower odds of experiencing FGM was reported in; women with at least secondary education (aOR;0.40, 95%CI:0.20,0.60), those from richest households (aOR;0.40, 95%CI: 0.20, 0.60) and those who said distance to a health facility was not a big problem (aOR;0.70, 95%CI: 0.50, 0.90).

Conclusion: Our study found that prevalence of FGM in Tanzania is 8.2%. The factors associated with experiencing FGM included woman's socio-demographic factors like older age, rural residency, lower or no education, poorest wealth quintile, supporting FGM to continue and being in unions. This calls for collaborative efforts between the government and other stakeholders to design targeted interventions as ending FGM require a multisectoral approach addressing aforementioned determinants across multiple levels including education and wealth creation programs particularly to uneducated and poorest women from rural areas.

Keywords: DHS; Female genital mutilation; Tanzania; Women.

Full URL: https://doi.org/10.1186/s12905-025-03965-z

2025-08042

Female Genital Mutilation: Health Services [written answer]. House of Commons (2025), Hansard Written question 63321, 27 June 2025

To ask the Secretary of State for Health and Social Care, how much funding his Department has (a) allocated to and (b) spent on the treatment and care of individuals subject to female genital mutilation in each financial year since 2014-15. (© UK Parliament 2025)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-06-27/63321

2025-07642

Female Genital Mutilation [written answer]. House of Commons (2025), Hansard Written question 63320, 27 June 2025

To ask the Secretary of State for the Home Department, how much funding her Department has (a) allocated to and (b) spent on prevention of female genital mutilation in each financial year since 2014-15. (© UK Parliament 2025)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-06-27/63320

2025-06775

Gender Based Violence [written answer]. House of Commons (2025), Hansard Written question 58046, 6 June 2025

To ask the Secretary of State for Health and Social Care, what funding his Department provides to the Violence Against Women and Girls Strategy. (© UK Parliament 2025)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-06-06/58046

2025-06561

Female Genital Mutilation, January 2023 - March 2023. NHS Digital (2023), 1 June 2023

The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices. (Copyright © NHS England)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/january-2023---march-2023

2025-06560

Female Genital Mutilation, July - September 2023. NHS Digital (2023), 14 December 2023

This publication includes analysis of data for the months July 2023 to September 2023 from the Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) which is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices. The report includes data on the type of FGM, age at which FGM was undertaken and in which country, the age of the woman or girl at her latest attendance and if she was advised of the health implications and illegalities of FGM and various other analyses. Some data for earlier years are reported. (Copyright © NHS England)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/july---september-2023

2025-06559

Female Genital Mutilation, October - December 2023. NHS Digital (2024), 16 May 2024

This publication includes analysis of data for the months October 2023 to December 2023 from the Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) which is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices. The report includes data on the type of FGM, age at which FGM was undertaken and in which country, the age of the woman or girl at her latest attendance and if she was advised of the health implications and illegalities of FGM and various other analyses. Some data for earlier years are reported. (Copyright © NHS England)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/october---december-2023

2025-06558

Female Genital Mutilation, January - March 2024. NHS Digital (2024), 11 July 2024

This publication includes analysis of data for the months January 2024 to March 2024 from the Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) which is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices. The report includes data on the type of FGM, age at which FGM was undertaken and in which country, the age of the woman or girl at her latest attendance and if she was advised of the health implications and illegalities of FGM and various other analyses. Some data for earlier years are reported. (Copyright © NHS England)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/january---march-2024

2025-06557

Female Genital Mutilation, Quarterly Report: July to September 2024. NHS Digital (2025), 6 March 2025

The Female Genital Mutilation Enhanced Dataset (FGMED) is a repository for data collected by healthcare providers in England where FGM was identified or a procedure for FGM was undertaken.

Data collected includes FGM type, age (at which FGM was undertaken and at latest attendance), country (of birth and where FGM was undertaken) and if the patient was advised of the health implications and illegalities of FGM.

This publication provides a CSV (comma-separated values) file containing data from FGMED for the period July to September 2024. Information on the fields, geographies and definitions is provided in the CSV metadata.

The publication also includes the FGM dashboard. This tool allows users to analyse and visualise the data. (Copyright © NHS England)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/july---september-2024

2025-06556

Female Genital Mutilation, Quarterly Report: October to December 2024. NHS Digital (2025), 6 March 2025

The Female Genital Mutilation Enhanced Dataset (FGMED) is a repository for data collected by healthcare providers in England where FGM was identified or a procedure for FGM was undertaken.

Data collected includes FGM type, age (at which FGM was undertaken and at latest attendance), country (of birth and where FGM was undertaken) and if the patient was advised of the health implications and illegalities of FGM.

This publication provides a CSV (comma-separated values) file containing data from FGMED for the period October to December 2024. Information on the fields, geographies and definitions is provided in the CSV metadata.

The publication also includes the FGM dashboard. This tool allows users to analyse and visualise the data. (Copyright © NHS England)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/october---december-2024

2025-06555

Female Genital Mutilation, Quarterly Report: January to March 2025. NHS Digital (2025), 12 June 2025

The Female Genital Mutilation Enhanced Dataset (FGMED) is a repository for data collected by healthcare providers in England where FGM was identified or a procedure for FGM was undertaken.

Data collected includes FGM type, age (at which FGM was undertaken and at latest attendance), country (of birth and where FGM was undertaken) and if the patient was advised of the health implications and illegalities of FGM.

This publication provides a CSV (comma-separated values) file containing data from FGMED for the period January to March 2025. Information on the fields, geographies and definitions is provided in the CSV metadata.

The publication also includes the FGM dashboard. This tool allows users to analyse and visualise the data. (Copyright © NHS England)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/january---march-2025

2025-06516

Sudan: Sexual and Reproductive Health [written answer]. House of Commons (2025), Hansard Written question 56320, 2 June 2025

To ask the Secretary of State for Foreign, Commonwealth and Development Affairs, what steps his Department is taking to promote sexual health in Sudan. (© UK Parliament 2025)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-06-02/56320

2025-06495

Sudan: Sexual Offences [written answer]. House of Commons (2025), Hansard Written question 56317, 2 June 2025

To ask the Secretary of State for Foreign, Commonwealth and Development Affairs, what steps his Department is taking to increase the provision of services to survivors of sexual violence in Sudan. (© UK Parliament 2025)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-06-02/56317

2025-06392

Exploring support for medicalized female genital mutilation/cutting: A study on migrant women living in Italy. Ortensi LE, Farina P, Carrillo DW, et al (2025), PLoS ONE vol 20, no 5, May 2025, e0322774

The medicalization of female genital mutilation/cutting (FGM/C) as a harm reduction strategy is a highly debated issue, although largely unexplored among migrants living outside practising countries. This study investigates the extent of the support for FGM/C conditioned on its medicalization among migrant women from FGM/C-practising countries residing in Italy, and the characteristics of women supporting the practice. Data are from a national survey on FGM/C conducted in Italy in 2016, covering a representative sample of 1,378 women aged 18 + who were born in Nigeria, Egypt, Eritrea, Senegal, Burkina Faso, Somalia, and Ivory Coast. A discrete choice framework and a multinomial probit choice model are adopted to analyze women's preferences about FGM/C continuation and medicalization. Findings indicate that, compared with women who support the practice unconditionally, the requirement of medicalization correlates with higher educational level, age, being in a couple, and being from a country where FGM/C is more commonly medicalized. Perceived benefits linked to increased support for FGM/C medicalization include religious approval, better marriage prospects, cleanliness, and conformity to traditional cultural values. Our data show that higher education is a critical, but not unique, factor in understanding the support for FGM/C in its medicalized form.

(© 2025 Ortensi et al)

Full URL: https://doi.org/10.1371/journal.pone.0322774

2025-06331

Female Genital Mutilation: Prosecutions [written answer]. House of Commons (2025), Hansard Written question 55769, 30 May 2025

To ask the Solicitor General, what recent steps she has taken to help increase prosecution rates for offences relating to female genital mutilation. (© UK Parliament 2025)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-05-30/55769

2025-06238

What is currently known about female genital mutilation and incontinence: a narrative literature review. Kingston C, Hassan A, Kaur H, et al (2025), Journal of Obstetrics and Gynaecology vol 45, no 1, 2025, 2508980

Background

An estimated 230 million girls and women are living with female genital mutilation (FGM) which causes ongoing physical and psychological harm. This review aims to explore what is known about FGM and incontinence, including the underexamined implications for women's health, and identify gaps in the literature.

Methods
A comprehensive database search was conducted using MEDLINE, CINAHL Plus, APA Psych Info, AMED, Child Development and Adolescent Studies, and PubMed. To gather all relevant complications of FGM, no restrictions were imposed on date or study type. Themes were identified by organising the 20 eligible articles by symptom type.

Results
The findings indicate that urological symptoms such as dribbling incontinence, slow micturition, urgency, stress incontinence and overactive bladder are prevalent among women who have undergone FGM. Additional complications include fistulas, pelvic organ prolapse, somatic symptoms, and urinary tract infections. The impact of FGM and incontinence on quality of life and daily activities remains under-explored, with the lived experiences of affected women largely unreported.

Conclusions
FGM has multiple urogynaecological consequences, with more severe forms causing increased symptoms and associated complications. This review highlights the need for further research into the biopsychosocial impacts of FGM and incontinence to provide evidence-based support for affected women. (© Author)
Full URL: https://doi.org/10.1080/01443615.2025.2508980

2025-05847

Obstetrical management and outcomes of female genital mutilations in a high resource expert center.. Bediat A, Chatzistergiou K, Chanier JB, et al (2025), American Journal of Obstetrics & Gynecology MFM vol 7, no 7, July 2025, 101695

The aim of this study was to assess the association between female genital mutilation (FGM) and obstetrical outcomes including cesarean delivery (CD), operative delivery (OD), post-partum hemorrhage (PPH) due to vaginal laceration, obstetrical anal sphincter injury (OASIS), episiotomy, complex perineal laceration (anterior tears involving the clitoris or urethra requiring senior obstetrician intervention), and neonatal intensive care unit (NICU) admission in a high resource setting where clinicians are trained in FGM management. (© Author)

2025-05367

Exploring the health complications of female genital mutilation through a systematic review and meta-analysis. Pallitto C, Ruiz-Vallejo F, Mochache V, et al (2025), BMC Public Health vol 25, no 1387, 14 April 2025

Background
Female genital mutilation (FGM) is a harmful practice that affects an estimated 230 million women and girls. Previous research indicates that FGM is associated with increased risk of short- and long-term health complications. Understanding the health complications is important in ensuring high quality care for women and girls already affected and for advocating for prevention of the practice.

Objective
The objective of this study was to conduct a systematic review and meta-analysis of all existing evidence on the association between FGM and a range of health complications.

Methods
We conducted a systematic review of the literature on the health complications of FGM published between February 2009 and December 2022, applying search strategies and terms aligned with previous reviews. We identified studies that compared women with various types of FGM versus those without for six domains of health complications (i.e., immediate, obstetric & neonatal, gynecological, urological, sexual and mental). Random effects meta-analysis was conducted by health condition and FGM type. Immediate health complications were analysed separately based on data from population-based surveys.

Results
We analysed data from 78 studies (n = 486,949), of which 67 informed the meta-analyses comparing women with and without FGM and 11 informed analyses on the immediate health complications. Most of the studies (N = 68) were conducted in high FGM prevalence countries. Among women and girls living with FGM compared to those without, we

found an increased risk for obstetric complications, including prolonged/obstructed labor, obstetric tears, caesarean birth, postpartum hemorrhage, episiotomy, fetal distress, extended maternal hospital stay, neonatal asphyxia, and stillbirth/neonatal death; gynecological complications, including genital tissue damage, genitourinary tract infections, and menstrual difficulties; urological complications, including urinary tract infections and difficulty urinating; sexual complications including dyspareunia and sexual dysfunction; and mental health complications including depression or anxiety and somatoform disorder.

Conclusion
These results support results from previous research finding an association between FGM and a range of health complications over the life course. This calls for strengthening health systems to provide high-quality care for women and girls at-risk of or affected by FGM and ensuring that FGM prevention and care services are included in essential health service packages. (Author)
Full URL: https://doi.org/10.1186/s12889-025-21584-z

2025-05145

WHO guideline on the prevention of female genital mutilation and clinical management of complications. World Health Organization (2025), 28 April 2025. 104 pages

In 2016, the World Health Organization (WHO) published the WHO guidelines on the management of health complications from female genital mutilation. That publication's main purpose was to provide evidence-informed recommendations on managing health complications associated with FGM. The current revised guideline has an expanded scope, providing up-to-date recommendations on FGM prevention as well as clinical management of complications.

The process of updating and revising this guideline resulted in eight recommendations relating to training and capacity-building of health workers on FGM prevention and care, including access to capacity-building resources; educational interventions targeting women and girls living with or at risk of FGM as well as men and boys in FGM-affected communities; deinfibulation for women with Type III FGM, including the timing of deinfibulation; mental health interventions for women and girls living with FGM and having symptoms of anxiety, depression or post-traumatic stress disorder (PTSD); and surgical and non-surgical sexual health interventions.

In addition, three best practice statements are presented on the development and enforcement of laws and policies against FGM, the need for professional codes of conduct for health workers and the importance of counselling and informed consent prior to deinfibulation. Considerations on implementing the recommendations are also discussed.

Full URL: https://www.who.int/publications/i/item/9789240107281

2025-04397

Female Genital Mutilation and Forced Marriage [written answer]. House of Lords (2025), Hansard Written question HL6265, 27 March 2025

Lord Hanson of Flint responds to a written question from The Lord Bishop of St Albans to His Majesty's Government, regarding when they will publish the feasibility study on the possibility of developing prevalence estimates of female genital mutilation and forced marriage, and their response to that study. (JSM)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-03-27/HL6265

2025-04274

Development Aid [written answer]. House of Lords (2025), Hansard Written question HL6065, 24 March 2025

Baroness Chapman of Darlington responds to a written question from Lord Mohammed of Tinsley, to His Majesty's Government, regarding what assessment they have made of the impact of the reduction of Official Development Assistance on (1) levels of infant mortality, and (2) the effectiveness of programmes seeking to reduce female genital mutilation, in the Global South. (MB)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-03-24/HL6065

2025-03663

Female Genital Mutilation [Parliamentary Debate]. House of Lords (2025), Hansard vol 844: 25 March 2025

Transcript of a parliamentary debate which took place in the House of Lords on 25 March 2025, in response to an oral question from Lord Berkeley of Knighton to His Majesty's Government, regarding what assessment they have made of the prevalence of female genital mutilation nationally. (JSM)

Full URL: https://hansard.parliament.uk/lords/2025-03-25/debates/CC6B5830-933A-4F88-999C-3E23BD7F1D98/FemaleGenitalMutilation

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2025-03530

Female genital mutilation. House of Commons (2025), Hansard 5 March 2025

Correspondence from Rt Hon Baroness Chapman of Darlington, Minister of State for Development, DCDO, re Female genital mutilation, dated 5 March 2025. (Author)

Full URL: https://committees.parliament.uk/publications/47144/documents/244164/default/

2025-03273

Female Genital Mutilation [written answer]. House of Lords (2025), Hansard Written question HL5374, 27 February 2025

Baroness Chapman of Darlington responds to a written question from Lord Bishop of St Albans to His Majesty's Government regarding what assessment they have made of (1) the study by Arpita Ghosh, Heather Flowe and James Rockey Estimating excess mortality due to female genital mutilation, published August 2023, and (2) the number of avoidable deaths resulting from female genital mutilation (FGM); and of the organisations which receive FGM aid grants from the UK, how many provide medical assistance to women and girls suffering life-threatening complications as a result of FGM, including severe bleeding, obstructed labour, and infection. (EA)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-02-27/HL5374

2025-02933

Ultrasound-guided staging and reversal of female genital mutilation. Baumfeld Y, Welch E, Shobeiri SA, et al (2025), International Journal of Gynecology & Obstetrics vol 168, no 2, February 2025, pp 832-835

Importance

FGM/C is common, effecting over 200 million women worldwide and has substantial associated morbidity. We seek improving the reversal procedure using ultrasound imaging.

Objective

The use of peri- and intraoperative ultrasound imaging for reconstructive surgery following FGM/C for staging and surgical planning, with focus on the clitoral structures and blood flow.

Study design

This is a case series of patients with FGM/C who were evaluated and underwent reconstructive surgical management at a single institution between 2018 and 2022. Ultrasound examination with Doppler imaging was performed. The electronic medical record was queried for data regarding patient characteristics, examination and ultrasound findings, and surgical and postoperative course.

Results

Seven patients are described in this case series who sustained the FGM/C with classifications ranging from Ia to IIIb. The primary complaints were dyspareunia or apareunia. Six of seven (86%) reported anorgasmia. Four of seven (57%) had prior vaginal deliveries, and one of seven (14%) was delivered only by cesarean sections, two of seven (29%) have not been able to have intercourse. Ultrasound examination was utilized to facilitate recognition of the anatomic structures during the reconstruction, and Doppler was used to evaluate the clitoral blood flow. Doppler was useful to delineate clitoral tissues from a closely involved periclitoral inclusion cyst, aiding in surgical excision while minimizing clitoral vascular or nerve injury. Postoperative anatomical restoration, sexual function, and alleviation of dyspareunia were excellent. None of the patients reported decreased sexual pleasure postoperatively.

Conclusions

Ultrasound imaging with Doppler can be utilized to facilitate personalized approaches to optimize both anatomical and functional results in cases of genital reconstruction. (Author)

2025-02542

The effect of intrapartum deinfibulation on obstetric outcomes and postpartum sexual function in pregnant women

with Type 3 Female Genital Mutilation/Cutting. Akpak YK, Aktürk E, Oral S, et al (2025), Archives of Gynecology and Obstetrics vol 311, no 4, April 2025, pp 933 - 940

Purpose

Female Genital Mutilation/Cutting (FGM/C) is a surgical intervention that is still performed in large numbers worldwide and has severe effects in terms of both obstetric and sexual consequences. Due to the increase in immigration, it has become more frequent in many countries. This study aims to compare the labor performance, complications, and postpartum sexual function of Type 3 Female Genital Mutilation/Cutting (FGM/C) pregnant women undergoing deinfibulation with Type 3 FGM/C patients without deinfibulation.

Methods

This is a prospective study of pregnant women with Type 3 FGM/C and puerperium patients at Nyala Turkish Training and Research Hospital in Sudan over 4 years, from September 2018 to September 2022. Type 3 FGM/C patients who underwent deinfibulation were compared with those who did not, considering age, parity, and obstetric and neonatal outcomes and the Female Sexual Function Index (FSFI) scores at 3 months.

Results

In our homogeneous Type 3 FGM/C group mainly consisting of primiparous women, it was found that more episiotomy procedures were performed. The second stage of labor was significantly prolonged, and perineal damage was greater in the group without deinfibulation. In addition, postpartum hemorrhage and hospitalization of mother and baby were longer in the group without deinfibulation. In the second part of our study, we compared the FSFI scores between the deinfibulation group and the episiotomy subgroup. The results indicated that the deinfibulation group exhibited higher scores across all FSFI domains.

Conclusion

Type 3 FGM/C is definitely associated with poor obstetric and sexual outcomes. It is essential to include partners in family discussions and to protect the perineum by performing deinfibulation and episiotomy at appropriate times and in the correct manner during labor.

What does this study adds to the clinical work

The contribution of the deinfibulation procedure, which is recognized for its obstetric benefits, should also be communicated to families and spouses in terms of its long-term impact on sexual performance. By sharing this information, the devastating effects of Female Genital Mutilation/Cutting (FGM/C) can be mitigated, both obstetrically and sexually. (Author)

Full URL: https://doi.org/10.1007/s00404-024-07923-2

2025-02533

Female Genital Mutilation [written answer]. House of Lords (2025), Hansard Written question HL4860, 10 February 2025

Lord Collins of Highbury responds to a written question from Lord Alton of Liverpool to His Majesty's Government regarding how much of the UK development budget is set aside in (1) the current, and (2) the forthcoming, financial year for the elimination of female genital mutilation; to which agencies the money is to be given; and the countries in which they are working. (AS)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-02-10/HL4860

2025-02532

Female Genital Mutilation [written answer]. House of Lords (2025), Hansard Written question HL4858, 10 February 2025

Lord Collins of Highbury responds to a written question from Lord Alton of Liverpool to His Majesty's Government regarding what progress is being made toward the 2030 target to eliminate female genital mutilation. (AS)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-02-10/HL4858

2025-02530

Female Genital Mutilation [written answer]. House of Lords (2025), Hansard Written question HL4859, 10 February 2025

Lord Collins of Highbury responds to a written question from Lord Alton of Liverpool to His Majesty's Government regarding what estimate they have made of the number of girls globally who (1) are at risk of, and (2) have been subjected to, female genital mutilation. (AS)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-02-10/HL4859

2025-02214

Development Aid: Female Genital Mutilation [written answer]. House of Lords (2025), Hansard Written question HL4707, 4 February 2025

Lord Collins of Highbury responds to a written question from Baroness Northover, to His Majesty's Government, further to the Written Answer by Lord Collins of Highbury on 29 January (HL4113), regarding which organisations received female genital mutilation grants in the years listed, together with grant sizes. (MB)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-02-04/HL4707

2025-02212

Development Aid: Female Genital Mutilation [written answer]. House of Lords (2025), Hansard Written question HL4708, 4 February 2025

Lord Collins of Highbury responds to a written question from Baroness Northover, to His Majesty's Government, further to the Written Answer by Lord Collins of Highbury on 29 January (HL4113), regarding the achievements and outcomes of the female genital mutilation grants provided. (MB)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-02-04/HL4708

2025-01942

Pass the Mic: A Survivor's Perspective on How Midwives Can Help End Female Genital Mutilation. International Confederation of Midwives (2025), The Midwives' Voice 3 February 2025

This issue of 'Pass the Mic' deals with female genital mutilation (FGM) and presents an interview with a survivor of this harmful practice: midwife, nurse and passionate advocate, Catherine Chacha, from Kenya. (JSM)

Full URL: https://internationalmidwives.org/pass-the-mic-a-survivors-perspective-on-how-midwives-can-help-end-female-genital-mutilation/

2025-01386

Female Genital Mutilation [written answer]. House of Lords (2025), Hansard Written question HL4112, 15 January 2025

Lord Collins of Highbury responds to a written question from Baroness Northover to His Majesty's Government, regarding what steps they are taking to accelerate progress in combatting female genital mutilation worldwide. (JSM)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-01-15/HL4112

2025-01375

Development Aid: Female Genital Mutilation [written answer]. House of Lords (2025), Hansard Written question HL4113, 15 January 2025

Lord Collins of Highbury responds to a written question from Baroness Northover, to His Majesty's Government, regarding how much funding they provided to combatting female genital mutilation globally in each year from 2019 onwards. (JSM)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2025-01-15/HL4113

2025-01155

Prevalence and factors associated with female genital mutilation/cutting among Tanzanian women who gave birth in the five years prior to the survey: A population-based study. Moshi FV (2024), PLoS ONE vol 19, no 12, December 2024, e0310337

Background: Female Genital Mutilation/Cutting (FGM/C) poses a significant public health challenge in developing countries, leading to increased risks of adverse obstetric outcomes such as caesarean section, postpartum hemorrhage, episiotomy, difficult labor, obstetric tears/lacerations, instrumental delivery, prolonged labor, and extended maternal hospital stays. The study aimed to determine the prevalence and factors associated with FGM/C among Tanzanian women who had given birth within five years preceding the Survey.

Method: This study utilized an analytical cross-sectional design based on data from the 2015-2016 Tanzania Demographic and Health Survey and Malaria Indicators Survey (TDHS-MIS). A total of 5,777 women who had given birth within the five years preceding the survey and who provided responses to questions regarding female circumcision were included in the analysis. Descriptive analysis was employed to examine the prevalence of FGM/C among women in Tanzania. Additionally, multiple logistic regression was used to identify factors associated with

FGM/C within this population.

Results: The prevalence of FGM/C was 12.1% at 95%CI of 11.3% to 13%. Factors associated with FGM/C were marital status [married (AOR = 3.141 at 95%CI = 1.757-5.616,p<0.001), living with male partners (AOR = 2.001 at 95%CI = 1.082-3.699, p = 0.027), widowed (AOR = 2.922 at 95%CI = 1.201-7.111, p = 0.03)] never in union a reference population; wealth index [poorest (AOR = 2.329 at 95% CI = 1.442-3.763, p = 0.001), middle (AOR = 1.722 at 95% CI = 1.075-2.758, p = 0.024), richer (AOR = 1.831 at 95%CI = 1.205-2.781, p = 0.005)] in reference to richest women; zones [Northern zone, (AOR = 91.787 at 95%CI = 28.41-296.546, p<0.001), central zone, (AOR = 215.07 at 95%CI = 67.093-689.423,p<0.001), southern highlands, (AOR = 12.005 at 95% CI = 3.49-41.298, p<0.001), lake zone (AOR = 13.927 at 95%CI = 4.338-44.714,p<0.001), eastern zone, (AOR = 24.167 at 95% CI = 7.299-80.017, p<0.001)]; place of childbirth [outside health facility (AOR = 1.616 at 95%CI = 1.287-2.03, p<0.001)] in reference to health facility childbirth; parity [para 5+ (AOR = 2.204 at 95% CI = 1.477-3.288,p<0.001)] para one a reference population; and opinion on whether FGM/C stopped or continued [continued (AOR = 8.884 at 95% CI = 5.636-14.003, p<0.001).

Conclusion: This study underscores the persistent issue of FGM/C in Tanzania, particularly among married women, those from lower-income households, and those living in regions with high prevalence. Women giving birth outside health facilities and those with multiple children are at higher risk. The study emphasizes the need for targeted interventions addressing socio-cultural factors, alongside providing legal, healthcare, and psychological support to those affected. Educational campaigns and community engagement, especially with traditional and religious leaders, are crucial for challenging cultural beliefs and reducing FGM/C's prevalence.

Full URL: https://doi.org/10.1371/journal.pone.0310337

2025-01103

Female genital mutilation. World Health Organization (2024), 5 February 2024

Key facts from the World Health Organization regarding the practice of female genital mutilation (FGM). (JSM)
Full URL: https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation

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2025-01102

A Robust Cross-Sectional Assessment of the Impacts of COVID-19 Pandemic on the Prevalence of Female Genital Mutilation Among 0–14 Years Old Girls in Nigeria. Visée C, Morlighem C, Nnanatu CC (2025), Women's Health 26 May 2025, online

Background:
Female genital mutilation (FGM) is a human rights violation that still affects more than 3 million girls aged 0-14 years each year. To achieve the Sustainable Development Goal 2030 agenda, efforts have been made at the local, national and international levels to end the practiceby the year 2030. However, the recent COVID-19 pandemic may have reversed the progress made due to increased rates of early marriage of girls, violence against children and school closures during lockdowns. Although some surveys have examined changes in FGM prevalence over the COVID-19 period, changes at the national and sub-national levels among 0-14 years old girls have not been quantified.
Objectives:
This study aimed to understand the potential impacts of the COVID-19 pandemic on the likelihood of FGM among girls aged 0-14 years, and whether it affected progress towards the elimination of FGM. Design We used Bayesian hierarchical regression modelsimplemented within the integrated nested Laplace Approximations (INLA) frameworks.
Methods:
We modelled the likelihood and prevalence of FGM among girls aged 0-14 years before and after the COVID-19 pandemic in Nigeria, with respect to individual and community-level characteristics, using Bayesian hierarchical models. We used the 2018 Demographic and Health Survey as the pre□COVID-19 period and the 2021 Multiple Indicator Cluster Survey as the post-COVID-19 period. Results At the state level, FGM prevalence varied geographically and increased by 23% and 27% in the northwestern states of Katsina and Kana respectively. There were 11% increase in Kwara and 14%
increase in Oyo. However, at the national level the prevalence of FGM was found to decrease from 19.5% to 12.3% between 2018 and 2021. Cultural factors were identified as the key drivers of FGM among 0-14 years old girls in Nigeria. The changes in the likelihood of girls undergoing FGM across the two time periods also varied across ethnic

and religious groups following COVID-19 pandemic.
Conclusion:
Our findings highlight that FGM is still a social norm in some states/regions and groups in Nigeria, thereby highlighting the need for a continued but accelerated FGM interventions throughout the country. (Author)
Full URL: https://doi.org/10.1177/1745505724131194

2025-01101

Taking care of women living with female genital mutilation or cutting: Characteristics of the pool of users of two healthcare facilities in Turin, Northern Italy. Romanisio M, Canavese A, Castagna P, et al (2025), Forensic Science International vol 367, no 112344 February 2025

Female genital mutilation (FGM) is a form of gender-based violence (GBV) that may lead to adverse consequences on the physical and psychological health of survivors. Patients living with FGM have unique health needs, which have to be addressed from the perspective of human rights and sexual and reproductive health. The aim of this study was to understand the characteristics of the pool of users of two services targeting this population in Turin, given the significance this may have due to the high migratory flows from countries were FGM is performed. A retrospective review of medical records of patients who accessed FGM-C related care in two healthcare facilities in Turin was performed. The most represented type of FGM was IIb. All patients were of African origin. Many presented psychological sequelae, while a smaller group presented uro-gynaecological symptoms. A high number of survivors were subjected to other forms of GBV during their lifetime. These findings highlight the need for an integrated and multidisciplinary service for the management of survivors of FGM. (Author)

Full URL: https://doi.org/10.1016/j.forsciint.2024.112344

2025-01100

Understanding the Lived Experiences of Women Underwent Female Genital Mutilation (FGM) in Bichena Town, North-Western Ethiopia. Bihonegn AA, Hailu KH, Shiferaw AM (2025), Journal of Social Service Research 20 January 2025, online

Female genital mutilation (FGM) remains a widespread and harmful traditional practice, despite legislative measures to protect girls and women's rights in Ethiopia. The purpose of this qualitative study was to understand the experiences of women who underwent Female genital mutilation (FGM). Eight in-depth interviews were conducted with purposefully selected participants in Bichena town. Thematic analysis was used, and yielded three major themes: Reasons for continuity; Living with FGM; Location and Circumcisers. Findings of the study showed that participants identified limiting female sexuality, deep-rooted cultural beliefs and religion as justification for the continuity of FGM. The study also revealed that participants experienced mixed feelings; the majority reported experiences of loss of sexual desires, painful intercourse, and conflicts of spousal relationship, while some felt no negative consequences from the practice. Participants further reported that the operation of circumcision is performed using traditional circumcisers at parents' home. The FGM experiences of these participants highlight the critical need for community-based intervention to cease this harmful customary practice. Long-term ethnographic study is required to validate our conclusion that FGM is one of the manifestations of gender-based human rights violation to control women's sexuality and autonomy. Our study has special implications for adding knowledge in the social service research and providing insight on how to integrate FGM into an intervention area in social change practice. (Author)

2025-01099

Prosecutions for female genital mutilation in Swedish courts: Tip of the iceberg or manifestation of epistemic injustice?. Johnsdotter S, Wendel L (2205), International Journal of Law, Crime and Justice vol 80, no 100714, March 2025

Highlights

- The scarcity of criminal court cases on FGM aligns with research indicating that migration often leads to abandoning the practice.
- The prevailing public discourse around FGM paves the way for epistemic injustice.
- An analysis of Swedish FGM prosecutions reveals a risk that stereotypes based on ethnicity and religion may influence court decisions.
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The legal handling of suspected cases must be conducted in accordance with the rule of law. (Author)

Full URL: https://doi.org/10.1016/j.ijlcj.2024.100714

2025-01098

Female Genital Mutilation and Cutting: Essentials for Pediatric Nurse Practitioners. Hornor G (2025), Journal of Pediatric Health Care vol 39, no 1, January-February 2025, pp 112-121

Female genital mutilation and cutting (FGM/C) is a serious global public health problem, violating the basic human rights of girls and women. FGM/C is a form of child maltreatment. According to the World Health Organization 200 million girls and women have undergone FGM/C in thirty countries in Africa, the Middle East, and Asia. FGM/C is also a concern in the United States (U.S.). Approximately 513,000 girls and women living in the U.S. are at risk for FGM/C or its consequences, representing a 4-fold increase within a decade. FGM/C places victims at risk for significant physical and psychological trauma and also results in a substantial cost to society. Studies indicate that healthcare professionals, including nurses and advanced practice registered nurses, report a lack of knowledge and comfort related to the identification and clinical management of FGM/C. It is critical that all healthcare professionals, including pediatric nurse practitioners (PNP), possess a thorough understanding of FGM/C and intervene appropriately. This continuing education article will define FGM/C, describe cultural implications, discuss possible short- and long-term consequences, and explore implications for practice. (Author)

Full URL: https://doi.org/10.1016/j.pedhc.2024.07.010

2025-01097

Factors associated with disapproval of female genital mutilation among schoolgirls in the Borena and Jimma zones of Ethiopia. Teferi HM, Jembere GB, Enqubahiri S, et al (2025), International Journal of Adolescence and Youth vol 30, no 1, January 2025

This research assessed the prevalence of and factors associated with disapproval of female genital mutilation/cutting (FGM/C) in the Borena and Jimma zones of Ethiopia using a cross-sectional study among 679 schoolgirls aged 15–24 years old. Results show an overall 80.7% prevalence of attitudes against FGM/C. Individuals from Borena [AOR = 1.76;95% CI: 1.03,2.98] and Christian religion followers compared to Muslims [AOR = 2.12; 95% CI: 1.07, 4.20] had higher odds of expressing attitudes against FGM/C. Those participants who agree to the statement ‘a woman or man can suggest using a condom’ [AOR = 2.79; 95% CI:1.73, 4.52] and ‘it is okay for a woman to say no to sexual intercourse’ [AOR = 2.46; 95% CI:1.31, 4.61] were also significantly more likely to oppose FGM/C. Through this study, we have identified the influence of geography, culture, and religion in shaping attitudes towards FGM and noted the missed opportunity of using school-based interventions to tackle this issue. (Author)

Full URL: https://doi.org/10.1080/02673843.2025.2455001

2025-01096

Female genital mutilation among children in Ethiopia: A time-to-event analysis of age at circumcision. Ofori MA, Bekalo DB, Mensah DK, et al (2025), PLoS ONE vol 20, no 1, January 2025, e0317966

Female Genital Mutilation (FGM) has become a global health concern. It is a deeply entrenched harmful practice involving partial or total removal of the external female genitalia for non-medical reasons. To inform effective policymaking and raise awareness about FGM’s health risks, understanding socioeconomic and demographic factors influencing the timing of girls’ circumcision is crucial. This study employed semi-parametric survival models to examine the association between residential status and time-to-circumcision of girls in Ethiopia. The data used in this study was the 2016 Ethiopian Demographic and Health Survey (EDHS) report, which was conducted by the Central Statistical Agency (CSA). The analysis revealed that residential status (rural vs urban, HR = 1.73: 1.35–2.70), religion (Muslim vs Christian, HR = 1.51: 1.38–2.70), mother’s educational level (none vs higher, HR = 5.25: 2.23–12.36 or primary vs higher HR = 4.12: 1.25–9.68), father’s educational level (none vs higher, HR = 1.65: 1.12–2.43), and mother’s age (15–24 years vs 35 +, HR = 1.89: 1.21–2.95 or 24–34 years vs 35 +, HR = 1.55: 1.18–2.02) are significant risk factors for age at circumcision. Mother’s age and family wealth index were time dependent risk factors. Effective interventions to reduce FGM prevalence would need to address multiple aspects simultaneously, including improving access to education (especially for girls and women), targeting both urban and rural areas with awareness campaigns, and considering culturally sensitive approaches that take into account religious and traditional beliefs while promoting the health and rights of girls and women. (Author)

Full URL: https://doi.org/10.1371/journal.pone.0317966

2025-01094

Female Genital Mutilation Datasets. NHS Digital (2024), 17 January 2024

The Female Genital Mutilation (FGM) Enhanced Dataset supports the Department of Health's FGM Prevention Programme by presenting a national picture of the prevalence of FGM in England. (Author)

Full URL: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/female-genital-mutilation-datasets

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2025-01092

Female Genital Mutilation, April - June 2024. NHS Digital (2024), 14 November 2024

This publication includes analysis of data for the months April 2024 to June 2024 from the Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) which is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices. The report includes data on the type of FGM, age at which FGM was undertaken and in which country, the age of the woman or girl at her latest attendance and if she was advised of the health implications and illegalities of FGM and various other analyses. Some data for earlier years are reported. (Author)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/april---june-2024

2025-01089

Country policy and information note: female genital mutilation (FGM), Nigeria, July 2022 (accessible) [Last updated 10 January 2025]. HM Government (2022), July 2022

This note provides country of origin information (COI) and analysis of COI for use by Home Office decision makers handling particular types of protection and human rights claims (as set out in the Introduction section). It is not intended to be an exhaustive survey of a particular subject or theme. (Author)

Full URL: https://www.gov.uk/government/publications/nigeria-country-policy-and-information-notes/country-policy-and-information-note-female-genital-mutilation-fgm-nigeria-july-2022-accessible

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2024-14062

Female Genital Mutilation: Convictions [written answer]. House of Lords (2024), Hansard Written question HL2776, 21 November 2024

Lord Ponsonby of Shulbrede responds to a written question from Lord Swire to His Majesty's Government, regarding how many convictions there have been of female genital mutilation in each of the last five years. (MB)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-11-21/HL2776

2024-14058

Female Genital Mutilation: Prosecutions [written answer]. House of Lords (2024), Hansard Written question HL2775, 21 November 2024

Lord Ponsonby of Shulbrede responds to a written question from Lord Swire to His Majesty's Government, regarding how many prosecutions there have been for female genital mutilation in each of the past five years. (MB)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-11-21/HL2775

2024-13971

Female Genital Mutilation [written answer]. House of Commons (2024), Hansard Written question HL2564, 14 November 2024

Lord Hanson of Flint responds to a written question from the Lord Bishop of St Albans to His Majesty's Government, regarding what steps they will take to ensure better co-ordination of guidance given to medical practitioners, teachers, and faith leaders on reporting and protecting girls from female genital mutilation. (AS)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-11-14/HL2564

2024-13965

Female Genital Mutilation: Prosecutions [written answer]. House of Commons (2024), Hansard Written question HL2563, 14 November 2024

Lord Hermer responds to a written question from the Lord Bishop of St Albans to His Majesty's Government, regarding what steps they will take to increase prosecution rates against those who have committed offences relating to female genital mutilation. (AS)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-11-14/HL2563

2024-13719

"A part of my life". A qualitative study about perceptions of female genital mutilation and experiences of healthcare among affected women residing in Sweden. Eshraghi B, Marions L, Berger C, et al (2024), BMC Women's Health vol 24, no 304, 22 May 2024

Background

Female genital mutilation (FGM) is defined as all procedures involving partial or total removal of the external female genitalia, or other injuries to them for non-medical reasons. Due to migration, healthcare providers in high-income countries need to better understand the consequences of FGM. The aim of this study was to elucidate women's experiences of FGM, with particular focus on perceived health consequences and experiences of healthcare received in Sweden.

Methods

A qualitative study was performed through face-to-face, semi-structured interviews with eight women who had experienced FGM in childhood, prior to immigration to Sweden. The transcribed narratives were analyzed using content analysis.

Results

Three main categories were identified : "Living with FGM", "Living with lifelong health consequences" and "Encounters with healthcare providers". The participants highlighted the motives behind FGM and their mothers' ambivalence in the decision process. Although the majority of participants had undergone FGM type 3, the most severe type of FGM, the lifelong health consequences were diverse. Poor knowledge about FGM, insulting attitude, and lack of sensitive care were experienced when seeking healthcare in Sweden.

Conclusions

Our findings indicate that FGM is a complex matter causing a diversity in perceived health consequences in women affected. Increased knowledge and awareness about FGM among healthcare providers in Sweden is of utmost importance. Further, this subject needs to be addressed in the healthcare encounter in a professional way. (Author)

Full URL: https://doi.org/10.1186/s12905-024-03149-1

2024-13718

The women's health needs study among women from countries with high prevalence of female genital mutilation living in the United States: Design, methods, and participant characteristics. Besera G, Snead MC, Goodwin M, et al (2024), PLoS ONE vol 19, no 5, 31 May 2024, e0302820

Background

The Women's Health Needs Study (WHNS) collected information on the health characteristics, needs, and experiences, including female genital mutilation (FGM) experiences, attitudes, and beliefs, of women aged 18 to 49 years who were born, or whose mothers were born, in a country where FGM is prevalent living in the US. The purpose of this paper is to describe the WHNS design, methods, strengths and limitations, as well as select demographic and health-related characteristics of participants.

Methods

We conducted a cross-sectional survey from November 2020 –June 2021 in four US metropolitan areas, using a hybrid venue-based sampling (VBS) and respondent-driven sampling (RDS) approach to identify women for recruitment.

Results

Of 1,132 participants, 395 were recruited via VBS and 737 RDS. Most were born, or their mothers were born, in either a West African country (Burkina Faso, Guinea, Mali, Mauritania, Sierra Leone, The Gambia) (39.0%) or Ethiopia (30.7%). More than a third were aged 30–39 years (37.5%) with a majority who immigrated at ages ≥13 years (86.6%) and had lived in the United States for ≥5 years (68.9%). Medicaid was the top health insurer (52.5%), followed by private health insurance (30.5%); 17% of participants had no insurance. Nearly half of women reported 1–2 healthcare visits within the past 12 months (47.7%). One in seven did not get needed health care due to cost (14.8%). Over half have ever used contraception (52.1%) to delay or avoid pregnancy and 76.9% had their last pelvic and/or Papanicolaou (pap) exam within the past 3 years. More than half experienced FGM (55.0%). Nearly all women believed that FGM should be stopped (92.0%).

Conclusion
The VBS/RDS approach enabled recruitment of a diverse study population. WHNS advances research related to the health characteristics, needs, and experiences of women living in the US from countries where FGM is prevalent. (Author)
Full URL: https://doi.org/10.1371/journal.pone.0302820

2024-13716

Understanding Professionals' Knowledge Regarding Factors Influencing Changes in Attitudes toward Female Genital Mutilation/Cutting in Post-Migration Communities in Geneva, Switzerland. Salah N, Cantoreggi N, Petignat P, et al (2024), International Journal of Environmental Research and Public Health vol 21, no 6, 31 May 2024, p 716
Female genital mutilation or cutting (FGM/C) is a practice involving the partial or complete removal of the external female genitalia for non-medical reasons. To facilitate attitude changes, the ecological model of behavior change considers multiple levels of influence and their relationships with environmental and behavioral factors. The combined effects of migration and cultural adaptation result in a transformative process that leads to decreased support for FGM/C. This qualitative study aimed to gain knowledge from FGM/C field professionals regarding the factors promoting behavioral changes in migrant communities in Geneva, Switzerland. Between September and October 2023, we conducted semi-structured interviews using a reflexive thematic analysis. Our qualitative research is reported in accordance with the COREQ criteria. A data analysis was performed using NVivo 14 software. Four influential dimensions were identified, each with associated factors. The first dimension, the social level, includes (1) the impact and implementation of anti-FGM/C laws. The second dimension, the community level, encompasses four factors such as (2) religion, (3) a multifaceted examination of social aspects, (4) navigating language barriers and raising awareness, and (5) cultural adaptation processes. The third dimension, the interpersonal level, includes factors such as (6) changing views on the marriage prerequisite. Finally, the fourth dimension, the personal level, is associated with (7) women's experiences and perspectives regarding FGM/C. The findings highlight seven environmental factors, both within and across dimensions of the ecological model, that interact with human behavior to enable an adaptive cultural process. This process influences changes in attitudes and behaviors regarding FGM/C. (Author)
Full URL: https://doi.org/10.3390/ijerph21060716

2024-13713

Reconstructive surgery for women with female genital mutilation: A scoping review. Almadori A, Palmieri S, Coho C, et al (2024), BJOG: An International Journal of Obstetrics and Gynaecology vol 131, no 12, November 2024, pp 1604-1619
Background
Female genital mutilation (FGM) is a global public health concern. However, reconstructive surgery remains unavailable in many countries.

Objectives
This scoping review, guided by Joanna Briggs Institute (JBI) principles, explores indications, referral routes, eligibility, care pathways and clinical outcomes of reconstructive surgery for FGM.

Search strategy
Medical Subject Headings (MeSH) terms and subject headings were searched in EMBASE, MEDLINE, SCOPUS, Web of Science and publicly available trial registers.

Selection criteria
Any primary experimental and quasi-experimental study addressing reconstructive surgery for FGM, and its impact on women, published before June 2023.

Data collection and analysis
After removing duplicates from the search results, titles and abstracts were screened and data were extracted. Disagreements were resolved through panel discussion. The Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) flow diagram depicts the search results and inclusion process.

Main results
A total of 40 studies were included. Multidisciplinary teams were involved in 40% (16/40) of the studies, and psychosexual counselling was offered in 37.5% (15/40) of studies. Clitoral reconstruction using Foldes' technique was

predominant (95%, 38/40). A total of 7274 women underwent some form of reconstruction. Post-surgery improvement was reported in 94% of the cases (6858/7274). The complication rate was 3% (207/7722 women with reconstruction).

Conclusions

Further research and clinical trials are needed. Although the outcomes suggest improved sexual function and quality of life post-surgery, the evidence remains limited. Advocating surgical reconstruction for survivors of FGM is vital for addressing health disparities and potential cost-effectiveness. (Author)

Full URL: https://doi.org/10.1111/1471-0528.17886

2024-13712

Effectiveness of health education intervention on intention not to perform female genital mutilation/cutting in the future among key decision-makers: a systematic review and meta-analysis. Seifu W, Yadeta TA, Argaw GS, et al (2024), BMC Women's Health vol 24, no 581, 29 October 2024

Background

Female Genital Mutilation/Cutting (FGM/C) is a form of gender-based violence that has negative health consequences. The decision to perform FGM/C is often made collectively and a variety of actors influence the decision. There is inconsistent and inconclusive evidence that health education interventions lead behavioural changes related to FGM/C among key decision-makers. Therefore, the aim of this systematic review and meta-analysis was to examine the effectiveness of health education interventions on decision-makers intentions not to perform FGM/C in the future.

Methods

A systematic review and meta-analysis were performed according to the Preferred Item for Systematic Review and Meta-analysis (PRISRMA) guideline. Studies were obtained from databases such as PubMed, Google Scholar, EMBASE, CINAHL, Cochrane, African Journals Online and relevant lists of identified studies (interventional studies related to FGM/C among key decision-makers). Unpublished sources and organizational websites were also searched for relevant articles. The quality of studies was assessed using the Quality Assessment Tool for Quantitative Studies developed by the Effective Public Health Practice Project's. The meta-analysis was carried out using STATA.17 and Review Manager 5.3 software. Heterogeneity and publication bias were assessed using the I2 statistic and funnel plot, respectively. The pooled effect size with a 95% confidence interval was presented using a forest plot and random effect model.

Results

This meta-analysis included nineteen studies with a total of 13,326 study participants. The overall pooled relative risk of intention not to perform FGM/C in the future was 1.55 (95% CI;1.24, 1.94). In the subgroup analysis, the effect of health education on intention not to perform in the future was higher in studies that used both health education and other interventions (RR = 3.75, 95% CI; 2.04, 6.88) compared to those using only health education (RR = 1.35, 95% CI; 0.95, 1.92). Studies with longer intervention duration (above 12 months) had a greater effect on intention not to perform (RR = 1.34, 95% CI; 0.86, 2.09) compared to studies with a short intervention period (6–12 months) (RR = 1.14, 95% CI; 0.61, 2.15).

Conclusion

This review examined the impact of health education on key decisions-makers' intention not to perform FGM/C in the future. Although the pooled effect size estimate may have been influenced by heterogeneity, the results suggest that education about FGM/C has a positive influence on the intentions of key decision-makers. It is recommended that health education interventions target local decision-makers such as religious and clan leaders and include them in initiatives aimed at preventing and eliminating FGM/C.

PROSPERO registration number

CRD42024542541. (Author)

Full URL: https://doi.org/10.1186/s12905-024-03427-y

2024-13443

COVID-19 and Female Genital Mutilation/Cutting and child marriage: An online multi-country cross sectional survey. Pande S, Shamu S, Abdelhamed A, et al (2024), PLoS ONE vol 19, no 10, 31 October 2024, e0304671

Female Genital Mutilation/Cutting (FGM/C) and child marriage are prevalent in many countries in Asia and Africa.

These practices are a violation of human rights and have significant impacts on the physical and mental well-being of those affected. COVID-19 restrictions such as lockdowns and closure of schools may have influenced the occurrence of FGM/C and child marriage. This analysis reported on the impact of these restrictions on FGM/C and child marriage. The International Sexual Health And REproductive Health (I-SHARE) research team organised a multi-country online survey. Sampling methods included convenience samples, online panels, and population-representative samples. Data collected included the impact of COVID-19 restrictions on the occurrence, intention to practice and change in plans to organise FGM/C and child marriage. Data were analysed from 14 countries that reported on FGM/C and child marriage using basic descriptive statistics. Given it was an online survey, we had more responses from urban areas. Among the 22,724 overall participants, 8,829 participants (38.9%) responded to the survey items on FGM/C and child marriage and were included in this analysis. 249 (3.4%) participants stated that FGM/C occurred in their community during COVID-19. Out of this, COVID-19 affected the plans of 26 (20%) participants intending to organise circumcision and 15% of participants planned to organise FGM/C earlier. People with a worry about finances during COVID-19 were more likely to have an earlier plan to organise FGM/C during COVID-19. In total, 1,429 (13%) participants reported that child marriage occurred in their community. The pandemic affected plans of 52 (13%) participants intending to arrange child marriage and 7.7% (29/384) participants expressed intent to arrange the marriage sooner than planned. People with financial insecurities during COVID-19 were more likely to arrange a child marriage earlier. Thus, our study found that the pandemic impacted plans related to FGM/C and child marriage practices, resulting in many carrying out the practices sooner or later than initially planned. (Author)

Full URL: https://doi.org/10.1371/journal.pone.0304671

2024-13442

A Critique of Some Harmful Cultural Practices Against Females in Selected African Countries: A Social Work Perspective. Osam E (2024), Journal of Public Administration, Policy and Governance Research vol 2, no 4, 2024, pp 100-119

The review focused on some harmful cultural practices against females in selected African countries. The methodology was a documentary study with data obtained from secondary sources. The theoretical perspective relied on three theories, social convention, anomie, and social learning theory. Findings: The review reported on some harmful cultural practices that violated the human rights of females. These are Female Genital Mutilation [FGM], flogging of child brides, widowhood sexual rites, child sexual initiation ceremonies, breast ironing, child marriages, and child slavery and the associated risks stated. The Social Work perspective identified adverse consequences of all the cultural practices relating to the physical, emotional, and psychological well-being of female survivors. The review condemned the use of females to sustain barbaric cultural rites that have lasted for centuries. Conclusion: The rejection of all harmful cultural practices and the education of male and female children to have a future to embrace new mind-sets of modernity that ends all barbaric cultural practices. Recommendations: There should be continuous sensitization against harmful cultural practices and the need to strengthen human rights for all. Also, the prosecutions of violators must be intensified to serve as deterrence. (Author)

Full URL: https://jpapgr.com/index.php/research

2024-13428

Cluster randomised trial of a health system strengthening approach applying person-centred communication for the prevention of female genital mutilation in Guinea, Kenya and Somalia. Balde MD, Ndavi PM, Mochache V, et al (2024), BMJ Open vol 14, no 7 4 July 2024, e078771

Introduction:

There is limited evidence on effective health systems interventions for preventing female genital mutilation (FGM). This study tested a two-level intervention package at primary care applying person-centred communication (PCC) for FGM prevention.

Methods:

A cluster randomised trial was conducted in 2020–2021 in 180 antenatal care (ANC) clinics in Guinea, Kenya and Somalia. At baseline, all clinics received guidance and materials on FGM prevention and care; at month 3, ANC providers at intervention sites received PCC training. Data were collected from clinic managers, ANC providers and clients at baseline, month 3 and month 6 on primary outcomes, including delivery of PCC counselling, utilisation of level one materials, health facility preparedness for FGM prevention and care services and secondary outcomes related to clients' and providers' knowledge and attitudes. Data were analysed using multilevel and single-level logistic regression models.

Results:
Providers in the intervention arm were more likely to deliver PCC for FGM prevention compared with those in the control arm, including inquiring about clients' FGM status (adjusted OR (AOR): 8.9, 95% CI: 6.9 to 11.5; p<0.001) and FGM-related beliefs (AOR: 9.7, 95% CI: 7.5 to 12.5; p<0.001) and discussing why (AOR: 9.2, 95% CI: 7.1 to 11.9; p<0.001) or how (AOR: 7.7, 95% CI: 6.0 to 9.9; p<0.001) FGM should be prevented. They were more confident in their FGM-related knowledge (AOR: 7.0, 95% CI: 1.5 to 32.3; p=0.012) and communication skills (AOR: 1.8; 95% CI: 1.0 to 3.2; p=0.035). Intervention clients were less supportive of FGM (AOR: 5.4, 95% CI: 2.4 to 12.4; p<0.001) and had lower intentions of having their daughters undergo FGM (AOR: 0.3, 95% CI: 0.1 to 0.7; p=0.004) or seeking medicalised FGM (AOR: 0.2, 95% CI: 0.1 to 0.5; p<0.001) compared with those in the control arm.

Conclusion:
This is the first study to provide evidence of an effective FGM prevention intervention that can be delivered in primary care settings in high-prevalence countries.

Trial registration and date:
PACTR201906696419769 (3 June 2019). (Author)
Full URL: https://bmjopen.bmj.com/content/14/7/e078771

2024-13427

The feasibility, acceptability, appropriateness and impact of implementing person-centered communication for prevention of female genital mutilation in antenatal care settings in Guinea, Kenya and Somalia. Navdi P, Balde MD, Milford C, et al (2024), Global Public Health vol 19, no 1, 10 July 2024, 2369100

Background
There is limited evidence on how to engage health workers as advocates in preventing female genital mutilation (FGM). This study assesses the feasibility, acceptability, appropriateness and impact of a person-centered communication (PCC) approach for FGM prevention among antenatal care (ANC) providers in Guinea, Kenya and Somalia.

Methods
Between August 2020 and September 2021, a cluster randomised trial was conducted in 180 ANC clinics in three countries testing an intervention on PCC for FGM prevention. A process evaluation was embedded, comprising in-depth interviews (IDIs) with 18 ANC providers and 18 ANC clients. A qualitative thematic analysis was conducted, guided by themes identified a priori and/or that emerged from the data.

Results
ANC providers and clients agreed that the ANC context was a feasible, acceptable and appropriate entry point for FGM prevention counselling. ANC clients were satisfied with how FGM-related information was communicated by providers and viewed them as trusted and effective communicators. Respondents suggested training reinforcement, targeting other cadres of health workers and applying this approach at different service delivery points in health facilities and in the community to increase sustainability and impact.

Conclusion
These findings can inform the scale up this FGM prevention approach in high prevalence countries. (Author)
Full URL: https://doi.org/10.1080/17441692.2024.2369100

2024-13426

Comparison of Menstrual Symptoms in University Students with and without Female Genital Mutilation/Cutting. Altunkurek ŞZ, Yeşilyurt E, Hassan Mohamed S (2024), International Journal of Women's Health vol 16, 2 September 2024, pp 1451–1462

Purpose
The aim of this study was to compare the menstrual symptoms and dysmenorrhea in university students who underwent Female genital mutilation/cutting (FGM/C), in Mogadishu, Somalia, and students who did not undergo FGM/C in Ankara, Türkiye.

Methods
A comparative cross-sectional study design was used.

Results

Among the participants with FGM/C, 88.5% were Type 1 and the age at FGM/C was 8 years. The pain severity was 6.20±2.54 in women with FGM/C and was higher than that of those without FGM/C (5.97±2.32), but no significant difference was found. Among those who had FGM/C, 66% had a menstrual duration of 3–5 days, while 52.0.% of those who did not have FGM/C had a menstrual duration of 6–8 days ($p<0.05$). While 85.1% of those without FGM/C had a menstrual cycle of 21–35 days, 35% of those with FGM/C had a menstrual cycle of less than 20 days ($p<0.05$). It was found that 95% of those who have undergone female circumcision and 90.2% of those who have not had dysmenorrhea ($p<0.05$). Painkillers were always used by 28% of women with FGM/C and 26.3% of women without FGM/C ($p<0.05$). The total MSS score of those who have not had FGM/C was 3.34±0.72 and the score of those who have had FGM/C was 2.91±0.74 ($p<0.05$). The negative effects sub-dimension score was found to be higher in the non-FGM/C group with 3.20±0.75, while the coping methods sub-dimension score was higher in the FGM/C group with 2.91±1.13 ($p<0.05$).

Conclusion

FGM/C is still common in Somalia. Our study results showed that having FGM/C may cause differences in dysmenorrhea and menstrual symptoms. Efforts to increase students' effective coping with menstrual symptoms and dysmenorrhea are thought to be useful. (Author)

Full URL: https://doi.org/10.2147/IJWH.S469902

2024-13425

Female genital mutilation and safer sex negotiation among women in sexual unions in sub-Saharan Africa: Analysis of demographic and health survey data. Aboagye RG, Ahinkorah BO, Seidu A-A, et al (2024), PLoS ONE vol 19, no 5, 17 May 2024, e0299034

Background

The practice of female genital mutilation is associated with harmful social norms promoting violence against girls and women. Various studies have been conducted to examine the prevalence of female genital mutilation and its associated factors. However, there has been limited studies conducted to assess the association between female genital mutilation and markers of women's autonomy, such as their ability to negotiate for safer sex. In this study, we examined the association between female genital mutilation and women's ability to negotiate for safer sex in sub-Saharan Africa (SSA).

Methods

We pooled data from the most recent Demographic and Health Surveys (DHS) conducted from 2010 to 2020. Data from a sample of 50,337 currently married and cohabiting women from eleven sub-Saharan African countries were included in the study. A multilevel binary logistic regression analysis was used to examine the association between female genital mutilation and women's ability to refuse sex and ask their partners to use condom. Adjusted odds ratios (aORs) with a 95% confidence interval (CI) were used to present the findings of the logistic regression analysis. Statistical significance was set at $p<0.05$.

Results

Female genital mutilation was performed on 56.1% of women included in our study. The highest and lowest prevalence of female genital mutilation were found among women from Guinea (96.3%) and Togo (6.9%), respectively. We found that women who had undergone female genital mutilation were less likely to refuse sex from their partners (aOR = 0.91, 95% CI = 0.86, 0.96) and ask their partners to use condoms (aOR = 0.82, 95% CI = 0.78, 0.86) compared to those who had not undergone female genital mutilation.

Conclusion

Female genital mutilation hinders women's ability to negotiate for safer sex. It is necessary to implement health education and promotion interventions (e.g., decision making skills) that assist women who have experienced female genital mutilation to negotiate for safer sex. These interventions are crucial to enhance sexual health outcomes for these women. Further, strict enforcement of policies and laws aimed at eradicating the practice of female genital mutilation are encouraged to help contribute to the improvement of women's reproductive health. (Author)

and source are credited.
Full URL: https://doi.org/10.1371/journal.pone.0299034

2024-13424

The comparison of sexual function in types I and II of female genital mutilation. Hassannezhad K, Asadzadeh F, Iranpour S, et al (2024), BMC Women's Health vol 24, no 31, 8 January 2024

Background

Female genital mutilation has many sexual, physical, and psychological consequences. The present study aimed to examine the relationship between Female Genital Mutilation/Cutting (FGM/C), and Sexual Function among circumcised women in Sardasht City, Iran."

Methods

In this present cross-sectional study, 197 women who were mutilated entered the study by simple random sampling from two healthcare centers in Sardasht, Iran. A gynecologist first performed a genital examination to identify the type of female genital mutilation of participants. Subsequently, Socio-demographic and FGM/C-related characteristics checklist and the female sexual function index questionnaire were completed by interview method. Data were analyzed using SPSS 23 software.

Results

Type I and II of female genital mutilation were performed in 73.1 and 26.9% of the participants, respectively. The age range of performing female genital mutilation in type I and II of female genital mutilation was 4–10 years old in 67.4% and 71.1% respectively. Traditional practitioners/local women carried out the circumcision in all of the participants, and Sunnah/tradition was reported as the most common reason for doing this procedure. The average total score of FSFI index in type I and II of female genital mutilation was 23.5 ± 2.0 and 17.4 ± 2.39, respectively. In all domains of FSFI, women with type II of female genital mutilation obtained lower scores than women with type I.

Conclusion

Circumcised women have reduced scores in all domains of FSFI, and the severity of sexual dysfunction is related to the type of FGM/C. Considering the prevalence of female genital mutilation and its adverse effects, it is imperative to initiate cultural improvements through education and awareness. By educating and raising awareness among individuals about this issue, we can foster positive changes and address the problem effectively.
Full URL: https://doi.org/10.1186/s12905-023-02860-9

2024-13421

"People will talk about her if she is not circumcised": Exploring the patterning, drivers and gender norms around female genital mutilation in Ethiopia's Somali region. Presler-Marshall E, Jones N, Endale K (2024), Social Science and Medicine vol 345, March 2024, 116664

Over the past decade there has been a burgeoning literature on social norms and the need to understand their context-specific patterning and trends to promote change, including to address the harmful practice of female genital mutilation (FGM), which affects around 200 million girls and women globally. This article draws on mixed-methods data collected in 2022 and 2023 with 1,020 adolescents and their caregivers, as well as key informants, from Ethiopia's Somali region to explore the patterning, drivers, and decision-making around FGM. Findings indicate that almost all Somali girls can expect to undergo FGM before age 15, and that infibulation is near universal. Critically, however, we find that respondents' understanding of infibulation is rooted in traditional practice, and many girls are now "partially" infibulated—an invasive procedure that girls nonetheless see as an improvement over the past. These shifts reflect religious leaders' efforts to eliminate traditional infibulation—and the health risks it entails—by promoting "less invasive" types of FGM as a requirement of Islam. We also find evidence of emergent medicalization of the practice, as mothers—who are the primary decision-makers—seek to further reduce risks. Adult and adolescent respondents agree that FGM is a deeply embedded social norm, but distinguish between FGM as a perceived religious requirement, and infibulation as a cultural requirement. For girls and women, the importance of FGM is framed around social acceptance, whereas boys and men focus on FGM as a requirement for marriage as it allows families to control girls' sexuality. The article concludes by reflecting on the implications of our findings for programming in high-prevalence contexts. Key conclusions include that FGM interventions should not rely on empowering individuals as "champions of change" but rather prioritize engagement with whole communities, and should be open in the short term to incremental harm-reduction approaches. (Author)
Full URL: https://doi.org/10.1016/j.socscimed.2024.116664

2024-13417

Rethinking the Definition of Medicalized Female Genital Mutilation/Cutting. Van Eekert N, Barrett H, Kimani S, et al (2024), Archives of Sexual Behavior vol 53, February 2024, pp 441–453

In 2015, the international community agreed to end Female Genital Mutilation/Cutting (FGM/C) by 2030. However, the target is unlikely to be met as changes in practice, including medicalized female genital mutilation/cutting (mFGM/C), challenge abandonment strategies. This paper critically reviews the current World Health Organization (WHO) definition of mFGM/C to demonstrate that mFGM/C, as currently defined, lacks detail and clarity, and may serve as an obstacle to the collection of credible, reliable, and comparable data relevant to targeted FGM/C prevention policies and programs. The paper argues that it is necessary to initiate a discussion on the revision of the current WHO definition of mFGM/C, where different components (who-how-where-what) should be taken into account. This is argued by discussing different scenarios that compare the current WHO definition of mFGM/C with the actual practice of FGM/C on the ground. The cases discussed within these scenarios are based on existing published research and the research experience of the authors. The scenarios focus on countries where mFGM/C is prevalent among girls under 18 years, using data from Demographic Health Surveys and/or Multiple Indicator Cluster Surveys, and thus the focus is on the Global South. The paper places its arguments in relation to wider debates concerning female genital cosmetic surgery, male genital circumcision and consent. It calls for more research on these topics to ensure that definitions of FGM/C and mFGM/C reflect the real-world contexts and ensure that the human rights of girls and women are protected. (Author)

2024-13415

Politicization of international aid: Religious responses to criminalizing female genital mutilation in Sudan. Tønnessen L, Al-Nagar S (2024), Women's Studies International Forum vol 105, July-August 2024, 102943

International aid to protect women and girls against religiously sanctioned violence in predominantly Muslim countries is prone to politicization and opposition by conservative religious actors. In Sudan religious leaders had varied responses to an internationally funded campaign to criminalize female genital mutilation/cutting (FGM/C) in 2009. In the capital Khartoum, this campaign provoked politicization of aid and counter- mobilization by national conservative religious leaders, while in the eastern town of Gedarif local religious leaders supported criminalization. Based on fieldwork conducted from 2008 to 2018, the study suggests that the power based of religious leaders and their inclusion in, or exclusion from, anti- FGM/C efforts accounted for this differential response. Even when successful, the inclusion of religious leaders as “agents of change” strengthened their power and the role of religion in state and society to levels that may endanger the rights of women and girls. (Author)

Full URL: https://doi.org/10.1016/j.wsif.2024.102943

2024-13407

Female genital mutilation: trends, economic burden of delay and basis for public health interventions. Cordova-Pozo K, Abdalla HHI, Moller AB (2024), International Journal for Equity in Health vol 23, no 73, 2024

Background

The practice of female genital mutilation (FGM) is a health and social problem. Millions of girls and women have undergone FGM or will soon, and more information is needed to effectively reduce the practice. The aim of this research is to provide an overview of the FGM trendlines, the inequality of its prevalence, and the economic burden. The findings shed light on 30-year trends and the impact of the pandemic on planned efforts to reduce FGM which helps with public health interventions.

Methods

Temporal trend analysis, and graphical analysis were used to assess the change and inequality over the last 30 years. We included 27 countries in which FGM is prevalent. We calculated the extra economic burden of delayed interventions to reduce FGM like COVID-19.

Results

For the 27 countries analyzed for temporal trendlines, 13 countries showed no change over time while 14 had decreasing trends. Among the 14, nine countries, Uganda, Togo, Ghana, Benin, Kenya, Nigeria, Central African Republic, Chad, and Ethiopia had high year-decrease (CAGR − 1.01 and − 10.26) while five, Côte d’Ivoire, Egypt, Gambia, Djibouti, and Mali had low year-decrease (CAGR>-1 and < 0). Among these five are the highest FGM

prevalence similar distribution regardless the wealth quintiles or residence. There is an economic burden of delay or non-decline of FGM that could be averted.

Conclusion
Findings indicate that some countries show a declining trend over time while others not. It can be observed that there is heterogeneity and homogeneity in the FGM prevalence within and between countries which may indicate inequality that deserves further investigation. There is considerable economic burden due to delays in the implementation of interventions to reduce or eliminate FGM. These insights can help in the preparation of public health interventions. (Author)
Full URL: https://doi.org/10.1186/s12939-024-02140-4

2024-13402

"All you Gain is Pain and Sorrow": Facilitators and Barriers to the Prevention of Female Genital Mutilation in High-income Countries. Younas F (2024), Trauma, Violence, & Abuse vol 25, no 4, 2024, pp 2891-2906

Background:
Female genital mutilation (FGM) is a harmful practice that has long-lasting negative impacts on the physical and psychological health of victims. Deemed a global concern, this practice persists in high-income countries (HIC) among certain migrant communities. Given the deleterious effects of the practice, we conducted an updated systematic review of the facilitators and barriers associated with the prevention of FGM in HIC.

Method:
A systematic review of published qualitative studies of FGM in HIC was conducted from 2012 to 2022. The search resulted in 276 studies. Of these, the majority were from low- and middle-income countries (LMIC) and excluded. A total of 14 studies were deemed fit for inclusion and none were excluded during quality appraisal. Relevant data were extracted from the studies and thematically analyzed to identify prevalent themes.

Results:
A total of 12 themes were identified and the majority reflected barriers to the prevention of FGM including beliefs about female virtue, beliefs about social sanctions, and the preservation of culture, among others. Facilitators to the prevention of FGM were fewer and included memory and trauma from experiencing FGM, knowledge and awareness of the female anatomy, and legislative protection from FGM due to migration. A few themes, such as religious beliefs, acted as both facilitators and barriers.

Conclusion:
Findings highlight the importance of shared cultural and social threads among FGM practicing communities in HIC. Interventions can use these findings to guide the development of sociocultural strategies centered on community-level prevention and reduction of FGM in HIC. (Author)
Full URL: https://doi.org/10.1177/15248380241229744

2024-13398

Prevalence of female genital mutilation and associated factors among women and girls in Africa: a systematic review and meta-analysis. Ayenew AA, Mol BW, Bradford B, et al (2024), Systematic Reviews vol 13, no 26, 12 January 2024

Background
Female genital mutilation (FGM) has zero health benefits. It can lead to short- and long-term risks and complications, including physical, sexual, and mental health and well-being of girls and women. It is a worldwide public health issue with more than 80% prevalence in Africa. It is a global imperative to strengthen work for the elimination, and the United Nations Sustainable Development Goal (SDG) strives to eliminate FGM and monitor the progress made. However, one of a challenge in tracking progress is establishing baseline prevalence data within regions and countries. Therefore, this review aimed to pool the prevalence of FGM in Africa and identify the promoting factors among women and girls.

Methods
This review was conducted according to the PRISMA checklist guideline. Both published and unpublished studies conducted from 2012 onwards were eligible. Studies written in non-English languages were excluded. To retrieve relevant studies; PubMed/Medline, Google Scholar, Science Direct, African Journals Online databases, and African Index Medicus (AIM) were searched using a combination of searching terms. The Newcastle-Ottawa Assessment Scale

(NOS) tool was used to assess the quality of each included study. The Cochran's Q chi-square and I2 statistical tests were used to evaluate the heterogeneity of the included studies. The Funnel plot and Egger's regression test (p value < 0.05) were used to evaluate meh publication bias. We used STATA for analysis and the overall and subgroup pooled effect size was estimated using the random effect model with DerSimonian and Laired pooled effect method. The overall prevalence of FGM and the adjusted odds ratio (AOR) with 95%CI (confidence interval) for contributing factors were calculated and presented using a forest plot.

Result

This study included 155 primary studies conducted on the prevalence and/or factors associated with FGM in Africa. The pooled prevalence of FGM was 56.4% (95%CI 49.7–63.6). The primary factors promoting the practice of FGM were family history of circumcision (AOR = 13.71, 95%CI 9.11−20.62), being a Muslim religion follower (AOR = 3.51, 95%CI 2.61−4.71), poor wealth index (AOR = 1.38, 95%CI1.27−1.51), higher age (AOR = 2.95, 95%CI 2.49−3.38), not attending formal education (AOR = 3.28, 95%CI 2.62−4.12), and rural residency (AOR = 2.27, 95%CI 1.84−2.80).

Conclusion

The prevalence of FGM in Africa was found to be high. This study also observed a variation in FGM prevalence across regions and countries and a slight temporal decline over the study period. As the global community enters the final decade dedicated to eliminating FGM, there remains much to be done to achieve the elimination goal. (Author)

Full URL: https://doi.org/10.1186/s13643-023-02428-6

2024-13397

Effectiveness of health education intervention on intention not to perform female genital mutilation/cutting in the future among key decision-makers: a systematic review and meta-analysis. Seifu W, Yadeta TA, Argaw GS, et al (2024), BMC Women's Health vol 24, no 581, 29 October 2024

Background

Female Genital Mutilation/Cutting (FGM/C) is a form of gender-based violence that has negative health consequences. The decision to perform FGM/C is often made collectively and a variety of actors influence the decision. There is inconsistent and inconclusive evidence that health education interventions lead behavioural changes related to FGM/C among key decision-makers. Therefore, the aim of this systematic review and meta-analysis was to examine the effectiveness of health education interventions on decision-makers intentions not to perform FGM/C in the future.

Methods

A systematic review and meta-analysis were performed according to the Preferred Item for Systematic Review and Meta-analysis (PRISRMA) guideline. Studies were obtained from databases such as PubMed, Google Scholar, EMBASE, CINAHL, Cochrane, African Journals Online and relevant lists of identified studies (interventional studies related to FGM/C among key decision-makers). Unpublished sources and organizational websites were also searched for relevant articles. The quality of studies was assessed using the Quality Assessment Tool for Quantitative Studies developed by the Effective Public Health Practice Project's. The meta-analysis was carried out using STATA.17 and Review Manager 5.3 software. Heterogeneity and publication bias were assessed using the I2 statistic and funnel plot, respectively. The pooled effect size with a 95% confidence interval was presented using a forest plot and random effect model.

Results

This meta-analysis included nineteen studies with a total of 13,326 study participants. The overall pooled relative risk of intention not to perform FGM/C in the future was 1.55 (95% CI;1.24, 1.94). In the subgroup analysis, the effect of health education on intention not to perform in the future was higher in studies that used both health education and other interventions (RR = 3.75, 95% CI; 2.04, 6.88) compared to those using only health education (RR = 1.35, 95% CI; 0.95, 1.92). Studies with longer intervention duration (above 12 months) had a greater effect on intention not to perform (RR = 1.34, 95% CI; 0.86, 2.09) compared to studies with a short intervention period (6–12 months) (RR = 1.14, 95% CI; 0.61, 2.15).

Conclusion

This review examined the impact of health education on key decisions-makers' intention not to perform FGM/C in the future. Although the pooled effect size estimate may have been influenced by heterogeneity, the results suggest that education about FGM/C has a positive influence on the intentions of key decision-makers. It is recommended that

health education interventions target local decision-makers such as religious and clan leaders and include them in initiatives aimed at preventing and eliminating FGM/C.

PROSPERO registration number
CRD42024542541.

Full URL: https://doi.org/10.1186/s12905-024-03427-y

2024-12727

Female Genital Mutilation, Annual Report - April 2022 to March 2023. NHS Digital (2023), 10 August 2023

This publication includes analysis of data for the year April 2022 to March 2023 from the Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) which is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices. The report includes data on the type of FGM, age at which FGM was undertaken and in which country, the age of the woman or girl at her latest attendance and if she was advised of the health implications and illegalities of FGM and various other analyses. Some data for earlier years are reported. (Author)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/april-2022-to-march-2023

2024-12726

Female Genital Mutilation, Annual Report - April 2023 to March 2024. NHS Digital (2024), 19 September 2024

This publication includes analysis of data for the year April 2023 to March 2024 from the Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) which is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices. The report includes data on the type of FGM, age at which FGM was undertaken and in which country, the age of the woman or girl at her latest attendance and if she was advised of the health implications and illegalities of FGM and various other analyses. Some data for earlier years are reported. (Author)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/april-2023-to-march-2024

2024-12438

East Africa: Gender Based Violence [written answer]. House of Commons (2024), Hansard Written question 6971, 4 October 2024

Anneliese Dodds responds to a written question from Adam Jogee to the Secretary of State for Foreign, Commonwealth and Development Affairs, regarding what steps he is taking to help tackle violence against women and girls in (a) Uganda and (b) East Africa. (MB)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-10-04/6971

2024-11732

Female genital mutilation/cutting in women delivering in France: An observational national study. Cinelli H, Lelong N, Lesclingand M, et al (2025), International Journal of Gynecology & Obstetrics vol 168, no 2, February 2025, pp 693-700

Objective

International migration from source countries has meant that clinicians in high income countries, that is, receiving countries, are increasingly caring for affected women affected by female genital mutilation/cutting (FGM/C). The aim of the present study was to assess the prevalence of FGM/C among women at childbirth, and its association with pregnancy outcomes.

Methods

This was an observational study using data from a cross-sectional population-based study from the French National Perinatal Survey of 2021 (ENP) conducted in all maternity units in mainland France and including all women delivering a live birth during 1 week in March 2021 (N = 10 928). We estimated the FGM/C prevalence using (i) the diagnosed cases and (ii) the indirect prevalence estimated by UNICEF in each source country. We compared population characteristics and perinatal outcomes between women diagnosed with FGM/C and two groups: (i) women originating in source countries and diagnosed as without FGM/C and (ii) all women without diagnosis of FGM/C whatever the country of birth.

Results

Diagnosed prevalence of FGM/C was 95% (95% CI: 0.78–1.14] and the indirect computed estimation prevalence was

estimated at 1.53% (95% CI: 1.31–1.77) in 113 and 183 women, respectively. Labor and delivery outcomes were globally similar in women with FGM/C and the other two groups. Only episiotomy was more frequently performed in women with FGM/C than in the other two groups.

Conclusion
In receiving countries, obstetric outcomes of women with FGM/C can be similar to those of other women, which does not preclude need of further research and training to provide the most appropriate care, including enhanced attention to diagnosis. (Author)
Full URL: https://doi.org/10.1002/ijgo.15880

2024-10113

Female Genital Mutilation and Forced Marriage [written answer]. House of Lords (2024), Hansard Written question HL529, 30 July 2024

Lord Hanson of Flint responds to a written question from The Lord Bishop of St Albans to His Majesty's Government, further to the Written Answer by Lord Sharpe of Epsom on 23 May (HL4639), regarding when the findings of the feasibility study on the possibility of developing prevalence estimates for female genital mutilation and forced marriage will be published. (MB)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-07-30/HL529

2024-09557

R v Noor: a landmark case in female genital mutilation prosecution. Saund-Matharu H, Home J (2024), British Journal of Midwifery vol 32, no 8, August 2024, pp 440–445

This article on the case of R v Noor (2024) discusses the second successful UK prosecution under the Female Genital Mutilation Act 2003, marking a significant legal precedent in addressing female genital mutilation. It underscores the critical role of midwives in detecting, reporting and caring for victims, highlighting the intersection of healthcare, law and ethics in combating this practice. By examining the case of Amina Noor, who took a child abroad for female genital mutilation, the article elucidates the legal ramifications of such acts. It stresses the importance of midwifery awareness, education and collaboration with legal entities to protect women and girls. The article advocates for continuous professional development, the use of legal tools such as female genital mutilation protection orders and a Commissioner to prevent female genital mutilation, emphasising the collective responsibility of healthcare professionals in eradicating this harmful practice and safeguarding vulnerable individuals. (Author)

2024-08785

Female Genital Mutilation/Cutting Related to Reproductive Health Needs During Pregnancy and Birth. Hawkins SS (2024), JOGNN: Journal of Obstetric, Gynecologic and Neonatal Nursing vol 53, no 4, July 2024, pp 324-337

Female genital mutilation and cutting (FGM/C) is a human rights violation and a form of gender-based violence. Yet it is estimated that more than 230 million women and girls globally and over half a million women and girls living in the United States have been subjected to FGM/C or are at risk. Due to rising rates of immigration to the United States, it is more likely that health care providers will encounter patients subjected to FGM/C. In this column, I review clinicians' knowledge of and experience in delivering care to women with FGM/C, patient experiences, the role of clinical guidelines, screening, research gaps, laws, and data. I conclude with recommendations from professional organizations related to the reproductive health needs of women affected by FGM/C during pregnancy and birth. (Author)

2024-06286

Pre-service education and continuous professional development on female genital mutilation/cutting for maternal health professionals in OECD countries: A scoping review. Apini-Welcland L, Daniele MAS, Rocca-Ihenacho L, et al (2024), Midwifery vol 135, August 2024, 104027

Background
Female Genital Mutilation/Cutting can cause sequalae throughout pregnancy, childbirth, and the postpartum period. Due to changing patterns in migration flows, the practice evolved into a global phenomenon. Health professionals should ensure high quality of care during maternity service provision.

Objective
This scoping review aimed to map available evidence on pre-service and continuous professional development

education about Female Genital Mutilation/Cutting for maternal health professionals and identify developmental needs for topic inclusion into teaching.

Methodology
The review was conducted in accordance with the PRISMA-ScR guidelines. A protocol was developed and is publicly available (medRxiv 2022.08.16.22278598). Three databases (CINAHL, Embase, Medline) and other educational sources were searched. During the final stages of the review an ethical application was submitted and approved. Expert interviews were added to gain insights from practice.

Results
The search identified 224 records. After title and abstract screening, 33 studies were selected for full-text review, resulting into the inclusion of 4 studies and 12 non-research educational sources. Scoping the topic revealed that Female Genital Mutilation/Cutting is often included ad-hoc or stand-alone during trainings and it remains unclear, who owes the responsibility. There is lack of knowledge about which competencies are needed for the different levels of health cadres, how competencies are achieved and outcomes measured.

Conclusion
More transparency into training on Female Genital Mutilation/Cutting and about how competency levels are achieved, maintained and evaluated is required. Further research and interdisciplinary collaboration could focus on the development of specific modules and lead to service improvement. (Author)
Full URL: https://doi.org/10.1016/j.midw.2024.104027

2024-06122

Male or female genital cutting: why 'health benefits' are morally irrelevant. Earp BD (2021), Journal of Medical Ethics vol 47, no 12, December 2021, e92

The WHO, American Academy of Pediatrics and other Western medical bodies currently maintain that all medically unnecessary female genital cutting of minors is categorically a human rights violation, while either tolerating or actively endorsing medically unnecessary male genital cutting of minors, especially in the form of penile circumcision. Given that some forms of female genital cutting, such as ritual pricking or nicking of the clitoral hood, are less severe than penile circumcision, yet are often performed within the same families for similar (eg, religious) reasons, it may seem that there is an unjust double standard. Against this view, it is sometimes claimed that while female genital cutting has 'no health benefits', male genital cutting has at least some. Is that really the case? And if it is the case, can it justify the disparate treatment of children with different sex characteristics when it comes to protecting their genital integrity? I argue that, even if one accepts the health claims that are sometimes raised in this context, they cannot justify such disparate treatment. Rather, children of all sexes and genders have an equal right to (future) bodily autonomy. This includes the right to decide whether their own 'private' anatomy should be exposed to surgical risk, much less permanently altered, for reasons they themselves endorse when they are sufficiently mature. (Author)

2024-05483

Female genital mutilation is on the rise in Africa: disturbing new trends are driving up the numbers. Bradley T (2024), The Conversation 12 May 2024

Despite campaigns to end the practice, there are 30 million more women and girls globally who have undergone female genital mutilation than eight years ago. This article examines the alarming trends that are affecting progress made towards eliminating the practice. (MB)
Full URL: https://theconversation.com/female-genital-mutilation-is-on-the-rise-in-africa-disturbing-new-trends-are-driving-up-the-numbers-227175

2024-05384

The impact of community led alternative rite of passage on eradication of female genital mutilation/cutting in Kajiado County, Kenya: A quasi-experimental study. Muhula S, Mveyange A, Oti SO, et al (2021), PLoS ONE vol 16, no 4, April 2021, e0249662

Introduction
In Kenya, Female Genital Mutilation/Cutting (FGM/C) is highly prevalent in specific communities such as the Maasai and Somali. With the intention of curtailing FMG/C prevalence in Maasai community, Amref Health Africa, designed and implemented a novel intervention—community-led alternative rite of passage (CLARP) in Kajiado County in Kenya since 2009. The study: a) determined the impact of the CLARP model on FGM/C, child early and forced

marriages (CEFM), teenage pregnancies (TP) and years of schooling among girls and b) explored the attitude, perception and practices of community stakeholders towards FGM/C.

Methods
We utilised a mixed methods approach. A difference-in-difference approach was used to quantify the average impact of the model with Kajiado as the intervention County and Mandera, Marsabit and Wajir as control counties. The approach relied on secondary data analysis of the Kenya Demographic and Health Survey (KDHS) 2003, 2008–2009 and 2014. A qualitative approach involving focus group discussions, in-depth interviews and key informant interviews were conducted with various respondents and community stakeholders to document experiences, attitude and practices towards FGM/C.

Results
The CLARP has contributed to: 1) decline in FGM/C prevalence, CEFM rates and TP rates among girls by 24.2% ($p<0.10$), 4.9% ($p<0.01$) and 6.3% ($p<0.01$) respectively. 2) increase in girls schooling years by 2.5 years ($p<0.05$). Perceived CLARP benefits to girls included: reduction in teenage marriages and childbirth; increased school retention and completion; teenage pregnancies reduction and decline in FGM/C prevalence. Community stakeholders in Kajiado believe that CLARP has been embraced in the community because of its impacts in the lives of its beneficiaries and their families.

Conclusion
This study demonstrated that CLARP has been positively received by the Maasai community and has played a significant role in attenuating FGM/C, CEFM and TP in Kajiado, while contributing to increasing girls' schooling years. CLARP is replicable as it is currently being implemented in Tanzania. We recommend scaling it up for adoption by stakeholders implementing in other counties that practice FGM/C as a rite of passage in Kenya and across other sub Saharan Africa countries. (Author)
Full URL: https://doi.org/10.1371/journal.pone.0249662

2024-05344

The Gambia: Female Genital Mutilation [written answer]. House of Lords (2024), Hansard Written question HL3714, 15 April 2024

Lord Benyon responds to a written question from Lord Alton of Liverpool to His Majesty's Government, regarding whether they are working with the United Nations and World Health Organisation in their efforts to strengthen laws and policies to protect women and girls from female genital mutilation in The Gambia, as committed to in the International Women and Girls Strategy 2023 to 2030. (JSM)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-04-15/HL3714

2024-05099

The Gambia: Women [written answer]. House of Commons (2024), Hansard Written question 21623,15 April 2024

Mr Andrew Mitchell responds to a written question from Mrs Pauline Latham to the Deputy Foreign Secretary, regarding whether he has made representations to his Gambian counterpart on (a) that country's obligations under the Convention on the Elimination of All Forms of Discrimination against Women and (b) ensuring a continuing ban on female genital mutilation. (JSM)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-04-15/21623

2024-04997

United Nations [written answer]. House of Commons (2024), Hansard Written question 22142,16 April 2024

Mr Andrew Mitchell responds to a written question from Marsha De Cordova to the Deputy Foreign Secretary, regarding what his priorities are for the UN Summit of the Future on 22-23 September 2024. Listed among those priorities are: to defend positions on human rights and gender, notably sexual health and reproductive rights and Female Genital Mutilation, and advance women's participation at all levels of decision-making. (JSM)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-04-16/22142

2024-04311

The Gambia: Female Genital Mutilation [written answer]. House of Lords (2024), Hansard Written question HL3491, 20 March 2024

Lord Benyon responds to a written question from Lord Stevens of Birmingham to His Majesty's Government, regarding

what representations they have made to the government of the Gambia concerning new legislation which would decriminalise female genital mutilation. (MB)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-03-20/HL3491

2024-03747

Developing Countries: Female Genital Mutilation [written answer]. House of Commons (2024), Hansard Written question 18638, 14 March 2024

Mr Andrew Mitchell responds to a written question from Jeremy Corbin to the Minister of State, Foreign, Commonwealth and Development Office, regarding what funding from the public purse was provided to grassroots organisations working to eradicate FGM in their communities in each of the last five years. (JSM)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-03-14/18638

2024-03745

Developing Countries: Female Genital Mutilation [written answer]. House of Commons (2024), Hansard Written question 18637, 14 March 2024

Mr Andrew Mitchell responds to a written question from Jeremy Corbin to the Minister of State, Foreign, Commonwealth and Development Office, regarding what criteria his Department uses to assess the effectiveness of programs working on eradicating FGM that his Department (a) has awarded and (b) plans to award funds to. (JSM)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-03-14/18637

2024-03744

Developing Countries: Female Genital Mutilation [written answer]. House of Commons (2024), Hansard Written question 18636, 14 March 2024

Mr Andrew Mitchell responds to a written question from Jeremy Corbin to the Minister of State, Foreign, Commonwealth and Development Office, regarding to which (a) charities and (b) other organisations his Department has allocated funding to help tackle FGM in the last five years. (JSM)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-03-14/18636

2024-03743

Kenya: Female Genital Mutilation [written answer]. House of Commons (2024), Hansard Written question 18635, 14 March 2024

Mr Andrew Mitchell responds to a written question from Jeremy Corbin to the Minister of State for Foreign, Commonwealth and Development Office, regarding what criteria his Department uses to determine whether to allocate funding to organisations to help tackle FGM in Kenya. (JSM)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-03-14/18635

2024-03292

Midwives' experiences of providing intrapartum care to women with female genital mutilation in a northwest trust: research proposal with methodology rationale. Braimah D (2024), MIDIRS Midwifery Digest vol 34, no 1, March 2024, pp 75-79

Background

Female genital mutilation (FGM) is defined by the World Health Organization (WHO (2023)) as 'the total or partial removal of the external female genitalia' on non-medical grounds. The UK has experienced high levels of migration in recent years, increasingly from countries with FGM practice. This has resulted in midwives' facing the challenges of caring for women with FGM, who often present with complex needs. It is crucial for midwives to feel competent and safe as the primary professionals caring for all women in labour. No study has explored midwives' experiences of providing intrapartum care to women with FGM in the north-west of England. Therefore, this research will be pertinent to filling a gap in evidence in the maternity literature.

Aim

To explore midwives' experiences of providing intrapartum care to women with FGM, in a north-west England trust. This will highlight challenges and barriers faced by midwives, subsequently identifying any support and training needs in providing culturally sensitive intrapartum care to women with FGM specific to the north-west of England.

Method

This research proposal adopts a qualitative–phenomenological paradigm. Semi-structured interviews will be conducted with potentially five midwives recruited from Trust A (a north-west NHS trust) working on a birth unit, via

purposive sampling.
Findings
Thematic analysis will be used to extract relevant findings from
audio-recorded interviews.
Dissemination of findings
The study's findings will be disseminated to participants,
the public and relevant health professionals, regardless of the desirability of results, in peer-reviewed journals, other midwifery publications, conferences and events. (Author)

2024-03090

Mandatory reporting of female genital mutilation: Q and A for regulated professionals. Royal College of Midwives (2017), February 2017. 4 pages

This Q and A document gives relevant professionals and the police an understanding of the female genital mutilation (FGM) mandatory reporting duty. (Author)

Full URL: https://www.rcm.org.uk/media/1878/mandatory-reporting-fgm.pdf

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2024-02868

Female Genital Mutilation and Forced Marriage [written answer]. House of Lords (2024), Hansard Written question HL2409, 12 February 2024

Lord Sharpe of Epsom responds to a written question from The Lord Bishop of St Albans to His Majesty's Government, further to the Written Answer by Lord Stewart of Dirleton on 29 March 2023 (HL6584), when the government-funded feasibility study on the prevalence of female genital mutilation and forced marriage in England and Wales will be published. (JSM)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-02-12/hl2409

2024-02867

Female Genital Mutilation: Prosecutions [written answer]. House of Lords (2024), Hansard Written question HL2408, 12 February 2024

Lord Sharpe of Epsom responds to a written question from The Lord Bishop of St Albans to His Majesty's Government, regarding how many female genital mutilation offences were recorded between April 2022 and March 2023; and of those, how many prosecutions have occurred. (JSM)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-02-12/hl2408

2024-02163

Second UK conviction for FGM. Albert J (2024), British Journal of Midwifery vol 32, no 2, February 2024, pp 106–107

Juliet Albert explores what the second UK conviction against female genital mutilation means for midwives, and the legislation surrounding this issue. (Author)

2024-02031

Strengthening woman-centred care for pregnant women with female genital mutilation in Australia: a qualitative muti-method study. Turkmani S, Dawson D (2024), Frontiers in Global Women's Health 16 January 2024, online

Woman-centred care is a collaborative approach to care management, where the woman and her health provider recognise one another's expertise and interact based on mutual respect to provide adequate information and individualised care. However, woman-centred care has not been fully achieved, particularly for women who have experienced female genital mutilation in high-income countries. A lack of clear guidelines defining how to implement woman-centred care may negatively impact care provision. This study sought to explore the quality of point-of-care experiences and needs of pregnant women with female genital mutilation in Australia to identify elements of woman-centred care important to women and how woman-centred care can be strengthened during consultations with health professionals. This multi-method qualitative study comprised two phases. In phase one, we conducted interviews with women with female genital mutilation to explore their positive experiences during their last pregnancy, and in phase two, a workshop was held where the findings were presented and discussed to develop recommendations for guidelines to support woman-centred care. The findings of the first phase were presented under three distinct categories of principles, enablers, and activities following a framework from the literature. In phase two, narrative storytelling allowed women to share their stories of care, their preferences, and how they

believe health providers could better support them. Their stories were recorded visually. This study highlights the importance of a comprehensive approach to woman-centred care involving experts, clinicians, community members, and women in designing education, tools, and guidelines. (Author)

Full URL: https://doi.org/10.3389/fgwh.2024.1248562

2024-01994

Africa: Female Genital Mutilation [written answer]. House of Commons (2024), Hansard Written question 12802, 2 February 2024

Mr Andrew Mitchell responds to a written question from Ms Lyn Brown to the Secretary of State for Foreign, Commonwealth and Development Affairs, regarding what recent steps he has taken to help end female genital mutilation in (a) Sierra Leone and (b) other African states. (MB)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2024-02-02/12802

2024-00136

The Gambia: Women [written answer]. House of Lords (2023), Hansard Written question HL1253, 18 December 2023

Lord Benyon responds to a written question from Baroness Bennett of Manor Castle to His Majesty's Government, regarding what assessment they have made of potential plans to repeal the law banning female genital mutilation (FGM) in the Gambia; whether representations have been made to the government of the Gambia to protect women and girls in the country from FGM and sexual violence; what plans they have to ensure the safety and security of human rights defenders and social activists in the Gambia; and what access to resources, if any, they have made available to civil society groups and grassroots organisations working to strengthen women's and girl's rights in the Gambia. (JSM)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2023-12-18/HL1253

2023-13179

"A lot of them have scary tears during childbirth…" experiences of healthcare workers who care for genitally mutilated females. Obiora OL, Maree JE, Nkosi-Mafutha NG (2021), PLoS ONE vol 16, no 1, January 2021, e0246130

Despite concerted efforts to curb Female Genital Mutilation/Cutting (FGM/C), it is still a contributor to the high morbidity and mortality rates among females in Africa. According to available literature, the experiences of healthcare workers who care for the genitally mutilated females in Nigeria have not been described, hindering efforts towards ending this procedure through evidence-based, community-led interventions. This qualitative study described the experiences of healthcare workers caring for the genitally mutilated females in South-Eastern Nigeria. In-depth interviews conducted with 17 participants resulted in two themes and five sub-themes. The participants faced major challenges in caring for these females as the complications of FGM/C resulted in situations requiring advanced skills for which they were ill-prepared. Irrespective of this complex situation, the participants believed FGM/C was an age-old cultural practice; some even supported its continuation. The solution to this problem is not simple. However, educational programmes involving all cadres of healthcare workers could assist with eradicating this practice. Also, enforcing the anti-FGMC law could enhance the eradication of this procedure. (Author)

Full URL: https://doi.org/10.1371/journal.pone.0246130

2023-12813

Trend in female genital mutilation and its associated adverse birth outcomes: A 10-year retrospective birth registry study in Northern Tanzania. Suleiman IR, Maro E, Shayo BC, et al (2021), PLoS ONE vol 16, no 1, January 2021, e0244888

Background

Approximately 200 million women and girls were reported to have undergone female genital mutilation worldwide in 2015.UNICEF's data based on household survey estimates 15% of women from 15–49 years have undergone FGM from year 2004–2015. Despite this, reliable data on trend of prevalence of female genital mutilation and its associated birth outcomes have not been documented in Tanzania. This study aimed at determining the trends of female genital mutilation and associated maternal and neonatal adverse outcomes in northern Tanzania.

Methods

A cross-sectional study was conducted using maternally-linked data from Kilimanjaro Christian Medical birth registry involving 30,286 women who gave birth to singletons from 2004–2014. The prevalence of female genital mutilation was computed as proportion of women with female genital mutilation yearly over 10 years. Odds ratios with 95% confidence intervals for adverse birth outcomes associated with female genital mutilation were estimated using

multivariable logistic regression model.

Results

Over the 10-year period, the prevalence of female genital mutilation averaged 15.4%. Female genital mutilation decreased from 23.6% in 2005 to 10.6% in 2014. Female genital mutilation was associated with increased odds for caesarean section (aOR1.26; 95% CI: 1.18–1.34), post-partum haemorrhage (aOR 1.31; 95% CI: 1.10–1.57) and long hospital stay (aOR 1.21; 95% CI: 1.14–1.29). Female genital mutilation also increased women's likelihood of delivering an infant with low Apgar score at 5th minute (aOR 1.60; 95% CI: 1.37–1.89).FGM type III and IV had increased odds of caesarean section, episiotomy and prolonged duration of hospital stay as compared to FGM type I and II, although the association was statistically insignificant.

Conclusion

Female genital mutilation prevalence has declined over the study period. Our study has demonstrated that postpartum haemorrhage, delivery by caesarean section, long maternal hospital stays and low APGAR score are associated with FGM. Initiatives to mitigate FGM practice should be strengthened further to reduce/eliminate this practice. Moreover, surgical interventions to improve severe form FGM are welcomed to improve the aforementioned aspects of obstetric outcome in this locality. (Author)

Full URL: https://doi.org/10.1371/journal.pone.0244888

2023-12371

Attitude towards female circumcision among women in Ethiopia. Alemu DG, Haile ZT, Conserve DF (2021), Sexual & Reproductive Healthcare vol 29, September 2021, 100647

Female genital mutilation or cutting (FGM/C) is a global phenomenon mostly practiced in Africa, Asia, and the middle east. It involves the removal of the external female genitalia for non-medical reasons. The practice cuts across different ethnic and religious groups in Africa and is associated with several health complications. The following study assessed attitude towards the practice among Ethiopian women aged 15–49. Using the Ethiopia Demographic and Health Survey from 2016 as a data source, we analyzed a sample of 6984 women. We used the respectable femininity discourse to inform our variable selection. The main outcome variable assessed whether women supported or rejected the continuation of the practice. In the bivariate analysis, all the sociodemographic variables including women's circumcision experience were strongly associated with the outcome variable. In the multiple logistic regression, only education, wealth, religion, and circumcision status were independently associated with women's attitude towards FGM/C. For instance, compared to women with no education, women with at least a secondary education were more than 4 times (AOR 4.2, 95% CI 2.53–7.04, P-Value < 0.001) more likely to agree with the termination of the practice. Our findings suggest that changing attitudes towards FGM/C may require uplifting the social and economic status of women, working with those who have experienced FGM/C and collaborating with religious leaders. (Author)

2023-12367

Defibulated immigrant women's sexual and reproductive health from the perspective of midwives and gynaecologists as primary care providers in Sweden – A phenomenographic study. Ahmed CA, Khokhar AT, Erlandsson K, et al (2021), Sexual & Reproductive Healthcare vol 29, September 2021, 100644

Objective

To capture care providers' perceptions of defibulated immigrant women's sexual and reproductive health, illuminated by their experiences as care providers for these women.

Methods

Individual interview study with 13 care providers at Swedish healthcare facilities: six gynaecologists and seven midwives caring for defibulated immigrant women, analysed with a phenomenographic method.

Findings

One of the care providers' perceptions of women who had been defibulated was that they had an altered genital function, meaning a wider introitus, improved vaginal intercourse, and more ease urinating and menstruating. The care providers also perceived that women who were defibulated had to balance their wellbeing, struggling between a positive self-image and handling their emotions. Existing in-between cultural values led to a fear of being excluded while at the same time having a desire to be included in the new culture.

Conclusion
Defibulation affects women's sexual and reproductive health and calls for a holistic perspective when providing services, individualized according to the woman's care needs. Support and counselling, should include information about defibulation already during the adolescent years to promote sexual and reproductive health and well-being. (Author)
Full URL: https://doi.org/10.1016/j.srhc.2021.100644

2023-12356

The experiences and psychological outcomes for pregnant women who have had FGM: A systematic review. Wood R, Richens Y, Lavender T (2021), Sexual & Reproductive Healthcare vol 29, September 2021, 100639

Female genital mutilation (FGM) is a global issue, with 200 million women and girls thought to be affected. FGM is defined as removal of female external genitalia, either partial or total, for non-medical purposes. FGM is embedded in tradition, including cultural beliefs about sexual behaviour. Associated risks include haemorrhage, infection, death, dyspareunia, childbirth complications and psychological issues. Although FGM negatively impacts on women's psychological wellbeing, little is known about the impact on pregnancy experiences. Psychological consequences of FGM are likely to be intensified during pregnancy when women have concerns about their own and their baby's wellbeing. This mixed-method systematic review aimed to provide insight into the psychological impact of FGM on women who subsequently become pregnant. Nine electronic databases were searched, using a search strategy to identify relevant studies. Studies were considered for inclusion if they were primary studies (qualitative, quantitative or mixed-method) involving pregnant women of any age who have previously undergone FGM. Relevant studies were evaluated using the MMAT appraisal tool. Analysis was guided by the review questions and the evidence identified. One quantitative and 9 qualitative papers were included. Qualitative data were analysed using meta-ethnography. Narrative analysis of the quantitative study was conducted. Findings relate to power of choice linked to reinfibulation, deinfibulation, birth procedures and pain management; importance of knowledgeable and sensitive health care professionals; and relived trauma experienced during childbirth. These findings could inform the development of supportive interventions for women with FGM within maternity services. (Author)

2023-12285

What women want: A reflexive thematic analysis of the healthcare experiences of women with female genital mutilation/cutting in South Australia. Diaz MP, Brown AE, Fleet J-A, et al (2023), Women and Birth: Journal of the Australian College of Midwives vol 36, no 6, November 2023, pp e652-e660

Background
Global migration has seen an increase in female genital mutilation/cutting (FGM/C) cases observed in countries where it is not part of the cultural norm. This shift has led to many healthcare professionals (HCPs) reporting a lack of knowledge and skills necessary to support the needs of women with FGM/C.

Aim
To explore the experiences and needs of women with FGM/C accessing women's health services in South Australia.

Methods
Women with FGM/C were recruited through purposive and snowball sampling to participate in one-to-one semi-structured interviews. The voice recorded interviews were transcribed verbatim, coded, and analysed using Braun and Clarke's reflexive thematic analysis to determine themes.

Findings
Ten migrant and refugee women living in South Australia, were interviewed. Four themes and 13-subthemes were identified. The main themes were, 1) the healthcare experience, 2) cultural values shape the healthcare experience, 3) speaking up about female genital cutting and 4) working together to improve healthcare experiences.

Discussion
Women's cultural needs, not their health needs, play a fundamental role on how women experienced healthcare services. When women's cultural values and traditions are acknowledged by HCPs, they are more likely to trust and feel confident to engage with services and seek medical support. Areas identified for improvement included access to the right interpreters, having more time during appointments, opportunities for continuity of care and the inclusion of family in care and treatment decisions.

Conclusion
Women with FGM/C have specific health and cultural needs that can be met through education and provision of woman-centred care. (Author)
Full URL: https://doi.org/10.1016/j.wombi.2023.06.004

2023-11692

Female Genital Mutilation Protection Orders [written answer]. House of Lords (2023), Hansard Written question HL10774, 24 October 2023

Lord Bellamy responds to a written question from Baroness Jenkin of Kennington to His Majesty's Government, further to the Written Answer by Lord Bellamy on 21 September (HL10037), regarding how many female genital mutilation protection orders have been breached since 2018; and what steps they have taken in response to those breaches. (MB)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2023-10-24/hl10774

2023-11293

Female Genital Mutilation [written answer]. House of Lords (2023), Hansard Written question HL10458, 2 October 2023

Lord Ahmad of Wimbledon responds to a written question from Baroness Hodgson of Abinger to His Majesty's Government, regarding what steps they are taking to (1) address, and (2) advocate against, the incidence of female genital mutilation being performed by healthcare workers in countries where it is nationally banned but historically performed. (JSM)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2023-10-02/hl10458

2023-11144

Female genital mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk Interim report on provisional estimates. Macfarlane A, Dorkenoo E (2014), 21 July 2014. 24 pages

This report contains provisional estimates of the numbers of women with female genital mutilation(FGM) living in England and Wales, the numbers of women with FGM giving birth and the numbersof girls born to women with FGM. These are headline figures for England and Wales as a whole. Further work is under way to provide estimates at a local authority level and to refine these national analyses. These will be published later in the full project report. (Author)
Full URL: https://tfl.ams3.cdn.digitaloceanspaces.com/media/documents/FGM-statistics-report-21-07-14-no-embargo.pdf

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2023-11139

Impact of psychological disorders after female genital mutilation among Kurdish girls in Northern Iraq. Kizilhan JI (2011), European Journal of Psychiatry vol 25, no 2, June 2011, pp 92-100

Background and Objectives: This study investigated the mental health status of young girls after genital mutilation in Northern Iraq. Although experts assume that circumcised girls are more prone to psychiatric illnesses than non-circumcised girls, little research has been conducted to confirm this claim. For the purpose of this study, it was assumed that female genital mutilation is connected with a high rate of posttraumatic stress disorders (PTSD).
Methods: The psychological impact of female genital mutilation was assessed in Northern Iraq with 79 circumcised Kurdish girls who were between 8 and 14 years of age. Thirty uncircumcised girls from the above area and thirty-one uncircumcised girls from other areas of Iraq served as comparison subjects. A psychological interview and further questionnaires were used to assess traumatization and psychiatric illnesses.
Results: The circumcised girls showed a significantly higher prevalence of PTSD (44.3%), depression disorder (33.6%), anxiety disorder (45.6%) and somatic disturbance (36.7%) than the uncircumcised girls. We could not find any significant differences between the two control groups.
Conclusions: Within the circumcised group, a mental health problem can be diagnosed that may constitute the first evidence for the severe psychological consequences of juvenile girls´ genital mutilation. (Author)
Full URL: https://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S0213-61632011000200004#:~:text=https%3A//dx.doi.org/10.4321/S0213%2D61632011000200004

2023-11095

An updated systematic review and meta-analysis of the obstetric consequences of female genital mutilation/cutting.
Berg RC, Odgaard-Jensen J, Fretheim A, et al (2014), Obstetrics and Gynecology International 23 November 2014, Article ID 542859

In our recent systematic review in Obstetrics and Gynecology International of the association between FGM/C and

obstetric harm we concluded that FGM/C significantly increases the risk of delivery complications. The findings were based on unadjusted effect estimates from both prospective and retrospective studies. To accommodate requests by critics, we aimed to validate these results through additional analyses based on adjusted estimates from prospective studies. We judged that 7 of the 28 studies included in our original systematic review were prospective. Statistical adjustments for measured confounding factors were made in eight studies, including three prospective studies. The adjusted confounders differed across studies in number and type. Results from meta-analyses based on adjusted estimates, with or without data from retrospective studies, consistently pointed in the same direction as our earlier findings. There were only small differences in the sizes or the level of statistical significance. Using GRADE, we assessed that our confidence in the effect estimates was very low or low for all outcomes. The adjusted estimates generally show similar obstetric harms from FGM/C as unadjusted estimates do. Thus, the current analyses confirm the findings from our previous systematic review. There are sufficient grounds to conclude that FGM/C, with respect to obstetric circumstances, involves harm. (Author)

Full URL: https://www.hindawi.com/journals/ogi/2014/542859/

2023-10771

Everything you need to know about female genital mutilation (FGM) and what UNICEF is doing to stop it. (Author, edited)

Full URL: https://www.unicef.org/stories/what-you-need-know-about-female-genital-mutilation

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2023-10766

FGM Safeguarding Pathway. Department of Health (2017), 2017

Guidelines in the form of a flow chart to assist health care professionals where there are indications that female genital mutilation (FGM) has been performed on a patient. (JSM)

Full URL: https://assets.publishing.service.gov.uk/media/5a8197a940f0b62305b8fc87/FGM_Flowchart.pdf

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2023-10743

Female genital mutilation risk and safeguarding: guidance for professionals. FGM Prevention Programme, Department of Health (2016), May 2016

NB: This document supersedes the March 2015 guideline.

This guidance is aimed at healthcare professionals, local safeguarding children board members, named safeguarding leads, designated safeguarding professionals, commissioning
professionals, all other professionals involved in child protection and responsible for ensuring healthcare services have appropriate safeguarding arrangements

It has been developed to provide information about the specific issues frequently encountered when dealing with FGM. In addition, it provides a framework which organisations may wish to adopt to support professionals in the ongoing consideration of risks pertaining to FGM. (Author, edited)

Full URL: https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm

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2023-10115

Female Genital Mutilation, April 2023 - June 2023. NHS Digital (2023), 19 September 2023

This publication includes analysis of data for the months April 2023 to June 2023 from the Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) which is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices. The report includes data on the type of FGM, age at which FGM was undertaken and in which country, the age of the woman or girl at her latest attendance and if she was advised of the health implications and illegalities of FGM and various other analyses. Some data for earlier years are reported. (Author)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/april-2023---june-2023

2023-08886

Female Genital Mutilation - April 2022 to March 2023. (2023), NHS Digital 10 August 2023

The Female Genital Mutilation (FGM) statistics are an experimental statistics report which are produced annually. This report is made up of data added to the FGM Enhanced Dataset collection platform between April 2022 to March 2023.

(Author)
Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/april-2022-to-march-2023

2023-05359

Effects of clitoral reconstruction for female genital mutilation on perinatal outcomes: A retrospective case-control study. Madzou S, Reau-Giusti C, Hervé S, et al (2021), Journal of Gynecology, Obstetrics and Human Reproduction vol 50, no 5, May 2021, 101954

Objectives

To investigate the perinatal outcomes of women with a history of female genital mutilation (FGM) who underwent clitoral reconstruction (CR) compared with women with FGM who did not undergo CR.

Material and methods

Retrospective case-control study at Angers University Hospital, between 2005 and 2017. Inclusion criteria: pregnant women >18 years who underwent CR after FGM. Only the first subsequent delivery after CR was included. Each woman with CR was matched for age, ethnicity, FGM type, parity, and gestational age at the time of delivery with two women with FGM who did not undergo CR during the same period of time. At birth, the main outcomes were the need for episiotomy and having an intact perineum after delivery.

Results

84 women were included (28 in the CR group; 56 in the control group). In the CR group, patients required significantly fewer episiotomies (5/17[29.4 %]) compared to the control group (28/44[63.6 %], p = 0.02), even after excluding operative vaginal deliveries (2/13[15.4 %] vs 21/36[58.3], p < 0.01). CR reduces the risk of episiotomy (aOR = 0.15, 95 %CI [0.04–0.56]; p < 0.01) after adjusting on the infant weight and the need for instrumental delivery.

In the CR group, 47 % of the patients had an intact perineum after delivery, compared to 20.4 % in the control group (p = 0.04). CR increases the odds of having an intact perineum at birth by 3.46 times (CI95 %[1.04–11.49]; p = 0.04).

Conclusion

CR after FGM increases the chances of having an intact perineum after delivery by 3.46 times and reduces the risk of episiotomy by 0.15 times compared to women with FGM who did not underwent CR. (Author)

2023-05240

Supporting patients with female genital mutilation in primary care: a qualitative study exploring the perspectives of GPs' working in England. Dixon S, Hinton L, Ziebland S (2020), British Journal of General Practice vol 70, no 699, 2020, pp. e749-e756

Background Female genital mutilation (FGM) includes all procedures that intentionally harm or alter female genitalia for non-medical reasons. In 2015, reporting duties were introduced, applicable to GPs working in England including a mandatory reporting duty and FGM Enhanced Dataset. Our patient and public involvement work identified the exploration of potential impacts of these duties as a research priority.

Aim To explore the perspectives of GPs working in England on potential challenges and resource needs when supporting women and families affected by FGM.

Design and setting Qualitative study with GPs working in English primary care.

Method Semi-structured interviews focused around a fictional scenario of managing FGM in primary care. The authors spoke to 17 GPs from five English cities, including those who saw women who have experienced FGM often, rarely, or never. Interviews were audio recorded and transcribed verbatim for thematic analysis. Lipsky's theory of street-level bureaucracy was drawn on to support analysis.

Results Managing women with FGM was experienced as complex. Challenges included knowing how and when to speak about FGM, balancing care of women and their family's potential care and safeguarding needs, and managing the mandated reporting and recording requirements. GPs described strategies to manage these tensions that helped them balance maintaining patient–doctor relationships with reporting requirements. This was facilitated by access to FGM holistic services.

Conclusion FGM reporting requirements complicate consultations. The potential consequences on trust between women affected by FGM and their GP are clear. The tensions that GPs experience in supporting women affected by FGM can be understood through the theoretical lens of street-level bureaucracy. This is likely to be relevant to other areas of proposed mandated reporting. (Author)

Full URL: https://doi.org/10.3399/bjgp20X712637

2023-04179

Factors associated with female genital mutilation: a systematic review and synthesis of national, regional and community-based studies. El-Dirani Z, Farouki L, Akl C, et al (2022), BMJ Sexual & Reproductive Health vol 48, no 2, July 2022, pp. 169-178

Background This systematic review aimed to identify and describe the factors that influence female genital mutilation/cutting (FGM/C).

Methods Searches were conducted in Medline, PsycInfo, Web of Science, Embase and the grey literature from 2009 to March 2020 with no language restrictions, using related MESH terms and keywords. Studies were included if they were quantitative and examined factors associated with FGM/C. Two researchers independently screened studies for inclusion, extracted data and assessed study quality. The direction, strength and consistency of the association were evaluated for determinants, presented as a descriptive summary, and were disaggregated by age and region.

Results Of 2230 studies identified, 54 published articles were included. The majority of studies were from the African Region (n=29) followed by the Eastern Mediterranean Region (n=18). A lower level of maternal education, family history of FGM/C, or belonging to the Muslim religion (in certain contexts) increased the likelihood of FGM/C. The majority of studies that examined higher paternal education (for girls only) and living in an urban region showed a reduced likelihood of FGM/C, while conflicting evidence remained for wealth. Several studies reported that FGM/C literacy, and low community FGM/C prevalence were associated with a reduced likelihood of FGM/C.

Conclusions There were several characteristics that appear to be associated with FGM/C, and these will better enable the targeting of policies and interventions. Importantly, parental education may be instrumental in enabling communities and countries to meet the Sustainable Development Goals. (Author)

Full URL: http://dx.doi.org/10.1136/bmjsrh-2021-201399

2023-03729

Female Genital Mutilation: Prosecutions [written answer]. House of Lords (2023), Hansard Written question HL6584, 16 March 2023

Lord Stewart of Dirleton responds to a written question from The Lord Bishop of St Albans to His Majesty's Government, further to the Written Answer by Lord Sharpe of Epsom on 14 March (HL6096), regarding what assessment they have made of why there have only been two prosecutions for female genital mutilation out of the 229 offences recorded. (JSM)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2023-03-16/hl6584

2023-02828

Female Genital Mutilation [written answer]. House of Commons (2023), Hansard Written question 160351, 7 March 2023

Miss Sarah Dines responds to a written question asked by Gill Furniss to the Secretary of State for the Home Department, regarding whether the Forced Marriage Unit plans to take steps to publish data on the number of cases of female genital mutilation it is supporting. (MB)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2023-03-07/160351

2023-02777

International Women and Girls Strategy 2023-2030. Foreign, Commonwealth & Development Office (2023), March 2023, 28 pages

This first International Women and Girls Strategy Foreign, Commonwealth & Development Office aims to advance gender equality and challenge discrimination in order to provide women and girls with equal freedoms and rights to reach their full potential. The strategy highlights sexual and reproductive health rights as a development issue in the long term, including affording women access to safe abortion and comprehensive sexuality education. (JSM)

Full URL: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1141525/international-women-and-girls-strategy-2023-2030.pdf

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2023-01868

Mothers' perceptions of the medicalisation of female genital cutting among the Kisii population in Kenya. Van Eekert N, Van De Velde S, Anthierens S, et al (2022), Culture, Health & Sexuality vol 24, no 7, July 2022, pp 983-997

While within the Kisii community in Kenya the prevalence of female genital cutting (FGC) is decreasing, the practice is increasingly being performed by health professionals. This study aims to analyse these changes by identifying mothers' motives to opt for medicalised FGC, and how this choice possibly relates to other changes in the practice. We conducted face-to-face semi-structured in-depth interviews with mothers who had daughters around the age of cutting (8–14 years old) in Kisii county, Kenya. Transcripts of the interviews were coded and analysed thematically, applying researcher triangulation. According to mothers' accounts, the main driver behind the choice to medicalise was the belief that medicalising FGC reduces health risks. There were suggestions that medicalised FGC may be becoming the new community norm or the only option. The shift to medicalisation was examined in relation to other changes in the practice of FGC signalling how medicalisation may provide a way to increase the practice's secrecy and decrease its visibility. (Author)

2023-01866

Plurality of beliefs about female genital mutilation amidst decades of intervention programming in Narok and Kisii Counties, Kenya. Matanda DJ, Kabiru CW, Okondo C, et al (2022), Culture, Health & Sexuality vol 24, no 6, June 2022, pp 750-766

Female genital mutilation derails efforts to achieve gender equality and the empowerment of girls and women. In Kenya, national estimates show a steady decline in prevalence, although there is considerable variation at the sub-national level. There is a need to better understand female genital mutilation-related norms and meanings and whether there have been changes in these given long-term and diverse efforts to promote abandonment. Focusing on Narok and Kisii counties, we conducted a cross-sectional qualitative study to identify social norms surrounding the practice of female genital mutilation, as well as consensus or contestation with respect to these norms. Ten focus group discussions were held with men and women aged 18 years and older from the Maasai and Abagusii communities that have traditionally practised female genital mutilation. Study findings showed that norms associated with female genital mutilation such as sexuality and marriageability were actively contested by community members. This change may provide a useful starting point for programmes that seek to create dialogue and critical reflection on female genital mutilation to accelerate its abandonment. (Author)

2023-01861

Women who have undergone female genital mutilation/cutting's perceptions and experiences with healthcare providers in Paris. Azadi B, Tantet C, Sylla F, et al (2022), Culture, Health & Sexuality vol 24, no 4, April 2022, pp 583-596

Female genital mutilation/cutting (FGM/C) is a health and human rights issue and a dangerous form of gender-based violence. Given migratory flows from the countries in which it is practised, FGM/C concerns a substantial number of women living in Western countries. In this study, we looked at women who had undergone FGM/C experiences with French medical practitioners. We also discussed with them the desirability of screening for, and prevention of, FGM/C in international travel medicine centres. A qualitative approach was used to collect and analyse the data. Focus groups and semi-structured interviews were held with 26 women (24 participants in focus groups and 2 individual interviews). Transcriptions were coded and analysed thematically. All the participants came from sub-Saharan Africa. Their median age was 32.9 years. Persistent silence about FGM/C in the host society following immigration resulted in dissatisfaction with healthcare providers. Participants expected professionals to address the subject of FGM/C, feeling professionals should bring up the subject first so as to put women at ease. International travel medicine centres were discussed by some as a possible means of prevention. (Author)

2023-01840

Sexually destroyed or empowered? Silencing female genital cutting in close relationships. Lunde IB, Johansen REB, Hauge MI, et al (2021), Culture, Health & Sexuality vol 23, no 7, July 2021, pp 899-912

Based on fieldwork among Kurdish-Norwegian migrants, this study explored how female genital cutting (FGC) was a silenced topic between mothers and daughters, and between men and women. The silence was often broken when FGC was discussed as a practice that needed to be rejected. The main reasons for rejecting FGC were to support women's rights and to recognise the negative ways in which FGC affected women's sexuality. This way of breaking the silence on FGC was particularly helpful to some husbands and wives in their discussion of how FGC might have

affected their sexual relationships. Using theories of migrant women's sexual agency and embodiment, this study examined how the silencing of FGC in close relationships can be interpreted both as a sign of oppression and as a sign of empowerment. The analysis suggests that the stigmatisation that circumcised women can experience from condemnatory public discourse on FGC may sometimes lead to the negotiation of assertive female sexuality. (Author)

2023-01836

Learning through social interaction: Kenyan women against female genital cutting in Kenya. Nam Y (2021), Culture, Health & Sexuality vol 23, no 6, June 2021, pp 840-853

Female Genital Cutting (FGC) is a human rights issue that involves the partial or total removal of the external female genitalia for non-medical reasons. Drawing on in-depth interview data collected in 2017 with 20 women from three FGC-practising ethnic groups in Kenya, I argue that informal learning through social interaction plays a critical role in the ability of Kenyan women to oppose and work against FGC in their communities. In addition to knowledge gained through formal education such as schooling and anti-FGC campaigns, women learned about FGC and ways to resist the practice through social interaction with family members, role models and peers from non-FGC practising communities. These interactions have framed challenging FGC as a worthy behaviour to pursue. They also helped women reframe 'success.' While a hallmark of being a successful woman has traditionally been tied to FGC, through these interactions, women learned that they can achieve a respected status as a woman without undergoing FGC. Finally, they provided support for women to stay resilient in resisting FGC. Overall, informal learning is important for understanding how some Kenyan women resist FGC. (Author)

2023-01221

Mayor of London, Sadiq Khan, joins forces with survivors and campaigners to end female genital mutilation. Biggs J (2023), Cosmopolitan 6 February 2023, online

Reports that the Mayor of London, Sadiq Khan, has met with survivors of female genital mutilation (FGM) and campaigners involved in the 'FGM Stops Here' campaign, to mark International Day of Zero Tolerance for FGM on 6 February 2023. The campaign aims to demonstrate the determination of Londoners to end the practice, and highlight the adverse health and social effects the procedure can have on survivors and their families and features videos from FGM survivors, family members, health professionals, and activists. (JSM)

Full URL: https://www.cosmopolitan.com/uk/reports/a42774258/end-female-genital-mutilation-campaign/

2023-00941

FGM: 'I'll save another girl by talking about female genital mutilation'. Lissaman C (2023), BBC News 4 February 2023

As the huge task of ending female genital mutilation enters another year, a survivor and a detective explain how they became dedicated to the cause - and say grassroots activism is vital. (Author)

Full URL: https://www.bbc.co.uk/news/uk-england-birmingham-64484556?at_medium=RSS&at_campaign=KARANGA

2023-00314

A Place For Routine Episiotomy?. McDowell I (2020), Midwifery Matters no 167, Winter 2020, pp 20-22

Midwife Indie McDowell calls for sensitivity and understanding on this delicate issue. (Author)

2023-00029

Female Genital Mutilation, July 2022 - September 2022. NHS Digital (2022), London: NHS Digital 20 December 2022

Attendances of individuals with Female Genital Mutilation (FGM) which were added to the FGM Enhanced Dataset collection platform between 1st July 2022 - 30th September 2022 in England. (Author)

Full URL: https://www.gov.uk/government/statistics/female-genital-mutilation-july-2022-september-2022

2022-09771

Female Genital Mutilation: Scotland [written answer]. Scottish Parliament (2022), Official Report Written question S6W-11546, 12 October 2022

Keith Brown responds to a written question from Miles Briggs to the Scottish Government regarding how many cases of female genital mutilation have been prosecuted in each year since the Female Genital Mutilation (Protection and Guidance) (Scotland) Bill was passed. (JSM)

Full URL: https://archive2021.parliament.scot/parliamentarybusiness/28877.aspx?SearchType=Advance&ReferenceNumbers=S6W-11546&ResultsPerPage=10

2022-08106

Risk of obstetric anal sphincter injury associated with female genital mutilation/cutting and timing of deinfibulation.
Taraldsen S, Vangen S, Øian P, et al (2022), Acta Obstetricia et Gynecologica Scandinavica vol 101, no 10, October 2022, pp 1163-1173

Introduction
A greater risk of obstetric anal sphincter injury has been reported among African migrants in several host countries compared with the general population. To what degree female genital mutilation/cutting affects this risk is not clear. In infibulated women, deinfibulation prevents anal sphincter injury. Whether the timing of deinfibulation affects the risk, is unknown. This study aimed to investigate the risks of anal sphincter injury associated with female genital mutilation/cutting and timing of deinfibulation in Norway, and to compare the rates of anal sphincter injury in Somali-born women and the general population.

Material and methods
In a historical cohort study, nulliparous Somali-born women who had a vaginal birth in the period 1990–2014 were identified by the Medical Birth Registry of Norway and data collected from medical records. Exposures were female genital mutilation/cutting status and deinfibulation before labor, during labor or no deinfibulation. The main outcome was obstetric anal sphincter injuries.

Results
Rates of obstetric anal sphincter injury did not differ significantly by female genital mutilation/cutting status (type 1–2: 10.2%, type 3: 11.3%, none: 15.2% P = 0.17). The total rate of anal sphincter injury was 10.3% compared to 5.0% among nulliparous women in the general Norwegian population. Women who underwent deinfibulation during labor had a lower risk than women who underwent deinfibulation before labor (odds ratio 0.48, 95% confidence interval 0.27–0.86, P = 0.01).

Conclusions
The high rate of anal sphincter injury in Somali nulliparous women was not related to type of female genital mutilation/cutting. Deinfibulation during labor protected against anal sphincter injury, whereas deinfibulation before labor was associated with a doubled risk. Deinfibulation before labor should not be routinely recommended during pregnancy. (Author)
Full URL: https://doi.org/10.1111/aogs.14424

2022-07973

Q&A Joy Clarke. Silverwood-Cope O (2021), Midwifery Matters no 169, Summer 2021, pp 18-19
FGM Specialist midwife and mentor talks to Oli Silverwood-Cope. (Author)

2022-07367

Female Genital Mutilation (FGM) Annual Report - April 2021 to March 2022 (experimental statistics report). NHS Digital (2022), 4 August 2022
Attendances of individuals with Female Genital Mutilation (FGM) which were added to the FGM Enhanced Dataset collection platform between 1st April 2021 - 31st March 2022. (Author)
Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/april-2021---march-2022

2022-06178

Female Genital Mutilation [written answer]. House of Commons (2022), Hansard Written question 21278, 20 June 2022
Vicky Ford responds to a written question asked by Wendy Chamberlain to the Secretary of State for Foreign, Commonwealth and Development Affairs, regarding what steps her department is taking to meet the goal set out in the government's strategy for international development, published on 16 May 2022, to end the practice of female genital mutilation. (LDO)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2022-06-20/21278

2022-06174

Integrating female genital mutilation content into nursing and midwifery curricula: a practical guide. World Health

Organization (2022), February 2022. 36 pages

This guide is intended to promote a global health sector response to FGM for the provision of high-quality prevention and care services to women and girls at risk of FGM or living with the consequences of FGM. It also aims to support the systematic development of pre-service and in-service FGM content for midwifery and nursing education curricula which are relevant to context and need. This document could also be used for training materials of other cadres of health-care providers.

Curriculum planners can use this document to update an existing curriculum to include FGM prevention and care, or to develop a new one if a suitable curriculum does not exist. The process described here will follow the same steps in both cases; however, some adaptations would be made depending on whether it is an initial curriculum development process or an update. It is intended that this document be used as appropriate for a particular context to ensure midwives and nurses are able to provide the care that women and girls need. (Author)

Full URL: https://www.who.int/publications/i/item/9789240042025

2022-06017

Female Genital Mutilation and Cutting and Obstetric Outcomes. Bonavina G, Kaltoud R, Ruffolo AF, et al (2022), Obstetrics & Gynecology vol 140, no 1, July 2022, pp 87-90

The aim of this prospective study was to investigate the association of type III female genital mutilation/cutting (FGM/C) and de-infibulation with immediate maternal and neonatal outcomes. Women with type III FGM/C were compared with women with type I or II FGM/C or no FGM/C. Only uncomplicated singleton, full-term pregnancies with the fetus in vertex presentation were included. There was a greater frequency of postpartum hemorrhage and the use of mediolateral episiotomy in women with type III FGM/C. Mediolateral episiotomy was associated with a reduced rate of any spontaneous perineal laceration as well as third-degree and fourth-degree lacerations in women with type III FGM/C who underwent de-infibulation. (Author)

2022-05444

Female Genital Mutilation, January 2022 - March 2022. NHS Digital (2022), 9 June 2022

Cases of Female Genital Mutilation (FGM) added to the FGM Enhanced Dataset collection platform between January 2022 and March 2022 in England. (Author, edited)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/jan-2022---march-2022

2022-05442

Female Genital Mutilation - October 2021 to December 2021. NHS Digital (2022), 17 March 2022

Cases of Female Genital Mutilation (FGM) added to the FGM Enhanced Dataset collection platform between October 2021 and December 2021 in England. (Author, edited)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/oct-2021-dec-2021

2022-05441

Female Genital Mutilation - July 2021 to September 2021. NHS Digital (2021), 25 November 2021

Cases of Female Genital Mutilation (FGM) added to the FGM Enhanced Dataset collection platform between July 2021 and September 2021 in England. (Author, edited)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/july-2021-to-september-2021

2022-05144

A prospective cohort study of the relationship of female genital mutilation with birth outcomes in Somalia. Kulaksiz D, Nor IA, Erin R, et al (2022), BMC Women's Health vol 22, no 202, 31 May 2022

Background

Female genital mutilation (FGM) is defined as the partial or complete removal of the external female genitalia for non-medical reasons. There are some complications related to childbirth that concern both the mother and the baby. In this study, we aimed to evaluate the birth outcomes of FGM, which is widely applied in Somalia.

Methods

The study included 268 women who gave birth at 37–42 weeks of gestation with a cephalic singleton, 134 with FGM

and 134 without FGM. This study was designed a prospective cohort study and conducted between January 2019 and December 2020. Patients' ages, duration of delivery, FGM types, caesarean section requirements, before and after birth hemoglobin levels, birth weeks, baby birth weights and perineal tear data were recorded. In addition, we analyzed neonatal intensive care needs and APGAR scores for infants.

Results
In patients with FGM, it was determined that the outlet obstruction increased 2.33 times, perineal tears increased 2.48 times, the need for caesarean section increased 2.11 times compared to the control group, and the APGAR score below 7 at the 5th minute in the children increased 2 times and the need for neonatal intensive care increased 1.87 times.

Conclusions
FGM causes increased risk of perineal tear, prolongation in the second stage of labour, increased need for emergency caesarean section, and increased need for NICU for infants. Prevention of FGM will help reduce both obstetric and neonatal complications. (Author)
Full URL: https://doi.org/10.1186/s12905-022-01790-2

2022-05126

Midwives' experiences of providing intrapartum care to women with female genital mutilation. Bajada M, Spiteri G (2022), MIDIRS Midwifery Digest vol 32, no 2, June 2022, pp 201-207

Introduction: Female genital mutilation (FGM) involves the partial or total removal of the external female genitalia for non-medical reasons. Due to the increasing numbers of migrants from countries where female genital mutilation is performed, European midwives are facing new challenges when providing intrapartum care to these women. Therefore, this study aimed to explore midwives' experiences of providing intrapartum care to women with FGM.

Methods: A qualitative research paradigm was used. A self-designed semi-structured interview schedule was undertaken to elicit data from six midwives who were recruited via purposive sampling. All participants worked at a delivery suite and were directly involved in intrapartum care. Thematic analysis was then undertaken on the interview data.

Results: Midwives lacked knowledge of FGM which leads to a lack of confidence when providing these women with intrapartum care. Midwives experienced many challenges and described feelings of shock, uncertainty and fear when providing intrapartum care to these women. Midwives described difficulty when performing invasive intrapartum procedures. Communication also featured as another challenge when caring for women with FGM in labour.

Conclusion: As the primary caregivers of women in labour midwives need to feel competent in the care they are providing to all women in an attempt to improve outcomes but also to increase job satisfaction. This study highlights the importance of increasing the knowledge surrounding FGM among midwives as well as improving the communication between midwives and these women. (Author)

2022-04430

"Do no harm". Lived experiences and impacts of FGM safeguarding policies and procedures, Bristol study. Abdelshahid A, Smith K, Habane K (2021), 44 pages. 2021

Report from the Foundation for Women's Health Research and Development (FORWARD) and the University of Huddersfield which examines the views, lived experiences and impact of female genital mutilation (FGM) safeguarding policies and procedures both among African diaspora communities and regulated professionals in Bristol. (CI)
Full URL: https://doi.org/10.34696/ercs-2v52

2022-03658

The Female Genital Mutilation (FGM) – migration matrix: The case of the Arab League Region. Barrett HR, Bedri N, Krishnapalan N (2021), Health Care for Women International vol 42, no 2, 2021, pp 186-212

The movement of people from and to countries and regions with different Female Genital Mutilation (FGM) prevalence and practices and the implications for the elimination of FGM are under researched. In this article, we intend to examine the factors that support or deter Female Genital Mutilation (FGM) in the context of internal, regional and international migration in and from countries in the Arab League Region. We selected the Arab League

Region as the focus of this article as it contains countries with some of the highest FGM adult prevalence rates in the world, as well as countries where FGM is not traditionally performed. It is also a region with high levels of population mobility including internal, regional and international flows of migration. The region thus provides a case study, which can help elucidate other geographical migration-FGM contexts. (Author)

Full URL: https://doi.org/10.1080/07399332.2020.1789642

2022-03651

Minority migrant men's attitudes toward female genital mutilation: Developing strategies to engage men. Axelsson TK, Strid S (2020), Health Care for Women International vol 41, no 6, 2020, pp 709-726

This article explores minority migrant men's attitudes towards female genital mutilation (FGM), and how these attitudes can be used to develop strategies to engage men in the eradication of FGM. Based on interviews and focus group discussions, the article finds that men's attitudes can be enabling, disabling or neutral: the identification of and variations between these need to be taken into account when developing strategies to engage men in the eradication of FGM. There is currently a window of opportunity for involving minority migrant men in the prevention of FGM and in the challenging of a minority migrant gender regime. (Author)

Full URL: https://doi.org/10.1080/07399332.2019.1687707

2022-02841

The comparison of sexual function in women with or without experience of female genital circumcision: A case-control study in a Kurdish region of Iran. Laleh SS, Maleki A, Samiei V, et al (2022), Health Care for Women International vol 43, no 1-3, 2022, pp 194-206

Studies on the sexual consequences of female genital circumcision are controversial. In this article, we intend to compare the sexual function in women with or without experience of circumcision in the Kurdish region of Mahabad in Iran. In this case-control study 550 women completed the demographic and Female Sexual Function Index (FSFI) questionnaires. Female genital circumcision was associated with reduction of lubrication and sexual satisfaction as well as increasing dyspareunia compared to the uncircumcised women. However, there was no significant difference between two groups regarding to arousal, desire and orgasm of women. (Author)

2022-02300

Statement opposing female genital mutilation [Last updated 19 March 2021]. Home Office, Department for Education, Department for International Development, et al (2012), London: HM Government 23 November 2012

This outlines what FGM is, the legislation and penalties involved and the help and support available. The statement is often referred to as a health passport. (Author)

Full URL: https://www.gov.uk/government/publications/statement-opposing-female-genital-mutilation

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2022-01803

Commentary: What should referral pathways have to improve healthcare experiences of women with female genital mutilation in Australia?. Njue C, Ameyaw EK, Ahinkorah BO, et al (2021), Reproductive Health vol 18, no 223, 7 November 2021

Background

We examined the evidence derived from healthcare professionals' interfacing with women with female genital mutilation (FGM) to comprehend the referral pathways available to these women in Australia.

Main body

Clinicians encountered FGM-related complications that included ruptured bladder and total urinary incontinence. Midwives and paediatricians indicated a lack of referral pathways for FGM, but used their discretion to refer such cases to social work departments, obstetric/gynaecological units, child protection service providers, psychological counsellors and surgeons. The continuum of care for women with FGM is characterised by inadequate and lack of clear referral pathways. This underscores the need to develop and strengthen referral pathways in response to physical, birthing and psychological complications of women with FGM to improve their care experiences in Australia.

Short conclusion

Capacity building initiatives on FGM-prevention and care for trainees and practising health providers and community involvement in high burden areas/populations should be implemented to promote uptake and utilization of the referral services. Provision of infrastructural support, including clinical management tools, job aids, posters, referral algorithms and electronic patient records with "drop-down menus" for referral sites for health complications of FGM

to reinforce the providers' efforts are critical. (Author)
Full URL: https://doi.org/10.1186/s12978-021-01274-w

2022-01733

It's a woman's thing: gender roles sustaining the practice of female genital mutilation among the Kassena-Nankana of northern Ghana. Akweongo P, Jackson EF, Appiah-Yeboah S, et al (2021), Reproductive Health vol 18, no 52, 1 March 2021

Introduction
The practice of female genital mutilation (FGM/C) in traditional African societies is grounded in traditions of patriarchy that subjugate women. It is widely assumed that approaches to eradicating the practice must therefore focus on women's empowerment and changing gender roles.

Methods
This paper presents findings from a qualitative study of the FGM/C beliefs and opinions of men and women in Kassena-Nankana District of northern Ghana. Data are analyzed from 22 focus group panels of young women, young men, reproductive age women, and male social leaders.

Results
The social systemic influences on FGM/C decision-making are complex. Men represent exogenous sources of social influence on FGM/C decisions through their gender roles in the patriarchal system. As such, their FGM/C decision influence is more prominent for uncircumcised brides at the time of marriage than for FGM/C decisions concerning unmarried adolescents. Women in extended family compounds are relatively prominent as immediate sources of influence on FGM/C decision-making for both brides and adolescents. Circumcised women are the main source of social support for the practice, which they exercise through peer pressure in concert with co-wives. Junior wives entering a polygynous marriage or a large extended family are particularly vulnerable to this pressure. Men are less influential and more open to suggestions of eliminating the practice of FGM/C than women.

Conclusion
Findings attest to the need for social research on ways to involve men in the promotion of FGM/C abandonment, building on their apparent openness to social change. Investigation is also needed on ways to marshal women's social networks for offsetting their extended family familial roles in sustaining FGM/C practices. (Author)
Full URL: https://doi.org/10.1186/s12978-021-01085-z

2022-01732

Insights into preventing female genital mutilation/cutting in Sri Lanka: a qualitative interpretative study. Dawson A, Wijewardene K (2021), Reproductive Health vol 18, no 51, 28 February 2021

Background
FGM/C is a cultural practice associated with adverse health outcomes that involves the partial or complete removal of the external female genitalia or injury to the genitalia. FGM/C is a form of violence against women and girls. There are no laws that specifically outlaw FGM/C in Sri Lanka and no national prevalence data. There is a lack of evidence about this practice to inform prevention efforts required to achieve the Sustainable Development Goal (SDG) target 5.3.2, which focuses on the elimination of all harmful practices, including FGM/C.

Methods
We undertook a qualitative interpretative study to explore the knowledge and perceptions of community members, religious leaders and professionals from the health, legal and community work sectors in five districts across Sri Lanka. We aimed to identify strategies to end this practice.

Results
Two-hundred-and twenty-one people participated in focus group discussions and key informant interviews. A template analysis identified five top-level themes: Providers, procedures and associated rituals; demand and decision-making; the role of religion; perceived benefits and adverse outcomes; ways forward for prevention.

Conclusions
This study delivered detailed knowledge of FGM/C related beliefs, perceptions and practitioners and provided opportunities to develop an integrated programming strategy that incorporates interventions across three levels of prevention. (Author)

Full URL: https://doi.org/10.1186/s12978-021-01114-x

2022-01728

A cross-sectional study on pelvic floor symptoms in women living with Female Genital Mutilation/Cutting. Binkova A, Uebelhart M, Dällenbach P, et al (2021), Reproductive Health vol 18, no 39, 12 February 2021

Background

Female Genital Mutilation/Cutting (FGM/C) concerns over 200 million women and girls worldwide and is associated with obstetric trauma and long-term urogynaecological and psychosexual complications that are often under-investigated and undertreated. The aim of this study was to assess the pelvic floor distress and the impact of pelvic floor and psychosexual symptoms among migrant women with different types of FGM/C.

Methods

This cross-sectional study was conducted between April 2016 and January 2019 at the Division of Gynaecology of the Geneva University Hospitals. The participants were interviewed on socio-demographic and background information, underwent a systematic gynaecological examination to assess the presence and type of FGM/C and eventual Pelvic Organ Prolapse (POP), and completed six validated questionnaires on pelvic floor and psychosexual symptoms (PFDI-20 and PFIQ7 on pelvic floor distress and impact, FISI and WCS on faecal incontinence and constipation, PISQ-IR and FGSIS on sexual function and genital self-image). The participants' scores were compared with scores of uncut women available from the literature. The association between selected variables and higher scores for distress and impact of pelvic floor symptoms was assessed using univariate and multivariable linear regression models.

Results

124 women with a mean age of 31.5 (± 7.5), mostly with a normal BMI, and with no significant POP were included. PFDI-20 and PFIQ-7 mean (± SD) scores were of 49.5 (± 52.0) and 40.7 (± 53.6) respectively. In comparison with the available literature, the participants' scores were lower than those of uncut women with pelvic floor dysfunction but higher than those of uncut women without such disorders. Past violent events other than FGM/C and forced or arranged marriage, age at FGM/C of more than 10, a period of staying in Switzerland of less than 6 months, and nulliparity were significantly associated with higher scores for distress and impact of pelvic floor symptoms, independently of known risk factors such as age, weight, ongoing pregnancy and history of episiotomy.

Conclusions

Women with various types of FGM/C, without POP, can suffer from pelvic floor symptoms responsible for distress and impact on their daily life.

Trial registration. The study protocol was approved by the Swiss Ethics Committee on research involving humans (protocol n°15-224). (Author)

Full URL: https://doi.org/10.1186/s12978-021-01097-9

2022-01637

Do educated women in Sierra Leone support discontinuation of female genital mutilation/cutting? Evidence from the 2013 Demographic and Health Survey. Ameyaw EK, Yaya S, Seidu A-A, et al (2020), Reproductive Health vol 17, no 174, 7 November 2020

Introduction

Female genital mutilation/cutting (FGM/C) comprises all procedures that involve the total or partial elimination of the external genitalia or any injury to the female genital organ for non-medical purposes. More than 200 million females have undergone the procedure globally, with a prevalence of 89.6% in Sierra Leone. Education is acknowledged as a fundamental strategy to end FGM/C. This study aims to assess women's educational attainment and how this impacts their views on whether FGM/C should be discontinued in Sierra Leone.

Methods

We used data from the 2013 Sierra Leone Demographic and Health Survey. A total of 15,228 women were included in the study. We carried out a descriptive analysis, followed by Binary Logistic Regression analyses. We presented the results of the Binary Logistic Regression as Crude Odds Ratios (COR) and Adjusted Odds Ratios (AOR) with 95% confidence intervals (CIs).

Results

Most of the women with formal education (65.5%) and 15.6% of those without formal education indicated that FGM/C should be discontinued. Similarly, 35% of those aged 15–19 indicated that FGM/C should be discontinued. Women with a higher education level had a higher likelihood of reporting that FGM/C should be discontinued [AOR 4.02; CI 3.00–5.41]. Christian women [AOR 1.72; CI 1.44–2.04], those who reported that FGM/C is not required by religion [AOR 8.68; CI 7.29–10.34], wealthier women [AOR 1.37; CI 1.03–1.83] and those residing in the western part of Sierra Leone [AOR 1.61; CI 1.16–2.23] were more likely to state that FGM/C should be discontinued. In contrast, women in union [AOR 0.75; CI 0.62–0.91], circumcised women [AOR 0.41; CI 0.33–0.52], residents of the northern region [AOR 0.63; CI 0.46–0.85] and women aged 45–49 [AOR 0.66; CI 0.48–0.89] were less likely to report that FGM/C should be discontinued in Sierra Leone.

Conclusion

This study supports the argument that education is crucial to end FGM/C. Age, religion and religious support for FGM/C, marital status, wealth status, region, place of residence, mothers' experience of FGM/C and having a daughter at home are key influences on the discontinuation of FGM/C in Sierra Leone. The study demonstrates the need to pay critical attention to uneducated women, older women and women who have been circumcised to help Sierra Leone end FGM/C and increase its prospects of achieving Sustainable Development Goals (SDG) three and five. (Author)

Full URL: https://doi.org/10.1186/s12978-020-01027-1

2022-01635

Socio-economic and demographic determinants of female genital mutilation in sub-Saharan Africa: analysis of data from demographic and health surveys. Ahinkorah BO, Hagan Jr JE, Ameyaw EK, et al (2020), Reproductive Health vol 17, no 162, 22 October 2020

Background

Owing to the severe repercussions associated with female genital mutilation (FGM) and its illicit status in many countries, the WHO, human rights organisations and governments of most sub-Saharan African countries have garnered concerted efforts to end the practice. This study examined the socioeconomic and demographic factors associated with FGM among women and their daughters in sub-Saharan Africa (SSA).

Methods

We used pooled data from current Demographic and Health Surveys (DHS) conducted between January 1, 2010 and December 31, 2018 in 12 countries in SSA. In this study, two different samples were considered. The first sample was made up of women aged 15–49 who responded to questions on whether they had undergone FGM. The second sample was made up of women aged 15–49 who had at least one daughter and responded to questions on whether their daughter(s) had undergone FGM. Both bivariate and multivariable analyses were performed using STATA version 13.0.

Results

The results showed that FGM among women and their daughters are significantly associated with household wealth index, with women in the richest wealth quintile (AOR, 0.51 CI 0.48–0.55) and their daughters (AOR, 0.64 CI 0.59–0.70) less likely to undergo FGM compared to those in the poorest wealth quintile. Across education, the odds of women and their daughters undergoing FGM decreased with increasing level of education as women with higher level of education had the lowest propensity of undergoing FGM (AOR, 0.62 CI 0.57–0.68) as well as their daughters (AOR, 0.32 CI 0.24–0.38). FGM among women and their daughters increased with age, with women aged 45–49 (AOR = 1.85, CI 1.73–1.99) and their daughters (AOR = 12.61, CI 10.86–14.64) more likely to undergo FGM. Whiles women in rural areas were less likely to undergo FGM (AOR = 0.81, CI 0.78–0.84), their daughters were more likely to undergo FGM (AOR = 1.09, CI 1.03–1.15). Married women (AOR = 1.67, CI 1.59–1.75) and their daughters (AOR = 8.24, CI 6.88–9.87) had the highest odds of undergoing FGM.

Conclusion

Based on the findings, there is the need to implement multifaceted interventions such as advocacy and educational strategies like focus group discussions, peer teaching, mentor–mentee programmes at both national and community levels in countries in SSA where FGM is practiced. Other legislative instruments, women capacity-building (e.g., entrepreneurial training), media advocacy and community dialogue could help address the challenges associated with FGM. Future studies could consider the determinants of intention to discontinue or continue the practice using more accurate measures in countries identified with low to high FGM prevalence. (Author)

Full URL: https://doi.org/10.1186/s12978-020-01015-5

2022-01614

Towards a better estimation of prevalence of female genital mutilation in the European Union: a situation analysis. De Schrijver L, Van Baelen L, Van Eekert N, et al (2020), Reproductive Health vol 17, no 105, 8 July 2020

Background

Female genital mutilation (FGM) is a harmful cultural practice that is predominantly documented in Africa, but also occurs in other parts of the world. Due to migration, women who have undergone FGM can also be found in the European Union (EU). Due to a lack of systematic representative surveys on the topic in EU, the prevalence of FGM and the number of women and children subjected to the practice remains unknown. However, information on the magnitude of the problem in the EU is necessary for policy makers to design and track preventive measures and to determine resource allocation.

Methods

Between March 2015 and May 2015, we performed a situation analysis consisting of a critical interpretive synthesis and SWOT-analysis of available at the time peer reviewed and grey literature document on national prevalence studies on FGM in the EU. Studies estimating the prevalence of FGM and the number of girls and women subjected to the practice in the EU were mapped to analyse their methodologies and identify their Strengths, Weakness, Opportunities and Threats (SWOT). Distinction was made between direct and indirect estimation methods.

Results

Thirteen publications matched the prioritized inclusion criteria. The situation analysis showed that both direct and indirect methodologies were used to estimate FGM prevalence and the number of girls and women subjected to FGM in the EU. The SWOT-analysis indicated that due to the large variations in the targeted population and the available secondary information in EU Member States, one single estimation method is not applicable in all Member States.

Conclusions

We suggest a twofold method for estimating the number of girls and women who have undergone FGM in the EU. For countries with a low expected prevalence of women who have undergone FGM, the indirect method will provide a good enough estimation of the FGM prevalence. The extrapolation-of-FGM-countries-prevalence-data-method, based on the documented FGM prevalence numbers in DHS and MICS surveys, can be used for indirect estimations of girls and women subjected to FGM in the EU. For countries with a high expected prevalence of FGM in the EU Member State, we recommend to combine both a direct estimation method (e.g. in the form of a survey conducted in the target population) and an indirect estimation method and to use a sample design as developed by the FGM-PREV project. The choice for a direct or indirect method will ultimately depend on available financial means and the purpose for the estimation. (Author)

Full URL: https://doi.org/10.1186/s12978-020-00947-2

2022-01599

Is female genital mutilation associated with eclampsia? Evidence from a nationally representative survey data. Bellizzi S, Say L, Rashidian A, et al (2020), Reproductive Health vol 17, no 68, 20 May 2020

Background

Studies have shown the impact of female genital mutilation (FGM), especially infibulation (WHO type III), on reproductive health, and adverse obstetric outcomes like postpartum haemorrhage and obstructed labour. However, whether an association exists with maternal hypertensive complication is not known. The present study sought to investigate the role of the different types of FGM on the occurrence of eclampsia.

Methods

The study used data from the 2006 Demographic and health survey of Mali. The proportion of eclampsia in women with each type of FGM and the unadjusted and adjusted odds ratios (OR) were calculated, using women without FGM as reference group. Unadjusted and adjusted OR were also calculated for women who underwent infibulation compared to the rest of the population under study (women without FGM and women with FGM type I, II, and IV).

Results

In the 3997 women included, the prevalence of infibulation was 10.2% (n = 407) while 331 women did not report FGM (8.3%). The proportion of women reporting signs and symptoms suggestive of eclampsia was 5.9% (n = 234).

Compared with the absence of female genital mutilation and adjusted for covariates, infibulation was associated with

eclampsia (aOR 2.5; 95% CI:1.4–4.6), while the association was not significant in women with other categories of FGM. A similar aOR was found when comparing women with infibulation with the pooled sample of women without FGM and women with the other forms of FGM.

Conclusion
The present study suggests a possible association between infibulation and eclampsia. Future studies could investigate this association in other settings. If these findings are confirmed, the possible biological mechanisms and preventive strategies should be investigated. (Author)
Full URL: https://doi.org/10.1186/s12978-020-00918-7

2022-01592

Beyond will: the empowerment conditions needed to abandon female genital mutilation in Conakry (Guinea), a focused ethnography. Doucet M-H, Delamou A, Manet H, et al (2020), Reproductive Health vol 17, no 61, 6 May 2020

Background
Female genital mutilation (FGM) can give rise to immediate and long-term health problems for girls/women. Numerous studies have identified the sociocultural determinants of this tradition, but so far, in a national context where FGM is highly practiced, virtually none have focused on people refusing to have their daughters cut. We therefore aimed to understand the sociocultural dynamics underlying the non-practice of FGM in Guinea, a country which has one of the most prevalent rates of this practice in the world. This research explored the demographic and sociocultural profiles of Guineans who do not practice FGM, as well as their non-practice experience in a context of high FGM prevalence and social pressure.

Methods
We used a “focused ethnography” methodology and conducted semi-structured individual interviews with 30 women and men from different generations (young adults, parents, grandparents) living in Conakry, Guinea.

Results
We found that participants 1) do not disclose their non-practicing status in the same way, and 2) have different experiences with social pressure. A typology was created to describe participants as per their various profiles and experiences, which we named as: 1) the “activists”, 2) the “discrete”, 3) the “courageous”, 4) the “strategists”.

Discussion
Wanting to stop practicing FGM is not enough. The main empowering conditions allowing people to enact their decision not to have their daughters undergo FGM are: benefiting from social support (positive social capital), or being financially independent from the traditional solidarity network (sufficient economic capital). We therefore recommend finding ways to increase women’s/families’ empowerment to enact their decision not to practice FGM, mainly by: 1) providing them with new sources of social support, and 2) supporting them to gain more financial independence, including through schooling and improved access to better-paid employment.

Conclusions
This study was the first to explore the experience of people who do not practice FGM in a context of high FGM prevalence and social pressure. The results and recommendations of this research can inform strategies for FGM abandonment and therefore contribute to improving or developing intervention strategies that promote the health and well-being of girls and women. (Author)
Full URL: https://doi.org/10.1186/s12978-020-00910-1

2022-01350

Female genital mutilation (FGM) in Egypt, knowledge and concepts of Egyptian medical students: a cross-sectional study. Galal AF, El Gelany S, Goma K (2022), Journal of Obstetrics and Gynaecology 7 March 2022, online

There are many factors contributing to the existence of female genital mutilation (FGM). FGM has a long list of recorded complications, which include physical, obstetric, sexual, psychological and death. We assessed the knowledge, attitudes and perceptions of FGM practice among Egyptian medical students. An online questionnaire was distributed. One thousand one hundred and forty-one participants completed questionnaires. 71.2% were aware of FGM complications especially among females. Two-thirds reported illegality. 7.8% were in favour of FGM conduct with a higher male preference. Religious and traditional factors were the principle contributing factors to the practice. Three quarters of female students did not agree that FGM increased the chance of marriage. Almost one-fifth of

female students reported having been subject to FGM, with a high level of dissatisfaction. It was shown that Egyptian medical students lacked knowledge about FGM with no structured training, so every effort should be done to end this inhumane practice.

Impact Statement
What is already known on this subject? The conduct of female genital mutilation (FGM) in Egypt is motivated by a variety of factors, including social notions, cultural beliefs and theological misunderstanding. FGM has a long list of recorded complications, which might include physical, obstetric, sexual, psychological and even death.

What do the results of this study add? This study provides policy makers and community managers with the evidence needed to advocate for the addition of FGM education to be introduced across the board in medical school curriculums.

What are the implications of these findings for clinical practice and/or further research? Possible elimination of the practice and further research on how to eradicate the roots behind it. (Author)

2022-01208

Trends and Determinants of Female Genital Mutilation in Ethiopia: Multilevel Analysis of 2000, 2005 and 2016 Ethiopian Demographic and Health Surveys. Alemu AA (2021), International Journal of Women's Health Vol 13, 2021, pp 19-29

Background: Female genital mutilation (FGM) is a harmful practice that causes health-related problems in the life of the affected women and girls. Though FGM is declared as a human right violation, studies revealed it is being practiced throughout Ethiopia. Therefore, this study was conducted to assess the prevalence, trends, and predictors of FGM among reproductive-aged (1549 years) women in Ethiopia.
Methods: Trends of FGM among reproductive-age women were estimated using the three Ethiopian Demographic and Health Survey (EDHS): 2000 (n=15,367), 2005 (n=14,070) and 2016 (n=7248) data. Multilevel logistic regression analysis was conducted to identify both individual- and community-level factors of FGM using the latest (2016) EDHS. To adjust potential confounders, the analysis was conducted considering sample weighting, clustering, and stratifications using STATA-14 software.
Results: The prevalence of FGM among women of reproductive age in Ethiopia decreased from 79.91% in 2000 to 70.37% in 2016. Similarly, FGM among daughters of circumcised mothers decreased from 56.16% in 2000 to 16.76% in 2016. Being Muslim (adjusted odds ratio [AOR] 5.48; 95% confidence interval [CI]: 4.23, 7.09), attending higher education (AOR 0.40; 95% CI: 0.29, 0.54), 45– 49 years old (AOR 5.06; 95% CI: 3.38, 7.57), marriage at ≥ 18 years (AOR 0.80; 95% CI: 0.66, 0.96), not working (AOR 1.20; 95% CI: 1.02, 1.41), married (AOR 1.41; 95% CI: 1.12, 1.77) and residing in peripheral region (AOR 3.0.4; 95% CI: 1.96, 4.70) were determinants of FGM.
Conclusion: Though the reduction of FGM among women of reproductive age in Ethiopia was minimal, it was encouraging among daughters of circumcised women over the last 16 years. Education, religion, age, age at marriage, occupation, marital status, and geographical regions were determinants of FGM. Combined and integrated interventions based on the identified factors are recommended to abandon FGM in Ethiopia. (Author)
Full URL: https://doi.org/10.2147/IJWH.S287643

2022-00515

Violence Against Women and Girls [debate]. House of Commons (2022), Hansard vol 709, 28 Febuary 2022

Transcript of a House of Commons debate on the Government's response to the issue of violence against women and girls, including domestic abuse, stalking, forced marriage and female genital mutilation. (MB)
Full URL: https://hansard.parliament.uk/commons/2022-02-28/debates/FF8B59BF-058A-458D-97A8-CA0F9F6A3ED2/ViolenceAgainstWomenAndGirls

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2021-14467

The impact of female genital mutilation/cutting on obstetric outcomes and its management. Akpak YK, Yilmaz I (2022), Journal of Maternal-Fetal and Neonatal Medicine vol 35, no 5, 2022, pp 927-932

Objectives
Female genital mutilation/cutting (FGM/C) is a surgical intervention that is still widely performed around the world with serious obstetric and neonatal outcomes. We aimed to determine the obstetric and neonatal effects of FGM/C in pregnant women in a hospital with high standards of care in Sudan, where this is a common case, using a homogenous patient group.

Methods
This is a retrospective cohort study in pregnant women with FGM/C, conducted at Nyala, Sudan-Turkey Training and Research Hospital. The inclusion criteria were: >18 years of age, history of FGM/C, vertex presentation, full-term birth, and single pregnancy. FGM/C group was compared with women without FGM/C (control group) who were monitored for the same period of 8 months in terms of age, parity, gestational age, and obstetric and neonatal outcomes.

Results
A total of 220 eligible pregnant women were included in the study. Each group consisted of 110 pregnant women (FGM/C and control groups). We noticed that in the FGM/C group more emergency C-sections occurred, the second stage of the delivery was prolonged significantly, and episiotomy and periclitoral injuries were higher. Also, it was seen that postpartum blood loss and hospitalization of the mother lasted longer in the FGM/C group. No significant differences were found between the two groups with regard to newborns.

Conclusions
FGM/C is definitely associated with poor obstetric outcomes. These patients should be diagnosed during the antenatal period, and the delivery processes should be managed by experienced healthcare professionals according to the type of FGM/C. (Author)

2021-13979

Women's rights groups call on Sierra Leone to criminalise FGM after recent death and complications. Mahase E (2022), BMJ vol 376, 2 February 2022, o284

Women's rights organisations from Sierra Leone and around the world have united to call on the country's government to criminalise female genital mutilation (FGM) after another death linked to the procedure. (Author)

2021-13807

Are Health Care Professionals Prepared to Provide Care for Patients Who Have Experienced Female Genital Cutting? A Cross-Sectional Survey of Canadian Health Care Providers. Deane A, Mattatall FM, Brown A (2022), JOGC [Journal of Obstetrics and Gynaecology Canada] vol 44, no 4, April 2022, pp 403-406

Health care professionals may be underprepared to address the unique needs of patients who have experienced female genital cutting. This cross-sectional survey found that health care professionals in a large Canadian city report an overall lack of knowledge and preparedness to provide care for these patients and to address issues of defibulation, reinfibulation, child safeguarding, and legalities surrounding female genital cutting. Barriers to providing quality care include lack of training and clinical exposure. Health care professionals have indicated strong interest in further training, and consolidated efforts should be made to implement culturally informed care into health professional education. (Author)

2021-13763

Female genital mutilation and skilled birth attendance among women in sub-Saharan Africa. Seidu A-A, Aboagye RG, Sakyi B, et al (2022), BMC Women's Health vol 22, no 26, 30 January 2022

Background
There is evidence that women who have had their genitals cut suffer substantial difficulties during and/or after childbirth, including the need for a caesarean section, an episiotomy, an extended hospital stay, post-partum bleeding, and maternal fatalities. Whether or not women in sub-Saharan Africa who have undergone female genital mutilation utilize the services of skilled birth attendants during childbirth is unknown. Hence, we examined the association between female genital mutilation and skilled birth attendance in sub-Saharan Africa.

Methods
The data for this study were compiled from 10 sub-Saharan African countries' most recent Demographic and Health Surveys. In the end, we looked at 57,994 women between the ages of 15 and 49. The association between female genital mutilation and skilled birth attendance was investigated using both fixed and random effects models.

Results
Female genital mutilation and skilled birth attendance were found to be prevalent in 68.8% and 58.5% of women in sub-Saharan Africa, respectively. Women with a history of female genital mutilation had reduced odds of using skilled

birth attendance (aOR = 0.91, 95% CI = 0.86–0.96) than those who had not been circumcised. In Ethiopia, Guinea, Liberia, Kenya, Nigeria, Senegal, and Togo, women with female genital mutilation had reduced odds of having a trained delivery attendant compared to women in Burkina Faso.

Conclusion
This study shed light on the link between female genital mutilation and skilled birth attendance among sub-Saharan African women. The study's findings provide relevant information to government agencies dealing with gender, children, and social protection, allowing them to design specific interventions to prevent female genital mutilation, which is linked to non-use of skilled birth attendance. Also, health education which focuses on childbearing women and their partners are necessary in enhancing awareness about the significance of skilled birth attendance and the health consequences of female genital mutilation. (Author)
Full URL: https://doi.org/10.1186/s12905-021-01578-w

2021-13092

Female genital mutilation [written answer]. House of Lords (2021), Hansard Written question HL4929, 14 December 2021

Lord Kamall responds to a written question from Lord Berkeley of Knighton to Her Majesty's Government, regarding what assessment they have made of female genital mutilation in England. (MB)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2021-12-14/hl4929

2021-12832

Female Genital Mutilation: Clinics [written answer]. House of Commons (2021), Hansard Written question 57306, 15 October 2021

Gillian Keegan responds to a written question from Annelise Dodds to the Secretary of State for Health and Social Care, regarding what assessment he has made of the effect of the closure of specialist FGM clinics on survivors of FGM in the UK. (JSM)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2021-10-15/57306

2021-12658

Developing Countries: Females [written answer]. House of Commons (2021), Hansard Written question 89537, 8 December 2021

Vicky Ford responds to a written question from Mr Virendra Sharma to the Secretary of State for Foreign, Commonwealth and Development Affairs, regarding when she plans to restore the women and girls development budget to what it was prior to the reduction in Official Development Assistance. (MB)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2021-12-08/89537

2021-12657

UN Population Fund [written answer]. House of Commons (2021), Hansard Written question 89539, 8 December 2021

Vicky Ford responds to a written question from Mr Virendra Sharma to the Secretary of State for Foreign, Commonwealth and Development Affairs, with reference to her plans to restore budgets for women and girls to levels from before reductions in Official Development Assistance, regarding whether sexual and reproductive health and rights funding will be restored to UNFPA and its supply programme. (MB)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2021-12-08/89539

2021-12656

Developing Countries: Females [written answer]. House of Commons (2021), Hansard Written question 89538, 8 December 2021

Vicky Ford responds to a written question from Mr Virendra Sharma to the Secretary of State for Foreign, Commonwealth and Development Affairs, regarding what (a) organisations and (b) governments will have their development budgets for women and girls restored to the pre-Official Development Assistance reduction levels. (MB)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2021-12-08/89538

2021-12302

Developing Countries: Family Planning and Female Genital Mutilation [written answer]. House of Commons (2021), Hansard Written question 80945, 24 November 2021

Wendy Morton responds to a written question from Yasmin Qureshi to the Secretary of State for Foreign, Commonwealth and Development Affairs, regarding whether she will restore funding for (a) women and girls to access family planning and contraceptive supplies and (b) efforts to end female genital mutilation. (JSM)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2021-11-24/80945

2021-12234

A critical review to explore the knowledge and attitude of men from an FGM-practising country on the practice of FGM. Andrews J (2021), MIDIRS Midwifery Digest vol 31, no 4, December 2021, pp 425-430

Background: Female genital mutilation (FGM) is a human rights violation of women and girls and the practice remains prevalent worldwide (World Health Organization (WHO) 2016). FGM is an emotive and sensitive subject area, making it difficult to research (Safari 2013). A UK-based study which investigated the perceptions of women who have had FGM found that spouses are influential in decision making (Safari 2013). This finding suggests that there is a need to educate men from FGM-high-prevalence countries about the complications of FGM and the support they need to give women who have suffered FGM (Safari 2013).
Objective: To explore the knowledge and attitudes of men from high-prevalence FGM-practising countries towards the practice of FGM.
Methods: Electronic databases CINAHL, MEDLINE and Scopus were searched using appropriate search terms combined with Boolean operators and truncation. Inclusion and exclusion criteria were established to select suitable research.
Results: Seven research studies were suitable for inclusion in the review. From these studies three themes emerged: variation in men's perception; men's perception of the impact of FGM and men's role in ending FGM.
Conclusions and recommendations: Increasing men's knowledge of the impact of FGM will support the abolition of the practice. However, more research is required to further increase knowledge of men's perceptions of FGM in a local setting. (Author)

2021-12142

Female Genital Mutilation - July 2021 to September 2021. NHS Digital (2021), London: NHS Digital 25 November 2021

Cases of Female Genital Mutilation (FGM) added to the FGM Enhanced Dataset collection platform between July 2021 and September 2021 in England. (Author, edited)
Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/july-2021-to-september-2021

2021-12074

Factors contributing to the perpetuation and eradication of female genital mutilation/cutting in sub-Saharan women living in Spain. del Mar Pastor-Bravo M, Almansa-Martínez P, Jiménez-Ruiz I (2022), Midwifery vol 105, February 2022, 103207

Objective
Female Genital Mutilation/ Cutting (FGM / C) is one of the most widespread traditional practices harmful to the health of women and girls in the world. Its spread to the West highlights the need to establish preventive actions in European countries taking into account the affected population. That is why this study is aimed at finding out the elements that support the continuation of FGM/C and those that promote the change of attitudes and fight against FGM / C from the perspective of the sub-Saharan women themselves who reside in Spain.

Design
Qualitative exploratory research that uses the method of life stories through an open interview.

Participants and Setting
The participants were 24 women living in the Region of Murcia (Spain) who come from sub-Saharan countries where FGM / C is commonly practised.

Findings
Arguments supporting FGM / C, the lack of knowledge and family pressure are identified as factors that perpetuate the practice, whereas the motivating factors for the change in attitudes that make most of the interviewees oppose FGM / C are the awareness of the consequences on health and close negative experiences, growing awareness of their rights, supportive legislation and breaking the taboo related to this practice to question justifications for FGM / C and share experiences.

Key conclusion and implications for practice
Being aware of the arguments of both sides, women who defend FGM/C and those who oppose it, is a valuable source of information that obstetrics, midwifery and nursing professionals can use. The study provides the core elements that any healthcare education program should incorporate to prevent female genital mutilation / circumcision. (Author)

2021-11493

Scotland: Female Genital Mutilation [written answer]. Scottish Parliament (2021), Official Report Written question S6W-03630, 11 October 2021

Keith Brown responds to a written question from Miles Briggs to the Scottish Government, regarding how many cases of female genital mutilation have been (a) reported and (b) investigated in the last 12 months. (JSM)

Full URL: https://archive2021.parliament.scot/parliamentarybusiness/28877.aspx?SearchType=Advance&ReferenceNumbers=S6W-03630

2021-10532

Female Genital Mutilation: Victim Support Schemes [written answer]. House of Commons (2021), Hansard Written question 57305, 15 October 2021

Gillian Keegan responds to a written question asked by Annaliese Dodds to the Secretary of State for Health and Social Care, regarding what assessment he has made of the adequacy of specialist NHS provision for survivors of FGM in (a) Slough and (b) Milton Keynes compared to the known number of FGM survivors in each of those towns. (LDO)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2021-10-15/57305

2021-10531

Female Genital Mutilation: Clinics [written answer]. House of Commons (2021), Hansard Written question 56347, 15 October 2021

Gillian Keegan responds to a written question asked by Annaliese Dodds to the Secretary of State for Health and Social Care, regarding how many specialist FGM clinics (a) have closed over the last ten years or (b) are in the process of closing. (LDO)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2021-10-15/56347

2021-08796

Female genital mutilation (FGM): migrant health guide. Public Health England (2021), Public Health England 13 September 2021

Advice and guidance on the health needs of migrant patients for healthcare practitioners. (Author)

Full URL: https://www.gov.uk/guidance/female-genital-mutilation-fgm-migrant-health-guide

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2021-08143

Female Genital Mutilation - January to March 2021. NHS Digital (2021), London: NHS Digital 27 May 2021

Cases of Female Genital Mutilation (FGM) added to the FGM Enhanced Dataset collection platform between January and March 2021 in England. (Author, edited)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/january-to-march-2021

2021-08142

Female Genital Mutilation - April 2021 to June 2021. NHS Digital (2021), London: NHS Digital 26 August 2021

Cases of Female Genital Mutilation (FGM) added to the FGM Enhanced Dataset collection platform between April 2021 and June 2021 in England. (Author, edited)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/april-2021-to-june-2021

2021-08042

The perception of high school students in The Gambia towards the practice of female genital mutilation. Sanneh AB (2021), International Journal of Gynecology & Obstetrics vol 155, no 3, December 2021, pp 541-542

This study investigated the practice of female genital mutilation in The Gambia. The results of this study indicated that the opinion of female students on the practice of FGM has not changed (in that they support of FGM) as shown in

Table 1. (Author)

2021-06407

Association between maternal attitude towards female circumcision and daughter's circumcision status. Alemu DG, Haile ZT (2021), International Journal of Gynecology & Obstetrics 1 June 2021, online

Objective

Female genital mutilation is a public health problem resulting in multiple health complications. In Ethiopia, female circumcision is widely practiced, with women taking center stage in the perpetuation of the practice. Using the Theory of Planned Behavior for variable selection, the following study assessed the association between maternal attitude towards female circumcision and daughter's circumcision status.

Methods

From the 2016 Ethiopian Demographic and Health Survey, we analyzed a subsample of 6948 women. The outcome variable assessed daughter's circumcision status; the main independent variable assessed participant's opinion towards female circumcision. We conducted univariate, bivariate, and multiple logistic regression analyses.

Results

In the bivariate analysis, none of the variables, except for religion, showed any association with daughter's circumcision status. In the multivariable regression model, several variables showed a significant association with daughter's circumcision status. Older, rural, and circumcised women were more likely to have at least one daughter circumcised, but wanting female circumcision to stop, being a Muslim, and having at least a secondary education were negatively associated with daughter's circumcision status.

Conclusion

Our findings suggest that eliminating female circumcision may require changing maternal attitudes towards the practice by targeting rural, circumcised, and older women with no formal education. (Author)

2021-04741

Conversations about FGM in primary care: a realist review on how, why and under what circumstances FGM is discussed in general practice consultations. Dixon S, Duddy C, Harrison G, et al (2021), BMJ Open Vol 11, no 3, March 2021, e039809

Objectives Little is known about the management of female genital mutilation (FGM) in primary care. There have been significant recent statutory changes relevant to general practitioners (GPs) in England, including a mandatory reporting duty. We undertook a realist synthesis to explore what influences how and when GPs discuss FGM with their patients.

Setting Primary care in England.

Data sources Realist literature synthesis searching 10 databases with terms: GPs, primary care, obstetrics, gynaecology, midwifery and FGM (UK and worldwide). Citation chasing was used, and relevant grey literature was included, including searching FGM advocacy organisation websites for relevant data. Other potentially relevant literature fields were searched for evidence to inform programme theory development. We included all study designs and papers that presented evidence about factors potentially relevant to considering how, why and in what circumstances GPs feel able to discuss FGM with their patients.

Primary outcome measure This realist review developed programme theory, tested against existing evidence, on what influences GPs actions and reactions to FGM in primary care consultations and where, when and why these influences are activated.

Results 124 documents were included in the synthesis. Our analysis found that GPs need knowledge and training to help them support their patients with FGM, including who may be affected, what needs they may have and how to talk sensitively about FGM. Access to specialist services and guidance may help them with this role. Reporting requirements may complicate these conversations.

Conclusions There is a pressing need to develop (and evaluate) training to help GPs meet FGM-affected communities' health needs and to promote the accessibility of primary care. Education and resources should be developed in partnership with community members. The impact of the mandatory reporting requirement and the Enhanced Dataset

on healthcare interactions in primary care warrants evaluation.

PROSPERO registration number CRD42018091996. (Author)
Full URL: http://dx.doi.org/10.1136/bmjopen-2020-039809

2021-04071

Female genital mutilation and obstetric outcome: A cross-sectional comparative study in a tertiary hospital in Abakaliki South East Nigeria. Anikwe CC, Ejikeme BN, Obiechina NJ, et al (2019), European Journal of Obstetrics & Gynecology and Reproductive Biology: X Vol 1, January 2019, 100005

Background
Female genital mutilation (FGM) is an assault on womanhood.

Objective
To compare the obstetric outcome between parturient with genital mutilation with a cohort that has no genital mutilation.

Materials and methods
This cross-sectional prospective study was done in the labour ward of Federal Teaching Hospital Abakaliki between 1st January 2013 and 31st December 2013. The obstetrics outcome of 260 consenting healthy parturients with FGM in the 1st stage of labour was compared with 260 cohorts with no FGM and also in labour. Data were obtained with a structured questionnaire and analysed using IBM SPSS Statistic version 20. Simple percentage odd ratio and Chi-square were used for data analysis at a p-value of < 0.05.

Results
The mean age and gestational age of the women were 27.9 ± 4.8 years and 38.9 ± 1.5 weeks respectively. Majority of the women, 308 or 77.0%, belonged to social class 4 and 82.0% had Type 2 FGM. More than 90.0% of the women had a vaginal delivery and the 2nd stage of labour lasted more than 2 h in 13.4% of the women (OR = 0.78 95% CI 0.64-0.97). Parturient with FGM had increased odd of perineal tear (OR = 0.76 95% CI 0.63 - 0.91) and episiotomy (OR = 1.69 95% CI 1.17–2.45). The mode of delivery and neonatal Apgar scores were not significantly influenced by the presence of FGM (P > 0.05).

Conclusion
The study has shown that FGM in labour increases the odds of developing perineal trauma which may be associated with a host of short- and long-term complications. We recommend continued awareness creation to stop FGM. (Author)
Full URL: https://doi.org/10.1016/j.eurox.2019.100005

2021-04003

How women with female genital mutilation (FGM) experience postpartum care using the UK's National Health Service (NHS), a focused ethnographic study. Seymour R, Barrett H, Brown K, et al (2021), MIDIRS Midwifery Digest vol 31, no 2, suppl, June 2021, pp 178-179

Ethnographic study exploring the postnatal experiences of women with female genital mutilation (FGM) in the United Kingdom (UK). Several themes emerged indicating that women felt there was too much focus on the law in the antenatal period and there was a 'top-down' approach to the management of FGM. (LDO)

2021-03702

Digital health innovation to support sensitive enquiry about female genital mutilation. McEwan J, Bedford H (2021), British Journal of Midwifery vol 29, no 5, May 2021, pp 252-259

Health professionals working in community settings are increasingly using mobile technologies to access information and support clients. A Mary Seacole Leadership Award enabled the production of an app, 'Let's talk FGM' (later becoming the web app letstalkfgm.nhs.uk), to assist health professionals to make sensitive inquiry about female genital mutilation (FGM). This article outlines the rationale for the project and the steps needed for successful app development. It illustrates how clinical practitioners can respond to service users' needs, and in collaboration with colleagues and community groups, create responsive, usable tools which harness digital technology. It also showcases the role of partnership working and networking to develop the skills needed to lead within digital health. (Author)

2021-03597

United States' Obstetrician/Gynecologists' Readiness to Care for Women Affected by Female Genital Cutting. Fay KE, Snead CM, Huennekens K, et al (2022), Journal of Women's Health vol 31, no 3, March 2022, pp 431-438

Background: Female genital cutting (FGC) is a form of gender-based violence with obstetrical and gynecological complications that require recognition and care. Data suggest that United States' physicians are not prepared to care for those who have been affected by this practice. This study evaluated the knowledge and practices of United States' obstetricians and gynecologists to care for patients who have undergone FGC.

Materials and Methods: This was a cross-sectional confidential survey distributed electronically to a sample of clinically active members of the American College of Obstetricians and Gynecologists. The survey consisted of questions characterizing care of patients who had undergone FGC and barriers to optimal support.

Results: Five hundred forty-eight participants representing a wide range of years in practice, geographical locations, subspecializations, and patient demographics participated. Sixty-six percent of participants had cared for patients who had undergone FGC. Participants' description of their patient population racial/ethnic composition did not correlate with likelihood of treating this patient population. Forty percent of participants reported some form of education about FGC, more often among women, younger physicians, and those in practice for fewer years. Thirty-one percent of participants were comfortable counseling about and 20% were comfortable performing deinfibulation; these percentages were higher among those who had received education or had recently cared for an affected patient. Participants reported insufficient training as the largest barrier to providing care to women.

Conclusions: While most physicians in this national cohort had cared for women who had undergone cutting, a minority had any form of education. However, prior education correlated with indicators of improved care. Physicians require additional guidance in treating this important and growing patient population. (Author)

2021-03484

Women’s empowerment and female genital mutilation intention for daughters in Sierra Leone: a multilevel analysis. Ameyaw EK, Anjorin S, Ahinkorah BO, et al (2021), BMC Women's Health vol 21, no 200, 13 May 2021

Background

Female genital mutilation is common in Sierra Leone. Evidence indicates that empowering women provides protective benefits against female genital mutilation/cutting (FGM/C). Yet, the relationship between women’s empowerment and their intention to cut their daughters has not been explored in Sierra Leone. The aim of this study was to assess the association between women’s empowerment and their intention to have their daughters undergo FGM/C in the country.

Methods

Data for this study are from the 2013 Sierra Leone Demographic and Health Survey. A total of 7,706 women between the ages of 15 and 49 were included in the analysis. Analysis entailed generation of descriptive statistics (frequencies and percentages), and estimation of multi-level logistic regression models to examine the association between women’s empowerment, contextual factors and their intentions to cut their daughters.

Results

A significantly higher proportion of women who participated in labour force reported that they intended to cut their daughters compared to those who did not (91.2%, CI = 90.4–91.9 and 86.0%, CI = 84.1–87.8, respectively). Similarly, the proportion intending to cut their daughters was significantly higher among women who accepted wife beating than among those who rejected the practice (94.9%, CI = 93.8–95.8 and 86.4% CI = 84.9–87.8, respectively). A significantly higher proportion of women with low decision-making power intended to cut their daughters compared to those with high decision-making power (91.0%, CI = 89.0–92.8 and 85.0% CI = 82.2–87.4, respectively). Results from multivariate regression analysis showed that the odds of intending to cut daughters were significantly higher among women who participated in labour force (aOR = 2.5, CI = 1.3–4.7) and those who accepted wife beating than among those who did not (aOR = 2.7, CI = 1.7–4.5). In contrast, the likelihood of intending to cut daughters was significantly lower among women with high than low knowledge (aOR = 0.4, CI = 0.3–0.7), and among those aged 45–49 than among those aged 15–19 (aOR = 0.2, CI = 0.0–0.6).

Conclusion

The findings underscore the need to align anti-FGM/C policies and programmes to women who have undergone

FGM/C, those with low knowledge, women who support wife beating and young women. Such interventions could highlight the adverse implications of the practice by stressing the psychological, health and social implications of FGM/C on its survivors. (Author)

Full URL: https://doi.org/10.1186/s12905-021-01340-2

2021-03139

Attitudes towards comparison of male and female genital cutting in a Swedish Somali population. Hanberger A, Essén B, Wahlberg A (2021), Acta Obstetricia et Gynecologica Scandinavica vol 100, no 4, April 2021, pp 604-613

Introduction

In Sweden, the law treats female genital cutting (FGC) differently from male genital cutting (MGC). However, the comparability of the medical, ethical, and legal aspects of genital cutting of girls and boys are increasingly discussed by scholars, although little is known about how practicing communities view these aspects. This study aimed to explore attitudes towards comparison of genital cutting of girls and boys among Swedish Somalis, and to investigate factors associated with considering the two practices to be comparable.

Material and methods

In a cross-sectional questionnaire with 648 Swedish Somali men and women from four Swedish cities, descriptive statistics and logistic regression were used for the analysis.

Results

Among the Swedish Somalis, 10% considered FGC and MGC to be comparable practices. A majority (98%) of the participants thought FGC could cause long-term health complications, but only 1% considered the physical health disadvantage of MGC would outweigh the physical health benefits. FGC was perceived to be a violation of children's rights by 60%, whereas this proportion for MGC was 3%. Individuals who had a dominant bridging social capital and those who expressed that performing FGC follows religion were more likely to think that FGC and MGC were comparable practices.

Conclusions

The increased global attention and emphasis on the comparability of genital cutting of boys and girls was not reflected in this study among Swedish Somalis. Rather, attitudes reflected the common description of the two practices in global public health campaigns, portraying FGC as a harmful practice violating children's rights, while describing MGC as a public health measure. Social interactions and separation of FGC from religion could explain why FGC and MGC were not considered comparable. (Author)

2021-03036

How to ensure policies and interventions rely on strong supporting facts to improve women's health: The case of female genital cutting, using Rosling's Factfulness approach. Essén B, Mosselmans L (2021), Acta Obstetricia et Gynecologica Scandinavica vol 100, no 4, April 2021, pp 579-586

Rosling et al's book Factfulness aims to inspire people to use strong supporting facts in their decision-making, with 10 rules of thumb to fight dramatic instincts. In this paper, the Factfulness framework is applied to female genital cutting (FGC), in order to identify possible biases and promote evidence-based thinking in studies on FGC, clinical guidelines on management of FGC, and interventions aimed at abolishing FGC. The Factfulness framework helps to acknowledge that FGC is not a uniform practice and helps address that variability. This framework also highlights the importance of multidisciplinarity to understand causalities of the FGC issue, which the authors argue is essential. This paper highlights the fact that FGC is a dynamic practice, with changes in the practice that are ongoing, and that those changes are different in different contexts. The "zero tolerance" discourses on FGC fail to acknowledge this. Factfulness encourages us to be more critical of methodologies used in the area of FGC, for example when estimating girls at risk of FGC in migration contexts. Factfulness provides the tools to calculate risks rather than judgments based on fear. This may help limit stigmatization of women with FGC and to allocate resources to health problems of migrant women based on real risks. The framework also calls for more research and production of less biased facts in the field of FGC, in order to improve interventions aimed at abolishing FGC, and clinical guidelines for the treatment of FGC. Factfulness is a useful and structured foundation for reflection over constructs, biases and disputes surrounding FGC, and can help improve the quality of future evidence-based interventions and education that address the actual needs of women with FGC and girls at risk of FGC. (Author)

2021-02869

Cohort analysis of the state of female genital cutting in Nigeria: prevalence, daughter circumcision and attitude towards its discontinuation. Gbadebo BM, Salawu AT, Afolabi RF, et al (2021), BMC Women's Health vol 21, no 182, 29 April 2021

Background

Female genital cutting (FGC) inflicts life-long injuries on women and their female children. It constitutes a violation of women's fundamental human rights and threats to bodily integrity. Though decreasing, the practice is high and widespread in Nigeria despite efforts towards its eradication. This study was conducted to perform cohort analysis of the state of FGC between the years 2009 and 2018 in Nigeria.

Results

The study found that that FGC has reduced over the years from 56.3% among the 1959–1963 birth cohort to 25.5% among 1994–1998 cohorts but a rise in FGC between 1994–1998 cohorts and 1999–2003 cohorts (28.4%). The percentage of respondents who circumcised their daughters reduced from 40.1% among the oldest birth cohort to 3.6% among the younger cohort. Birth-cohort, religion, education, residence, region, and ethnicity were associated with FGC. Factors associated with the daughter's circumcision were birth-cohort, religion, residence, region, ethnicity, wealth, marital status, FGC status of the respondent, and FGC required by religion. Similar factors were found for discontinuation intention.

Conclusions

The practice of FGC is still high but decreasing among younger birth-cohorts in Nigeria. There is no significant change in the perception of the discontinuation of FGC. More awareness about the adverse effects of FGC, particularly among women with poor education in Nigeria will greatly reduce this cultural menace's timely eradication. (Author)

Full URL: https://doi.org/10.1186/s12905-021-01324-2

2021-02823

Survey of obstetricians' approach to the issue of reinfibulation after childbirth in women with prior female genital mutilation. Naz A, Lindow SW (2021), AJOG Global Reports vol 1, no 2, May 2021, 100010

The procedure of re-infibulation (RI) is the re-suturing (usually after vaginal childbirth) of the incised scar tissue in women with previous female genital mutilation (FGM). Many authorities do not recommend the practice of RI.

We sought to assess Physicians approach to the practice of RI, via a structured on line, anonymous questionnaire that was sent to 130 practicing Obstetricians & Gynecologists through Survey Monkey. The questionnaire was completed by 98 (75.4%).

This survey showed that 76% (74/98) of Obstetricians agree with a standard policy of not performing RI. However 37% (27/74) of those who refused to perform RI would agree to undertake it if the woman insisted because she feared marital problems or divorce and 73% (54/74) of them would offer treatment from an Obstetrician with a different view.

The complex nature of RI is discussed and an alternative approach is suggested. (Author)

Full URL: https://doi.org/10.1016/j.xagr.2021.100010

2021-02632

Female genital mutilation/cutting, timing of deinfibulation, and risk of cesarean section. Taraldsen S, Vangen S, Øian P, et al (2021), Acta Obstetricia et Gynecologica Scandinavica vol 100, no 4, April 2021, pp 587-595

Introduction

The impact of female genital mutilation/cutting on obstetric outcomes in high-income countries is not clear. In general, women with female genital mutilation/cutting type 3 (infibulation) seem to be most at risk of adverse outcomes such as cesarean section. Deinfibulation is recommended to prevent obstetric complications. Whether the timing of this procedure affects the complication risk is not known. The aims of this study were, first, to examine the association between female genital mutilation/cutting and the risk of cesarean section in Norway, and, second, whether the timing of deinfibulation affected the cesarean section risk.

Material and methods

This was a historical cohort study of nulliparous Somali-born women who gave birth in Norway between 1990 and 2014. The Medical Birth Registry of Norway identified the women. Data were collected from medical records at 11

participating birth units. The exposures were female genital mutilation/cutting status and deinfibulation before pregnancy, during pregnancy, or no deinfibulation before labor onset. The main outcome was odds ratio (OR) of cesarean section. Type of cesarean section, primary indications, and neonatal outcomes were secondary outcomes.

Results
Women with female genital mutilation/cutting type 3 had lower risk of cesarean section compared with women with no female genital mutilation/cutting (OR 0.54, 95% CI 0.33-0.89 P = .02). Among the 1504 included women, the cesarean section rate was 28.0% and the proportion of emergency operations was 92.9%. Fetal distress was the primary indication in approximately 50% of cases, across the groups with different female genital mutilation/cutting status. Women who had no deinfibulation before labor onset had lower risk of cesarean section compared with those who underwent deinfibulation before or during pregnancy (OR 0.64, 95% CI 0.46-0.88 P = .01).

Conclusions
High risk of cesarean section in Somali nulliparous women was not related to the type of female genital mutilation/cutting in the present study. Deinfibulation before labor did not protect against cesarean section. Our findings indicate that nulliparous Somali women are at high risk of intrapartum complications. Future research should focus on measures to reduce maternal morbidity and on how timing of deinfibulation affects the outcomes of vaginal births. (Author)

2021-02334

Developing an app to support sensitive enquiry and discussion about female genital mutilation. McEwan J, Bedford H (2021), Journal of Health Visiting vol 9, no 4, April 2021, pp 164-171

Health professionals working in community settings are increasingly using mobile technologies to access information and support clients. A Mary Seacole Leadership Award enabled the production of an app, Let's talk FGM, to assist health professionals to make sensitive inquiry about female genital mutilation (FGM). This article outlines the rationale for the project and the steps needed for successful app development. It illustrates how clinical practitioners can respond to service users' needs and, in collaboration with colleagues and community groups, create responsive, usable tools to harness digital technology. It also showcases the role of partnership working and networking to develop the skills needed to lead in digital health. (Author)

2021-02133

Changing the narrative: what student midwives need to know about deinfibulation. Hall D, Nowobilska-Dean K (2021), The Student Midwife vol 4, no 2, April 2021, pp 24-27

In the final instalment of a two-part series about female genital cutting (FGC), Denise Hall and Krystyna Nowobilska-Dean explore deinfibulation as a clinical skill that can be used to facilitate vaginal birth for FGC survivors. (Author, edited)

2021-01815

Prevalence and adverse obstetric outcomes of female genital mutilation among women in rural Northern Ghana. Nonterah EA, Kanmiki EW, Agorinya IA, et al (2020), European Journal of Public Health vol 30, no 3, June 2020, pp 601-607

Background
Female genital mutilation (FGM) is commonly practiced in sub-Saharan Africa and results in adverse pregnancy outcomes among affected women. This paper assessed the prevalence and effects of FGM on pregnancy outcomes in a rural Ghanaian setting.

Methods
We analyzed 9306 delivery records between 2003 and 2013 from the Navrongo War Memorial Hospital. Multivariable logistic regression analyses were used to determine the effects of FGM on pregnancy outcomes such as stillbirth, birth weight, postpartum haemorrhage, caesarean and instrumental delivery. We also assessed differences in the duration of stay in the hospital by FGM status.

Results
A greater proportion of mothers with FGM (24.7%) were older than 35 years compared with those without FGM (7.6%). FGM declined progressively from 28.4% in 2003 to 0.6% in 2013. Mothers with FGM were nearly twice as likely to have caesarean delivery (adjusted odds ratios = 1.85 with 95%CI [1.72, 1.99]) and stillbirths (1.60 [1.21, 2.11]) compared with

those without. Similarly, they had a 4-fold increased risk of post-partum haemorrhage (4.69 [3.74, 5.88]) and more than 2-fold risk lacerations/episiotomy (2.57 [1.86, 3.21]) during delivery. Average duration of stay in the hospital was higher for mothers with FGM from 2003 to 2007.

Conclusions
Despite significant decline in prevalence of FGM, adverse obstetric outcomes are still high among affected women. Increased public health education of circumcised women on these outcomes would help improve institutional deliveries and heighten awareness and prompt clinical decisions among healthcare workers. Further scale-up of community level interventions are required to completely eliminate FGM. (Author)
Full URL: https://doi.org/10.1093/eurpub/ckz195

2021-01662

Changes in the prevalence and trends of female genital mutilation in Iraqi Kurdistan Region between 2011 and 2018. Shabila NP (2021), BMC Women's Health vol 21, no 137, 1 April 2021

Background
Female genital mutilation (FGM) is commonly practiced in Iraqi Kurdistan Region, where there are extensive efforts to combat the practice over the last decade. This study aimed to determine the trends and changes in the FGM prevalence in Iraq between 2011 and 2018 and assess their associated factors.

Methods
Secondary data analysis of the Iraq Multiple Indicator Cluster Survey 2011 and 2018 was carried out to calculate the prevalence and the relative changes in the prevalence of FGM for 2011 and 2018 by governorate. The change in the prevalence was compared with the changes in other exposure variables such as age, education level, wealth, and area of residence over the same period.

Results
The prevalence of FGM in 2018 was high in Erbil and Suleimaniya governorates (50.1% and 45.1%). The prevalence of FGM decreased remarkably from 2011 to 2018 in all governorates of the Iraqi Kurdistan Region. The decrease in the prevalence was statistically significant in Erbil and Suleimaniya. FGM prevalence declined remarkably in all age, education level, residence area groups, and most economic level groups. Such decline was associated with a significant increase in the education level, wealth, and urban residence. The decline was highest in the younger age groups, with a relative change of − 43.0% among 20–24 years and − 39.2% among 15–19 years. The decline was also highest in those with secondary and higher education (relative change = −32%). The decline was higher in rural areas than in urban areas (relative change = −35.3% and − 27.4%, respectively). The decline was higher among the poorest and second wealth quintile (relative change = −38.8% and − 27.2%, respectively).

Conclusion
The trend of FGM in Iraqi Kurdistan Region declined remarkably and significantly from 2011 to 2018. Further decline is predicted because of having lower rates and a higher decline in the younger age groups. However, the rates remained high in Erbil and Suleimaniya governorates that need further intensifying the preventive measures. The education level of women plays a primary role in decreasing the prevalence and should be considered in future efforts to ban the practice. (Author)
Full URL: https://doi.org/10.1186/s12905-021-01282-9

20210113-18*

Developing Countries: Genito-urinary Medicine [written answer]. House of Commons (2020), Hansard Written question 130017, 15 December 2020

Wendy Morton responds to a written question from Yasmin Qureshi to the Secretary of State for Foreign, Commonwealth and Development Affairs, regarding what steps he has taken as a result of the UK's endorsement of the Guttmacher-Lancet integrated definition of Sexual and Reproductive Health and Rights in 2019. (Author)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2020-12-15/130017

2021-00891

Conducting an asylum evaluation focused on female genital mutilation/cutting status or risk. Mishori R, Ottenheimer D, Morris E (2021), International Journal of Gynecology & Obstetrics vol 153, no 1, April 2021, pp 3-10

Background

Female genital mutilation or cutting (FGM/C) is considered a human rights violation and is practiced all over the world. It has been used as a basis for seeking asylum in various countries, including in the USA since 1996, and the precedent-setting matter of Kissindja. Clinicians in the USA and elsewhere who perform asylum evaluations may be called upon to evaluate women who seek asylum based on their FGM/C status or risk. In this manuscript, we provide expert-informed best practices to conduct asylum evaluations based specifically on FGM/C. We review evidence-based history taking, physical examination unique to the population of women and girls affected by FGM/C, and consider the evaluation in the context of trauma-informed care.

Conclusion
Although general clinical skills often suffice to perform asylum evaluations, FGM/C represents a unique niche within the field of gynecological asylum evaluations and requires additional background knowledge and clinical competencies.

Ethical approval
As this is a clinical review and does not involve patients or research subjects no ethical approval was sought or was necessary.

2021-00819

COVID-19 hindering progress against female genital mutilation. Anon (2021), The Lancet Public Health vol 6, no 3, March 2021, p 136

Editorial presenting some statistical evidence of the decline of female genital mutilation (FGM), with 26 countries across the Middle East and Africa having banned the harmful procedure. However, in countries such as Guinea, Mali, Sudan, and Somalia, the rate of FGM is as high as 90%, and it is believed that the COVID-19 pandemic may hamper progress in eradicating the practice. (JSM)

Full URL: https://doi.org/10.1016/S2468-2667(21)00030-X

2021-00648

Female Genital Mutilation [written answer]. House of Commons (2021), Hansard Written question 157139, 23 February 2021

Victoria Atkins responds to a written question asked by Sarah Champion to the Secretary of State for the Home Department, with reference to FORWARD UK's February 2021 report entitled Do No Harm: Lived Experiences and Impacts of FGM Safeguarding Policies and Procedures, if the Government will make an assessment of the effectiveness of the safeguarding approach for FGM in the UK. (LDO)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2021-02-23/157139

2021-00567

Antenatal birth preparedness and complication readiness among women who have undergone female genital mutilation in North Eastern Kenya in 2015. Wamae R, Kamau K, Jaidesa G, et al (2019), East African Medical Journal vol 96, no 5, 2019

Background: Female genital mutilation (FGM) causes a wide range of obstetric complications with associated poor pregnancy outcomes. Antenatal care (ANC) provides an ideal opportunity for birth preparedness and complication readiness in women with FGM.
Objective of the study: To assess birth preparedness and complication readiness following antenatal care visits among women who have undergone female genital mutilation in North Eastern Kenya.
Study design: Descriptive cross sectional
Study Setting: Garissa Level 5 Hospital, Kenya (GL5H)
Study Participants: 311 postnatal mothers who had received antenatal care
Results: The prevalence of FGM was found to be 85%. 80% mothers attended 2 or more antenatal visits and started at least by 14 weeks gestation. Of these, only 4% (11/263) were asked about type of FGM they had undergone, while only 6% (15/263) were examined for FGM status during their antenatal visits. On birth complications associated to FGM, only 11% (29/263) were informed about bleeding, episiotomy and perineal tears, 9% (24/263) were informed about poor neonatal outcomes, 10% (26/263) were informed about need to deliver in an emergency obstetric care (EmOC) facility. Of the 85% who had undergone FGM, 7% (19/263) were informed about de-infibulation and 5% (13/263) about re-infibulation. Only 7% (18/263) were informed about reduction in dyspareunia, reduction in dysmenorrhoea and increase in urine passage after delivery.
Conclusion: Antenatal care, which offers an opportunity for prevention of obstetric complications and better

pregnancy outcomes among women who have undergone female genital mutilation, is underutilized. (Author)

2021-00509

Female Genital Mutilation October 2020 - December 2020. NHS Digital (2021), London: NHS Digital 25 February 2021

Cases of Female Genital Mutilation (FGM) added to the FGM Enhanced Dataset collection platform between October 2020 and December 2020 in England. (Author, edited)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/october-2020---december-2020

2021-00304

Developing Countries: Female Genital Mutilation [written answer]. House of Commons (2021), Hansard Written question 144987, 28 January 2021

Wendy Morton responds to a written question from Yasmin Qureshi to the Secretary of State for Foreign, Commonwealth and Development Affairs, regarding what steps he is taking to enable the UK to use its presidencies of the G7 and COP26 to ensure that it and other nations (a) build on initial progress on eradicating female genital mutilation and (b) make a renewed commitment to SDG 4. (Author, edited)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2021-01-28/144987

2021-00049

Female Genital Mutilation [written answer]. House of Commons (2021), Hansard Written question 144986, 28 January 2021

Wendy Morton responds to a written question from Yasmin Qureshi to the Secretary of State for Foreign, Commonwealth and Development Affairs, regarding what targeted support he is providing to potential victims of female genital mutilation. (JSM)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2021-01-28/144986

20201209-20*

Medicalization of female genital cutting in Malaysia: A mixed methods study. Rashid A, Iguchi Y, Afiqah SN (2020), PLoS Medicine vol 17, no 10, October 2020

Background

Despite the clear stand taken by the United Nations (UN) and other international bodies in ensuring that female genital cutting (FGC) is not performed by health professionals, the rate of medicalization has not reduced. The current study aimed to determine the extent of medicalization of FGC among doctors in Malaysia, who the doctors were who practiced it, how and what was practiced, and the motivations for the practice.

Methods and findings

This mixed method (qualitative and quantitative) study was conducted from 2018 to 2019 using a self-administered questionnaire among Muslim medical doctors from 2 main medical associations with a large number of Muslim members from all over Malaysia who attended their annual conference. For those doctors who did not attend the conference, the questionnaire was posted to them. Association A had 510 members, 64 male Muslim doctors and 333 female Muslim doctors. Association B only had Muslim doctors; 3,088 were female, and 1,323 were male. In total, 894 questionnaires were distributed either by hand or by post, and 366 completed questionnaires were received back. For the qualitative part of the study, a snowball sampling method was used, and 24 in-depth interviews were conducted using a semi-structured questionnaire, until data reached saturation. Quantitative data were analysed using SPSS version 18 (IBM, Armonk, NY). A chi-squared test and binary logistic regression were performed. The qualitative data were transcribed manually, organized, coded, and recoded using NVivo version 12. The clustered codes were elicited as common themes. Most of the respondents were women, had medical degrees from Malaysia, and had a postgraduate degree in Family Medicine. The median age was 42. Most were working with the Ministry of Health (MoH) Malaysia, and in a clinic located in an urban location. The prevalence of Muslim doctors practising FGC was 20.5% (95% CI 16.6-24.9). The main reason cited for practising FGC was religious obligation. Qualitative findings too showed that religion was a strong motivating factor for the practice and its continuation, besides culture and harm reduction. Although most Muslim doctors performed type IV FGC, there were a substantial number performing type I. Respondents who were women (adjusted odds ratio [aOR] 4.4, 95% CI 1.9-10.0. P ≤ 0.001), who owned a clinic (aOR 30.7, 95% CI 12.0-78.4. P ≤ 0.001) or jointly owned a clinic (aOR 7.61, 95% CI 3.2-18.1. P ≤ 0.001), who thought that FGC was legal in Malaysia (aOR 2.09, 95% CI 1.02-4.3. P = 0.04), and who were encouraged in religion (aOR 2.25, 95% CI 3.2-18.1. P = 0.036) and thought that FGC should continue (aOR 3.54, 95% CI 1.25-10.04. P = 0.017) were more likely to practice FGC. The main limitations of the study were the small sample size and low response rate.

Conclusions

In this study, we found that many of the Muslim doctors were unaware of the legal and international stand against FGC, and many wanted the practice to continue. It is a concern that type IV FGC carried out by traditional midwives may be supplanted and exacerbated by type I FGC performed by doctors, calling for strong and urgent action by the Malaysian medical authorities. (Author)

Full URL: https://doi.org/10.1371/journal.pmed.1003303

20201207-6*

Immigrants: Detainees [written answer]. House of Commons (2020), Hansard Written question 122657, 30 November 2020

Chris Philp responds to a written question from Caroline Lucas to the Secretary of State for the Home Department, regarding whether women held at (a) Dungavel and (b) Colnbrook immigration removal centres have access to doctors and other medical staff with (i) knowledge of and (ii) expertise in gender-based violence; what assessment she has made of the effect of detaining women at immigration removal centres predominantly holding men on her ability to fulfil her duties under section 149 of the Equality Act 2010 (Public Sector Equality Duty) b); and if she will make a statement. (JSM)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2020-11-30/122657

20201127-19*

Female Genital Mutilation July - September 2020. NHS Digital (2020), London: NHS Digital 26 November 2020

Cases of Female Genital Mutilation (FGM) added to the FGM Enhanced Dataset collection platform between 1 July 2020 to 30 September 2020. England. (Author)

Full URL: https://www.gov.uk/government/statistics/female-genital-mutilation-july-september-2020

20201022-5*

Female Genital Mutilation and Forced Marriage [written answer]. House of Commons (2020), Hansard Written question 102747, 13 October 2020

Wendy Morton responds to a written question asked by Yasmin Qureshi to the Secretary of State for Foreign, Commonwealth and Development Affairs, regarding the steps he is taking to eliminate (a) child, (b) early and (c) forced marriage and (d) female genital mutilation. (LDO)

Full URL: https://questions-statements.parliament.uk/written-questions/detail/2020-10-13/102747

20201015-36*

Changing the narrative: do midwives need culturally sensitive education about female genital cutting?. Mahmood L, Burnett A (2020), The Student Midwife vol 3, no 4, October 2020, pp 12-15

In this two-part series, Lieqa Mahmood and Alicia Burnett draw from an interview with Female Genital Cutting (FGC) survivor and activist Hibo Wardere to raise awareness of FGC. In this instalment, Alicia explores the anatomy of the vulva, pretexts underpinning FGC and arguments for culturally sensitive FGC midwifery education. The Student Midwife acknowledges the limitations of exploring this complex subject in a two-part series and refers readers to the additional reading. We also extend our gratitude to Hibo for her courage, commitment and time. (Author, edited)

20201015-11*

The Acton Model: support for women with female genital mutilation. Albert J, Wells M (2020), British Journal of Midwifery vol 28, no 10, October 2020, pp 697-708

Objectives

To identify the presenting characteristics, needs and clinical management of non-pregnant women with female genital mutilation who attended the Sunflower clinic, a midwife-led specialist service.

Methods

This was a retrospective case series review examining referral patterns, clinical findings and subsequent management between 1 April 2018 and 31 March 2019.The review was conducted at a multi-disciplinary female genital mutilation clinic for non-pregnant women aged 18 years and over in West London.

Results

There were 182 attendances at the clinic (88 new patients; 94 follow-up appointments). Almost half (52%) had type 3 mutilation, 32% had type 2; 9% had a history of type 3; 5% had type 1; one had type 4 and one declined assessment. A total of 35 women (40%) disclosed at least one psychological symptom (such as depression, anxiety, flashbacks,

nightmares) during initial consultation.
Conclusions
Non-pregnant women attending female genital mutilation services present with a wide range of psychological and physical problems. Holistic woman-centred models of care appear to facilitate access to deinfibulation and counselling, which in turn may reduce long-term costs to the NHS. Safeguarding is an intrinsic part of midwives' work and is sometimes complex. The authors recommend a revision of the World Health Organization classifications to specify partial or total removal of the clitoral glans (rather than the clitoris as a whole) as this is inaccurate and may have a negative psychological impact for women. (Author)
Full URL: https://doi.org/10.12968/bjom.2020.28.10.697

20200923-6*

Somalia: Female Genital Mutilation and Marriage [written answer]. House of Lords (2020), Hansard Written question HL7889, 7 September 2020

Baroness Sugg responds to a written question from Baroness Stroud to Her Majesty's Government, regarding their strategy to address (1) female genital mutilation, and (2) child marriage, in Somalia, following the introduction of the Sexual Intercourse Related Crimes Bill in the Parliament of Somalia; and what protections they have established for the protection of British-Somali citizens from (1) female genital mutilation, and (2) child marriage. (JSM)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2020-09-07/HL7889

20200921-102*

National FGM Centre: Finance [written answer]. House of Lords (2020), Hansard Written question HL7624, 2 September 2020

Baroness Berridge responds to a written question from Baroness Cox to Her Majesty's Government, regarding what plans they have, if any, to reverse their decision to cap the funding of the National FGM Centre. (JSM)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2020-09-02/HL7624

20200918-4*

Female Genital Mutilation [written answer]. House of Lords (2020), Hansard Written question HL7730, 2 September 2020

Baroness Williams of Trafford responds to a written question from Baroness Tonge to Her Majesty's Government, regarding how many women and girls in the UK they estimate have been affected by female genital mutilation/cutting (FGM/C); how many women and girls were treated in the UK for matters related to FGM/C in the year to March; of those, how many were born in the UK; what assessment they have made of those figures; and what plans, if any, they have (1) to cut funding to, and (2) to close, centres in the UK. (Author, edited)
Full URL: https://questions-statements.parliament.uk/written-questions/detail/2020-09-02/HL7730

20200915-85

Suffering in silence. Karim S (2020), Midwives vol 23, September 2020, pp 49-50

Sarian Karim is an FGM survivor. After years of withheld trauma and physical pain she found the courage to speak up. She now runs a safe space for others to talk. (Author)

20200909-35*

Knowledge, attitude, practice, and predictors of female genital mutilation in Degadamot district, Amhara regional state, Northwest Ethiopia, 2018. Melese G, Tesfa M, Sharew Y, et al (2020), BMC Women's Health vol 20, no 178, 14 August 2020

Background
Female genital mutilation is defined as all procedures that involve partial or total removal of external female genitalia, or other injuries to the female genital organs for cultural and religious purposes. In Ethiopia, the prevalence of female genital mutilation practice was 70.8% according to Ethiopian demographic and health survey 2016. This practice is against females' reproductive health rights with many serious consequences in physical, mental, social and psychological makeup. Therefore, this study aimed to assess knowledge, attitude, practice, and predictors of female genital mutilation in Degadamot district.
Methods
A community-based cross-sectional study design was conducted. Three hundred twenty-five mothers who had under 5 years old female children were selected using systematic random sampling from seven kebeles of Degadamot district. Data were collected using an adapted semi-structured face to face interview questionnaire. Data were entered into Epi-data version 3.1 and then exported to SPSS version 20 for analysis. Logistic regression analysis with

95% confidence intervals was carried out to determine the associations between predictor variables and outcome variables.

Result

The finding of this study revealed that 56.6% of mothers had good knowledge about female genital mutilation and 54.2% of participants had a favorable attitude about female genital mutilation. 70.8% of under 5 years old female children's had female genital mutilation. Marital status AOR = 7.19(95%CI3.22-16.03), monthly income AOR = 1.97(95% CI 0.26-3.81), custom AOR = 2.13(95% CI 1.20-3.78), belief AOR =2.47(95% CI 1.39-4.39), value AOR = 0.37(95% CI 0.22-0.63), and attitude AOR = 24.4(95% CI 20.01-34.76) towards female genital mutilation had significant association with female genital mutilation practice.

Conclusion

Prevalence of FGM practices among female children of under 5 years of age was found to be high as compared to the national level (64%). 56.6% of mothers had good knowledge about FGM. The majority of the women had a favorable attitude to keep FGM practice among their under 5 years old daughters. Marital status, monthly income, custom, belief, value, and attitude had a significant association with FGM practice. (Author)

Full URL: https://doi.org/10.1186/s12905-020-01041-2

20200902-33*

Health Services: Domestic Violence [written answer]. House of Commons (2020), Hansard Written question 77659, 21 July 2020

Ms. Nadine Dorries responds to a written question from Jess Phillips to the Secretary of State for Health and Social Care, regarding what plans he has to ensure the adequacy of funding for the effective provision of (a) services and (b) referrals in relation to incidences of violence against women and girls. (Author)

Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2020-07-21/77659/

20200827-4*

Female Genital Mutilation, April - June 2020. NHS Digital (2020), London: NHS Digital 27 August 2020

Cases of Female Genital Mutilation (FGM) added to the FGM Enhanced Dataset collection platform between 1 April 2020 to 30 June 2020 in England. (Author, edited)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/april-2020---june-2020

20200723-66*

A review of the law surrounding female genital mutilation protection orders. Home J, Rowland A, Gerry F, et al (2020), British Journal of Midwifery vol 28, no 7, July 2020, pp 418-429

Performing female genital mutilation (FGM) is prohibited within the UK by the FGM Act of 2003. A mandatory reporting duty for FGM requires regulated health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18-year-olds to the police. An application to the court for an FGM protection order (FGMPO) can be made to keep individual women and girls safe from FGM. This paper reveals the significant disconnect between the number of FGMPO applications and known recorded cases of FGM. The introduction of FGMPOs requires critical exploration as there is insufficient evidence to show that FGMPOs are effective in protecting women and girls from FGM. It is therefore unclear what impact, if any, FGMPOs are having upon the protection of women and girls at risk of FGM. The barriers to the implementation of FGMPOs and possible solutions are discussed. (Author)

20200723-16*

Female Genital Mutilation [written answer]. House of Lords (2020), Hansard Written question HL6592, 7 July 2020

Baroness Williams of Trafford responds to a written question asked by Baroness Tonge to Her Majesty's Government, regarding the measures in place to monitor and assess the effectiveness of the Mandatory Reporting of Female Genital Mutilation duty, which came into force on 31 October 2015. (LDO)

Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2020-07-07/HL6592/

20200723-15*

Female Genital Mutilation: Children [written answer]. House of Lords (2020), Hansard Written question HL6591, 7 July 2020

Baroness Williams of Trafford responds to a written question asked by Baroness Tonge to Her Majesty's Government, regarding the number of reports of cases of female genital mutilation, or suspected female genital mutilation, they have received under the mandatory reporting for under-18s duty in the Serious Crime Act 2015 since that Act received Royal Assent. (LDO)

Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2020-07-07/HL6591/

20200721-35*

Estimates of female genital mutilation/cutting in the Netherlands: a comparison between a nationwide survey in midwifery practices and extrapolation-model. Kawous R, van den Muijsenbergh METC, Geraci D, et al (2020), BMC Public Health vol 20, no 1033, 29 June 2020

Background

Owing to migration, female genital mutilation or cutting (FGM/C) has become a growing concern in host countries in which FGM/C is not familiar. There is a need for reliable estimates of FGM/C prevalence to inform medical and public health policy. We aimed to advance methodology for estimating the prevalence of FGM/C in diaspora by determining the prevalence of FGM/C among women giving birth in the Netherlands.

Methods

Two methods were applied to estimate the prevalence of FGM/C in women giving birth: (I) direct estimation of FGM/C was performed through a nationwide survey of all midwifery practices in the Netherlands and (II) the extrapolation model was adopted for indirect estimation of FGM/C, by applying population-based-survey data on FGM/C in country of origin to migrant women who gave birth in 2018 in the Netherlands.

Results

A nationwide survey among primary care midwifery practices that provided care for 57.5% of all deliveries in 2018 in the Netherlands, reported 523 cases of FGM/C, constituting FGM/C prevalence of 0.54%. The indirect estimation of FGM/C in an extrapolation-model resulted in an estimated prevalence of 1.55%. Possible reasons for the difference in FGM/C prevalence between direct- and indirect estimation include that the midwives were not being able to recognize, record or classify FGM/C, referral to an obstetrician before assessing FGM/C status of women and selective responding to the survey. Also, migrants might differ from people in their country of origin in terms of acculturation toward discontinuation of the practice. This may have contributed to the higher indirect-estimation of FGM/C compared to direct estimation of FGM/C.

Conclusions

The current study has provided insight into direct estimation of FGM/C through a survey of midwifery practices in the Netherlands. Evidence based on midwifery practices data can be regarded as a minimum benchmark for actual prevalence among the subpopulation of women who gave birth in a given year. (Author)

Full URL: https://doi.org/10.1186/s12889-020-09151-0

20200715-36*

Female Genital Mutilation [written answer]. House of Commons (2020), Hansard Written question 23441, 2 March 2020

Victoria Atkins responds to a written question asked by Hywel Williams to the Secretary of State for the Home Department, regarding the amount of funding the Government has allocated to tackling female genital mutilation in each financial year since 2015; and how that funding was allocated. (LDO)

Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2020-03-02/23441/

20200713-22*

The medicalisation of female genital cutting: harm reduction or social norm?. Van Eekert N, Buffel V, De Bruyn S, et al (2021), Sociology of Health & Illness vol 43, no 2, February 2021, pp 263-280

Today, female genital cutting is increasingly practised by trained healthcare providers. While opposition to medicalised female genital cutting (FGC) is strong, little is known about the underlying motivation for this medicalisation trend in practising communities. We formulated three hypotheses based on medicalisation theories. The medicalisation of FGC: (i) is stratified and functions as a status symbol, (ii) functions as a harm-reduction strategy to conform to social norms while reducing health risks and (iii) functions as a social norm itself. Conducting multilevel multinomial regressions using the 2005, 2008 and 2014 waves of the Egyptian Demographic Health Survey, we examined the relationship between the mother's social position, the normative context in which she lives and her decision to medicalise her daughter's cut, compared to the choice of a traditional or no cut. We found that an individual woman's social position, as well as the FGC prevalence and percentage of medicalisation at the governorate

level, was associated with a mother's choice to medicalise her daughter's cut. Further research on factors involved in decision-making on the medicalisation of FGC is recommended, as an in-depth understanding of why the decision is made to medicalise the FGC procedure is relevant to both the scientific field and the broader policy debate. (Author)

20200713-19*

An examination of the medicalization trend in female genital cutting in Egypt: How does it relate to a girl's risk of being cut?. Van Eekert N, Biegel N, Gadeyne S, et al (2020), Social Science and Medicine vol 258, August 2020, 113003

Female Genital Cutting (FGC) is increasingly being performed by trained health professionals. International, national, and local institutions strongly oppose this medicalization trend, arguing that the involvement of health-care providers in the performance of FGC will counteract efforts to eliminate the practice. However, no empirical research to date has confirmed or refuted this claim. Therefore, it remains unclear how the medicalization of FGC relates to changes in the prevalence of the practice.

In the current paper, we aim to fill this gap in the literature by examining the association between this medicalization trend and the risk of FGC. We focus on Egypt because of its high medicalization and prevalence rates and its unique history of FGC legislation. We performed a discrete-time event-history regression analysis combined with governorate fixed effects using the Egyptian Demographic Health Surveys from 2005, 2008, and 2014 (N = 49,273 daughters clustered within 29,810 mothers).

Our results show that increasing medicalization rates coexist with decreasing prevalence rates. This effect is particularly pronounced in a context where a substantial number of cuts were medicalized (estimated at 40% and above). This effect is significantly more pronounced in higher educated mothers.

Our study thus shows that the medicalization of FGC can coincide with decreasing prevalence rates of FGC. Medicalization of FGC may take place in a context where an awareness of the health hazards related to FGC is more pronounced, thereby also discouraging the practice as a whole. In addition, the medicalization of FGC may make the practice more individualized and therefore reduce the incentives for FGC. (Author)

20200710-35*

Maternity care of women affected by female genital mutilation/cutting: An audit of two Australian hospitals. Shukralla HK, McGurgan P (2020), Women and Birth: Journal of the Australian College of Midwives vol 33, no 4, pp E326-E331

Background

Pregnant women affected by female genital mutilation/cutting are at risk of adverse maternal outcomes compared to unaffected women, and sometimes require procedures to facilitate giving birth that midwives and doctors do not routinely perform. These women require culturally sensitive care. Current health professional literature provides evidence that midwives and doctors need further knowledge and training in this area.

Aims

This audit aimed to describe the demographic characteristics of pregnant women with female genital mutilation/cutting giving birth at two Perth maternity units, in addition to assessing health provider compliance with the local female genital mutilation/cutting Clinical Guideline.

Materials and methods

The clinical database used by public maternity units in Western Australia was used to identify affected women who gave birth during 2014 at King Edward Memorial Hospital or Osborne Park Hospital. Demographic characteristics and information about antenatal care and maternal outcomes were collected.

Results

53 women fulfilled the audit criteria. Prevalence of pregnant women with female genital mutilation/cutting varied from 0.33% to 2.18% between the two units. Compliance with the Female Genital Mutilation/Cutting Clinical Guideline was generally suboptimal. While no woman was deinfibulated antenatally, 26% of women required intrapartum deinfibulation to give birth.

Conclusions

Women with female genital mutilation/cutting make up more than 2% of the antenatal population in some Perth metropolitan maternity units. Health care provider knowledge of, and compliance with, the Female Genital Mutilation/Cutting Clinical Guideline was poor in the two units studied. It appears that healthcare professionals need more education and training to provide affected women with the best care. (Author)

20200709-32*

Female Genital Mutilation [written answer]. House of Lords (2020), Hansard Written question HL5970, 22 June 2020

Baroness Williams of Trafford responds to a written question asked by Lord Alton of Liverpool to Her Majesty's

Government, regarding the steps they are taking to address the challenges and barriers experienced by the UK in relation to measures to prevent female genital mutilation, including the use of protection orders to minimise the risk of exposure of women and girls at risk of mutilation when travelling outside the UK. (LDO)

Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2020-06-22/HL5970/

20200630-10*

Female Genital Mutilation [written answer]. House of Commons (2020), Hansard Written question 62628, 22 June 2020

Wendy Morton responds to a written question asked by Anthony Mangnall to the Secretary of State for International Development, regarding the steps her Department is taking to prevent female genital mutilation in countries overseas. (LDO)

Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2020-06-22/62628/

20200624-13*

Trends and Spatio-temporal variation of female genital mutilation among reproductive-age women in Ethiopia: a Spatio-temporal and multivariate decomposition analysis of Ethiopian demographic and health surveys. Tesema GA, Agegnehu CD, Teshale AB, et al (2020), BMC Public Health vol 20, no 719, 19 May 2020

Background

Female genital mutilation (FGM) is a serious health problem globally with various health, social and psychological consequences for women. In Ethiopia, the prevalence of female genital mutilation varied across different regions of the country. Therefore, this study aimed to investigate the trend and determinants of female genital mutilation among reproductive-age women over time.

Methods

A secondary data analysis was done using 2000, 2005, and 2016 Demographic Health Surveys (DHSs) of Ethiopia. A total weighted sample of 36,685 reproductive-age women was included for analysis from these three EDHS Surveys. Logit based multivariate decomposition analysis was employed for identifying factors contributing to the decrease in FGM over time. The Bernoulli model was fitted using spatial scan statistics version 9.6 to identify hotspot areas of FGM, and ArcGIS version 10.6 was applied to explore the spatial distribution FGM across the country.

Results

The trends of FGM practice has been decreased from 79.9% in 2000 to 70.4% in 2016 with an annual reduction rate of 0.8%. The multivariate decomposition analysis revealed that about 95% of the overall decrease in FGM practice from 2000 to 2016 was due to the difference in the effects of women's characteristics between the surveys. The difference in the effects of residence, religion, occupation, education, and media exposure were significant predictors that contributed to the decrease in FGM over time. The spatial distribution of FGM showed variation across the country. The SaTScan analysis identified significant hotspot areas of FGM in Somali, Harari, and Afar regions consistently over the three surveys.

Conclusion

Female genital mutilation practice has shown a remarkable decrease over time in Ethiopia. Public health programs targeting rural, non-educated, unemployed, and those women with no access to media would be helpful to maintain the decreasing trend of FGM practice. The significant Spatio-temporal clustering of FGM was observed across regions in Ethiopia. Public health interventions must target the identified clusters as well. (Author)

Full URL: https://doi.org/10.1186/s12889-020-08882-4

20200619-27*

Educating women and girls on female genital mutilation. Albert J (2020), British Journal of Midwifery vol 28, no 5, May 2020, pp 286-287

Juliet Albert provides a first-hand account of her trip to a female genital mutilation refuge centre in Kenya. (Author)

20200609-33*

Female Genital Mutilation: Coronavirus [written answer]. House of Commons (2020), Hansard Written question 52007, 1 June 2020

Wendy Morton responds to a written question asked by Seema Malhotra to the Secretary of State for International Development, regarding what assessment she has made of the accuracy of the estimate by the UN Population Fund that the COVID-19 pandemic could result in an additional 2 million girls worldwide being subject to female genital

mutilation (FGM). (LDO)

Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2020-06-01/52007/

20200529-32*

'When my mother called me to say that the time of cutting had arrived, I just escaped to Belgium with my daughter': identifying turning points in the change of attitudes towards the practice of female genital mutilation among migrant women in Belgium. Agboli AA, Richard F, Aujoulat I (2020), BMC Women's Health vol 20, no 107, 19 May 2020

Background

Female Genital Mutilation (FGM) is a public health concern with negative consequences on women's health. It is a harmful practice which is recognized in international discourses on public health as a form of gender-based violence. Women are not only victims of this, but also perpetrators. The practice of FGM remains a social norm which is difficult to change because it is deeply rooted in tradition and is embedded in the patriarchal system. However, some women have managed to change their attitudes towards it and have spoken out against it. This study identifies and describes turning points that have been defined as significant and critical events in the lives of the women, and that have engendered changes in their attitudes towards the practice of FGM.

Methods

We have conducted an inductive qualitative study based on the life story approach, where we interviewed 15 women who have undergone FGM. During the interviews, we discussed and identified the turning points that gave the research participants the courage to change their position regarding FGM. The analysis drew on lifeline constructions and thematic analysis.

Results

Six common turning points relating to a change in attitude towards FGM were identified: turning points related to (i) encounters with health professionals, (ii) education, (iii) social interactions with other cultures and their own culture, (iv) experiences of motherhood, (v) repeated pain during sexual or reproductive activity, and (vi) witnessing the effects of some harmful consequences of FGM on loved ones.

Conclusions

The turning points identified challenged the understanding of what it means to be a 'member' of the community in a patriarchal system; a 'normal woman' according to the community; and what it means to be a 'good mother'. Moreover, the turning points manifested in conjunction with issues centered on emotional responses and coming to terms with conflicts of loyalty, which we see as possible triggers behind the shift experienced by the women in our sample. (Author)

Full URL: https://doi.org/10.1186/s12905-020-00976-w

20200528-18*

Female Genital Mutilation (FGM) Enhanced Dataset: January 2019 to March 2019, England, experimental statistics. NHS Digital (2019), London: NHS Digital 24 May 2019

The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices. (Author)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/january-to-march-2019

20200528-17*

Female Genital Mutilation (FGM) Enhanced Dataset: April 2018 to March 2019, England, experimental statistics, Annual Report. NHS Digital (2019), London: NHS Digital 25 July 2019

The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices. (Author)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/april-2018---march-2019

20200528-16*

Female Genital Mutilation (FGM) Enhanced Dataset: April 2019 to June 2019, England, experimental statistics. NHS Digital (2019), London: NHS Digital 22 August 2019

The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices.

(Author)
Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/april-2019---june-2019

20200528-15*

Female Genital Mutilation (FGM) Enhanced Dataset: July 2019 to September 2019 England, experimental statistics. NHS Digital (2019), London: NHS Digital 28 November 2019

The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices. (Author)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/july---september-2019

20200528-14*

Female Genital Mutilation (FGM) Enhanced Dataset: October 2019 to December 2019, England, experimental statistics. NHS Digital (2020), London: NHS Digital 27 February 2020

The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices. (Author)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/october-2019---december-2019

20200528-13*

Female Genital Mutilation (FGM) Enhanced Dataset: January 2020 to March 2020, England, experimental statistics. NHS Digital (2020), London: NHS Digital 28 May 2020

The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices. (Author)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/january-2020---march-2020

20200526-28*

The decline of FGM in Egypt since 1987: a cohort analysis of the Egypt Demographic and Health Surveys. van Rossem R, Meekers D (2020), BMC Women's Health vol 20, no 100, 11 May 2020

Background
Female genital mutilation (FGM) has been a longstanding tradition in Egypt and until recently the practice was quasi-universal. Nevertheless, there are indications that the practice has been losing support and that fewer girls are getting cut. This study analyzes the prevalence of FGM in different birth cohorts, to test whether the prevalence declined over time. The study also examines whether such a decline is occurring in all segments of society or whether it is limited mostly to certain more modernized segments of society.
Methods
This study pooled data from the 2005, 2008 and 2014 waves of the Egypt Demographic and Health Surveys (EDHS). The women participating in the EDHS provided data on 62,507 girls born to them between 1987 and 2014, including whether they were cut and at what age. Kaplan-Meier and Weibull proportional hazard survival analyses were used to examine trends in the prevalence and hazards of FGM across birth cohorts. Controls for region, religion and socioeconomic status of the parents were included in the Weibull regression.
Results
The results show a steady decline in FGM across the birth cohorts studied. The base hazard for the 2010 birth cohort is only 30% that of the 1987 one. Further analyses show that the decline in FGM occurred in all segments of Egyptian society in a fairly similar manner although differences by region, religion and socioeconomic status persisted.
Conclusions
This study confirms that FGM is declining in Egypt. The proportion of girls getting cut has declined rapidly over the past few decades. This decline is not limited to the more modernized segments of society, but has spread to the more traditional segments as well. The latter increases prospects for the eventual eradication of the practice. (Author)

Full URL: https://doi.org/10.1186/s12905-020-00954-2

20200513-49

The importance of men in the eradication of female genital mutilation. Esegbona-Adeigbe S, Olayiwola W (2020), MIDIRS

Midwifery Digest vol 30, no 2, June 2020, pp 257-262

Discusses the influence of men on female genital mutilation (FGM/C) and the importance of educating men in the United Kingdom who come from countries where FGM/C is prevalent. The authors suggest that educational programmes should be targeted at adolescent men, programmes should use men to educate other men, and the focus should be on health and legal implications rather than demoting the importance of cultural practices. (LDO)

20200511-10*

The lived experience among Somali women of giving birth in Sweden: an interpretive phenomenological study.
Wallmo S, Allgurin K, Berterö C (2020), BMC Pregnancy and Childbirth vol 20, no 262, 1 May 2020

Background

The health care-seeking behaviour among Somali women is different from Swedish women's behaviour, and this may have consequences for birth giving. The aim of the study was to identify and describe Somali women's lived experience of birth giving in Sweden.

Methods

Qualitative individual interviews were conducted in Swedish with seven Somali women. The sample was purposeful, and the snowball sampling method was used. The interviews were digitally recorded and transcribed verbatim. Data were analysed using interpretative phenomenological analysis.

Results

Four themes emerged during the analysis which revealed the Somali women's lived experiences of giving birth in Sweden. a) Being recognised and confirmed as a woman. Somali women consider it important to be confirmed as a woman by the surrounding and professionals during pregnancy and birth giving. b) Communication is important for the women's independence. There is a need to provide a structure for how this information is given and adaptation regarding content and format .c) Something naturally becomes unknown and complicated. Somali women come from a different culture, which affects their lived experiences of pregnancy and birth giving. There is a need for improved and clearer information for these Somali women regarding pregnancy and birth giving in another culture- the Swedish context d) Professional and competent taking care of. The women appreciate if they are treated with competency and professionalism; they do not want to be discriminated. The women feel confidence in health care when they meet competent and professional health care professionals.

Conclusions

The findings in the study indicate that reproductive health care for Somali women should be improved with regard to cultural differences and lived experiences, as this affects their experience of pregnancy and childbirth in Sweden. There is a need for both knowledge and understanding in order to provide good quality care for these Somali women, especially those who have been genitally mutilated. (Author)

Full URL: https://doi.org/10.1186/s12884-020-02933-9

20200506-82*

Female genital mutilation [written answer]. House of Commons (2020), Hansard Written question 40519, 27 April 2020

Ms Nadine Dorries responds to a written question from Hywel Williams to the Secretary of State for Health and Social Care, regarding how much and what proportion of his Department's budget has been spent on tackling female genital mutilation in the UK in each financial year since 2015. (MB)

Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2020-04-27/40519/

20200504-15*

Prevalence, knowledge, attitude and practices of female genital mutilation and cutting (FGM/C) among United Arab Emirates population. Al Awar S, Al-Jefout M, Osman N, et al (2020), BMC Women's Health vol 20, no 79, 22 April 2020

Background

Female genital mutilation/cutting (FGM/C) is a common practice in developing countries, including the UAE, and presents a major health problem.

Methods

A questionnaire-based cross-sectional study was conducted among 1035 participants: 831 (80.3%) females and 204 (19.7%) males.

Results

The number of women with FGM/C was 344; hence the prevalence of FGM/C in our study was 41.4%. Type I was the most prevalent (62.8%), followed by Type II (16.6%) and Type III (5%). FGM/C was less prevalent among educated and

employed women (p-value < 0.001) and was mostly performed during infancy and childhood. Among the participants, 13.7% reported that their daughters had undergone FGM/C, with Type I being the most common, and 25% of them planned to have their future daughters undergo Type I FGM/C. While FGM/C was mostly performed by ritual circumcisers (74.4%), in 25 and 36.7% of the cases, it was performed by health professionals and in the clinic setting, respectively. About 69% of the participants considered FGM/C a custom, 72.8% were against the practice, and only 17.4% believed in its legality. Complications occurred in 30% of cases. The type of FGM/C was associated with the occurrence of complications: bleeding, difficulties in sexual life, and delivery-related problems (p-value < 0.05). One-fifth of the male participants expressed plans to circumcise future daughters (p-value < 0.001).
Conclusion
FGM/C remains a prevalent practice in the UAE and has a negative association with the general health of Emirati women. The lack of clear legislation to criminalize this practice is a problem to be addressed. In this context, national-level educational and legal strategies should be a priority. (Author)
Full URL: https://doi.org/10.1186/s12905-020-00949-z

20200423-14*

Might Reinfibulation be Medically Plausible in Carefully Screened Cases?. Voultsos P (2020), African Journal of Reproductive Health vol 24, no 1, March 2020, pp 165-181

In light of the relational account of autonomy and the modern (holistic and phenomenological) account of health, this paper examines ethical justifications for 'consensual' reinfibulation. Significant and constant discomfort in the body following deinfibulation might make a case for reinfibulation (considered as medical treatment in the traditional sense of the term). In any other case, the following requirements should be met for reinfibulation to be considered medically plausible: a) strong evidence that reinfibulation could help effectively improve woman's relational well-being, b) insignificant complications are expected, c) congruence between first-order and second-order autonomy or -in the context of political liberalism- strong second-order autonomy, d) an 'open door' for the woman to exit an oppressive context, e) rigorous scrutiny of woman's psychology, and f) woman's practical wisdom to organize her identity-related values, find a balance between her extreme emotions and realize her own goal of meaningful life in accordance with her own conception of the good. Conclusively, in carefully screened cases and individually judged requests for reinfibulation, it should not be ruled out that, after having been conducted a multi-disciplinary in-depth investigation at social, psychological and medical level may be met conditions that make a case for reinfibulation. (Afr J Reprod Health 2020; 24[1]: 165-181). (Author)
Full URL: https://www.ajrh.info/index.php/ajrh/article/view/2078

20200417-13*

Painful gynecologic and obstetric complications of female genital mutilation/cutting: A systematic review and meta-analysis. Lurie JM, Weidman A, Huynh S, et al (2020), PLoS Medicine vol 17, no 3, 31 March 2020, e1003088

Background
The health complications experienced by women having undergone female genital mutilation/cutting (FGM/C) are a source of growing concern to healthcare workers globally as forced displacement and migration from countries with high rates of this practice increases. In this systematic review and meta-analysis, we investigate the association between FGM/C and painful gynecologic and obstetric complications in women affected by the practice.
Methods and findings
We performed a comprehensive literature search from inception to December 19, 2019 of Ovid MEDLINE, Ovid EMBASE, The Cochrane Library (Wiley), and POPLINE (prior to its retirement) for studies mentioning FGM/C. Two reviewers independently screened studies reporting prevalences of painful gynecologic and obstetric sequelae resulting from FGM/C. Random effects models were used to estimate pooled odds ratios (ORs) for outcomes obtained from cross-sectional, cohort, and case-control designs. Subgroup analysis was performed to assess and control for effect differences introduced by study design. Validated appraisal tools were utilized to assess quality and risk of bias. Our study was registered with PROSPERO. Two reviewers independently screened 6,666 abstracts. Of 559 full-text studies assessed for eligibility, 116 met eligibility criteria, which included studies describing the incidence or prevalence of painful sequelae associated with FGM/C. Pooled analyses after adjustment for study design found that FGM/C was associated with dyspareunia (6,283 FGM/C and 3,382 non-FGM/C participants; pooled OR: 2.47; 95% confidence interval [CI]: 1.45-4.21; I2: 79%; p-value < 0.01), perineal tears (4,898 FGM/C and 4,229 non-FGM/C participants; pooled OR: 2.63; 95% CI: 1.35-5.11; I2: 67%; p-value = 0.01), dysuria (3,686 FGM/C and 3,482 non-FGM/C participants; pooled OR: 1.43; 95% CI: 1.17-1.75; I2: 0%; p-value = 0.01), episiotomy (29,341 FGM/C and 39,260 non-FGM/C participants; pooled OR: 1.89; 95% CI: 1.26-2.82; I2: 96%; p-value < 0.01), and prolonged labor (7,516 FGM/C and 8,060 non-FGM/C participants; pooled OR: 2.04; 95% CI: 1.27-3.28; I2: 90%; p-value < 0.01). There was insufficient

evidence to conclude that there was an association between FGM/C and dysmenorrhea (7,349 FGM/C and 4,411 non-FGM/C participants; pooled OR: 1.66; 95% CI: 0.97-2.84; I2: 86%; p-value = 0.06), urinary tract infection (4,493 FGM/C and 3,776 non-FGM/C participants; pooled OR: 2.11; 95% CI: 0.80-5.54; I2: 90%; p-value = 0.10), instrumental delivery (5,176 FGM/C and 31,923 non-FGM/C participants; pooled OR: 1.18; 95% CI: 0.78-1.79; I2: 63%; p-value = 0.40), or cesarean delivery (34,693 FGM/C and 46,013 non-FGM/C participants; pooled OR: 1.51; 95% CI: 0.99-2.30; I2: 96%; p-value = 0.05). Studies generally met quality assurance criteria. Limitations of this study include the largely suboptimal quality of studies.

Conclusions

In this study, we observed that specific painful outcomes are significantly more common in participants with FGM/C. Women who underwent FGM/C were around twice as likely as non-FGM/C women to experience dyspareunia, perineal tears, prolonged labor, and episiotomy. These data indicate that providers must familiarize themselves with the unique health consequences of FGM/C, including accurate diagnosis, pain management, and obstetric planning. Review protocol registration: The review protocol registration in PROSPERO is CRD42018115848. (Author)

Full URL: https://doi.org/10.1371/journal.pmed.1003088

20200415-27*

Coding female genital mutilation/cutting and its complications using the International Classification of Diseases: a commentary. Cottler-Casanova S, Horowicz M, Gieszl S, et al (2020), BJOG: An International Journal of Obstetrics and Gynaecology vol 127, no 6, May 2020, pp 660-664

Commentary on the accurate coding of female genital mutilation/cutting (FGM/C) and its complications using the International Classification of Diseases (ICD). The authors propose a method of documenting FGM/C using the ninth (ICD-9) and tenth (ICD-10) revisions of ICD. (LDO)

20200408-2*

Female Genital Mutilation: Education [written answer]. House of Lords (2020), Hansard Written question HL2844, 23 March 2020

Baroness Berridge responds to a written question asked by BaronessTonge to Her Majesty's Government regarding what representations they have received about female genital mutilation education being taught in schools; and from whom. (MB)

Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2020-03-23/HL2844/

20200408-1*

Female Genital Mutilation: Education [written answer]. House of Lords (2020), Hansard Written question HL2845, 23 March 2020

Baroness Berridge responds to a written question asked by BaronessTonge to Her Majesty's Government regarding how female genital mutilation education is taught in schools. (MB)

Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2020-03-23/HL2845/

20200407-29*

Transforming social norms to end FGM in the EU: an evaluation of the REPLACE Approach. Barrett HR, Brown K, Alhassan Y, et al (2020), Reproductive Health vol 17, no 40, March 2020

Background

Despite numerous campaigns and interventions to end female genital mutilation (FGM), the practice persists across the world, including the European Union (EU). Previous interventions have focused mainly on awareness raising and legislation aimed at criminalizing the practice. Limited evidence exists on the effectiveness of interventions due in part to the lack of systematic evaluation of projects. This paper presents an evaluation of the REPLACE Approach, which is a new methodology for tackling FGM based on community-based behaviour change and intervention evaluation.

Methods

We developed, trialed and evaluated the REPLACE Approach through extensive engagement with eight FGM affected African diaspora communities in five EU countries. We employed qualitative and quantitative tools to obtain data to inform the development, implementation and evaluation of the Approach. These included community-based participatory action research, questionnaires and community readiness assessments. The research took place between

2010 and 2016.
Results
Findings suggested that the Approach has the capability for building the capacities of FGM affected communities to overturn social norms that perpetuate the practice. We observed that community-based action research is a useful methodology for collecting data in FGM intervention settings as it allows for effective community engagement to identify, educate and motivate influential community members to challenge the practice, as well as obtaining useful information on the beliefs and norms that shape the practice. We also found that community readiness assessments, pre and post intervention, were useful for tailoring interventions appropriately and for evaluating changes in attitudes and behaviour that may have resulted from the interventions.
Conclusion
This evaluation has demonstrated that the REPLACE Approach has the potential, over time, to bring about changes in norms and attitudes associated with FGM. Its strengths lay in the engagement with influential community members, in building the capacity and motivation of community members to undertake change, in recognising contextual differences in the barriers and enablers of FGM practice and in tailoring interventions to local community readiness to change, and then evaluating interventions to re-inform implementation. The next steps would therefore be to implement the Approach over a longer time frame to assess if it results in measurable change in behaviour. (Author)
Full URL: https://doi.org/10.1186/s12978-020-0879-2

20200402-31*

Female Genital Mutilation: Education [written answer]. House of Lords (2020), Hansard Written question HL2173, 3 March 2020

Baroness Berridge responds to a written question asked by Baroness Jenkin of Kennington to Her Majesty's Government regarding the impact of female genital mutilation education in schools. (LDO)
Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2020-03-03/HL2173/

20200402-27*

Female Genital Mutilation: Education [written answer]. House of Lords (2020), Hansard Written question HL2174, 3 March 2020

Baroness Berridge responds to a written question asked by Baroness Jenkin of Kennington to Her Majesty's Government, regarding the impact of female genital mutilation education in schools on the stigma experienced by children of African descent. (LDO)
Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2020-03-03/HL2174/

20200325-20*

Factors Influencing Neonatal Practice in a Rural Community in Kano (Northern), Nigeria. Farouk ZL, Slusher TM, Danzomo AA, et al (2019), Journal of Tropical Pediatrics vol 65, no 6, December 2019, pp 569-575

Nigeria has the highest number of neonatal and under-five deaths in Africa. Socio-cultural determinants play an important role in disease burden in low-middle income countries.
This study aimed to describe knowledge, attitudes and neonatal care practice among household caregivers in a rural community in Nigeria, specifically uvulectomy, female genital mutilation (FGM), failure to routinely immunize and unsafe cord care. Further, relationships between demographic characteristics and knowledge, attitudes and neonatal care practices among caregivers were analyzed.
The study design was descriptive correlational and cross-sectional. Consented caregivers (N = 298) were enrolled and interviewed using a structured questionnaire.
Data were collected on demographic characteristics of the study participants and practice of uvulectomy, FGM, immunization and cord care.
Statistically significant correlations were found between the practice of uvulectomy, FGM and failure to immunize based on occupation (p = 0.0202, p = 0.0290, p = 0.0071) and educational level (p =< 0.0001, p =< 0.0001, p =< 0.0001), with variations by ethnicity.
Intense, preventative health measures and maternal education to eliminate harmful care practices are essential to influence outcomes. (Author)

20200320-6*

Female genital mutilation [written answer]. House of Lords (2020), Hansard Written question HL2175, 3 March 2020

Lord Bethell responds to a written question from Baroness Jenkin of Kennington to Her Majesty's Government, regarding what (1) sexual and reproductive health and rights, and (2) female genital mutilation support, services exist for women with complications resulting from female genital mutilation in the UK. (CAP)

Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2020-03-03/HL2175/

20200319-75*

Exploring the capacity of the Somaliland healthcare system to manage female genital mutilation / cutting-related complications and prevent the medicalization of the practice: a cross-sectional study. Yussuf M, Matanda DJ, Powell RA, et al (2020), BMC Health Services Research vol 20, no 200, 12 March 2020

Female genital mutilation/cutting (FGM/C) negatively impacts the wellbeing of girls and women throughout their lifecycle. In Somalia, FGM/C prevalence is nearly universal (98%) among females aged 15-49 years, with infibulation prevalence at 77%. Whilst there is need to engage healthcare workers in the prevention and management of FGM/C, minimal information exists indicating healthcare systems' capacity to fulfil this role. This study explored factors impacting the capacity of the Somaliland healthcare system to prevent the medicalization, and manage the complications of, FGM/C.

Methods

A cross-sectional qualitative study using semi-structured key informant interviews, conducted in the Somali language, was undertaken in the Maroodi Jeex and Awdal regions of Somaliland, in rural and urban Borama and Hargeisa districts in December 2016. A total of 20 interviews were conducted with healthcare workers comprised of medical doctors, nurses, midwives and system administrators. Transcribed and translated interview data were analysed using the template analysis approach.

Results

Healthcare workers reported understanding the adverse impact of FGM/C on the health of girls and women. However, they faced multiple contextual challenges in their preventative and management roles at the individual level, e.g., they lacked specific formal training on the prevention and management of FGM/C complications and its medicalization; institutional level, e.g., many facilities lacked funding and equipment for effective FGM/C management; and policy level, e.g., no national policies exist on the management of FGM/C complications and against its medicalization.

Conclusion

Healthcare systems in urban and rural Somaliland have limited capacity to prevent, diagnose and manage FGM/C. There is a need to strengthen healthcare workers' skill deficits through training and address gaps in the health system by incorporating the care of girls and women with FGM-related complications into primary healthcare services through multi-sectoral collaboration and coordination, establishing clinical guidelines for FGM/C management, providing related equipment, and enacting policies to prevent the medicalization of the practice. (Author)

Full URL: https://doi.org/10.1186/s12913-020-5049-2

20200319-69*

Female genital mutilation [written answer]. House of Lords (2020), Hansard Written question HL2073, 2 March 2020

Baroness Williams of Trafford responds to a written question from Baroness Jenkin of Kennington to Her Majesty's Government, regarding what assessment they have made of the outcome of criminalising female genital mutilation. (JSM)

Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2020-03-02/HL2073/

20200312-3*

Female Genital Mutilation: Prosecutions [written answer]. House of Lords (2020), Hansard Written question HL2075, 2 March 2020

Lord Keen of Elie responds to a written question asked by Baroness Jenkin of Kennington to Her Majesty's Government concerning how many people have been (1) prosecuted for, and (2) found guilty of, female genital mutilation in the UK. (JSM)

Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2020-03-02/HL2075/

20200310-132*

'Promote locally led initiatives to fight female genital mutilation/cutting (FGM/C)' lessons from anti-FGM/C advocates in rural Kenya. Mwendwa P, Mutea N, Kaimuri MJ, et al (2020), Reproductive Health 28 February 2020, online

Background
Female Genital Mutilation/cutting (FGM/C) is a tradition rooted in culture and involves the partial or total removal or other injury to the female genital organs for non-medical reasons. In Kenya, initiatives to abandon the practice have included 'alternative' ritualistic programmes (ARPs) combined with intensive community sensitisation about FGM/C to achieve attitudinal and behavioural changes. While there are indications of the effectiveness of these interventions, FGM/C continues to be practiced within certain groups in Kenya. This study explored the views of anti-FGM/C advocates on the barriers and facilitators to tackling FGM/C within the Meru community in Kenya.
Methods
Data were obtained using 4 Focus Groups (FGs) with 30 anti-FGM/C advocates from Tigania East and West in Meru county. Thematic framework analysis guided the analysis based on four main questions: 1) How has the cultural meaning of FGM/C evolved over time? 2) What are the perceptions in relation to the effectiveness of anti-FGM/C interventions? 3) How effective are interventions and campaigns to end FGM/C in Meru county? 4) What actions are perceived as the most likely to bring about change?
Results
There has been a substantial shift in the culture of FGM/C and the number of families carrying out the practice in Meru county has decreased in recent years. Participants noted five actions likely to bring about change; 1) reviving and supporting ARPs, 2) encouraging fathers' involvement in the upbringing of their daughters,3) inclusion of the topic of FGM/C in the current education curriculum and public fora, 4) strengthening the community policing strategy -Nyumba Kumi, 5) and setting up community centers for orphans.
Conclusion
Our findings demonstrate the significance of locally led initiatives to fight FGM/C. It also became clear that change would have to start at the family level with parents, particularly fathers, taking on a more active role in the lives of their daughters. Providing education about FGM/C to communities, particularly young men coupled with keeping girls in school appeared to be some of the most effective ways of fighting FGM/C. At the community level, the church became particularly crucial in challenging the practice of FGM/C. (32 references) (Author)

Full URL: https://doi.org/10.1186/s12978-020-0884-5

20200309-18*

Female genital mutilation [written answer]. House of Commons (2020), Hansard Written question 23440, 2 March 2020

Wendy Morton responds to a written question asked by Hywel Williams to the Secretary of State for International Development, regarding how much and what proportion of Official Development Assistance was spent on tackling female genital mutilation in each financial year since 2015. (JSM)

Full URL: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2020-03-02/23440/

20200305-181*

Addressing female genital mutilation in the Asia Pacific: the neglected sustainable development target. Dawson A, Rashid A, Shuib R, et al (2020), Australian and New Zealand Journal of Public Health vol 44, no 1, February 2020, pp 8-10

Discusses female genital mutilation (FGM) and the paucity of research on FGM in the Asia-Pacific region. Explores the impact of religion, community education and government regulations. The authors conclude that further multi-disciplinary, evidence-based and culturally appropriate prevention efforts are needed. (42 references) (LDO)

20200304-35*

Shifts in FGM/C practice in Sudan: communities' perspectives and drivers. Bedri N, Sherfi H, Rudwan G, et al (2019), BMC Women's Health vol 19, no 168, 30 December 2019

Background
Although Sudan has one of the highest prevalence of female genital mutilation or cutting (FGM/C), there have been shifts in e practice. These shifts include a reduction in the prevalence among younger age cohorts, changes in the types of FGM/C, an increase in medicalization, and changes in age of the practice. The drivers of these shifts are not well understood.
Method
Qualitative data drawn from a larger study in Khartoum and Gedaref States, Family and Midwife individual interviews

and focus group discussions. Analysis and categorization within a Social Norms theoretical framework.
Results
Major findings confirmed shifts in the type FGM/C (presumably from infibulation to non-infibulating types) and increasing medicalization in the studied communities. These shifts were reported to be driven by social, professional and religious norms.
Conclusion
Changes in FGM practice in Sudan include drivers which will not facilitate abandonment of the practice instead lead to normalization of FGM/C. Yet professionalisation of Midwives including their oath to stop FGM/C has potential to facilitate abandonment rapidly if developed with other Sudan health professionals. (17 references) (Author)
Full URL: https://doi.org/10.1186/s12905-019-0863-6

20200302-10*

Guideline No. 395-Female Genital Cutting. Perron L, Senikas V, Burnett M, et al (2020), JOGC [Journal of Obstetrics and Gynaecology Canada] vol 42, no 2, February 2020, pp 204-217.e2
Objectives
To decrease the likelihood that the practice of female genital cutting (FGC) be continued in the future and to improve the care of girls and women who have been subjected to FGC or who are at risk by providing (1) information intended to strengthen knowledge and understanding of the practice, (2) information regarding the legal issues related to the practice, (3) guidance for the management of its obstetrical and gynaecological complications, and (4) guidance on the provision of culturally competent care to girls and women affected by FGC.
Options
Strategies for the primary, secondary, and tertiary prevention of FGC and its complications.
Outcomes
The short- and long-term consequences of FGC.
Intended Users
Health care providers delivering obstetrical and gynaecological care.
Target Population
Women from countries where FGC is commonly practised and Canadian girls and women from groups who may practise FGC for cultural or religious reasons.
Evidence
Published literature was retrieved through searches of PubMed, CINAHL, and the Cochrane Library in September 2010 using appropriate controlled vocabulary (e.g., Circumcision, Female) and key words (e.g., female genital mutilation, clitoridectomy, infibulation). Searches were updated and incorporated in the guideline revision December 2018.
Validation Methods
The quality of evidence in this document was rated using the criteria described in the Report of the Canadian Task Force on Preventive Health Care.
Benefits, Harms, and Costs
There are no anticipated harms or costs to health care facilities with implementation of this guideline. Benefits may include a greater willingness of women living with FGC to seek timely care. (65 references) (Author) [Replaces SOGC Clinical Practice Guideline No. 299]

20200225-19*

Correlations between the proportion of type III female genital mutilations in the series and adverse obstetric outcomes: a short meta-analysis. Indraccolo U, Indraccolo SR, Greco P, et al (2020), Journal of Maternal-Fetal and Neonatal Medicine vol 33, no 5, 2020, pp 880-882
Background: Authors have reported that evidence on health harms of female genital mutilation is poor.
Aim: Meta-analyzing prospective studies on adverse obstetric outcomes according to the severity of female genital mutilation.
Method: Prospective studies were already acknowledged in previous meta-analyses and used for calculations. The proportions of type III female genital mutilation were extracted by full-texts, along with the proportions of adverse obstetric outcomes. Assuming random models, the proportions were encoded for meta-analysis and weighted for the inverse of the variance. Nonparametric correlations among weighted proportions of type III female genital mutilation and weighted proportions of obstetric outcomes were built. Analyzable obstetric outcome were: cesarean section, instrumental delivery, episiotomy, post-partum hemorrhage, low Apgar score - need of resuscitation.
Results: Meta-analyzable series are few and heterogeneous. There is a trend of direct correlation among the proportion of type III female genital mutilations in the series and the proportion of cesarean section, instrumental

deliveries, post-partum hemorrhage and low Apgar scores at birth or need of neonatal resuscitation. The significance was reached for the post-partum hemorrhage and for the fetal adverse outcome.
Conclusion: It should be retained that type III female genital mutilation is likely to be a serious concern for birth. (18 references) (Author)

20200214-21*

The impact of health education on attitudes of parents and religious leaders towards female genital mutilation. Abdulah DM, Dawson A, Abdulaziz Sedo B (2020), BMJ Sexual and Reproductive Health vol 46, no 1, January 2020, pp 51-58

Background Previous studies conducted in Iraqi Kurdistan have reported that parent's decisions to circumcise their daughters are based on religious or cultural beliefs. Despite the widespread practice of female genital mutilation (FGM), the effectiveness of educational strategies to change attitudes towards FGM has not been examined in this region. The present investigation examined the effectiveness of a short-term educational intervention to change the attitudes of parents and religious leaders towards FGM.
Methods 192 Mullahs (religious leaders), 212 Mokhtars (traditional leaders) and 523 parents in rural areas in Iraqi Kurdistan were invited to participate in a pre- and post-test community-based interventional study in 2017. The Health Belief Model informed the intervention, and participants' attitudes were compared across two stages of the study.
Results The attitudes of Mullahs, Mokhtars and parents substantially changed from a position of supporting female circumcision to expressing a wish to abandon the practice and not cut their future daughters (OR 1.57, 95% CI 1.02 to 2.42; OR 1.99, 95% CI 1.3 to 3.04 and OR 0.13, 95% CI 0.09 to 0.18, respectively).
Conclusions The present study suggests that brief educational interventions can be an effective strategy for changing the attitudes of parents and public leaders towards FGM. Health education is a useful strategy for changing attitudes. However, such interventions must be delivered alongside other strategies to ensure a multifaceted approach to addressing complex social dynamics. A comprehensive public health approach is, therefore, necessary that includes legal measures, community-based action and an appropriate health system approach. (Author)

20200205-13*

Exploring barriers to seeking health care among Kenyan Somali women with female genital mutilation: a qualitative study. Kimani S, Kabiru CW, Muteshi J, et al (2020), BMC International Health and Human Rights vol 20, no 3, 28 January 2020

Background
Female genital mutilation/cutting (FGM/C) is a cultural practice associated with health consequences, women rights and deprivation of dignity. Despite FGM/C-related health consequences, circumcised women may encounter additional challenges while seeking interventions for reproductive health problems. Experiences of women/girls while accessing health services for reproductive health problems including FGM/C-related complications in poor, remote and hard to reach areas is poorly understood. We sought to explore barriers to care seeking among Somali women with complications related to FGM/C in public health facilities in Kenya.
Methods
We drew on qualitative data collected from purposively selected women aged 15-49 years living with FGM/C, their partners, community leaders, and health providers in Nairobi and Garissa Counties. Data were collected using in-depth interviews (n = 10), key informant interviews (n = 23) and 20 focus group discussions. Data were transcribed and analyzed thematically using NVivo version 12.
Results
Barriers were grouped into four thematic categories. Structural barriers to care-seeking, notably high cost of care, distance from health facilities, and lack of a referral system. Concerns regarding perceived quality of care also presented a barrier. Women questioned health professionals' and health facilities' capacity to offer culturally-sensitive FGM/C-specific care, plus ensuring confidentiality and privacy. Women faced socio-cultural barriers while seeking care particularly cultural taboos against discussing matters related to sexual health with male clinicians. Additionally, fear of legal sanctions given the anti-FGM/C law deterred women with FGM/C-related complications from seeking healthcare.
Conclusion
Structural, socio-cultural, quality of service, and legal factors limit health seeking for reproductive health problems including FGM/C-related complications. Strengthening health system should consider integration of FGM/C-related interventions with existing maternal child health services for cost effectiveness, efficiency and quality care. The interventions should address health-related financial, physical and communication barriers, while ensuring culturally-sensitive and confidential care. (80 references) (Author)
Full URL: https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/s12914-020-0222-6

20200204-26*

Health care providers' and mothers' perceptions about the medicalization of female genital mutilation or cutting in Egypt: a cross-sectional qualitative study. El-Gibaly O, Aziz M, Abou Hussein S (2019), BMC International Health and Human Rights vol 19, no 26, 27 August 2019

Background

Female genital mutilation/cutting (FGM/C) is a traditional harmful practice that has been prevalent in Egypt for many years. The medicalization of FGM/C has been increasing significantly in Egypt making it the country with the highest rate of medicalization. In this qualitative study, we explored the drivers and motives behind why healthcare professionals perform FGM/C and why mothers rely on them to perform the practice on their daughters.

Methods

The study drew on a 'mystery client' approach, coupled with in-depth interviews (IDIs) and focus group discussions (FGDs) with health care providers (i.e. physicians and nurses) and mothers. It was conducted in three geographic areas in Egypt: Cairo, Assiut and Al Gharbeya.

Results

Study findings suggest that parents who seek medicalized cutting often do so to minimize health risks while conforming to social expectations. Thus, the factors that support FGM/C overlap with the factors that support medicalization. For many mothers and healthcare providers, adherence to community customs and traditions was the most important motive to practice FGM/C. Also, the social construction of girls' well-being and bodily beauty makes FGM/C a perceived necessity which lays the ground for stigmatization against uncut girls. Finally, the language around FGM/C is being reframed by many healthcare providers as a cosmetic surgery. Such reframing may be one way for providers to overcome the law against FGM/C and market the operation to the clients.

Conclusion

These contradictions and contestations highlighted in this study among mothers and healthcare providers suggest that legal, moral and social norms that underpin FGM/C practice are not harmonized and would thus lead to a further rise in the medicalization of FGM/C. This also highlights the critical role that health providers can play in efforts to drive the abandonment of FGM/C in Egypt. (21 references) (Author)

Full URL: https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/s12914-019-0202-x

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20191104-11

What are the main challenges that midwives face while caring for women with female genital mutilation?. da Cruz Gomes SD (2019), MIDIRS Midwifery Digest vol 29, no 4, December 2019, pp 437-443

Female genital mutilation (FGM) is associated with short- and long-term health complications and is a safeguarding issue. It is illegal in the United Kingdom (UK). Many health care professionals (HP) - including midwives - lack confidence, knowledge and training in FGM. The aim of this literature review is to describe the main challenges that midwives face while caring for women with FGM. An integrative review was performed of publications from the period 2007 to 2017 included in the Google Scholar, CINAHL and PubMed databases. A final sample of nine research studies met the inclusion and exclusion criteria and from these, two quantitative studies, one mixed methods study and one qualitative research study were used to critically analyse the resulting themes: awareness and knowledge, and education and training. HP, including midwives, demonstrated a lack of awareness and knowledge concerning FGM, which subsequently impacted the care they provided to women, and the women's experiences. Furthermore, midwives reported the need for more training and education in FGM in order to provide women with safe, individualised care. (46 references) (Author)

20191031-48*

Geographical variation in the prevalence of female genital mutilation in the Kurdistan region of Iraq. Shabila N (2019), Eastern Mediterranean Health Journal vol 25, no 9, September 2019, pp 630-636

Background: Female genital mutilation is practised in the Kurdistan Region of Iraq but the reasons for this are not well understood.

Aims: This study aimed to determine the geographical clustering of female genital mutilation in the Kurdistan Region of Iraq.

Methods: A secondary analysis of data from the Iraq Multiple Indicator Cluster Survey 2011 was done. The sample included 11 384 women of reproductive age who reported having undergone genital mutilation. The prevalence of female genital was analysed according to Iraqi governorate including the three governorates of the Kurdistan Region of Iraq, district of the Kurdistan Region of Iraq, and age group (15-30 and 31-49 years).

Results: The prevalence of female genital mutilation was highest in Erbil (62.9%) and Sulaimany (55.8%) governorates

in the Kurdistan Region of Iraq. The prevalence was highest in the districts of Pishdar (98.1%), Rania (95.1%), Choman (88.5%), Dukan (83.8%) and Koya (80.4%). In 20 of the 33 districts, the prevalence of female genital mutilation was significantly lower in the younger age group (15-30 years). The difference between the two age groups was small and not statistically significant in the districts of Pishdar, Rania and Dukan. The main cluster of districts with a high prevalence of female genital mutilation is located in the eastern part of the Kurdistan Region of Iraq along the border with the Islamic Republic of Iran.
Conclusions: Further research is needed to explore the determinants of the continued high prevalence of female genital mutilation in this area. (21 references) (Author)
Full URL: https://doi.org/10.26719/emhj.19.009

20191029-25*

Improving care for women and girls who have undergone female genital mutilation/cutting: qualitative systematic reviews. Evans C, Tweheyo R, McGarry J, et al (2019), Health Services and Delivery Research vol 7, no 31, September 2019

Background
In a context of high migration, there are growing numbers of women living in the UK who have experienced female genital mutilation/cutting. Evidence is needed to understand how best to meet their health-care needs and to shape culturally appropriate service delivery.
Objectives
To undertake two systematic reviews of qualitative evidence to illuminate the experiences, needs, barriers and facilitators around seeking and providing female genital mutilation-/cutting-related health care from the perspectives of (1) women and girls who have experienced female genital mutilation/cutting (review 1) and (2) health professionals (review 2).
Review methods
The reviews were undertaken separately using a thematic synthesis approach and then combined into an overarching synthesis. Sixteen electronic databases (including grey literature sources) were searched from inception to 31 December 2017 and supplemented by reference list searching. Papers from any Organisation for Economic Co-operation and Development country with any date and in any language were included (Organisation for Economic Co-operation and Development membership was considered a proxy for comparable high-income migrant destination countries). Standardised tools were used for quality appraisal and data extraction. Findings were coded and thematically analysed using NVivo 11 (QSR International, Warrington, UK) software. Confidence in the review findings was evaluated using the Grading of Recommendations Assessment, Development, and Evaluation - Confidence in the Evidence from Reviews of Qualitative Research (GRADE-CERQual) approach. All review steps involved two or more reviewers and a team that included community-based and clinical experts.
Results
Seventy-eight papers (74 distinct studies) met the inclusion criteria for both reviews: 57 papers in review 1 (n = 18 from the UK), 30 papers in review 2 (n = 5 from the UK) and nine papers common to both. Review 1 comprised 17 descriptive themes synthesised into five analytical themes. Women's health-care experiences related to female genital mutilation/cutting were shaped by silence and stigma, which hindered care-seeking and access to care, especially for non-pregnant women. Across all countries, women reported emotionally distressing and disempowering care experiences. There was limited awareness of specialist service provision. Good care depended on having a trusting relationship with a culturally sensitive and knowledgeable provider. Review 2 comprised 20 descriptive themes synthesised into six analytical themes. Providers from many settings reported feeling uncomfortable talking about female genital mutilation/cutting, lacking sufficient knowledge and struggling with language barriers. This led to missed opportunities for, and suboptimal management of, female genital mutilation-/cutting-related care. More positive experiences/practices were reported in contexts where there was input from specialists and where there were clear processes to address language barriers and to support timely identification, referral and follow-up.
Limitations
Most studies had an implicit focus on type III female genital mutilation/cutting and on maternity settings, but many studies combined groups or female genital mutilation/cutting types, making it hard to draw conclusions specific to different communities, conditions or contexts. There were no evaluations of service models, there was no research specifically on girls and there was limited evidence on psychological needs.
Conclusions
The evidence suggests that care and communication around female genital mutilation/cutting can pose significant challenges for women and health-care providers. Appropriate models of service delivery include language support, continuity models, clear care pathways (including for mental health and non-pregnant women), specialist provision

and community engagement. Routinisation of female genital mutilation/cutting discussions within different health-care settings may be an important strategy to ensure timely entry into, and appropriate receipt of, female genital mutilation-/cutting-related care. Staff training is an ongoing need.

Future work

Future research should evaluate the most-effective models of training and of service delivery.

Study registration

This study is registered as PROSPERO CRD420150300012015 (review 1) and PROSPERO CRD420150300042015 (review 2).

Funding

The National Institute for Health Research Health Services and Delivery Research programme. (Author)

Full URL: https://doi.org/10.3310/hsdr07310

20190912-135*

RCM supports the launch of vital network of specialist FGM clinics. Royal College of Midwives (2019), London: RCM 12 September 2019

Comments on the launch by NHS England of eight Female Genital Mutilation (FGM) support clinics across Birmingham, Bristol, London and Leeds, as part of the NHS LongTerm Plan, offering a range of services to women aged 18 and over. The clinics will be staffed by multi-disciplinary teams comprising specialist midwives, nurses, doctors, specially trained counsellors and health advocates. (JSM)

Full URL: https://www.rcm.org.uk/media-releases/2019/september/rcm-supports-the-launch-of-vital-network-of-specialist-fgm-clinics/

20190815-9*

Preventing female genital mutilation in high income countries: a systematic review of the evidence. Njue C, Karumbi J, Esho T, et al (2019), Reproductive Health vol 16, no 113, 22 July 2019

Background

Female genital mutilation (FGM) is prevalent in communities of migration. Given the harmful effects of the practice and its illegal status in many countries, there have been concerted primary, secondary and tertiary prevention efforts to protect girls from FGM. However, there is paucity of evidence concerning useful strategies and approaches to prevent FGM and improve the health and social outcomes of affected women and girls.

Methods

We analysed peer-reviewed and grey literature to extract the evidence for FGM prevention interventions from a public health perspective in high income countries by a systematic search of bibliographic databases and websites using appropriate keywords. Identified publications were screened against selection criteria, following the PRISMA guidelines. We examined the characteristics of prevention interventions, including their programmatic approaches and strategies, target audiences and evaluation findings using an apriori template.

Findings

Eleven documents included in this review described primary and secondary prevention activities. High income countries have given attention to legislative action, bureaucratic interventions to address social injustice and protect those at risk of FGM, alongside prevention activities that favour health persuasion, foster engagement with the local community through outreach and the involvement of community champions, healthcare professional training and capacity strengthening. Study types are largely process evaluations that include measures of short-term outcomes (pre- and post-changes in attitude, knowledge and confidence or audits of practices). There is a dearth of evaluative research focused on empowerment-oriented preventative activities that involve individual women and girls who are affected by FGM. Beattie's framework provides a useful way of articulating negotiated and authoritative prevention actions required to address FGM at national and local levels.

Conclusion

FGM is a complex and deeply rooted sociocultural issue that requires a multifaceted response that encompasses socio-economic, physical and environmental factors, education and learning, health services and facilities, and community mobilisation activities. Investment in the rigorous longitudinal evaluation of FGM health prevention efforts are needed to provide strong evidence of impact to guide future decision making. A national evidence-based framework would bring logic, clarity, comprehension, evidence and economically more effective response for current and future prevention interventions addressing FGM in high income countries.

(60 references) (Author) [Please note: this article is a digital version which may undergo minor changes in the future]

Full URL: https://doi.org/10.1186/s12978-019-0774-x

20190808-60*

Obstetrical Complications of Female Genital Mutilation: Management Maternal-Fetal Medical Care and Prognosis, Obstetrical Gynecology Regional Hospital, Unit of N'zérékoré. Diallo BA, Bah EM, Bah OH, et al (2019), Open Journal of Obstetrics and Gynecology vol 9, no 2, February 2019, pp 196-206

Introduction: Female Genital Mutilation (FGM) is a public health problem. There are 100 to 140 million girls and women who suffer every year in the world [1]. The aim of this study is to improve the medical care and reduce complications of FGM at the Regionalhospital of N'zérékoré, to determine their frequency, and to evaluate the maternal-fetalprognosis. Methods: The study was conducted at the Regional Hospital of N'zérékoré. This was a cross-sectional, descriptive and analytic study of 6 months, from 1 September 2016 to 28 February 2017, including all pregnant women admitted for childbirth who had a complication of female genital mutilation. Results: A total of 1295 women gave birth in the service, of which 1204 women were women with female genital mutilation.
Given a frequency of 92.97%, of these 1204 mutilated women, 223 presented obstetrical complications during their delivery, a proportion of 17.22%. They were mostly young patients, mostly housewives who were not in school. Type II FGM was the most common (53.06%). Obstetric complications were dominated by complicated perinatal tears (54.08%), and hemorrhages (40.81%). The catch was dominated by perineorrhaphy. Conclusion: The frequency of FGM was 92.97% and that of their obstetric complications 17.22%. Most were house-wives, not in school. There was FGM type II. The abandonment of FGM would reduce maternal and perinatal morbidity and mortality. (12 references) (Author)

Full URL: https://doi.org/10.4236/ojog.2019.92020

20190703-37

A vindication of the rights of women. Anon (2019), Midwives vol 22, May 2019, pp 14-15

The theme for this year's International Day of the Midwife is defending the rights of women. The RCM and its members do this daily - here's a closer look behind the scenes at the campaigns making history. (Author)

20190621-92*

Supporting ALL victims of violence, abuse, neglect or exploitation: guidance for health providers. Viergever RF, Thorogood N, Wolf JRLM, et al (2018), BMC International Health and Human Rights vol 18, no 39, 19 October 2018

Smaller groups of victims of violence, abuse, neglect or exploitation - such as male victims of intimate partner violence (IPV), victims of elder abuse, victims of abuse by carers, victims of parent abuse, victims of human trafficking, girls and boys below 18 years engaging in sex work, victims of sexual exploitation by gangs or groups and victims of honour based violence (such as forced marriages and female genital mutilation) - are often in contact with the health care system without being identified as such and frequently do not receive appropriate treatment. To address this problem, two things need to happen: 1) that ALL groups of victims of violence, abuse, neglect or exploitation are explicitly listed in policies and protocols, and 2) that both the similarities as well as the differences between the groups with regard to identification, support and referral - described in this article - are explained, so that health providers are appropriately supported in this important function. (9 references) (Author)

Full URL: https://doi.org/10.1186/s12914-018-0178-y

20190620-85*

Risk assessment for antenatal depression among women who have undergone female genital mutilation or cutting: Are we missing the mark?. Boghossian AS, Freebody J, Moses R, et al (2020), Australian and New Zealand Journal of Obstetrics and Gynaecology (ANZJOG) vol 60, no 1, February 2020, pp 76-81

Background

Although prohibited by specific legislation in Australia, patterns of global migration underscore the importance for local clinicians to recognise and manage potential complications associated with female genital mutilation/cutting (FGM/C). The incidence of antenatal depression in Australia is 10% and may be higher among those with a history of FGM/C (RANZCOG 2 statement: Perinatal Anxiety and Depression, 2012). The phenomenon of cultural embedding could represent a protective factor against an increase in mental health problems among these women.

Aim

To determine whether women who have undergone FGM/C are at greater risk of depression in the antenatal period as defined by the Edinburgh Postnatal Depression Scale (EPDS).

Materials and Methods

A multicentre retrospective case-control study was performed. Participants who had delivered at either of two hospitals, had migrated from FGM/C-prevalent countries and who had undergone FGM/C were assessed and compared with the control group, case-matched by language and religion.

Results
Eighty-nine cases were included with an equal number of matched controls. No significant difference in the EPDS score was demonstrated when analysed as a continuous variable (P = 0.41) or as a categorical variable with a cut-off score of 12 (P = 0.12). There was no difference in the number of women who identified as having thoughts of self-harm between the two groups.
Conclusion
There was no identified increase in the risk of antenatal depression among women who have undergone FGM/C from high-prevalence countries. Consideration must be given to the utility of the EPDS in this population, as well as factors such as cultural embedding.
(Author)

20190528-14*

The experience of NHS care for women living with female genital mutilation. Ormrod J (2019), British Journal of Nursing vol 28, no 10, 23 May 2019, pp 628-633

This qualitative study aims to explore and analyse the experiences of women living with female genital mutilation (FGM) who have sought help from healthcare providers within the NHS. Nine women aged 20-46 years were recruited from support organisations in the north-west of England and interviewed about their experiences of NHS care and if any screening had taken place in relation to the consequences of living with FGM. The interviews were undertaken in English, audiotaped, transcribed and analysed using a framework analysis method. Eight of the women had given birth and the main contact with the NHS had been with midwifery, gynaecology and paediatric services. Three key themes emerged from the qualitative data: involvement with healthcare professionals; silent suffering; and compassionate communication. Findings highlight the importance of sensitive and culturally competent communication nurses require to support women and refer them to appropriate services. (Author)

20190513-14

Female genital mutilation: an act of violence. The public health approach. Sprawson E, Leavey C (2019), MIDIRS Midwifery Digest vol 29, no 2, June 2019, pp 189-195

The UK government maintains a commitment to end FGM both in the UK and abroad. As recently as November 2016, the Department for International Development (DFID) announced a commitment of £50 million in UK aid to assist with ending the practice (DFID 2018). The UN include it within their goal for sustainable development by 2030. We live in a culture which promotes the rights of the individual to express their culture and values freely, but this must not be at the expense of the basic human right to be free of violence. The public health approach to violence seeks to work by impacting the greatest number of the affected population. Working to support the abandonment of FGM fits within this scope, as it has the potential not only to improve the health of the current population but to improve the life chances of those yet to come. (50 references) (Author)

20190508-82*

Female Genital Mutilation (FGM) - October 2018 to December 2018, Experimental Statistics Report. NHS Digital (2019), London: NHS Digital 28 February 2019

The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices.
(Author)

Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/october-2018-to-december-2018

20190508-48

Midwives as 'defenders' - in the UK and abroad. Newman L (2019), British Journal of Midwifery vol 27, no 5, May 2019, p 277

An editorial discussing the campaign which have led to changes in medical care, including midwifery, by raising awareness of female genital mutilation. The author argues that changes should also be made in light of increasing knowledge regarding breast-ironing, a tradition originating in West Africa which also causes great harm to women and girls. Highlights the role of midwives in advocating for the rights of women to receive qualified medical care, and even hold perpetrators of gender-based violence to account. (KRB)

20190403-37*

Female genital cutting in Malaysia: a mixed-methods study. Rashid A, Iguchi Y (2019), BMJ Open vol 9, no 3, March 2019, e025078

Objective This study aimed to understand the reasons for the practice by the Muslim community, traditional practitioners and the views of religious scholars as well as the medicalisation trend of the practice of female genital cutting (FGC).

Design This is a mixed-method (qualitative and quantitative) study. A questionnaire was created and used by three trained research assistants for the quantitative component of the study. The qualitative component of the study included in-depth interviews and focus group interviews.

Setting This study was conducted in rural areas of two states in the Northern Peninsular Malaysia.

Participants Due to the sensitive nature of the study, the study sample was chosen using a snowball sampling method. Two of the three Northern states Mufti's approached consented to participate in the study.

Results Quantitative: There were 605 participants, most had undergone FGC (99.3%), were in the opinion FGC is compulsory in Islam (87.6%) and wanted FGC to continue (99.3%). Older respondents had FGC conducted by traditional midwives (X2=59.13, p<0.001) and younger age groups preferred medical doctors (X2=32.96, p<0.001) and would permit doctors (X2=29.17, p<0.001) to conduct FGC on their children. These findings suggest a medicalisation trend. Regression analysis showed the odds of FGC conducted by traditional midwives and nurses and trained midwives compared with medical doctors was 1.07 (1.05; 1.09) and 1.04 (1.01; 1.06), respectively. For every 1-year decrease in age, the odds of participants deciding medical doctors should perform FGC as compared with traditional midwives increase by 1.61.

Qualitative: Focus group discussions showed most believed that FGC is compulsory in Islam but most traditional practitioners and the Mufti's stated that FGC is not compulsory in Islam.

Conclusion Almost everyone in the community believed FGC is compulsory in Islam and wanted the practice to continue, whereas the traditional practitioners and more importantly the Mufti's, who are responsible in issuing religious edicts, say it is not a religious requirement.(Author)

20190320-15

Factors associated with female genital cutting in Yemen and its policy implications. Alosaimi AN, Essén B, Riitta L, et al (2019), Midwifery vol 74, July 2019, pp 99-106

Background

A tremendous number of girls in Yemen are still subjected to female genital cutting (FGC), which carries an increased risk of health complications and violates children's rights. This study describes the prevalence of FGC in four Yemeni provinces and investigates the determinants of FGC.

Methods

We analyzed data from women aged 15 to 49 years who responded to a sub-national household survey conducted in six rural districts of four Yemeni provinces in 2008-2009. Logistic regression was used to estimate the association between individual and household socioeconomic factors and FGC practices and attitudes.

Results

The prevalence of women's FGC was 48% while daughters' FGC was 34%. Almost 45.8% of the women surveyed believe the FGC practice should discontinue. Higher odds of FGC practice and positive attitude towards it were associated with older age, family marriage, and lower tertiles of wealth and education indices. Early marriage was also associated with increased odds of FGC practice ($p < 0.01$).

Conclusions

Socioeconomic indices and other individual factors associated with FGC are differing and complex. Younger generations of women are more likely to not have FGC and to express negative attitudes towards the tradition. Appropriate strategies to invest in girls' education and women's empowerment with effective engagement of religious and community leaders might support the change of attitudes and practice of FGC in the younger generation. (Author)

20190319-3

Maternity care experiences and health needs of migrant women from female genital mutilation-practicing countries in high-income contexts: A systematic review and meta-synthesis. Turkmani S, Homer CSE, Dawson A, et al (2019), Birth vol 46, no 1, March 2019, pp 3-14

Background

Female genital mutilation (FGM) is a cultural practice defined as the partial or total removal of the external female genitalia for nontherapeutic indications. Due to changing patterns of migration, clinicians in high-income countries are seeing more women from countries where the practice is prevalent. This review aims to understand the sociocultural

and health needs of these women and identify opportunities to improve the quality of maternity care for women with FGM.

Methods

We undertook a systematic review and meta-synthesis of peer-reviewed primary qualitative research to explore the experience and needs of migrant women with FGM receiving maternity care. A structured search of nine databases was undertaken, screened papers appraised, and a thematic analysis undertaken on data extracted from the findings and discussion sections of included papers.

Results

Sixteen peer-reviewed studies were included in the systematic review. Four major themes were revealed: Living with fear, stigma, and anxiety; Feelings of vulnerability, distrust, and discrimination; Dealing with past and present ways of life after resettlement; and Seeking support and involvement in health care.

Conclusions

The findings suggest that future actions for improving maternity care quality should be focused on woman-centered practice, demonstrating cultural safety and developing mutual trust between a woman and her care providers. Meaningful consultation with women affected by FGM in high-income settings requires cultural sensitivity and acknowledgment of their specific circumstances. This can be achieved by engaging women affected by FGM in service design to provide quality care and ensure woman-focused policy is developed and implemented. (73 references) (Author)

20190220-12*

Female genital mutilation/cutting in Africa: A complex legal and ethical landscape. Nabaneh S, Muula AS (2019), International Journal of Gynecology & Obstetrics vol 145, no 2, May 2019, pp 253-257

While international and regional human rights instruments have recognized female genital mutilation/cutting (FGM/C) as one of the most prevalent forms of violence against women and girls, in many African states FGM/C is a deeply entrenched cultural practice. There is a consensus against FGM, as evidenced by its criminalization in several African countries. The mere fact that the practice continues despite legislative measures to protect women and girls against FGM raises the question of whether change can be legislated. The present article summarizes the trends and effectiveness of FGM criminalization in Africa, including prohibition of medicalization of FGM. Against the backdrop of emerging debate on medicalization of FGM as a harm reduction strategy, we also examine its complex legal and ethical implications. The article argues that while criminalization may not be the best means of stopping FGM, it creates an enabling environment to facilitate the overall strategy of African governments in eradication of the practice. (Author)

20190215-12*

Understanding different positions on female genital cutting among Maasai and Samburu communities in Kenya: a cultural psychological perspective. Graamans E, Ofware P, Nguura P, et al (2019), Culture, Health & Sexuality vol 21, no 1, January 2019, pp 79-94

This paper presents an analysis of different positions on female genital cutting, either legitimising the practice or challenging it. The framework it offers has been developed from cultural psychological theory and qualitative data collected in Maasai communities around Loitokitok and Magadi, Kajiado County, and Samburu communities around Wamba, Samburu County, in Kenya. Over the course of one month, 94 respondents were interviewed using maximum variation sampling. Triangulation took place by means of participant observation of significant events, such as alternative rites, participation in daily activities and informal talks while staying at traditional homesteads and kraals. The framework adds to understanding of why more contextual approaches and holistic interventions are required to bring an end to female genital cutting. (28 references) (Author)

20190214-18

Female genital mutilation: Obstetric outcomes in metropolitan Sydney. Davis G, Jellins J (2019), Australian and New Zealand Journal of Obstetrics and Gynaecology (ANZJOG) vol 59, no 2, April 2019, pp 312-316

Background

Female genital mutilation (FGM) and its impact on women's health are becoming relevant in Australia due to increases in numbers of refugees and migrants from affected countries. Notwithstanding the psychological trauma from FGM, there is a broad range of sequelae relevant to obstetrics and gynaecology, particularly related to maternal morbidity from labour and delivery.

Aims

To assess the prevalence of FGM in our unit and document its effect on maternal and neonatal outcomes.
Methods
Retrospective cohort study of women affected by FGM who delivered at a metropolitan hospital in Sydney over a five-year period. The primary outcome was mode of delivery and secondary outcomes addressed maternal morbidity and neonatal nursery admission compared with women unaffected by FGM.
Results
A full data set was available for 141/142 women affected by FGM. The overall prevalence of FGM was 1.64%. The majority of women affected by FGM were documented to have FGM 3 (41.1%). There was no difference in caesarean section rate. Women with FGM were less likely to be delivered by vacuum or forceps (11.1% vs 2.8%; P = 0.0009). There was no difference in perineal trauma, postpartum haemorrhage and neonatal nursery admission. Women with FGM 3 were more likely to have an episiotomy (4.8% vs 25.9%; P = 0.0007) without an increase in anal sphincter injury (P = 0.7). Documentation complying with local policy and guidelines was poor.
Conclusions
FGM is increasingly common in Australia. This study adds to the Australian literature quantifying the effects on obstetric outcomes in these high-risk women. (Author)

20190213-176*

An exploration of attitudes towards female genital mutilation (FGM) in men and women accessing FGM clinical services in London: a pilot study. Larsson M, Cohen P, Hann G, et al (2018), Journal of Obstetrics and Gynaecology vol 38, no 7, October 2018, pp 1005-1009

This pilot study researched the attitudes towards and the knowledge of female genital mutilation (FGM) in adult women with FGM and their partners. The participant population consisted of English-speaking women and men over 18 years old attending specialist FGM clinics in two London hospitals. The participants completed a questionnaire on the attitudes and the knowledge of FGM, which were adapted with permission from the United Nations Children's Fund and the United States Agency for International Development household surveys. 54 participants (51 women, 3 men) took part in the surveys. 89% of participants thought that FGM should be stopped (95%CI: 0.81-0.97) and 72% said they knew FGM is illegal in the United Kingdom (UK). 15% reported that FGM caused no danger, or were unaware of any danger to women's health. This study demonstrates the opposition to FGM by participants, but some lack of knowledge regarding the legal and health implications. The exploration of attitudes in diaspora community groups is often cited as key to safeguarding girls from FGM. This is one of the first UK studies of individuals from FGM-practising communities, and we recommend use of the study questionnaires for a multicentre, cross-community study. (23 references) (Author)

20190204-23*

RCM responds to first ever guilty verdict for FGM in UK. Royal College of Midwives (2019), London: RCM 1 February 2019

Janet Fyle, Professional Policy Advisor at the Royal College of Midwives (RCM), responds to the news of the first ever guilty verdict for female genital mutilation (FGM) in the United Kingdom. (KRB)

Full URL: https://www.rcm.org.uk/news-views-and-analysis/news/%C2%A0rcm-responds-to-first-ever-guilty-verdict-for-fgm-in-uk

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20190204-2*

FGM 'increasingly performed on UK babies'. Collinson A, Furst J (2019), BBC News 4 February 2019

Reports that female genital mutilation (FGM) is increasingly being performed on very young babies and infants in the UK, therefore evading the law as detection by the authorities is made almost impossible. States that one victim was only a month old. Includes comments from Dr Charlotte Proudman, an FGM expert and barrister, Hibo Wadere, who forcibly underwent FGM at the age of six, and Linda Weil-Curiel, a lawyer whose work has resulted in over 100 convictions for FGM in France. (JSM)

Full URL: https://www.bbc.co.uk/news/uk-47076043

20181220-62*

Effect of female genital cutting performed by health care professionals on labor complications in Egyptian women: a prospective cohort study. Saleh WF, Torky HA, Youssef MA, et al (2018), Journal of Perinatal Medicine vol 46, no 4, May 2018, pp 419-424

Aim:
To examine the effect of the degree of female genital cutting (FGC) performed by health-care professionals on perineal scarring; delivery mode; duration of second stage of labor; incidence of perineal tears and episiotomy in a

cohort of uncircumcised versus circumcised (types I and II) women.
Methods:
A prospective cohort study included 450 primigravida women in active labor attending the Faculty of Medicine Cairo University Hospital between January 2013 and August 2014. Women were divided into three groups based on medical examination upon admission. Group I (Control) included 150 uncut women, Group II included 150 women with type I FGC and Group III included 150 women with type II FGC. A structured questionnaire elicited the information on women's socio-demographic characteristics including age, residence, occupation, educational level, age of marriage and FGC circumstances. Association between FGC and labor complications was examined. Main outcomes: risk of perineal scarring; delivery mode; duration of second stage of labor; incidence of perineal tears and episiotomy.
Results:
Family history of genitally cut mother/sister was the most significant socio-demographic factor associated with FGC. FGC especially type II was associated with significantly higher incidence of vulvar scar (P<0.0002), perineal tears (P<0.0001) and increased likelihood of additional vaginal and perineal trauma [odds ratio (OR): 1.85, 95% CI: 0.60-5.65. P≤0.001]. There was insignificant difference in risks of cesarean section (CS), instrumental delivery, episiotomy and short-term neonatal outcomes.
Conclusion:
The study strengthens the evidence that FGC increases the risk of tears in spite of medicalization of the practice. (30 references) (Author)

20181211-37

FGM/C: Education matters. Morris J (2018), Midwives vol 21, Winter 2018, pp 62-65

Midwives have the skills and knowledge to educate women and their families on the adverse consequences and illegality of FGM, writes Jamie Morris. (Author)

20181206-16*

'You take the private part of her body, … you are taking a part of her life': Voices of circumcised African migrant women on female genital circumcision (FGC) in Australia. Ogunsiji O, Wilkes L, Chok HN (2018), Health Care for Women International vol 39, no 8, 2018, pp 906-918

Western countries working toward eradication of female genital mutilation require better inclusion of women originally from countries where the practice is prevalent. However, few authors have examined the knowledge, attitudes, and experiences of circumcised African migrant women in western countries. Our findings from 40 responses from self-reported survey and five in-depth interviews show that the participating African migrant women know the reasons behind female genital circumcision (FGC), are living with the negative consequences of FGC, and have a zero tolerance attitude toward the practice. Circumcised women are in the best position to define their health needs and champion global efforts to eradicate FGC. (31 references) (Author)

20181122-122*

The lived experience of female genital cutting (FGC) in Somali-Canadian women's daily lives. Jacobson D, Glazer E, Mason R, et al (2018), PLoS ONE vol 13, no 11, 6 November 2018, e0206886

Many of the Somali women who have immigrated to other countries, including Canada, have experienced Female Genital Circumcision/ Mutilation/ Cutting (FGC). While there is literature on the medical aspects of FGC, we were interested in understanding the daily life experiences and bodily sensations of Somali-Canadian women in the context of FGC. Fourteen women living in the Greater Toronto Area were interviewed. Interview data were analyzed using a phenomenological approach. We found that the memory of the ceremonial cutting was vivid but was frequently described with acceptance and resignation-as something that just is; that was normal given the particular context, familial and cultural, and their young age. Most of the women recounted experiencing pain and discomfort throughout their adult lives but were intent on not noticing or giving the pain any power; they considered themselves healthy. The following themes emerged from our interviews: Every Body Had It: Discussing FGC, I'm Normal Aren't I?, and Feeling in My Body-all themes that work at normalizing their bodies in a society that they know views them as different. They dealt with both pain and pleasure in the context of their busy lives suggesting resilience in spite of the day-to-day difficulties of daily life. (90 references) (Author)

Full URL: https://doi.org/10.1371/journal.pone.0206886

20181030-34

UK midwives' knowledge and understanding of female genital mutilation. Mills E (2018), MIDIRS Midwifery Digest vol 28,

no 4, December 2018, pp 491-496

Between November 2017 and January 2018 the researcher, with funding from the Research Building Capacity Collaboration (RCBC), conducted an online survey exploring the knowledge and understanding of female genital mutilation (FGM) amongst UK midwives working within the NHS. The results showed that 10.6% (N=56) of respondents reported having had no formal training in FGM as a student midwife or as a qualified midwife. Sixty-two point five per cent (N=322), said they had no specialist FGM service within their health board or trust, or were unaware of one. When asked about the World Health Organization (WHO) classifications of FGM, 78.9% (N=404) were able to correctly identify all four types. All midwives responding recognised that FGM is illegal in the UK. However, when asked what potential health problems could be caused by FGM, 5% (N=26) responded that FGM could cause blindness, 4.6% (N=24) dementia and 6.6% (N=34) scurvy. Qualitative data explored challenges of caring for women with FGM and key themes identified communication, labour and birth, re-infibulation, safeguarding, training and education and the future for FGM. Excellent communication skills and empathy are essential and more robust training and regular updates on FGM need to be developed. Furthermore, clear pathways for care and referrals need to be utilised as all midwives should take responsibility for the future of eradicating FGM in the UK. (6 references) (Author)

20181023-18*

Multi-agency statutory guidance on female genital mutilation [Last updated 30 July 2020]. Department for Education, Department of Health and Social Care, Home Office (2016), London: HM Government 1 April 2016. 89 pages

This guidance on female genital mutilation (FGM) is for all persons and bodies in England and Wales.

You must read and follow this guidance if you are under statutory duties to safeguard and promote the welfare of children and vulnerable adults.

You should read this FGM guidance along-side other safeguarding guidance, including (but not limited to):

Working Together to Safeguard Children (2015) in England

Safeguarding Children: Working Together under the Children Act 2004 (2007) in Wales (Author)

Full URL: https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

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20181018-18*

Female genital mutilation: current awareness, believes and future intention in rural Egypt. Mohammed ES, Seedhom AE, Mahfouz EM (2018), Reproductive Health vol 15, no 175, 17 October 2018

Background

Female genital cutting, also termed female genital mutilation (FGM), is a damaging practice with no health benefits for girls or women, and is considered to be a violation of children's rights.

Methods

A cross-sectional, community-based study using interview administered questionnaire to explore knowledge and attitude of people living in a rural area in Minia. Systematic random sampling was used to interview 618 males and females above the age of 18 in the period from September to November 2016.

Results

FGM was performed on 76.6% of females, complications occurred in 35.6% of them. Females demonstrated a higher level of knowledge than males. Nearly 56% of respondents believed that this practice should continue. Females were more supportive of the continuation of FGM than men (60.3% vs. 47.9%). The attitude that FGM is a good practice, knowledge level, women's status and religion were significantly associated with women's willingness to subject their daughters to FGM in the future. Attitude was the only significant predictor associated with men's willingness to subject their daughters to FGM.

Conclusion

The strong correlation between social pressure and intentions to carry out FGM means that FGM practice will continue to be embraced among future generations unless policies are put in place to eradicate this practice through empowering females by education and reasonable income.

(22 references) (Author) [Please note: this article is a digital version which may undergo minor changes in the future]

Full URL: https://doi.org/10.1186/s12978-018-0625-1

20181017-40*

Pupil's perspectives on female genital cutting abandonment in Harari and Somali regions of Ethiopia. Abathun AD, Sundby J, Gele AA, et al (2018), BMC Women's Health vol 18, no 167, 17 October 2018

Background

Female Genital Cutting (FGC) is a harmful traditional practice that affects the physical and mental health of girls and women in many ways. In Ethiopia, although both governmental institutions and None-Governmental- Institutions

(NGOs) launched different campaigns against FGC, their effects on the peoples' attitudes towards the practice have not been deeply investigated yet. Hence, this study particularly aimed to investigate the pupils' perspectives on FGC abandonment in the Harari and the Somali Regional States of Ethiopia where the prevalence of the practice was thought to be high.
Methods
A school-based cross-sectional study was conducted in the Somali and the Harari Regional States of eastern Ethiopia from October to December 2015. While purposive sampling was implemented to select the study areas from the two Regional States, stratified random sampling method was used to select 480 study subjects from those areas.
Results
The findings showed that the participants who received information through multiple information channels were more likely to support the abandonment of FGC than those who received information from a single source ($p < 0.05$). Similarly, the findings indicated that school-based awareness campaigns and TV-based media communications were the main sources of information that influenced a high proportion of young people to support the abandonment of the practice. The findings revealed that the majority of the participants strongly supported the abandonment of FGC.
Conclusions
Multiple information channels that include school-based awareness campaigns were found to be the best way to support the abandonment of FGC. Although the study shows an impressive improvement among the school girls and boys in recognizing the harmful effects FGC, complete abandonment of the practice might not be easily achieved due to its deep-rooted nature. Thus, to quicken the perpetuation of FGC in the stated Regional States, awareness creating campaigns that change the attitudes of youths towards the practice should be delivered through various sources. In this regard, school-based education, school mini-media, social media, and using the co-curricular activities to uncover the danger of this harmful practice could play significant roles in changing the pupils' attitudes towards the practice. (39 references) (Author) [Please note: this article is a digital version which may undergo minor changes in the future]
Full URL: https://doi.org/10.1186/s12905-018-0653-6

20181010-30*

Female Genital Mutilation (FGM) - April 2018 to June 2018, Experimental Statistics Report. NHS Digital (2018), London: NHS Digital 27 September 2018

The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) supports the Department of Health's FGM Prevention Programme by presenting a national picture of the prevalence of FGM in England.
• There were 1,675 individual(1) women and girls who had an attendance where FGM was identified or a procedure related to FGM was undertaken in the period April 2018 to June 2018. These accounted for 2,075 attendances(2) reported at NHS trusts and GP practices where FGM was identified or a procedure related to FGM was undertaken.
• There were 1,015 newly recorded(3) women and girls in the period April 2018 to June 2018. Newly recorded means this is the first time they have appeared in this dataset. It does not indicate how recently the FGM was undertaken, nor does it mean that this is the woman or girl's first attendance for FGM.
• Definitions
(1) Individuals refers to all patients in the reporting period where FGM was identified or a procedure for FGM was undertaken. Each patient is only counted once.
(2) Total Attendances refers to all attendances in the reporting period where FGM was identified or a procedure for FGM was undertaken. Women and girls may have one or more attendances in the reporting period. This category includes both newly recorded and previously identified women and girls.
(3) Newly Recorded refers to an individual's first appearance in the FGM dataset. Newly recorded does not necessarily mean that the attendance is the woman's or girl's first attendance for FGM. (Author)
Full URL: https://files.digital.nhs.uk/A8/53CF17/FGM%202018%20Q2%20-%20Report.pdf

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20181008-15

The experience of maternity care for migrant women living with female genital mutilation: A qualitative synthesis.
Scamell M, Ghumman A (2019), Birth vol 46, no 1, March 2019, pp 15-23

Background
Increasing numbers of childbearing women with a history of female genital mutilation (FGM) are accessing maternity services in high-income countries across the world. For many of these women, their first contact with the health services in their host country is when they are pregnant. While the clinical consequences of certain categories of FGM are well documented, how high-risk maternity services - designed to mitigate the obstetric consequences of FGM - impact upon women's experience of childbearing is less clear.
Methods

Using a meta-synthesis approach, this paper synthesizes 12 qualitative research papers, conducted in 5 high-income countries, to explore how migrant women with a history of FGM experience maternity care in their host countries.
Results
One over-arching theme and four discrete subthemes of migrant women's experience of the maternity services in their host country were identified: feelings of alienation; fatalism and divine providence, positive and negative feelings about maternity care, different understandings of the birthing process, and feelings about FGM.
Conclusions
The findings illustrate that migrant women with a history of FGM frequently encounter negative attitudes when accessing the maternity services in their host countries. Women's experiences suggest a concerning absence of sensitive and empathetic care; a more woman-centered approach is recommended. (Author)

20180927-14*

Challenges in providing quality care for women with female genital cutting in Sweden - A literature review. Jordal M, Wahlberg A (2018), Sexual & Reproductive Healthcare vol 17, October 2018, pp 91-96

Due to migration, health care needs in relation to female genital cutting (FGC) are increasingly emerging in European health care contexts, with Sweden being no exception. Recent estimates suggest that up to 38 000 girls and women with some form of FGC are living in Sweden, the majority from Somalia. Despite receiving high numbers of immigrants from FGC practising countries, health care services in many European countries seem largely unprepared in caring for circumcised patients. This literature review aims to identify challenges involved in providing quality care for circumcised women in Sweden. Two themes were identified; lacking technical skills and communication problems and ethnocentric attitudes. Lacking technical skills involved midwives and gynaecologists feeling insecure in how to technically deal with infibulated women during childbirth, something that often resulted in ad hoc solutions and improvisation. They related this insecurity to a lack of theoretical and practical training of FGC related health problems. In communication problems and ethnocentric attitudes both health care professionals and circumcised women reported facing difficulties in communicating about FGC, largely due to language barriers and perceived sensitivity of the issue. In conclusion, skills among health care professionals in Sweden caring for circumcised patients could be strengthened. This should be taken into consideration when planning midwifery and gynaecology curricula, and in providing in-service training for health care professionals likely to meet circumcised women in their practice. (Author)

20180927-12*

FGM/C and its health consequences: implications for policy, advocacy and investment. Population Reference Bureau (2018), PRB Insights September 2018

A web feature, developed by the Population Reference Bureau (PRB) that offers a clear understanding of the health effects of Female Genital Mutilation/Cutting (FGM/C) to provide direction for future investment by donors, highlight important knowledge gaps for further research, help medical professionals identify and manage complications, and strengthen advocates' messages.
Explore the web feature to:
Understand the evidence of FGM/C's health consequences.
Identify health effects that require further investigation.
Discover how communities can act to end FGM/C. (Author, edited)
Full URL: https://interactives.prb.org/healthimpacts/index.html

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20180927-11*

Understanding the impact of medicalisation on female genital mutilation/cutting. Population Reference Bureau (2018), PRB Insights September 2018

A web feature developed by the Population Reference Bureau (PRB) that outlines the best available information on medicalization. Medicalization refers to the practice of FGM/C by any category of health care provider. The web feature synthesizes quantitative data on trends over time, the relationship between medicalization and overall FGM/C prevalence, and qualitative data on provider and community perspectives. It will provide policymakers, advocates, and program managers with a better understanding of medicalization, how it varies by context, and key recommendations on how to address the practice.
Explore the web feature to:
Understand the rates and trends of medicalization today.
Explore FGM/C and the practice of medicalization in Kenya, Egypt, Sudan, and Nigeria through country profiles.

Identify key steps that can be taken to end medicalization as well as FGM/C more broadly. (Author, edited)
Full URL: https://interactives.prb.org/medicalization/index.html

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20180920-53*

Coming of age: adolescent health. World Health Organization (2018), Geneva: World Health Organization September 2018

An in-depth online feature produced by the World Health Organization (WHO) advocating better health for adolescents and highlighting the range of health risks faced by young people, such as exposure to tobacco, alcohol and drugs, violence, mental health issues, sexually transmitted diseases, female genital mutilation (FGM) and teenage pregnancy. The package includes video, gifs, visuals and features on a range of topics on adolescent health and looks ahead to World Mental Health Day on 10 October, which this year will have a focus on the mental health of young people in a changing world. States that approximately 3000 adolescents die every day; in 2016 the lives of more than 1.1 million teenagers were lost to mainly preventable causes such as road injuries, complications in pregnancy or labour, or HIV/AIDS. Includes a video presentation from Leyla Hussein, who underwent female genital mutilation (FGM) as a child. Describes her experiences and how she is coming to terms with what happened. Stresses the importance of the correct use of language by health professionals: FGM is a form of child abuse, not a cultural practice. (JSM)

20180919-21*

Prevalence and factors associated with female genital mutilation among women of reproductive age in the Bawku municipality and Pusiga District of northern Ghana. Sakeah E, Debpuur C, Oduro AR, et al (2018), BMC Women's Health vol 18, no 150, 18 September 2018

Background
Globally, three million girls are at risk of female genital mutilation (FGM) and an estimated 200 million girls and women in the world have undergone FGM. While the overall prevalence of FGM in Ghana is 4%, studies have shown that the overall prevalence in the Upper East Region is 38%, with Bawku municipality recording the highest at 82%.
Methods
This study used a cross-sectional design with a quantitative approach: a survey with women of reproductive age (15-49).
Results
Among all respondents, 830 women who participated in the study, 61% reported having undergone FGM. Of those circumcised, 66% indicated their mothers influenced it. Three quarters of the women think FGM could be stopped through health education. Women who live in the Pusiga district (AOR: 1.66; 95% CI: 1.16-2.38), are aged 35-49 (AOR: 4.24; 95% CI: 2.62-6.85), and have no formal education (AOR: 2.78; 95% CI: 1.43-5.43) or primary education (AOR: 2.10; 95% CI: 1.03-4.31) were more likely to be circumcised relative to those who reside in Bawku Municipal, are aged 15-24, and had tertiary education. Likewise, married women (AOR: 3.82; 95% CI: 2.53-5.76) were more likely to have been circumcised compared with unmarried women. At a site-specific level, factors associated with FGM included age and marital status in Bawku, and age, marital status, and women's education in Pusiga.
Conclusion
Female Genital Mutilation is still being practiced in the Bawku Municipality and the Pusiga District of northern Ghana, particularly among women with low socio-economic status. Implementing interventions that would provide health education to communities and promote girl-child education beyond the primary level could help end the practice. (57 references) (Author) [Please note: this article is a digital version which may undergo minor changes in the future]
Full URL: https://doi.org/10.1186/s12905-018-0643-8

20180802-92*

Knowledge, attitudes and practices of primary healthcare professionals to female genital mutilation in Valencia, Spain: are we ready for this challenge?. Gonzalez-Timoneda A, Ruiz Ros V, Gonzalez-Timoneda M, et al (2018), BMC Health Services Research vol 18, no 579, 24 July 2018

Background
The practice of Female Genital Mutilation (FGM) is a deeply-rooted tradition in 30 Sub-Saharan and Middle-East countries which affects approximately 200 million women and girls worldwide. The practice leads to devastating consequences on the health and quality of life of women and girls in both the short and long term. Globalizing processes and migration flows have recorded cases of this practice worldwide representing for healthcare professionals an emerging challenge on how to approach their healthcare in a transcultural, ethical and respectful way. No survey to assess knowledge, attitudes and practices on FGM among primary healthcare professionals has

been conducted in the Valencian region of Spain to date.
Methods
The main purpose of this study is to assess the perceptions, knowledge, practices and attitudes of the primary healthcare professionals in relation to FGM in the Clínic-Malvarrosa healthcare area of Valencia. A cross-sectional descriptive study was conducted based on a self-administered questionnaire to general practitioners, paediatricians, nurses, midwives, gynaecologists, social workers and others.
Results
A total of 321 professionals answered the questionnaire. Less than 5% of professionals answered that they had ever found a case of FGM during their professional practice and 21.8% answered that they had ever worked with population at risk of FGM. Almost 15% of professionals answered that they had received training on FGM but of those who had received training, only 22.7% correctly identified the typology of FGM and less than 5% correctly identified the geographical area. Only 6.9% of the respondents admitted to know some protocol of action, being midwives, paediatricians and social workers the most aware professionals of such protocols.
Conclusion
This study demonstrates that FGM is a problem present in the population attending primary healthcare services in Valencia. However, the professionals showed a profound lack of knowledge around concept, typology, countries of prevalence of FGM and existent protocols of action. It is healthcare professional duty to recognize this situation and to follow the right protocols of action, refer these women and their families to the most appropriate services and professionals that fit their needs, ensuring a multidisciplinary, positive and transcultural care for these families.
(29 references) (Author) [Please note: this article is a digital version which may undergo minor changes in the future]
Full URL: https://doi.org/10.1186/s12913-018-3396-z

20180726-64*

Using electronic maternity records to estimate female genital mutilation in Lothian from 2010 to 2013. Ford CM, Darlow K, Massie A, et al (2018), European Journal of Public Health vol 28, no 4, August 2018, pp 657-661

Background
Female genital mutilation (FGM) is most commonly encountered in Africa and the Middle East, with migration from FGM-practicing countries meaning it is increasingly seen in Europe. Addressing FGM requires accurate information on who is affected but ascertainment is notoriously difficult. This study estimated FGM prevalence in women presenting for maternity care in the Lothian region of Scotland and compared this with that expected by extrapolation of survey data from women's country of birth.
Methods
Electronic clinical records were linked to birth registration data to estimate FGM in the obstetric patients in Lothian from 2010 to 2013.
Results
Among all, 107 women affected by FGM were detected, at a rate of 2.8/1000 pregnancies. Of 487 women from UNICEF-recognized FGM-practicing countries who accessed care, 87 (18%) had documented evidence of FGM (three quarters of whom came from Nigeria, Sudan or The Gambia). The prevalence was 54% of the level expected from the extrapolation method. Country of birth had a sensitivity of 81% for FGM.
Conclusion
Women from FGM-practicing countries commonly access maternity care in Lothian. This confirms the need for ongoing training and investment in identifying and managing FGM. Matching electronic clinical records with birth registration data was a useful methodology in estimating the level of FGM in the maternity population. In a European country like Scotland with modest migrant numbers, asking country of birth during pregnancy and making sensitive enquiries could detect 81% of women with FGM. Extrapolation from maternal country of birth surveys grossly overestimates the true prevalence. (Author)

20180725-47*

Sequela of female genital mutilation on birth outcomes in Jijiga town, Ethiopian Somali region: a prospective cohort study. Gebremicheal K, Alemseged F, Ewunetu H, et al (2018), BMC Pregnancy and Childbirth vol 18, no 305, 20 July 2018

Background
In Ethiopia, female genital mutilation (FGM) remains a serious concern and has affected 23.8 million women and girls, with the highest prevalence in Somali regional state. Even though FGM is reported to be associated with a range of obstetric complications, little is known about its effects on childbirth in the region. Therefore, the objective of this study was to test the hypothesis that FGM is a contributing factor to the increased risk of complication during childbirth.

Methods
Facility based cohort study, involving 142 parturients with FGM and 139 parturients without FGM, was conducted in Jijiga town from October to December, 2014. The study participants were recruited by consecutive sampling technique. Data were collected using a structured interviewer administered questionnaire and observational checklists. Data were analyzed using SPSS version 16 and STATA version 11.
Results
The existence of FGM was significantly associated with perinealtear [RR = 2.52 (95% CI 1.26-5.02)], postpartum blood loss [RR = 3.14 (95% CI 1.27-7.78)], outlet obstruction [RR = 1.83 (95% CI 1.19-2.79)] and emergency caesarean section [RR = 1.52 (95% CI 1.04-2.22)]. FGM type I and FGM type II did not demonstrate any association with prolonged 2nd stage of labour, emergency caesarean section, postpartum blood loss, and APGAR score < 7. FGM type III however was significantly associated with prolonged 2nd stage of labour [RR = 2.47 (95% CI 1.06-5.76)], emergency caesarean section [RR = 3.60 (95% CI 1.65-7.86)], postpartum blood loss [RR = 6.37 (95% CI 2.11-19.20] and APGAR score < 7 [RR = 4.41 (95% CI, 1.84-10.60)]. FGM type II and type III were significantly associated with perinealtear [RR = 2.45(95% CI 1.03-5.83)], [RR = 4.91(95% CI 2.46-9.77)] and outlet obstruction [RR = 2.38(95% CI 1.39-4.08)], [RR = 2.94(95% CI 1.84-4.71)] respectively.
Conclusion
Women with FGM are significantly more likely than those without FGM to have adverse obstetric outcomes. Risks seem to be greater with more extensive form of FGM. Adverse obstetric outcomes can therefore be added to the known harmful immediate and long-term effects of FGM.
(33 references) (Author) [Please note: this article is a digital version which may undergo minor changes in the future]
Full URL: https://doi.org/10.1186/s12884-018-1937-4

20180718-63*

Female Genital Mutilation (FGM) - April 2017 to March 2018, Annual Report, Experimental Statistics Report. NHS Digital (2018), London: NHS Digital 5 July 2018

The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices. The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) supports the Department of Health's FGM Prevention Programme by presenting a national picture of the prevalence of FGM in England.
• There were 6,195 individual women and girls who had an attendance where FGM was identified or a procedure related to FGM was undertaken in the period April 2017 to March 2018. These accounted for 9,490 attendances reported at NHS trusts and GP practices where FGM was identified or a procedure related to FGM was undertaken.
• There were 4,495 newly recorded women and girls in the period April 2017 to March 2018. Newly recorded means this is the first time they have appeared in this dataset. It does not indicate how recently the FGM was undertaken, nor does it mean that this is the woman or girl's first attendance for FGM.
• Definitions
1. Individuals refers to all patients in the reporting period where FGM was identified or a procedure for FGM was undertaken. Each patient is only counted once.
2. Total Attendances refers to all attendances in the reporting period where FGM was identified or a procedure for FGM was undertaken. Women and girls may have one or more attendances in the reporting period. This category includes both newly recorded and previously identified women and girls.
3. Newly Recorded refers to an individual's first appearance in the FGM dataset. Newly recorded does not necessarily mean that the attendance is the woman's or girl's first attendance for FGM. (Publisher, edited)
Full URL: https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/female-genital-mutilation-fgm---annual-report-2017-18

20180619-9*

Mandatory reporting of female genital mutilation in children in the UK. Malik Y, Rowland A, Gerry F, et al (2018), British Journal of Midwifery vol 26, no 6, June 2018, pp 377-386

Background
While female genital mutilation (FGM) has been illegal in the UK since 1985, research estimated that in 2015 there were over 100 000 women and girls resident in the UK subjected to FGM.
Aims
To determine the effect of changes in the legislation of 2015, which made reporting of FGM in girls under 18 mandatory.
Methods

Freedom of Information requests were sent to all 45 UK police authorities, asking the number of cases of FGM reported between specific dates, victims' ages, the occupation of the person reporting and the age and gender breakdown of the police force. Similar requests were sent to health and social care organisations.
Findings
Of 45 police authorities in the UK, six initially responded, with three stating that no cases of FGM had been reported. The remaining police authorities either provided partial information or declined the request. However, other sources indicated over 6000 reported cases between October 2014 and October 2015.
Conclusions
The ability of frontline professionals and policymakers to obtain, interpret and use data is affected by the secrecy that surrounds FGM, the complexities of investigation and the absence of a significant numbers of prosecutions. (Author)
Full URL: https://doi.org/10.12968/bjom.2018.26.6.377

20180613-6*

'FGM has stopped in Wales' but women still 'persecuted'. Hibbard S (2018), BBC News 12 June 2018

Reports that women from Wales' Somali community say they are persecuted by health workers although female genital mutilation (FGM) no longer happens in their community. Since 2014, a new safeguarding law has meant that all health care workers are obliged to report children they suspect to be at risk of FGM. The campaigners claim that health workers are accusing innocent families just because they are Somali. (CAP)
Full URL: https://www.bbc.co.uk/news/uk-wales-44440167

20180606-30

Female genital mutilation (FGM): how a grant has made a difference. Tuna B, Wallis S (2018), Australian Nursing and Midwifery Journal vol 25, no 9, April 2018, p 51

Reports that nurses and midwives working in Shepparton, Victoria, Australia, a leading destination point for immigrants and refugees, are addressing the issue of female genital mutilation, aided by a grant in 2015 from the Family and Reproductive Rights Education Program (FARREP), which has allowed: an educational workshop aimed at health professionals who may be working with women, girls and families affected by FGM; a community development and education program enabling bilingual workers and volunteers to teach in their own languages; dissemination of information and resources through the use of social media and other channels. (JSM)
Full URL: https://issuu.com/australiannursingfederation/docs/anmj_april_2018_issuu

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20180529-68*

Health care-seeking patterns for female genital mutilation/cutting among young Somalis in Norway. Mbanya VN, Gele AA, Diaz E, et al (2018), BMC Public Health vol 18, no 517, 18 April 2018

Background
Female genital mutilation/cutting (FGM/C) is a great concern, considering all the potential health implications. Use of health care services related to FGM/C by women who have been subjected to FGM/C in Norway remains to be understood. This study aims to explore the health care-seeking patterns for FGM/C-related health care problems, among young Somalis in Norway.
Methods
A cross-sectional study involving 325 young Somalis in Oslo was conducted in 2014 using respondent-driven sampling (RDS) technique. The RDS was initiated by a small number of recruited seeds, who were given coded coupons to recruit their peers to participate in the study. Eligible recruiters who participated in the study and redeemed their coupons created the first wave of respondents. The first wave further recruited their peers, the second wave. The cycle continued to attain the needed samples. Using interviews and structured questionnaires, data on socio-demographic, FGM/C status and FGM/C-related use of health care were obtained. Logistic regressions were used to compute the odds ratio (OR) and the confidence interval (CI) for the associations between demographic variables, to circumcision status and health care-seeking for FGM/C. This study will focus on the 159 female participants of the total 325.
Results
While 51.6% of the 159 women were subjected to FGM/C, only 20.3% of them used health care services for FGM/C-related problems. Women's FGM/C status was associated with age ≥ 12 years at migration, experience of stigma regarding FGM/C practice ($p < 0.05$), support of FGM/C practice, and place of birth of women ($p < 0.05$).
Conclusion
Only one-fifth of the women with FGM/C sought care for FGM/C-related health problems. Our study does not provide

the answers to why only a few of them sought care for FGM/C. However, as a large proportion of women did not seek care, it is important to investigate the reasons for this. For, we propose to conduct further research targeting girls and women who have undergone FGM/C to assess challenges in accessing health care services for proper intervention. (58 references) (Author) [Please note: BMC initially publishes articles in a provisional format. If there is a note on the document to indicate that it is still provisional, it may undergo minor changes]

Full URL: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-018-5440-7

20180510-53*

Women's wellbeing clinic opens for those affected by female genital mutilation. Ford S (2018), Nursing Times 2 May 2018

Cardiff and Vale University Health Board has launched the first specialist female genital mutilation clinic in Wales. (Author)

20180510-5*

Dorset FGM survivor says it shouldn't be a taboo. Everett S (2018), BBC News 10 May 2018

Salimata, a survivor of female genital mutilation (FGM), which was underwent in Senegal at the age of five, tells her story and the steps she has taken to raise awareness of this harmful procedure, often performed on young girls and women as a way of controlling sexuallity, in the hopes that this tradition will be eradicated. FGM has been illegal in the UK for 30 years. (JSM)

Full URL: http://www.bbc.co.uk/news/av/uk-england-dorset-44058167/dorset-fgm-survivor-says-it-shouldn-t-be-a-taboo

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20180508-72

A Meta-Synthesis of the Birth Experiences of African Immigrant Women Affected by Female Genital Cutting. Hamid A, Grace KT, Warren N (2018), Journal of Midwifery & Women's Health vol 63, no 2, March/April 2018, pp 185-195

Introduction

The purpose of this qualitative meta-synthesis was to understand the labor and birth experiences of immigrant women in countries of resettlement who have a history of female genital cutting (FGC), also known as female genital mutilation or female circumcision.

Methods

We used a meta-ethnography approach to synthesize the literature on this topic. We searched PubMed, Embase, Web of Science, CINAHL, PsycINFO, and Sociological Abstracts databases from inception to May 2016 using the search terms female genital cutting, female circumcision, clitorectomy, clitoridectomy, pharaonic circumcision, genital circumcision, female genital mutilation, infibulation, and deinfibulation. Our inclusion criteria were 1) peer-reviewed, original qualitative research; 2) focused on populations affected by FGC or their health care providers; 3) conducted in a country where FGC is not documented as an indigenous practice; 4) English language; and 5) included a description of postmigratory labor and birth experiences of women affected by FGC. Fourteen articles were included.

Results

Two new syntheses emerged from our sample of studies including African immigrant women primarily resettled in Europe and the United States. First, birth after FGC in the context of resettlement included pain and anxiety, and has the potential to retraumatize. Second, while women experienced nostalgia for familiar traditions and perceived disrespect in their new setting, they questioned traditions, including the role of FGC, in their and their daughters' lives.

Discussion

The negative birth experiences of women affected by FGC highlight the need to improve care for this population. Health care professionals can serve as a source of support for women affected by FGC by acknowledging and addressing FGC in their care and actively listening to their perspectives and concerns. (48 references) (Author)

20180508-34*

Mapping the lack of public initiative against female genital mutilation in Denmark. Christoffersen GM, Bruhn PJ, de Neergaard R, et al (2018), Reproductive Health vol 15, no 59, 7 April 2018

Background

Female genital mutilation (FGM) is a harmful practice prevalent in 35 countries, mainly in Africa, as well as in some Middle Eastern countries and a few Asian countries. FGM comprises all procedures that involve partial or complete resection of, or other injury to, external female genitalia for non-medical reasons. The practice of FGM has spread to Western countries due to migration. The European Institute for Gender Equality recommend that FGM be combatted by nationally coordinated efforts through implementation of national action plans, guidelines for professionals as well

as comprehensive research in the field. FGM was outlawed in Denmark 2003, but no national actions plan has been implemented. Instead, the task of combatting FGM is currently under the responsibility of local governments in the form of the 98 municipalities. The aim of this study is to investigate the Danish municipalities' efforts to prevent FGM on the local level, and whether these initiatives are in accordance with international recommendations and standards.
Methods
All 98 Danish municipalities were invited to respond to a questionnaire regarding FGM in their respective municipalities. The inclusion process and questionnaire was designed after a pilot study, which included 29 municipalities. The questionnaire consisted of four overall areas of focus: 'action plan', 'registration', 'information material' and 'preventive initiatives'. Demographic data were gathered from the 2017 census by Statistics Denmark. Risk countries were defined as countries with a tradition for FGM, identified from the 2016 UNICEF definition.
Results
A total of 67 municipalities participated in the study. At the time of census, 1.8% of the Danish population was immigrants with origins in risk countries. A total of 10.4% of the responding municipalities indicated to have implemented a specific action plan against FGM. A total of 7,5% had implemented specific preventive initiatives against FGM. Registration of reported FGM cases were indicated to be performed in 73.1% of the responding municipalities; however, only 17.9% stated to perform registration of FGM specifically as such, and not as general child abuse.
Conclusions
Our study shows that the current situation of FGM registration and prevention being under local administrative responsibility in the 98 Danish municipalities has led to a severe lack of coordinated public initiative against FGM.
(35 references) (Author) [Please note: BMC initially publishes articles in a provisional format. If there is a note on the document to indicate that it is still provisional, it may undergo minor changes]
Full URL: https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-018-0499-2

20180508-27*

Effectiveness of health education as an intervention designed to prevent female genital mutilation/cutting (FGM/C): a systematic review. Waigwa S, Doos L, Bradbury-Jones C, et al (2018), Reproductive Health vol 15, no 62, 12 April 2018
Background
Female Genital Mutilation/Cutting (FGM/C) is a harmful practice that violates the human rights of women and girls. Despite global efforts to restrict the practice, there have been few reports on major positive changes to the problem. Health education interventions have been successful in preventing various health conditions and promoting service use. They have also been regarded as promising interventions for preventing FGM/C. The objective of this systematic review is to synthesise findings of studies about effectiveness of health education as an intervention to prevent FGM/C.
Methods
The electronic databases searched were MEDLINE, EMBASE, Cochrane library, Web of Science, Psych INFO, CINAHL and ASSIA. Our search included papers published in the English language without date limits. Study quality was assessed using the Mixed Methods Appraisal Tool (MMAT). A predesigned data recording form was used to extract data from the included studies which were summarised by comparing similar themes.
Results
Twelve out of 359 individual studies met our inclusion criteria. Seven studies were quantitative, three were qualitative and two used mixed methods. Six studies tested before and after the interventions, four studies assessed the effectiveness of previous interventions used by different research teams and two studies endorsed the intervention. Four main factors emerged and were associated with facilitating or hindering the effectiveness of health education interventions: sociodemographic factors; socioeconomic factors; traditions and beliefs; and intervention strategy, structure and delivery.
Conclusions
It is vital to target factors associated with facilitating or hindering the effectiveness of health education for FGM/C. This increases the possibility of effective, collective change in behaviour and attitude which leads to the sustainable prevention of FGM/C and ultimately the improved reproductive health and well-being of individuals and communities.
(56 references) (Author) [Please note: BMC initially publishes articles in a provisional format. If there is a note on the document to indicate that it is still provisional, it may undergo minor changes]
Full URL: https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-018-0503-x

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20180419-23*

Health sector involvement in the management of female genital mutilation/cutting in 30 countries. Johansen REB, Ziyada MM, Shell-Duncan B, et al (2018), BMC Health Services Research vol 18, no 240, 4 April 2018

Background

For the last decades, the international community has emphasised the importance of a multisectoral approach to tackle female genital mutilation (FGM/C). While considerable improvement concerning legislations and community involvement is reported, little is known about the involvement of the health sector.

Method

A mixed methods approach was employed to map the involvement of the health sector in the management of FGM/C both in countries where FGM/C is a traditional practice (countries of origin), and countries where FGM/C is practiced mainly by migrant populations (countries of migration). Data was collected in 2016 using a pilot-tested questionnaire from 30 countries (11 countries of origin and 19 countries of migration). In 2017, interviews were conducted to check for data accuracy and to request relevant explanations. Qualitative data was used to elucidate the quantitative data.

Results

A total of 24 countries had a policy on FGM/C, of which 19 had assigned coordination bodies and 20 had partially or fully implemented the plans. Nevertheless, allocation of funding and incorporation of monitoring and evaluation systems was lacking in 11 and 13 of these countries respectively. The level of the health sectors' involvement varied considerably across and within countries. Systematic training of healthcare providers (HCP) was more prevalent in countries of origin, whereas involvement of HCP in the prevention of FGM/C was more prevalent in countries of migration. Most countries reported to forbid HCP from conducting FGM/C on both minors and adults, but not consistently forbidding re-infibulation. Availability of healthcare services for girls and women with FGM/C related complications also varied between countries dependent on the type of services. Deinfibulation was available in almost all countries, while clitoral reconstruction and psychological and sexual counselling were available predominantly in countries of migration and then in less than half the countries. Finally, systematic recording of FGM/C in medical records was completely lacking in countries of origin and very limited in countries of migration.

Conclusion

Substantial progress has been made in the involvement of the health sector in both the treatment and prevention of FGM/C. Still, there are several areas in need for improvement, particularly monitoring and evaluation.

(95 references) (Author) [Please note: BMC initially publishes articles in a provisional format. If there is a note on the document to indicate that it is still provisional, it may undergo minor changes]

Full URL: https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3033-x

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20180314-95*

Female genital mutilation de-infibulation: antenatal or intrapartum?. Gupta S, Latthe P (2018), Obstetrics, Gynaecology and Reproductive Medicine vol 28, no 3, March 2018, pp 61-98

Women who have had female genital mutilation (FGM) often experience adverse short and long term health effects. Owing to increasing international migration FGM has become a global concern. Health professionals involved in the care of these women need to be aware of the complications that it may present during labour as well as the sensitivity of the matter. This review summarises the studies available looking into the ideal time for deinfibulation. (4 references) (Author)

20180221-103

A survey of Australian midwives' knowledge, experience, and training needs in relation to female genital mutilation. Turkmani S, Homer C, Varol N, et al (2018), Women and Birth: Journal of the Australian College of Midwives vol 31, no 1, February 2018, pp 25-30

Background

Female genital mutilation (FGM) involves partial or total removal of the external female genitalia or any other injury for non-medical reasons. Due to international migration patterns, health professionals in high income countries are increasingly caring for women with FGM. Few studies explored the knowledge and skills of midwives in high income countries.

Aim

To explore the knowledge, experience and needs of midwives in relation to the care of women with FGM.

Methods

An online self-administered descriptive survey was designed and advertised through the Australian College of Midwives' website.

Results

Of the 198 midwives (24%) did not know the correct classification of FGM. Almost half of the respondents (48%)

reported they had not received FGM training during their midwifery education. Midwives (8%) had been asked, or knew of others who had been asked to perform FGM in Australia. Many midwives were not clear about the law or health data related to FGM and were not aware of referral paths for affected women.
Conclusion
As frontline providers, midwives must have appropriate up-to-date clinical skills and knowledge to ensure they are able to provide women with FGM the care they need and deserve. Midwives have a critical role to play in the collection of FGM related data to assist with health service planning and to prevent FGM by working closely with women and communities they serve to educate and advocate for its abandonment. Therefore, addressing educational gaps and training needs are key strategies to deliver optimal quality of care. (49 references) (Author)

20180201-21*

Prevalence and attitudes on female genital mutilation/cutting in Egypt since criminalisation in 2008. Alkhalaileh D, Hayford SR, Norris AH, et al (2018), Culture, Health & Sexuality vol 20, no 2, 2018, pp 173-182

Female genital mutilation/cutting (FGM/C), which can result in severe pain, haemorrhage and poor birth outcomes, remains a major public health issue. The extent to which prevalence of and attitudes toward the practice have changed in Egypt since its criminalisation in 2008 is unknown. We analysed data from the 2005, 2008 and 2014 Egypt Demographic and Health Surveys to assess trends related to FGM/C. Specifically, we determined whether FGM/C prevalence among ever-married, 15-19-year-old women had changed from 2005 to 2014. We also assessed whether support for FGM/C continuation among ever-married reproductive-age (15-49 years) women had changed over this time period. The prevalence of FGM/C among adolescent women statistically significantly decreased from 94% in 2008 to 88% in 2014 (standard error [SE] = 1.5), after adjusting for education, residence and religion. Prevalence of support for the continuation of FGM/C also statistically significantly decreased from 62% in 2008 to 58% in 2014 (SE = 0.6). The prevalence of FGM/C among ever-married women aged 15-19 years in Egypt has decreased since its criminalisation in 2008, but continues to affect the majority of this subgroup. Likewise, support of FGM/C continuation has also decreased, but continues to be held by a majority of ever-married women of reproductive age. (33 references) (Author)

20180115-1*

FGM: responding to female genital mutilation in Scotland: multi-agency guidance. November 2017. Scottish Government (2017), Scottish Government November 2017. 68 pages

This guidance provides a framework within which agencies and practitioners can develop and agree processes for working collaboratively and individually to promote the safety and wellbeing of women and girls. It covers; how to identify whether a girl including an unborn girl) or young woman may be at risk of FGM; how to identify a girl or woman who has undergone FGM; how to protect those at risk and support those already affected; and how to prevent and end FGM. (Author)

Full URL: http://www.gov.scot/Resource/0052/00528145.pdf

20180111-79*

Characteristics of female sexual dysfunctions and obstetric complications related to female genital mutilation in Omdurman maternity hospital, Sudan. Yassin K, Idris HA, Ali AA (2018), Reproductive Health vol 15, no 7, 8 January 2018

Background
Female genital mutilation (FGM) is a major public health problem, especially in developing countries.
Method
This was a prospective observational cohort study conducted over six months duration (1st July-31st December 2015) at Omdurman Maternity Hospital, Khartoum, Sudan, primarily to determine whether exposure to FGM/C (exposed Vs. non-exposed) and degree of exposure (type III Vs. type I) are associated with impaired sexual function or not?. As secondary objective, the study also investigated the association between FGM/C and postpartum complications (eg: difficulties in cervical examination, episiotomy wound infection, postpartum bleeding) by following the participants from the time of admission at the hospital, through vaginal delivery and until the 6th post-partum week.
Results
A total of 230 (subjected to FGM/C) and 190 (not subjected to FGM/C) women were approached. The clinical examinations evidenced that the majority (67.8%) had FGM type 3, while the remainder (32.2%) had type 1. The most common reported sexual complication was dyspareunia (76%). Bleeding following first attempt of sexual intercourse was reported in 35.2% followed by reduced sexual desire 62.6%, reduced sexual satisfaction 40.9% and need for surgery to release labial adhesions at first attempt of sexual intercourse 30.4%. With regard to FGM- related

complications that occurred during labor 76.5% required an episiotomy, 61.7% experienced difficulties in cervical examination, 57.8% needed defibulations during second stage of labor, 26.5% complicated by episiotomy wound infection and 2.2% developed obstetric hemorrhage. In this study FGM/C was a significant factor increasing the risk of sexual complications. Interestingly when using logistic regression analysis the FGM-related complications were not significantly varied by FGM/C types.
Conclusion
Our observations indicate that FGM/C is a serious public health problem and there should be an urgent intervention such as planned health education campaigns to end FGM/C practice.
(16 references) (Author) [Please note: BMC initially publishes articles in a provisional format. If there is a note on the document to indicate that it is still provisional, it may undergo minor changes]
Full URL: https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0442-y

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20180110-96*

Female Genital Mutilation/Cutting: A Well-Kept Secret in Pakistan. Moin A, Mustansar I (2017), JOGC [Journal of Obstetrics and Gynaecology Canada] vol 39, no 12, December 2017, pp 1127-1128

On May 14, 2017, the leaders and residents of 117 communities in the region of Kolda in southern Senegal were joined by representatives from the United Nations Children's Fund (UNICEF), the UN Population Fund (UNFPA), and the UN Joint Programme on Female Genital Mutilation/Cutting (FGM/C) to mark a significant occasion, an end to FGM/C in and around Kolda. On May 21, 2017, 62 additional communities renounced the practice in the Fouta region of Senegal, a current of positive social change now sweeping Africa, the leading region of the practice.
(5 references) (Author)

20180110-101*

Female Genital Cutting/Mutilation: a Challenge for Patients and Clinicians. Koukoui S (2017), JOGC [Journal of Obstetrics and Gynaecology Canada] vol 39, no 12, December 2017, pp 1185-1187

The increased migration of women with female genital cutting/mutilation (FGC/M) to countries in which it is not practised has rendered FGC/M a global public health issue, one confronted in Canada at an increasing rate. The SOGC initially instituted a policy against FCG/M back in 1992 and offered guidelines to clinicians treating this specific population. Yet studies on health care delivery for women with FGC/M who are living in Canada reveal significant lacunae.1,2 In light of these shortcomings and the scant research conducted since 1992, the SOGC announced that it 'supports research into FGC/M in Canada, including women's perception of FGC/M and their experiences accessing sexual and reproductive health care, and the perspective, knowledge and clinical practice of health professionals with respect to FGC/M.'3 The impetus for this commentary stems from both my research on FGC/M and my experience as a mental health clinician providing individual and group psychotherapy for women with FGC/M.
(6 references) (Author)

20171214-6*

I knew how it feels but couldn't save my daughter; testimony of an Ethiopian mother on female genital mutilation/cutting. Adinew YM, Mekete BT (2017), Reproductive Health vol 14, no 162, 1 December 2017

Background
World Health Organization defines female genital mutilation/cutting 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. The practice is common in Ethiopia, especially among Somali (99%) ethnic groups. Even though FGM/C is labeled illegal practice according to the revised 2005 Penal Code of the country, the practice is still responsible for misery of many girls in Ethiopia.
Methods
This personal testimony is presented using woman's own words. Data were collected through in-depth interview with a woman at Gursum health center, Somali regional state, eastern Ethiopia on June 19/2016. The interview was conducted in a private environment and original names were changed to overcome ethical concerns. Informed written consent was obtained from the participant prior to data collection. The interview was audio-taped using a digital voice recorder, later transcribed and translated verbatim from the local language, Amharic to English.
Results
The study participant described a range of experiences she had during her own and her daughter's circumcision. Three themes emerged from the woman's description: womanhood, social pressure and stigmatization of uncircumcised women and uncertain future.

Conclusion
Even though the national prevalence may show a decline, FGM/C is still practiced underground. Thus, anti-FGM/C interventions shall take in to account elders influence and incorporate a human rights approach rather than relying merely on the dire health consequences. Further exploration of the determinants of FGM/C on a wider scale is recommended.
(29 references) (Author) [Please note: BMC initially publishes articles in a provisional format. If there is a note on the document to indicate that it is still provisional, it may undergo minor changes]
Full URL: https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0434-y

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20171201-12*

Child abuse and neglect. National Institute for Health and Clinical Excellence (2017), London: NICE 9 October 2017. 58 pages
This guideline covers recognising and responding to abuse and neglect in children and young people aged under 18. It covers physical, sexual and emotional abuse, and neglect. The guideline aims to help anyone whose work brings them into contact with children and young people to spot signs of abuse and neglect and to know how to respond. It also supports practitioners who carry out assessments and provide early help and interventions to children, young people, parents and carers. Clinical features of abuse and neglect (including physical injury) are covered in NICE's guideline on child maltreatment. Recommendations relevant to both health and social care practitioners appear in both guidelines. (Author)
Full URL: https://www.nice.org.uk/guidance/ng76/resources/child-abuse-and-neglect-pdf-1837637587141

20171109-46*

Changing practices and shifting meanings of female genital cutting among the Maasai of Arusha and Manyara regions of Tanzania. Van Bavel H, Coene G, Leye E (2017), Culture, Health & Sexuality vol 19, no 12, December 2017, pp 1344-1359
Using mixed methods that combined participant observation and semi-structured in-depth interviews, this study looked at changing practices and shifting meanings of female genital cutting among the Maasai people in Tanzania. The findings suggest that an increasing social pressure to abandon female genital cutting has inspired the hiding of the practice, causing the actual cutting to become detached from its traditional ceremonial connotations. This detaching of cutting from ceremony has created a shift in meanings: the ceremony still carries the meaning of passage into adulthood, while the cutting seems to function as a way of inscribing Maasai identity into the body. The detaching of genital cutting from ceremony offers those willing to continue the practice the opportunity to do so without being prosecuted, and those unwilling to undergo or perform the practice the opportunity to evade it by faking the cutting without being socially sanctioned for it. Findings also suggest changing attitudes towards the practice among the younger generation as the result of education. Maasai culture and the practice of female genital cutting are not static but actively challenged and reinterpreted from within the community, with formally schooled and women taking up leading roles in reshaping gender norms. (44 references) (Author)

20171109-18*

Knowledge, attitude, and experience of health professionals of female genital mutilation (FGM): A qualitative study in Iraqi Kurdistan Region. Shabila NP, Ahmed HM, Safari K (2017), Health Care for Women International vol 38, no 11, October 2017, pp 1202-1218
We aimed to assess the knowledge, attitude, and experience of health professionals of female genital mutilation (FGM). The study involved content analysis of semistructured interviews with 21 health professionals. The participants had poor knowledge regarding different aspects of FGM including its types, prevalence, and complications as well as the existing legislation that prohibits FGM. They believed that FGM is mainly practiced for religious reasons and to reduce sexual desire/arousal. Health professionals are apparently not involved in performing FGM, and they do not support its continuation. Health professionals can take a leading role in raising the awareness of women and combating FGM. (37 references) (Author)

20171024-37*

Clinical indications for cesarean delivery among women living with female genital mutilation. Rodriguez MI, Say L, Abdulcadir J, et al (2017), International Journal of Gynecology & Obstetrics vol 139, no 1, October 2017, pp 21-27
Objective
To compare primary indications for cesarean delivery among patients with different female genital mutilation (FGM) status.
Methods

The present secondary analysis included data from women who underwent trial of labor resulting in cesarean delivery at 28 obstetric centers in six African countries between November 1, 2001, and March 31, 2003. Associations between cesarean delivery indications and FGM status were assessed using descriptive statistics and multivariable multinomial logistic regression.

Results

Data from 1659 women (480 patients with no type of FGM and 1179 patients with FGM [any type]) were included; cesarean delivery indications were collapsed into five categories (fetal indications, maternal factors, stage 1 arrest, stage 2 arrest, and other). The incidence of a clear medical indication for cesarean delivery did not differ between the groups (P=0.320). Among patients without a clear indication for cesarean delivery, women with FGM were more likely to have undergone cesarean delivery for maternal factors (adjusted relative risk ratio [aRRR] 3.92, 95% confidence interval [CI] 1.3-11.71), stage 1 arrest (aRRR 7.74, 95% CI 1.33-45.07), stage 2 arrest (aRRR 6.63, 95% CI 3.74-11.73), or other factors (aRRR 2.41, 95% CI 1.04-5.60) rather than fetal factors compared with women who had no type of FGM.

Conclusion

Among women with unclear medical indications, FGM was associated with cesarean delivery being performed for maternal factors or arrest disorders. (25 references) (Author)

20171017-59

Setting up a clinic to assess children and young people for female genital mutilation. Hodes D, Creighton SM (2017), Archives of Disease in Childhood: Education & Practice Edition vol 102, no 1, February 2017, pp 14-18

It is now mandatory for health, social care professionals and teachers to report to the police all under-18s where female genital mutilation (FGM) has been disclosed by the child or where physical signs of FGM are seen. Such referrals are likely to result in a request for medical examination. New multiagency statutory guidance sets out instructions for physical examination but provides no details how services should be set-up. This review gives practical guidance learnt from the first year of the UK's only dedicated children's FGM service. (17 references) (Author)

20171013-15*

Scotland's National Action Plan to Prevent and Eradicate Female Genital Mutilation (FGM). Scottish Government (2017), Scottish Government October 2017. 37 pages

This update report provides an update of the work that is being taken forward by the Scottish Government and its partners in the statutory and third sectors along with affected communities in relation to the actions and activities required to progress the outcomes of the FGM National Action Plan. (Author)

Full URL: http://www.gov.scot/Publications/2017/10/8829

20171012-31*

FGM/C in Indonesia. Population Reference Bureau (2017), Washington, DC: PRB 10 October 2017

A short video to complement the Population Reference Bureau's 2017 update of Female Genital Mutilation/Cutting [FGC/C]: Data and Trends, looking at the prevalence of FGM/C in Indonesia, particularly among girls under the age of 12. (JSM)

20171012-27*

Tracking progress in FGM/C rates. Population Reference Bureau (2017), Washing, DC: PRB 10 October 2017

A short video to complement the Population Reference Bureau's 2017 update of Female Genital Mutilation/Cutting [FGM/C]: Data and Trends, which compares the percentage of women who have undergone FGM/C in the oldest age group (45-49 years) with the percentage of those in the younger age group (15-19 years), in order to ascertain the rate of decline in this practice. (JSM)

20171012-26*

Looking beyond national prevalence rates. Population Reference Bureau (2017), Washington, DC: PRB 12 October 2017

A short video to complement the 2017 update of the Population Reference Bureau's 'Female Genital Mutilation/Cutting [FGM/C]: Data and Trends, looking at the rates of FGM in 29 countries. Explains why we need to look beyond the national figures, because in 13 countries where the national prevalence rate is between 4% and 69%: Benin, Central African Republic, Chad, Cote d'Ivoire, Ethiopia, Ghana, Guinea-Bissau, Iraq, Kenya, Mauritania, Senegal, Tanzania, and Yemen, there are 'hotspots' where the rate of FGM ranges from 41%-99%; a prime example being Kenya where the national average is 21% but in some northeastern counties 98% of girls and women between the ages of 15

and 49 have undergone the procedure. (JSM)

20171006-14*

Female genital mutilation/cutting: data and trends. Update 2017. Population Reference Bureau (2017), Population Reference Bureau February 2017. 11 pages

Presents the latest information on the practice of female genital mutilation (FGM) in 29 developing countries, with representative and comparable data. Stresses that although information from only 29 countries is shown here, the procedure is undertaken on a worldwide basis. Reports that daughters of women who have had some education are less likely to undergo FGM than daughters of women who have received no education. (JSM)

20171003-3*

A women's health issue: Female genital mutilation (FGM) in Australia. Diaz M, Steen M (2017), Australian Nursing and Midwifery Journal vol 25, no 3, September 2017, p 35

While developing an online module for perineal wound care, funded the The Wound Management Innovation Cooperative Research Centre (WMI CRC), the authors of this paper found a lack of information and resources for health professionals to support women with female genital mutilation (FGM) during pregnancy, childbirth and following birth in Australia. (Author)

20170928-3

Episiotomy and severe perineal trauma among Eastern African immigrant women giving birth in public maternity care: A population based study in Victoria, Australia. Belihu FB, Small R, Davey M-A, et al (2017), Women and Birth: Journal of the Australian College of Midwives vol 30, no 4, August 2017, pp 282-290

Background

Eastern African immigrants from countries affected by female genital mutilation have resettled in many developed countries, including Australia. Although possibly at risk of perineal trauma and episiotomy, research investigating their perineal status post-migration is sparse.

Aim

To investigate variations in episiotomy use and incidence of severe perineal tear for women born in Eritrea, Ethiopia, Somalia and Sudan compared with Australian-born women.

Methods

A population-based study of 203,206 Australian-born and 3502 Eastern African immigrant women admitted as public patients, with singleton vaginal births between 1999 and 2007, was conducted using the Victorian Perinatal Data Collection. Descriptive and multivariable logistic regression analysis adjusting for confounders selected a priori, were performed to compute incidence and adjusted odds ratios.

Findings

Overall, 30.5% Eastern African immigrants had episiotomy compared to 17.2% Australian-born women. Severe perineal trauma occurred in 2.1% of Eastern African immigrants and 1.6% of Australian-born women. While the odds of severe perineal trauma was significantly elevated only during non-instrumental vaginal births for Eastern African immigrants {ORadj1.56 95%CI(1.17, 2.12)}; that of episiotomy was increased during both non-instrumental {ORadj4.47 95%CI(4.10, 4.88)} and instrumental {ORadj2.51 95%CI(1.91, 3.29)} vaginal births.

Conclusions

Overall, Eastern African immigrant women experienced elevated odds of episiotomy and severe perineal tear. Health care providers need to be mindful of the increased risk of severe perineal tear in these women and enhance efforts in identification and treatment of severe perineal trauma to minimise associated short and long term morbidity. Strategies to reduce unneeded episiotomy and ways of enhancing perineal safety are also needed. (48 references) (Author)

20170922-13*

Equality Impact Assessment (EQIA) Record - Scotland's National Action Plan to Prevent and Eradicate Female Genital Mutilation (FGM) 2016 - 2020. Scottish Government (2017), Scottish Government 20 September 2017. 7 pages

FGM is an extremely harmful practice with devastating short and long term health consequences for girls and women and has been unlawful in Scotland since 1985. The Scottish Government and its partners have developed Scotland's National Action Plan to Prevent and Eradicate Female Genital Mutilation (FGM) 2016 - 2020. This EQIA process for the National Action Plan e has helped to identify various activities and actions to tackle this unacceptable practice in Scotland. The findings of this EQIA were negotiated and agreed with multi agency professionals and community

organisations. This will provide a vital link because we believe the solution to the elimination of this practice lies within the communities potentially affected by it. (Author)
Full URL: http://www.gov.scot/Resource/0052/00524977.pdf

20170921-91*

African male attitudes on female genital mutilation: an Australian survey. Shahid U (2017), Journal of Obstetrics and Gynaecology vol 37, no 8, November 2017, pp 1053-1058

Female genital mutilation (FGM) is a traditional practice where female genital organs are altered for non-medical reasons. The custom is outlawed in Australia and associated with an array of medical consequences. Due to the recent influx of migrants from regions endemic to FGM, the practice is becoming a growing concern locally. This federal government funded study aimed to elicit the poorly understood perceptions that young, Sub-Saharan African, migrant males residing in Townsville, Australia have on FGM. Through piloted questionnaires we found that amongst the 67 participants, 23.9% believed that FGM should be allowed under Australian Law. The independent predictors of supportive attitudes in favour of FGM were having resided in Australia for five or less years (p = .016, 95% CI 0.99-8.09) and coming from a basic educational background (high school or TAFE) (p = .003, 95% CI 1.3-12.4). This study also found that participant perceptions on FGM were amenable to change through educational interventional strategies.
Impact statement
Female genital mutilation (FGM) is a traditional practice where female genital organs are altered for non-medical reasons.
The role that males play in the continuation of this outlawed practice remains poorly understood. No research has ever been conducted in Australia looking at the perception that young, migrant males have on FGM.
Several European-based studies have examined the perceptions of older, poorly educated, migrant male cohorts. Generally, these studies show that the attitudinal support for FGM and intention to practice remains relatively high amongst these cohorts.
This study examined the attitudes of a young, Sub-Saharan African, migrant, male cohort residing in Australia. This adds to the literature base by establishing the perceptions and associated socio-demographic variables of this unique and influential subset of the migrant population.
This directly facilitates the development of interventional strategies against FGM by highlighting those most likely to have an attitudinal support in favour of FGM. Consequentially, this 'at risk' group can be more effectively focussed on interventional programmes and be further investigated in larger scale studies. (20 references) (Author)

20170919-9

What can be done to raise midwives' awareness of female genital mutilation?. Oginni J (2017), British Journal of Midwifery vol 25, no 9, September 2017, pp 556-561

Female genital mutilation (FGM) is a safeguarding issue on which many midwives and health professionals in the UK have limited knowledge. This review synthesises the available literature and examines the resulting themes: cultural sensitivity, training, language and cultural differences, all of which can act as barriers to safeguarding women in maternity services. By understanding the effects of FGM, midwives in the areas where FGM is less prevalent will be better able to care for these women when they encounter them, which may be increasingly likely, as the numbers of women migrating to the UK grow. (51 references) (Author)

20170918-17*

The global challenge to improve the sexual and reproductive health of women affected by FGM/C. McCauley M (2017), BJOG: An International Journal of Obstetrics and Gynaecology 8 September 2017. Accepted article

Against a background of an increasing demand for surgical intervention for the treatment of FGM/C related complications, Berg et al<comment> Note for typesetter: Please update reference when assigned to an issue.</comment> have conducted a systematic review of 62 studies involving 5829 women, to assess the effectiveness of defibulation, excision of cysts and clitoral reconstructive surgery. Berg et al report that defibulation showed a lower risk of Caesarean section and perineal tears; excision of cysts commonly resulted in resolution of symptoms; and clitoral reconstruction resulted in most women self-reporting improvements in their sexual health. However, Berg et al highlight that they had little confidence in the effect estimate for all outcomes as most of the studies were observational and conclude that there is currently poor quality of evidence on the benefits and/or harm of surgical interventions to be able to counsel women appropriately (Author)

20170913-51*

#EndFGM: It's Our Time Now. Part 3 of 3. Royal College of Midwives (2017), London: RCM 12 September 2017

These short powerful animated films have been developed by the Royal College of Midwives (RCM) in collaboration with The Royal College of Obstetricians and Gynaecologists (RCOG), The Royal College of General Practitioners (RCGP), Survivors of FGM, NGOs and a variety of local community partners. They are aimed at creating awareness around the health and physiological consequences of FGM and cut through much of the inaccurate and misleading information circulating in the public sphere about FGM. (Author)

Full URL: https://www.youtube.com/watch?v=FZ_6CCfWjPo

20170913-49*

#EndFGM: Our Daughters. Part 2 of 3. Royal College of Midwives (2017), London: RCM 12 September 2017

These short powerful animated films have been developed by the Royal College of Midwives (RCM) in collaboration with The Royal College of Obstetricians and Gynaecologists (RCOG), The Royal College of General Practitioners (RCGP), Survivors of FGM, NGOs and a variety of local community partners. They are aimed at creating awareness around the health and physiological consequences of FGM and cut through much of the inaccurate and misleading information circulating in the public sphere about FGM. (Author)

Full URL: https://www.youtube.com/watch?v=n1HA4QNv1dk

20170913-47*

#EndFGM: The Words Don't Come. Part 1 of 3. Royal College of Midwives (2017), London: RCM 12 September 2017

These short powerful animated films have been developed by the Royal College of Midwives (RCM) in collaboration with The Royal College of Obstetricians and Gynaecologists (RCOG), The Royal College of General Practitioners (RCGP), Survivors of FGM, NGOs and a variety of local community partners. They are aimed at creating awareness around the health and physiological consequences of FGM and cut through much of the inaccurate and misleading information circulating in the public sphere about FGM. (Author)

Full URL: https://www.youtube.com/watch?v=M5E936tbv4g

20170901-13*

Female genital mutilation. Dean E (2017), Nursing Standard vol 31, no 52, 23 August 2017, p 15

Female genital mutilation (FGM) is any procedure that removes all or part of the female genital organs for cultural or any other non-therapeutic reasons. FGM is a form of child abuse and gender violence against women. About 137,000 females in England and Wales have undergone it. (Author)

20170822-8*

Undoing female genital cutting: perceptions and experiences of infibulation, defibulation and virginity among Somali and Sudanese migrants in Norway. Johansen RE (2017), Culture, Health & Sexuality vol 19, no 4, April 2017, pp 528-542

This paper explores the dynamics of change in meaning-making about female genital cutting among migrants from Somalia and Sudan residing in Norway. In both countries, female genital cutting is almost universal, and most women are subjected to the most extensive form - infibulation - which entails the physical closure of the vulva. This closure must later be re-opened, or defibulated, to enable sexual intercourse and childbirth. Defibulation can also ease other negative health consequences of the practice. In Norway, surgical defibulation is provided on demand by the public health services, also beyond the traditional contexts of marriage and childbirth. This study explores experiences and perceptions of premarital defibulation. It explores whether Somali and Sudanese men and women understand defibulation as a purely medical issue or whether their use of the services is also affected by the cultural meaning of infibulation. This study analyses data from in-depth interviews with 36 women and men of Somali and Sudanese origin as well as participant observation conducted in various settings during 2014-2015. It reports that although all of the informants displayed negative attitudes towards infibulation, cultural meanings associated with virginity and virtue constitute a significant barrier to the uptake of premarital defibulation. (51 references) (Author)

Full URL: http://www.tandfonline.com/doi/full/10.1080/13691058.2016.1239838?scroll=top&needAccess=true

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20170811-6*

Baseline data from a planned RCT on attitudes to female genital cutting after migration: when are interventions justified?. Wahlberg A, Johnsdotter S, Selling KE, et al (2017), BMJ Open vol 7, no 8, August 2017, e017506

Objectives To present the primary outcomes from a baseline study on attitudes towards female genital cutting (FGC)

after migration.
Design Baseline data from a planned cluster randomised, controlled trial. Face-to-face interviews were used to collect questionnaire data in 2015. Based on our hypothesis that established Somalis could be used as facilitators of change among those newly arrived, data were stratified into years of residency in Sweden.
Setting Sweden.
Participants 372 Somali men and women, 206 newly arrived (0-4 years), 166 established (>4 years).
Primary outcome measures Whether FGC is acceptable, preferred for daughter and should continue, specified on anatomical extent.
Results The support for anatomical change of girls and women's genitals ranged from 0% to 2% among established and from 4% to 8% among newly arrived. Among those supporting no anatomical change, 75%-83% among established and 53%-67% among newly arrived opposed all forms of FGC, with the remaining supporting pricking of the skin with no removal of tissue. Among newly arrived, 37% stated that pricking was acceptable, 39% said they wanted their daughter to be pricked and 26% reported they wanted pricking to continue being practised. Those who had lived in Sweden ≤ 2 years had highest odds of supporting FGC; thereafter, the opposition towards FGC increased over time after migration.
Conclusion A majority of Somali immigrants, including those newly arrived, opposed all forms of FGC with increased opposition over time after migration. The majority of proponents of FGC supported pricking. We argue that it would have been unethical to proceed with the intervention as it, with this baseline, would have been difficult to detect a change in attitudes given that a majority opposed all forms of FGC together with the evidence that a strong attitude change is already happening. Therefore, we decided not to implement the planned intervention. (46 references) (Author)
Full URL: http://bmjopen.bmj.com/content/7/8/e017506

20170804-19*

Slow decline in new FGM cases shows need for more school nurses, says RCN. Anon (2017), Nursing Standard vol 31, no 46, 12 July 2017, p 11

The RCN has responded to the latest national figures on female genital mutilation (FGM), saying more school nurses are needed to tackle the problem. (Author)

20170803-20*

A systematic review of the evidence on clitoral reconstruction after female genital mutilation/cutting. Abdulcadir J, Rodriguez MI, Say L (2015), International Journal of Gynecology & Obstetrics vol 129, no 2, May 2015, pp 93-97

Background
Clitoral reconstruction is a new surgical technique for women who have undergone female genital mutilation/cutting (FGM/C).
Objectives
To review evidence on the safety and efficacy of clitoral reconstruction.
Search strategy
PubMed and Cochrane databases were searched for articles published in any language from database inception until May 2014. Search terms related to FGM/C and clitoral reconstruction were used in various combinations.
Selection criteria
Studies of any design that reported on safety or clinical outcomes (e.g. appearance, pain, sexual response, or patient satisfaction) associated with clitoral reconstruction after FGM/C were included.
Data collection and analysis
Evidence was summarized and systematically assessed via a standard data abstraction form.
Main results
Four of 269 identified articles were included. They were fair to poor in quality. Summary measures could not be computed owing to heterogeneity. The studies reported on immediate surgical complications, clitoral appearance, dyspareunia or chronic pain, and clitoral function postoperatively via non-standardized scales.
Conclusions
Women who request clitoral reconstruction should be informed about the scarcity of evidence available. Additional research is needed on the safety and efficacy of the procedure to identify both long-term outcomes and which women might benefit. (22 references) (Author)

20170803-123#

Female genital mutilation and the role of health-care practitioners. Isaacs D, Tobin B (2017), Journal of Paediatrics and Child Health vol 53, no 6, June 2017, pp 523-524

No abstract available.

20170727-22

The association between economic development, education and FGM in six selected African countries. Rawat R (2017), African Journal of Midwifery and Women's Health vol 11, no 3, July-September 2017, pp 137-146

Background:
The practice of female genital mutilation (FGM) is highly prevalent in countries in African and the Middle East and is present at all levels of society, due to beliefs that it ensures girls' purification for their marriage.
Objective:
To examine the effect of education and economic development on FGM by selected co-variants.
Methods:
Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS) (2010-13) data sets were used. The data used were from six selected African countries: Burkina Faso, Chad, Guinea, Mali, Sierra Leone and Somalia.
Findings:
The prevalence of FGM was significantly higher in Somalia (98.6%), Guinea (97.8%) and Mali (92.6%) in comparison with other selected countries. The results showed that education was statistically significant (168.34; P<0.001) in changing the percentage of FGM practices in the selected countries. The economic status of women was directly associated with mutilation practices, with FGM less likely to be found among higher educated women.
Conclusions:
In these countries, various programmes are run by the government, which have not affected FGM practices, as community beliefs are often stronger than a government programme. It may take a long time for significant decline of FGM, but increasing women's education level may lead to an immediate reduction in prevalence. (Author)

20170714-3*

Female genital mutilation (FGM) enhanced dataset. January 2017 to March 2017, England, experimental statistics. Health and Social Care Information Centre (2017), London: NHS Digital 6 June 2017. 20 pages

The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) supports the Department of Health's FGM Prevention Programme by presenting a national picture of the prevalence of FGM in England, drawing on data collected by a range of healthcare providers including acute hospital providers, mental health providers and GP practices. (Author, edited)

Full URL: http://www.content.digital.nhs.uk/catalogue/PUB24132/fgm-jan-2017-mar-2017-exp-rep.pdf

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20170704-3*

Female genital mutilation (FGM) enhanced dataset. April 2016 to March 2017, England, experimental statistics. Health and Social Care Information Centre (2017), London: NHS Digital 4 July 2017. 42 pages

The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) supports the Department of Health's FGM Prevention Programme by presenting a national picture of the prevalence of FGM in England, drawing on data collected by a range of healthcare providers including acute hospital providers, mental health providers and GP practices. (Author, edited)

Full URL: http://content.digital.nhs.uk/article/7758/Annual-statistical-publication-for-FGM-shows-5391-newly-recorded-cases-during-2016-17

20170616-14*

EBCOG position statement on female genital mutilation. European Board and College of Obstetrics and Gynaecology (EBCOG) (2017), European Journal of Obstetrics & Gynecology and Reproductive Biology vol 214, July 2017, pp 192-193

Female Genital Mutilation (FGM) affects more than 200 million girls and women in at least 30 countries, mostly in Africa, but also in the Middle East and Asia [1]. 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' [2]. Although FGM is traditional in many cultures, it is harmful to women's health and wellbeing. The development of effective strategies to diminish and prevent detrimental procedures is now a public health priority. (5 references) (Author)

20170524-51*

What do we know about assessing healthcare students and professionals' knowledge, attitude and practice regarding female genital mutilation? A systematic review. Abdulcadir J, Say L, Pallitto C (2017), Reproductive Health vol 14, no 64, 22 May 2017

Introduction

Improving healthcare providers' capacities of prevention and treatment of female genital mutilation (FGM) is important given the fact that 200 million women and girls globally are living with FGM. However, training programs are lacking and often not evaluated. Validated and standardized tools to assess providers' knowledge, attitude and practice (KAP) regarding FGM are lacking. Therefore, little evidence exists on the impact of training efforts on healthcare providers' KAP on FGM. The aim of our paper is to systematically review the available published and grey literature on the existing quantitative tools (e.g. scales, questionnaires) measuring healthcare students' and providers' KAP on FGM.

Main body

We systematically reviewed the published and grey literature on any quantitative assessment/measurement/evaluation of KAP of healthcare students and providers about FGM from January 1st, 1995 to July 12th, 2016. Twenty-nine papers met our inclusion criteria. We reviewed 18 full text questionnaires implemented and administered to healthcare professionals (students, nurses, midwives and physicians) in high and low income countries. The questionnaires assessed basic KAP on FGM. Some included personal and cultural beliefs, past clinical experiences, personal awareness of available clinical guidelines and laws, previous training on FGM, training needs, caregiver's confidence in management of women with FGM, communication and personal perceptions. Identified gaps included the medical, psychological or surgical treatments indicated to improve girls and women's health; correct diagnosis, recording ad reporting capacities; clitoral reconstruction and psychosexual care of circumcised women. Cultural and personal beliefs on FGM were investigated only in high prevalence countries. Few questionnaires addressed care of children, child protection strategies, treatment of short-term complications, and prevention.

Conclusion

There is a need for implementation and testing of interventions aimed at improving healthcare professionals' and students' capacities of diagnosis, care and prevention of FGM. Designing tools for measuring the outcomes of such interventions is a critical aspect. A unique, reproducible and standardized questionnaire could be created to measure the effect of a particular training program. Such a tool would also allow comparisons between settings, countries and interventions. An ideal tool would test the clinical capacities of providers in managing complications and communicating with clients with FGM as well as changes in KAP. (Author) [Please note: BMC initially publish articles in a provisional format. If there is a note on the document to indicate that it is still provisional, it may undergo minor changes]

Full URL: https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0318-1

20170519-60*

Knowledge and attitudes toward female genital cutting among West African male immigrants in New York City. Akinsulure-Smith AM, Chu T (2017), Health Care for Women International vol 38, no 5, May 2017, pp 463-477

In this project, we explored knowledge and attitudes toward female genital cutting (FGC) in a survey of 107 West African immigrants, including 36 men. Men in this study were as knowledgeable about the health consequences of FGC as women, though with a less nuanced understanding. They also rejected the practice at rates comparable to women. Despite this knowledge and rejection of FGC, most men did not express a personal preference for women with or without FGC in intimate relationships. Future research and interventions must explore men's opposition to FGC and emphasize the impact of FGC on their partners' gynecological and reproductive health. (59 references) (Author)

20170518-83*

Dismantling the man-made myths upholding female genital mutilation. Jiménez Ruiz I, Almansa Martínez P, Alcón Belchí C (2017), Health Care for Women International vol 38, no 5, May 2017, pp 478-491

Female genital mutilation (FGM) is internationally considered an affront to human rights and an act of violence against women and young girls. Furthermore, it hierarchizes and perpetuates inequality and denies women and girls the right to physical and psychosexual integrity. The aim of this study is to detect the weak points and false premises underlying male justification of FGM and to present demythologization as a health education tool. We used a qualitative methodology with an ethonursing focus via semistructured individual and group interviews in 25 men associated with FGM. Our results found that nine myths and their mythologization are presented through the masculine voices of those associated with this tradition. These myths are used as justification by men and women in

order to uphold the practice of FGM. Demythologization as a nursing intervention based on reorienting or restructuring models of cultural care allows us to work against the false premises making up the myths which act to protect this tradition. (22 references) (Author)

20170515-17*

Mothers' factors associated with female genital mutilation in daughters in the Iraqi Kurdistan Region. Shabila NP (2017), Women and Health vol 57, no 3, March 2017, pp 283-294

An important proactive factor for the continuation of female genital mutilation (FGM) is tradition and customs inherited in the family from mothers to daughters. Therefore, the aim of this study was to determine mothers' factors associated with the occurrence of FGM among their daughters. The datasets from the Iraq Multiple Indicator Cluster Survey 2011, on 5,184 women aged 15 to 49 years having at least one daughter, was used. Multivariate analysis based on a binary logistic regression model was applied. Mothers' age (adjusted odds ratio [aOR] = 8.18 at ages 25-34 years, aOR = 22.64 at ages 35-44 years, and aOR = 29.78 at ages 45-49 years, compared to the age group 15-24 years), educational level (aOR = 0.52 for primary education, aOR = 0.26 for secondary education, and aOR = 0.03 for higher education compared to uneducated), employment status (aOR = 0.55 for women having office work compared with unemployed), FGM status (aOR = 27.44 for circumcised mothers compared to uncircumcised), the governorate of residence (aOR = 18.73 for Suleimaniya and aOR = 33.23 for Erbil compared with Dohuk), and the wealth index of the household (aOR = 0.55 for richest group compared to the poorest) were significantly associated with the occurrence of FGM in daughters. Strategies aimed at preventing this harmful practice in the Iraqi Kurdistan Region should include female education and empowerment. (28 references) (Author)

20170512-1*

Community engagement on female genital mutilation. Local Government Association, Public Health England (2016), London: Local Government Association September 2016

In October 2014, the Local Government Association (LGA) first produced its FGM Guide for Councillors. Much has happened since then. Mandatory reporting to the police has been introduced for professionals, new statutory guidance has been produced and a number of female genital mutilation (FGM) Protection Orders have been taken out to protect actual or potential victims from FGM. Knowledge of the issue has become more widespread, and a series of innovation projects funded by the Department for Education (DfE) have been working on these issues at a local level. The LGA has also been engaged with this work through the creation of the National FGM Centre with Barnardo's. You can find more about the centre's work later on in this document. FGM is still a very real cause of anxiety for a number women and girls in our communities. These case studies provide some examples of how councils and their partners have been working with women and girls to raise awareness of FGM, provide support and protect vulnerable people who may be at risk. (Publisher)

20170505-26*

The mothering experience of women with FGM/C raising 'uncut' daughters, in Ivory Coast and in Canada. Koukoui S, Hassan G, Guzder J (2017), Reproductive Health vol 14, no 51, 5 April 2017

Background

While Female Genital Cutting (FGM/C) is a deeply entrenched cultural practice, there is now mounting evidence for a gradual decline in prevalence in a number of geographical areas in Africa and following migration to non-practicing countries. Consequently, there is now a growing number of women with FGM/C who are raising 'uncut' daughters. This study used a qualitative methodology to investigate the experience of women with FGM/C raising daughters who have not been subjected to the ritual. The aim of this study was to shed light on mothers' perception of the meaning and cultural significance of the practice and to gain insight into their mothering experience of 'uncut' girls.

Methods

To this end, in-depth interviews were conducted with fifteen mothers living in Abidjan, Ivory Coast and in Montreal, Canada (8 and 7, respectively).

Results

Thirteen mothers intrinsically refused to perpetuate FGM/C onto their daughters and two diasporic mothers were in favour of FGM/C but forewent the practice for fear of legal repercussions. Whether the eschewing of FGM/C was deliberate or legally imposed, raising 'uncut' daughters had significant consequences in terms of women's mothering experiences. Mothers faced specific challenges pertaining to community and family pressure to have daughters undergo FGM/C, and expressed concerns regarding their daughters' sexuality. Conversely, women's narratives were also infused with pride and hope for their daughters, and revealed an accrued dialogue between the

mother-daughter dyad about cultural norms and sexuality. Interestingly, women's mothering experience was also bolstered by the existence of informal networks of support between mothers with FGM/C whose daughters were 'uncut'. These communities of mothers engaged in open dialogue about the consequences of FGM/C and offered reciprocal solidarity and support in their decision to forego FGM/C for their children.
Conclusion
Women with FGM/C who are raising 'uncut' daughters in their homeland and in their country of immigration vastly report a positive experience. However, they also face specific challenges related to immigration, psychosocial, and psychosexual considerations, which must be tackled from a multidisciplinary perspective. (Author) [Please note: BMC initially publish articles in a provisional format. If there is a note on the document to indicate that it is still provisional, it may undergo minor changes]
Full URL: https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0309-2

20170504-28*

Voices Over Silence: a youth call to action on FGM. Welsh Government (2016), Welsh Government 13 September 2016

Short film which raises awareness of, and fights for cultural change on Female Genital Mutilation (FGM) in Wales by capturing young people's voices and views on this issue to support intergenerational conversations within a range of different communities and contexts. (Author, edited)
Full URL: https://www.youtube.com/watch?v=xqghjGBfB54

20170407-16*

In Kenya, a mother leads the movement to stop FGM in her community. Serem D (2017), New York: Unicef 9 February 2017

Reports how a young mother of five children, a member of the Massai community in Kenya, is refusing to allow her daughters to undergo the traditional practice of female genital mutilation, prevalent in her community, because of the painful experiences and outcomes she encountered when she was circumcised at the age of thirteen. Includes comments from a religious leader in north-eastern Kenya who denouces FGM, believing it to be contrary to the teachings of his faith. (JSM)
Full URL: https://www.unicef.org/infobycountry/kenya_94722.html?utm_source=unicef_news&utm_medium=rss&utm_campaign=rss_link

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20170407-11*

Women's right to receive safe and timely healthcare the focus of RCOG World Congress 2017. Royal College of Obstetricians and Gynaecologists (2017), London: RCOG 6 April 2017

Reports on the Royal College of Obstetricians and Gynaecologists' World Congress, which was held in Cape Town, South Africa, from the 20th-22nd March 2017. Issues discussed included: developing the World Health Organization's Safe Childbirth Checklist; mobile health solutions for reducing infant mortality in developing countries; female genital mutilation and the changes in law in the UK; and the changing impact of HIV on women and children in Africa. (JSM)
Full URL: https://www.rcog.org.uk/en/news/womens-right-to-receive-safe-and-timely-healthcare-the-focus-of-rcog-world-congress-2017/

20170330-92*

Intersexuality and the 'right to bodily integrity': critical reflections on female genital cutting, circumcision, and intersex 'normalizing surgeries' in Europe. Ammaturo FR (2016), Social and Legal Studies vol 25, no 5, October 2016, pp 591-610

In 2013, the Parliamentary Assembly of the Council of Europe passed a resolution on 'children's right to bodily integrity'. In the resolution, concerns were expressed for about practices carried out on children without their formal consent. Among these practices, female genital cutting (FGC), non-medical circumcision and 'normalizing' surgeries for intersex children were listed among these practices. As a result of the adoption of the resolution elicited, strong reactions, ensued especially from Jewish and Muslim communities, which widely practices male circumcision. Simultaneously, however, intersex activists welcomed the resolution, as it gave legitimacy to their long-standing call to establish a common framework for the evaluation of all invasive medical and surgical practices on children carried out without their informed consent (Preves, 2005). This article uses an examination of the resolution to reflect on both the emerging concept of the 'right to bodily integrity' and on current developments in the field of intersex human rights in Europe. Firstly, the article considers the political process leading to the adoption of the resolution, in order to understand and appraise the limitations of the choice to use the framework of the right to bodily integrity to jointly address jointly issues of FGC, circumcision and intersex 'normalizing surgeries' jointly,

without fully engaging with the cultural, religious and social factors underpinning each of these phenomena. Following this discussion, the article will further analyses the specific case of intersex rights, particularly in relation to the difficult balance between a medical and the juridical approach to intersexuality. This reflection will ultimately be useful to assess the role of the resolution in helping to subtract intersexuality from the sole gaze of medical practitioners at the advantage of a human rights approach which may best protect the interests of intersex children and adults. (Author)

20170330-64*

Episiotomy and obstetric outcomes among women living with type 3 female genital mutilation: a secondary analysis.
Rodriguez MI, Seuc A, Say L, et al (2016), Reproductive Health vol 13, no 131, October 2016

Background

To investigate the association between type of episiotomy and obstetric outcomes among 6,187 women with type 3 Female Genital Mutilation (FGM).

Methods

We conducted a secondary analysis of women presenting in labor to 28 obstetric centres in Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan between November 2001 and March 2003. Data were analysed using cross tabulations and multivariable logistic regression to determine if type of episiotomy by FGM classification had a significant impact on key maternal outcomes. Our main outcome measures were anal sphincter tears, intrapartum blood loss requiring an intervention, and postpartum haemorrhage.

Results

Type of episiotomy performed varied significantly by FGM status. Among women without FGM, the most common type of episiotomy performed was posterior lateral (25.4 %). The prevalence of the most extensive type of episiotomy, anterior and posterior lateral episiotomy increased with type of FGM. Among women without FGM, 0.4 % had this type of episiotomy. This increased to 0.6 % for women with FGM Types 1, 2 or 4 and to 54.6 % of all women delivering vaginally with FGM Type 3. After adjustment, women with an anterior episiotomy, (AOR = 0.15 95 %; CI 0.06-0.40); posterior lateral episiotomy (AOR = 0.68 95 %; CI 0.50-0.94) or both anterior and posterior lateral episiotomies performed concurrently (AOR = 0.21 95 % CI 0.12-0.36) were all significantly less likely to have anal sphincter tears compared to women without episiotomies. Women with anterior episiotomy (AOR = 0.08; 95%CI 0.02-0.24), posterior lateral episiotomy (AOR = 0.17 95 %; CI 0.05-0.52) and the combination of the two (AOR = 0.04 95 % CI 0.01-0.11) were significantly less likely to have postpartum haemorrhage compared with women who had no episiotomy.

Conclusions

Among women living with FGM Type 3, episiotomies were protective against anal sphincter tears and postpartum haemorrhage. Further clinical and research is needed to guide clinical practice of when episiotomies should be performed. (19 references) (Author)

Full URL: https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-016-0242-9

20170324-102*

Australian midwives' perspectives on managing obstetric care of women living with female genital circumcision/mutilation. Ogunsiji O (2016), Health Care for Women International vol 37, no 10, 2016, pp 1156-1169

Female genital mutilation (FGM) or female circumcision is a global health issue with increasing international migration of affected women and girls to countries unfamiliar with the practice. Western health care providers are unfamiliar with FGM, and managing obstetric care presents challenges to midwives who are in the forefront of care provision for the women. The participants in this Heideggerian qualitative interpretive study elucidated the strategies they used in overcoming the particular physical, emotional, and gynecological health issues with which mutilated women present. Ongoing emphases on women-centered, culturally competent maternity care are germane to optimal maternity care of circumcised women. (29 references) (Author)

20170315-79*

Fighting to combat FGM. Cordova S (2016), Nursing Times 23 June 2016

Joanne McEwan plays many roles in her daily life - nurse, mother, and health visitor in the community of Oxfordshire, to name a few. Her schedule is already full, but that hasn't stopped her from adding yet another title to the list: app developer, for an app that will help women who have been affected by female genital mutilation, or FGM. (Author)

Full URL: https://www.nursingtimes.net/break-time/role-models/fighting-to-combat-fgm/7005743.article

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20170308-62*

Female genital mutilation (FGM) - October 2016 to December 2016, experimental statistics report. NHS Digital (2017), London: HSCIC 7 March 2017. 19 pages

Presents the official figures providing experimental statistics on female genital mutilation (FGM) in England, from October 2016 to December 2016. Statistical tables to accompany this report can be found at: http://www.content.digital.nhs.uk/catalogue/PUB23494 (Publisher, edited)

Full URL: http://www.content.digital.nhs.uk/catalogue/PUB23494/fgm-oct-2016-dec-2016-exp-rep.pdf

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20170307-26*

Effects of female genital mutilation/cutting on the sexual function of Sudanese women: A cross-sectional study. Rouzi AA, Berg RC, Sahly N, et al (2017), American Journal of Obstetrics & Gynecology (AJOG) vol 217, no 1, pp 62.e1-62.e6

Background

Female Genital Mutilation/Cutting (FGM/C) is a cultural practice that involves several types of removal or other injury to the external female genitalia for non-medical reasons. While much international research has focused on the health consequences of the practice, little is known about sexual functioning among women with various types of FGM/C.

Objective(s)

To assess the impact of FGM/C on the sexual functioning of Sudanese women.

Study Design

This is a cross-sectional study conducted at Doctor Erfan and Bagedo Hospital, Jeddah, Saudi Arabia. Eligible women completed a survey and a clinical examination, which documented and verified women's type of FGM/C. The main outcome measure was female sexual function, as assessed by the Arabic Female Sexual Function Index (ArFSFI).

Results

107 eligible women completed the survey and the gynecological exam, which revealed that 39% of the women had FGM/C type I, 25% had type II, and 36% had type III. Reliability of self-report of the type of FGM/C was low, with underreporting of the extent of the procedure. The results showed that 92.5% of the women scored lower than the ArFSFI cut-off point for sexual dysfunction. The multivariable regression analyses showed that sexual dysfunction was significantly greater with more extensive type of FGM/C, across all sexual function domains (desire, arousal, lubrication, orgasm, satisfaction, and pain) and overall.

Conclusion(s)

The study documents that a substantial proportion of women subjected to FGM/C experience sexual dysfunction. It shows that the anatomical extent of FGM/C is related to the severity of sexual dysfunction. (Author)

20170223-87*

Female genital mutilation: Survey of paediatricians' knowledge, attitudes and practice. Sureshkumar P, Zurynski Y, Moloney S, et al (2016), Child Abuse & Neglect vol 55, May 2016, pp 1-0

The study objective was to determine paediatricians' experience with female genital mutilation (FGM) in Australian children and adolescents. A cross-sectional, pilot-tested national survey of paediatricians practising in Australia and contributing to the Australian Paediatric Surveillance Unit was conducted. Clinicians' knowledge, attitudes and clinical experience with FGM, awareness of clinical guidelines and education/training needs were recorded. Of 1311 paediatricians surveyed, 497 (38%) responded. Fifty-seven percent were aged 50 years or more, and 51.3% were males. Over half believed that FGM was performed in children in Australia and most were aware of its complications, but few asked about or examined for FGM. Fifty (10.3%) had seen at least one case of FGM in girls aged <18 years during their clinical career, including 16 (3.3%) in the past 5 years. Most were aware that FGM is illegal in Australia (93.9%), agreed all types of FGM were harmful (97.4%) and agreed that FGM violated human rights (98.2%). Most (87.6%) perceived FGM as a traditional cultural practice, although 11.6% thought it was required by religion. The majority (81.8%) knew notification of FGM to child protection authorities was mandatory. Over half (62.0%) were aware of the WHO Statement on FGM, but only 22.0% knew the WHO classification of FGM. These novel data indicate a minority of paediatricians in Australia have clinical experience with or education about FGM. Educational programs, best-practice clinical guidelines and policies are required to address knowledge gaps and help paediatricians identify, manage and prevent FGM in children. (Author)

20170217-34*

The Government response to the ninth report from the Home Affairs Select Committee session 2016-17 HC 390: Female genital mutilation: abuse unchecked. Presented to Parliament by the Secretary of State for the Home

Department by Command of Her Majesty. December 2016. Home Office: FGM Unit (2016), London: Home Office December 2016. 24 pages.

Research report presented to Parliament by the Secretary of State for the Home Department. Outlines twelve conclusions and recommendations in response to the Home Affairs Select Committee's report on female genital mutilation (FGM) and includes each government reply. Conclusions examine areas including instigating a single system for reporting individual cases, safeguarding issues, teaching children about FGM in high risk areas in schools, and recommendations include strengthening links with police and border control in the UK and overseas, and considering additional legislative measures, (AB)

Full URL: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/573777/57751_Cm_9375_FGM_print.pdf

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20170209-91

Stop cutting: the right to bodily integrity. Beal J (2016), Midwifery Today no 120, Winter 2016, pp 38-39

Outlines the different types of female genital mutilation and suggests that the harmful practice can be ended through education and the formation of partnerships between women and their families, local leaders, law enforcement and policy makers. (MB)

20170203-16*

Female genital mutilation among mothers and daughters in Harar, eastern Ethiopia. OljiraT, Assefa N, Dessie Y (2016), International Journal of Gynecology & Obstetrics vol 135, no 3, December 2016, pp 304-309

Objective

To assess the practice of female genital mutilation (FGM) among mothers and daughters, and to investigate sociodemographic factors influencing the practice of FGM in Harar, Ethiopia.

Methods

A community-based cross-sectional study was conducted among women aged 15 years or older who had at least one living daughter younger than 12 years via the Harar Health and Demographic Surveillance System 2013. Data were collected through face-to-face interviews. The practice of FGM was compared between mothers and their daughters. Whether the daughter had undergone FGM was included as an outcome variable in bivariate and multivariate analyses.

Results

Among 842 mothers, 669 (79.5%) reported that they had undergone FGM themselves, and 160 (19.0%) that their daughter had undergone FGM. Traditional practitioners were said to be the major performers of FGM by 151 (94.4%) mothers. Mothers whose daughter was mutilated mentioned social acceptance (144 [90.0%] women) and better marriage prospects (96 [60.0%]) as the major benefits. Genital mutilation of daughters was significantly associated with maternal age, education to grade 1-4, and FGM experience. Amhara ethnic origin was significantly associated with a reduced likelihood of FGM among daughters.

Conclusion

Over one generation, the incidence of FGM has reduced. Increasing advocacy against FGM and enforcement of law should be emphasized. (Author)

20170111-17*

Female genital mutilation: what do we know so far?. Siddiq I (2016), British Journal of Nursing vol 25, no 16, 8 September 2016, pp 912-916

Female genital mutilation (FGM) is a practice that is now familiar to UK health professionals. It continues to be a problem in high-risk populations and affects girls and women throughout their lives. Complications related to FGM are poorly reported and documented. Health professionals, therefore, must be aware of the adverse effects and how they affect obstetric, gynaecological and sexual function and general quality of life. They must also be sensitive towards the psychological and emotional issues relating to FGM. Sociocultural barriers make research and data-collection difficult in a cohort of women who prefer not to discuss or disclose such intimate issues. New guidelines on the management of health consequences in FGM have been published, but evidence is of poor quality. (Author)

20170111-16*

Intermittent self-catheterisation for urolgical problems caused by FGM. Duncan D (2016), British Journal of Nursing vol 25, no 18, 13 October 2016, pp S26-S31

This is the fourth and final article in a series on female genital mutilation (FGM). It describes the complications of FGM,

with a focus on the urinary ones. FGM refers to all procedures that involve partial or total removal of the external female genitalia and/or damage to other female genital organs for non-medical reasons. The World Health Organization (WHO) has classified FGM into four types (1-4). Women who have type 3 commonly experience long-term complications of their urological tract. The first-line treatment for type 3 FGM involves surgical defibulation, but this is not always successful and women can be left with neurogenic bladder dysfunction and urethral stricture disease. Intermittent self-catheterisation (ISC) enables these women to have control of their bladder function. (Author)

20170111-14*

Female genital mutilation: a urology focus. Clarke E (2016), British Journal of Nursing vol 25, no 18, 13 October 2016, pp 1022-1028

Female genital mutilation (FGM) is a collective term for the deliberate alteration, removal and cutting of the female genitalia. It has no known health benefits and can have negative physical and psychological consequences. The number of women and girls in the UK that are affected by FGM is unknown. Recent NHS data suggested that FGM has been evident (declared or observed) in women who have accessed health care; however, there are gaps in knowledge and a limited evidence base on the health consequences of FGM. This article explores the urological complications experienced by women who have undergone this practice, and the effects this can have on their health and wellbeing. (Author)

20170111-10*

Female genital mutilation and pregnancy: associated risks. Gayle C, Rymer J (2016), British Journal of Nursing vol 25, no 17, 22 September 2016, pp 978-983

Female genital mutilation (FGM) is a traditional practice that has no medical benefit and severe health consequences for girls and women. This article discusses the risks to patients who are pregnant and have had FGM. It will describe urinary tract infections caused by FGM, and how this condition increases the risk of preterm labour and delivery. It will also address the difficulty in vaginal examinations that can be caused by FGM and instances when this can delay diagnosis and treatment. In addition, it will explore a number of intrapartum risks caused by FGM and the role of deinfibulation in pregnancy. Finally, it will look at the link between maternal and fetal morbidity and mortality, and FGM. (Author)

20170109-53*

Health education and clinical care of immigrant women with female genital mutilation/cutting who request postpartum reinfibulation. Abdulcadir J, McLaren S, Boulvain M, et al (2017), International Journal of Gynecology & Obstetrics vol 73, no 1, January 2017, pp 69-72

Objective

To evaluate the percentage of women with female genital mutilation/cutting who request postpartum reinfibulation, and to assess outcomes after specific care and counseling.

Methods

A retrospective review was undertaken of consecutive medical files of immigrant women with FGM/C who attended a center in Geneva, Switzerland, between April 1, 2010, and January 8, 2014. The number of postpartum reinfibulation requests and outcomes were assessed. If a patient requests postpartum reinfibulation despite receiving detailed information and counseling, a longer follow-up is arranged for further counseling.

Results

Among 196 women with FGM/C, 8 (4.1%) requested postpartum reinfibulation. All eight were of East African origin, had FGM/C type III, and received a longer and more targeted follow-up than did those who did not request reinfibulation. After at least 1 year of follow-up, none of the eight was willing to undergo reinfibulation. One woman who attended the clinic only once during her first pregnancy consulted the emergency ward of the study center 3 years later because of postcoital bleeding following infibulation performed in her home country a few months after her second delivery in Switzerland.

Conclusion

Specific care and counseling for women with FGM/C type III can improve the acceptability of defibulation without reinfibulation. (Author)

20170105-56*

Attitude toward female genital mutilation among Somali and Harari people, Eastern Ethiopia. Abathun AD, Sundby J, Gele

AA (2016), International Journal of Women's Health vol 8, 6 October 2016, pp 557-569

Background: Female genital mutilation (FGM) is a worldwide problem, and it is practiced by many communities in Africa and Asia as well as immigrants from those areas. This practice results in short- and long-term health consequences on women's health. Like many other developing countries, FGM is widely practiced in Ethiopia, especially among Somali and Harari ethnic groups. Despite intensive campaigns against FGM in Ethiopia, since 2011, it has been practiced in the aforementioned communities. There is no recent information as to whether these campaigns have an impact on the attitude and practice of the community regarding FGM. This qualitative research was aimed at exploring the attitudes of Somali and Harari people between 18 and 65 years toward FGM.
Methods: A purposive sampling technique was used to recruit 64 (32 in each region) participants. Data were collected from October to December 2015 in Somali and Harari Regions.
Results: The findings showed that there was a strong support for the continuation of the practice among female discussants in Somali region, whereas male discussants from the same region and the majority of the participants from Harari region had a positive attitude toward the discontinuation of the practice. Marriageability was the major reason for practicing FGM in Somali region, whereas making girls calm, sexually inactive, and faithful for their husbands were mentioned in Harari region. Although young men in both the regions prefer to marry uncircumcised girls, the study showed that there are some differences in the attitude toward the FGM practice between the people in the two regions.
Conclusion: The findings show that there is an attitudinal difference between the people in the two regions, which calls for behavioral change communication using women-centered approach and culturally appropriate strategies. As young people in both the regions had the intention to marry uncircumcised girls, there has to be a strong advocacy and multisectoral collaboration to stop FGM in both the regions. (54 references) (Author) [Full article available online at: https://www.dovepress.com/attitude-toward-female-genital-mutilation-among-somali-and-harari-peop-peer-revie wed-fulltext-article-IJWH]

Full URL: https://www.dovepress.com/attitude-toward-female-genital-mutilation-among-somali-and-harari-peop-peer-reviewed-fulltext-article-IJWH

20161219-12*

Charity warns of FGM 'parties' taking place in England. Rhodes D (2016), BBC News 13 December 2016

News item reporting that a Leeds-based charity has warned that female genital mutilation (FGM) 'parties' are taking place in cities across England. The Black Health Initiative has said that they have been made aware of numerous FGM parties, with midwives being flown in from Africa to carry out the procedure. FGM is illegal in the UK and carries a sentence of up to 14 years in prison, however no one in the UK had ever been successfully prosecuted for a FGM offence. (CI)

Full URL: http://www.bbc.co.uk/news/uk-england-38290888

20161206-9*

Female genital mutilation (FGM) enhanced dataset, data quality statement [July -September 2016]. NHS Digital (2016), London: HSCIC 6 December 2016. 9 pages

Presents the sixth quarterly report on female genital mutilation (FGM) from the FGM Enhanced Dataset. (Publisher, edited)

20161206-7*

Female genital mutilation (FGM): July 2016 - September 2016. CCG report. NHS Digital (2016), London: HSCIC 6 December 2016

These tables are an accompaniment to Female genital mutilation (FGM): July 2016 - September 2016, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/574943/fgm-jul-2016-sep-2016-exp -rep.pdf

Full URL: https://www.gov.uk/government/statistics/female-genital-mutilation-july-to-sept-2016-enhanced-data-set

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20161206-6*

Female genital mutilation (FGM) enhanced dataset July 2016 to September 2016, England, experimental statistics. NHS Digital (2016), London: HSCIC 6 December 2016. 19 pages

Presents the official figures providing experimental statistics on female genital mutilation (FGM) in England, from July 2016 to September 2016. Statistical tables to accompany this report can be found at: https://www.gov.uk/government/statistics/female-genital-mutilation-july-to-sept-2016-enhanced-data-set

(Publisher, edited)

20161206-14*

Female Genital Mutilation (FGM): July 2016 - September 2016 Local authority report. NHS Digital (2016), London: HSCIC 6 December 2016.

These tables accompany the publication 'Female genital mutilation (FGM) - July 2016 - September 2016'. Available from: http://www.digital.nhs.uk/fgm

Full URL: https://www.gov.uk/government/statistics/female-genital-mutilation-july-to-sept-2016-enhanced-data-set

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20161130-78

Girls matter: tackling female genital mutilation in Nigeria. Momoh C (2016), African Journal of Midwifery and Women's Health vol 10, no 3, July-September 2016, p 113

Dr Comfort Momoh talks about the role she has played in integrating screening for female genital mutilation (FGM) in the United Kingdom and discusses her intention to facilitate attitudinal change in Nigeria.(MB)

20161129-58*

Obstetric care of women with female genital mutilation attending a specialized clinic in a tertiary center. Abdulcadir J, Dugerdil A, Yaron M, et al (2016), International Journal of Gynecology & Obstetrics vol 132, no 2, February 2016, pp 174-178

Objective

To study the obstetric outcomes of women attending a specialized clinic for women with female genital mutilation (FGM).

Methods

The medical charts of women with FGM who consecutively attended a specialized clinic between 2010 and 2012 were reviewed retrospectively. The present study focused on women attending for obstetric reasons. The outcome measures were type of delivery, reason for cesarean delivery or assisted delivery, blood loss, episiotomy, perineal tear, duration of the second stage of labor, postpartum complications, weight of the neonate, and Apgar score. Outcomes were compared between women with FGM type III who underwent defibulation, and patients with FGM type I and II.

Results

The clinic was attended by 129 women, 84 perinatally. Obstetric outcomes were similar to average outcomes for women without FGM presenting at the same department and in Switzerland generally. Specifically, 20 women had a cesarean delivery. An assisted delivery was performed for 18 patients; among these, only eight had experienced obstructed labor. No statistically significant differences were found for the outcome measures when women with FGM type III were compared to FGM type I and II.

Conclusions

Routine obstetric follow-up combined with specialized care for women with FGM, including defibulation, can avoid inappropriate obstetric practices and reduce obstetric complications known to be associated with FGM. (24 references) (Author)

20161128-2*

Female genital alteration: a compromise solution. Arora KS, Jacobs AJ (2016), Journal of Medical Ethics vol 42, no 3, March 2016, pp 148-154

Despite 30 years of advocacy, the prevalence of non-therapeutic female genital alteration (FGA) in minors is stable in many countries. Educational efforts have minimally changed the prevalence of this procedure in regions where it has been widely practiced. In order to better protect female children from the serious and long-term harms of some types of non-therapeutic FGA, we must adopt a more nuanced position that acknowledges a wide spectrum of procedures that alter female genitalia. We offer a revised categorisation for non-therapeutic FGA that groups procedures by effect and not by process. Acceptance of de minimis procedures that generally do not carry long-term medical risks is culturally sensitive, does not discriminate on the basis of gender, and does not violate human rights. More morbid procedures should not be performed. However, accepting de minimis non-therapeutic f FGA procedures enhances the effort of compassionate practitioners searching for a compromise position that respects cultural differences but protects the health of their patients. (51 references) (Author)

Full URL: http://jme.bmj.com/content/early/2016/02/21/medethics-2014-102375.full

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20161128-11*

Multidisciplinary approach to the management of children with female genital mutilation (FGM) or suspected FGM: service description and case series. Creighton SM, Dear J, de Campos C, et al (2016), BMJ Open vol 6, no 2, February 2016,

Objective To describe the first dedicated clinic in the UK for children with suspected or confirmed female genital mutilation (FGM) including referral patterns, clinical findings and subsequent management.

Design and setting A prospective study of all children seen in a dedicated multidisciplinary FGM clinic for children over a 1-year period.

Population Patients aged under 18 years referred for clinical assessment or for a second opinion on Digital Versatile Disc (DVD) images.

Methods and main outcome measures Data were collected on reasons for referral, demography, genital examination findings including FGM type, and clinical recommendations.

Results 38 children were referred of whom 18 (47%) had confirmed FGM; most frequently type 4 (61%). Social care and police referred 78% of cases. According to UK law FGM had been performed illegally in three cases. Anonymous information given to the police led to the referral of six children, none of whom had had FGM.

Conclusions Mandatory reporting and increased media attention may increase the numbers of referrals of children with suspected FGM. This patient group have complex needs and management in a dedicated multidisciplinary service is essential. Paediatricians and gynaecologists should have the skills to carry out the consultation and detect all types of FGM including type 4 which was the most common type seen in this series. This is the first dedicated FGM service for children in the UK and similar clinics in high-prevalence areas should be established. (17 references) (Author) [The full version of this article is available free of charge at: http://bmjopen.bmj.com/content/6/2/e010311.long]

Full URL: http://bmjopen.bmj.com/content/6/2/e010311.long

20161109-38*

Obstetric outcomes for women with female genital mutilation at an Australian hospital, 2006-2012: a descriptive study. Varol N, Dawson A, Turkmani S, et al (2016), BMC Pregnancy and Childbirth vol 16, no 328, 28 October 2016

Background

Women, who have been subjected to female genital mutilation (FGM), can suffer serious and irreversible physical, psychological and psychosexual complications. They have more adverse obstetric outcomes as compared to women without FGM. Exploratory studies suggest radical change to abandonment of FGM by communities after migration to countries where FGM is not prevalent. Women who had been subjected to FGM as a child in their countries of origin, require specialised healthcare to reduce complications and further suffering. Our study compared obstetric outcomes in women with FGM to women without FGM who gave birth in a metropolitan Australian hospital with expertise in holistic FGM management.

Methods

The obstetric outcomes of one hundred and ninety-six women with FGM who gave birth between 2006 and 2012 at a metropolitan Australian hospital were analysed. Comparison was made with 8852 women without FGM who gave birth during the same time period. Data were extracted from a database specifically designed for women with FGM and managed by midwives specialised in care of these women, and a routine obstetric database, ObstetriX. The accuracy of data collection on FGM was determined by comparing these two databases. All women with FGM type 3 were deinfibulated antenatally or during labour. The outcome measures were (1) maternal: accuracy and grade of FGM classification, caesarean section, instrumental birth, episiotomy, genital tract trauma, postpartum blood loss of more than 500 ml; and (2) neonatal: low birth weight, admission to a special care nursery, stillbirth.

Results

The prevalence of FGM in women who gave birth at the metropolitan hospital was 2 to 3 %. Women with FGM had similar obstetric outcomes to women without FGM, except for statistically significant higher risk of first and second degree perineal tears, and caesarean section. However, none of the caesarean sections were performed for FGM indications. The ObstetriX database was only 35 % accurate in recording the correct FGM type.

Conclusion

Women with FGM had similar obstetric outcomes to women without FGM in an Australian metropolitan hospital with expertise in FGM management. Specialised FGM services with clinical practice guideline and education of healthcare professionals may increase the detection rate of FGM and improve obstetric management of women with FGM. (36 references) (Author) [Please note: BMC initially publish articles in a provisional format. If there is a note on the document to indicate that it is still provisional, it may undergo minor changes] [The full version of this article is available free of charge at: https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-1123-5]

Full URL: https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-1123-5

20161017-35*

Female Genital Mutilation: A Visual Reference and Learning Tool for Health Care Professionals. Abdulcadir J, Catania L, Hindin MJ, et al (2016), Obstetrics & Gynecology vol 128, no 5, November 2016, pp 958-963

Female genital mutilation comprises all procedures that involve partial or total removal of the external female genitalia or injury to the female genital organs for nonmedical reasons. Health care providers for women and girls living with female genital mutilation have reported difficulties in recognizing, classifying, and recording female genital mutilation, which can adversely affect treatment of complications and discussions of the prevention of the practice in future generations. According to the World Health Organization, female genital mutilation is classified into four types, subdivided into subtypes. An agreed-upon classification of female genital mutilation is important for clinical practice, management, recording, and reporting, as well as for research on prevalence, trends, and consequences of female genital mutilation. We provide a visual reference and learning tool for health care professionals. The tool can be consulted by caregivers when unsure on the type of female genital mutilation diagnosed and used for training and surveys for monitoring the prevalence of female genital mutilation types and subtypes.

(Author)

Full URL: http://journals.lww.com/greenjournal/Abstract/publishahead/Female_Genital_Mutilation__A_Visual_Reference_and.98600.aspx

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20161005-40

Female genital mutilation: an 'old' problem with no place in a modern world. Clarke E, Richens Y (2016), Acta Obstetricia et Gynecologica Scandinavica vol 95, no 10, October 2016, pp1193-1195

Representatives from the FGM National Clinical Group, UK, give an overview of the practice of FGM worldwide. Describes the various historical attempts from government and health bodies to eradicate the practice and considers the current strategy. Includes a fact sheet and supporting information. (15 references) (TC)

20160928-41

Female genital mutilation/cutting among women of Somali and Kurdish origin in Finland. Koukkula M, Keskimäki I, Koponen P, et al (2016), Birth vol 43, no 3, September 2016, pp 240-246

Background

The tradition of female genital mutilation/cutting (FGM/C) has spread in Europe as a result of immigration. Although it is known to have negative health impacts, the exact prevalence of FGM/C and its health effects in Finland are unknown. This study explores the prevalence of FGM/C, the sociodemographic characteristics associated with it, and its health effects among women of Somali and Kurdish origin in Finland.

Methods

Data were obtained from the Migrant Health and Well Being Study carried out in 2010-2012. This study uses data from interviews with Somali (N = 165) and Kurdish origin (N = 224) women. The participation rate was 37 percent for Somali and 54 percent for Kurdish origin women.

Results

The prevalence of FGM/C was 69 percent among those of Somali origin and 32 percent among those of Kurdish origin. Having no education and older age were significantly associated with FGM/C, as was marriage amongst women of Somali origin, and the practice of Islam among women of Kurdish origin. Reporting good self-perceived health was more common among women without FGM/C. Outpatient visits to medical doctors were less common among women of Somali origin with FGM/C, compared with women without FGM/C. About 26 percent of Somali origin and 39 percent of Kurdish origin women with FGM/C reported reproductive or other health problems because of FGM/C.

Discussion

FGM/C is more common in Finland than previously assumed, particularly among women of Kurdish origin. Women with FGM/C need improved access to culturally competent health services to address the health impacts of FGM/C. Education and outreach to immigrant communities to prevent future FGM/C are also urgently needed. (28 references) (Author)

20160916-5

Caring for women affected by FGM. Jones M, Johns H (2016), Australian Midwifery News vol 16, no 1, Autumn 2016, pp 20-21

Provides an introduction to female genital mutilation (FGM), including its definition, and short and long term physical and psychological consequences, with a history of the Royal Women's Hospital in Melbourne's care provision for

women affected by FGM. Among the services offered at the hospital is the African Women's Clinic, which has been operating since 2010, offering deinfibulation, and information about FGM to empower women and strengthen them to discuss the subject in their own communities. The article gives an overview of clinical assessment in cases of FGM, and how practitioners communicate with patients. (KRB)

20160913-48*

Is female circumcision evolving or dissolving in Norway? A qualitative study on attitudes toward the practice among young Somalis in the Oslo area. Gele AA, Sagbakken M, Kumar BN (2015), International Journal of Women's Health vol 7, 26 November 2015, pp 933-943

Abstract: Female genital mutilation or female circumcision (FC) is increasingly visible on the global health and development agenda - both as a matter of social justice and equality for women and as a research priority. Norway is one of the global nations hosting a large number of immigrants from FC-practicing countries, the majority from Somalia. To help counteract this practice, Norway has adopted a multifaceted policy approach that employs one of the toughest measures against FC in the world. However, little is known about the impact of Norway's approach on the attitudes toward the practice among traditional FC-practicing communities in Norway. Against this background, this qualitative study explores the attitudes toward FC among young Somalis between the ages of 16 to 22 living in the Oslo and Akershus regions of Norway. Findings indicate that young Somalis in the Oslo area have, to a large extent, changed their attitude toward the practice. This was shown by the participants' support and sympathy toward criminalization of FC in Norway, which they believed was an important step toward saving young girls from the harmful consequences of FC. Most of the uncircumcised girls see their uncircumcised status as being normal, whereas they see circumcised girls as survivors of violence and injustice. Moreover, the fact that male participants prefer a marriage to uncircumcised girls is a strong condition for change, since if uncut girls are seen as marriageable then parents are unlikely to want to circumcise them. As newly arrived immigrants continue to have positive attitudes toward the practice, knowledge of FC should be integrated into introduction program classes that immigrants attend shortly after their residence permit is granted. This study adds to the knowledge of the process of the abandonment of FC among immigrants in Western countries. (36 references) (Author) [Full article available online at: https://www.dovepress.com/is-female-circumcision-evolving-or-dissolving-in-norway-a-qualitative--peer-reviewed-fulltext-article-IJWH]

Full URL: https://www.dovepress.com/is-female-circumcision-evolving-or-dissolving-in-norway-a-qualitative--peer-reviewed-fulltext-article-IJWH

20160912-24*

Female genital mutilation (FGM) enhanced dataset April 2016 to June 2016, England, experimental statistics. NHS Digital (2016), London: Health and Social Care Information Centre 6 September 2016. 18 pages

Provides information and statistics on the number of cases recorded at NHS Trusts or GP practices during April and June 2016, where female genital mutilation (FGM) was identified or a procedure for FGM was undertaken. Presents data in a number of formats, including by region of England, type of FGM, age group, country of birth, and country where the FGM was undertaken. (JSM)

20160823-36

'We've come so far but there is still more to be done to eradicate FGM'. Bhardwa S (2016), British Journal of Midwifery vol 24, no 8, August 2016, p 547

In celebration of the second anniversary of the Girl Summit, a new short film dispelling the myths around female genital mutilation was shown at a parliamentary reception in July. (Author)

20160816-75*

Attitudes to female genital mutilation/cutting among male adolescents in Ilorin, Nigeria. Adeniran AS, Ijaiya MA, Fawole AA, et al (2016), South African Medical Journal (SAMJ) vol 106, no 8, 2016, pp 822-823

Background. The central role of males in female reproductive health issues in patriarchal societies makes them an important group in the eradication of female genital mutilation/cutting (FGM/C).

Objective. To determine knowledge about and attitudes to FGM/C among male adolescents, and their preparedness to protect their future daughters from it.

Methods. A cross-sectional survey among male adolescent students in Ilorin, Nigeria. Participants completed a self-administered questionnaire after consent had been obtained from them or their parents. Statistical analysis was with SPSS version 20.0 (IBM, USA). A p-value of <0.05 was taken as significant.

Results. Of 1 536 male adolescents (mean age 15.09 (standard deviation 1.84) years, range 14 - 19), 1 184 (77.1%) were aware of FGM/C, 514 (33.5%) supported female circumcision, 362 (23.6%) would circumcise their future daughters, 420 (27.3%) were of the opinion that FGM/C had benefits, mostly as a necessity for womanhood (109, 7.1%), and 627 (40.8%) perceived it as wickedness against females; 546 (35.5%) were aware of efforts to eradicate FGM/C, and 42.2% recommended education as the most important intervention to achieve this.
Conclusion. Education and involvement in advocacy may transform male adolescents into agents for eradication of FGM/C. (13 references) (Author)
Full URL: http://www.samj.org.za/index.php/samj/article/view/10124/7545

20160812-37*

Prevalence and associated factors of female genital cutting among young adult females in Jigjiga district, eastern Ethiopia: a cross-sectional mixed study. Gebremariam K, Assefa D, Weldegebreal F (2016), International Journal of Women's Health vol 8, 9 August 2016, pp 357-365

Purpose: The aim of this study was to assess the prevalence and associated factors of female genital cutting (FGC) among young adult (10-24 years of age) females in Jigjiga district, eastern Ethiopia.
Methods: A school-based cross-sectional mixed method combining both quantitative and qualitative research methods was employed among 679 randomly selected young adult female students from Jigjiga district, Somali regional state, eastern Ethiopia, from February to March 2014 to assess the prevalence and associated factors with FGC. A pretested structured questionnaire was used to collect data. The qualitative data were collected using focus group discussion.
Results: This study depicted that the prevalence of FGC among the respondents was found to be 82.6%. The dominant form of FGC in this study was type I FGC, 265 (49.3%). The majority of the respondents, 575 (88.3%), had good knowledge toward the bad effects of FGC. Four hundred and seven (62.7%) study participants had positive attitude toward FGC discontinuation. Religion, residence, respondents' educational level, maternal education, attitude, and belief in religious requirement were the most significant predictors of FGC. The possible reasons for FGC practice were to keep virginity, improve social acceptance, have better marriage prospects, religious approval, and have hygiene.
Conclusion: Despite girls' knowledge and attitude toward the bad effects of FGC, the prevalence of FGC was still high. There should be a concerted effort among women, men, religious leaders, and other concerned bodies in understanding and clarifying the wrong attachment between the practice and religion through behavioral change communication and advocacy at all levels.
(28 references) (Author) [Full article available online at: https://www.dovepress.com/prevalence-and-associated-factors-of-female-genital-cutting-among-youn-peer-reviewed-article-IJWH]
Full URL: https://www.dovepress.com/prevalence-and-associated-factors-of-female-genital-cutting-among-youn-peer-reviewed-article-IJWH

20160722-14*

Female Genital Mutilation (FGM) - April 2015 to March 2016, Experimental Statistics. Health and Social Care Information Centre (2016), London: HSCIC 21 July 2016

This is the first ever annual statistical publication for Female Genital Mutilation (FGM), and shows 5,700 newly recorded cases in England during 2015-16; it also shows that there were 8660 total attendances during the same period where FGM was identified or a medical procedure for FGM was undertaken.
The dataset includes information gathered from acute trusts, mental health trusts, GP practices and community services within mental health trusts. (CI)
Full URL: http://www.hscic.gov.uk/catalogue/PUB21206

20160718-66*

'Between Two Cultures'. A rapid PEER study exploring migrant communities' views on female genital mutilation in Essex and Norfolk, UK. Norman K, Gegzabher SB, Otoo-Oyortey N (2016), London: National FGM Centre July 2016. 55 pages

This report shares the findings from a rapid PEER study, carried out by migrant women and men living in Norfolk and Essex, UK. Eighteen Peer Researchers, (15 women and 3 men) were recruited through local community organisations and trained and supported by FORWARD and Barnardo's to design and carry out conversational interviews with their peers focusing on life in the UK, and Female Genital Mutilation. The study focused on low prevalence areas as identified in the UK Prevalence study on FGM.
The aims of this research were to:

- Shed light on the lived realities of migrants from these countries and gain insights into their communities' views on FGM in the UK as well as back in their country of origin.
- For the first time, research attitudes and support for FGM in predominantly white British areas that are considered 'low prevalence' for the practice.
- Use the findings to inform and strengthen FGM prevention programmes.
- Empower those involved in the research, strengthening their voice and ensuring that they are at the centre of research and programmes that concern them. (Publisher)

Full URL: http://nationalfgmcentre.org.uk/wp-content/uploads/2015/12/Peer-Research-National-FGM-Centre.pdf

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20160718-60*

'The Tackling FGM Initiative: Evaluation of the Second Phase (2013-2016)'. Brown E, Porter C (2016), London: Options Consultancy Services Limited 11 July 2016

Evaluation of the Tackling FGM Initiative which, during its six-year life, has worked to strengthen the prevention of FGM at community level. (CI)

20160713-21

Girls matter: tackling female genital mutilation. Momoh C (2016), British Journal of Midwifery vol 24, no 7, July 2016, p 466

Dr Comfort Momoh MBE, who founded one of the first support services for women and girls living with female genital mutilation, has visited Nigeria in her quest to end the practice. (Author)

20160706-15

FGM. Hehir B (2016), Association for Improvements in Maternity Services (AIMS) vol 28, no 2, 2016, pp 16-17

Brid Hehir suggests a change in the way women are supported and cared for. (Author)

20160516-45*

WHO guidelines on the management of health complications from female genital mutilation. Stein K, Chou D, on behalf of the World Health Organization Guideline Development Group (2016), Geneva: World Health Organization 2016. 64 pages

Female genital mutilation (FGM) comprises all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons. The procedure has no known health benefits. Moreover, the removal of or damage to healthy genital tissue interferes with the natural functioning of the body and may cause several immediate and long-term health consequences. Girls and women who have undergone FGM are therefore at risk of suffering from its complications throughout their lives. In addition, FGM violates a series of well-established human rights principles, including the principles of equality and non-discrimination on the basis of sex, the right to life when the procedure results in death, and the right to freedom from torture or cruel, inhuman or degrading treatment or punishment, as well as the rights of the child.

The practice - prevalent in 30 countries in Africa and in a few countries in Asia and the Middle East - is now present across the globe due to international migration. Health-care providers in all countries may therefore face the need to provide health care to this population. Unfortunately, health workers are often unaware of the many negative health consequences of FGM and many remain inadequately trained to recognize and treat them properly. Recognizing the persistence of FGM despite concerted efforts to eradicate or abandon the practice in some affected communities, and acknowledging the 200 million girls and women living with or at risk of suffering the associated negative health consequences, these guidelines aim to provide up-to-date, evidence-informed recommendations on the management of health complications from FGM. This document also intends to provide standards that may serve as the basis for developing local and national guidelines and health-care provider training programmes. (88 references) (Author)

Full URL: http://apps.who.int/iris/bitstream/10665/206437/1/9789241549646_eng.pdf?ua=1

20160512-12*

Female genital mutilation/cutting: changes and trends in knowledge, attitudes, and practices among health care professionals in The Gambia. Kaplan Marcusán A, Riba Singla L, Laye M, et al (2016), International Journal of Women's Health vol 8, 12 April 2016, 103-117

Background: Female genital mutilation/cutting (FGM/C) is a harmful traditional practice that affects two out of three

girls in The Gambia, seriously threatening their life and well-being with severe health consequences. By tracking the reference values established in former research conducted between 2009 and 2011, the objectives of this study are to explore trends and to measure and assess changes in knowledge, attitudes, and practices regarding FGM/C among health care professionals (HCPs) in The Gambia.
Methods: A cross-sectional descriptive study was designed to collect and analyze data from an overall stratified sample consisting of 1,288 HCPs including health professionals and students throughout the six regions of The Gambia. Data were collected by the implementation of a self-administered written knowledge, attitudes, and practices questionnaire between 2012 and 2014.
Results: The results of this study showed that 76.4% of HCPs are eager to abandon FGM/C, and 71.6% of them regard it as a harmful practice with negative consequences on life and health. HCPs reported more knowledge and favorable attitudes towards FGM/C abandonment, being better able to identify the practice, more aware of its health complications, and more concerned in their essential role as social agents of change. However, 25.4% of HCPs still embraced the continuation of the practice, 24.4% expressed intention of subjecting their own daughters to it, and 10.5% declared to have performed it within their professional praxis.
Conclusion: Findings confirm progress in knowledge and attitudes regarding FGM/C among HCPs, who are better skilled to understand and manage the consequences. Nevertheless, discrepancies between information, intention, and behavior unveil resistance in practice and proves that FGM/C medicalization is increasing. Thus, there is an urgent need to support HCPs in the integration of FGM/C preventive interventions within the public health system, to address arguments favoring medicalization, and to use data to design appropriate strategies. (21 references) (Author) [Full article available online at: https://www.dovepress.com/female-genital-mutilationcutting-changes-and-trends-in-knowledge-attit-peer-reviewed-fulltext-article-IJWH]

Full URL: https://www.dovepress.com/female-genital-mutilationcutting-changes-and-trends-in-knowledge-attit-peer-reviewed-fulltext-article-IJWH

20160511-5*

Adolescent girls in Egypt. Roudi F (2016), PRB Policy Brief April 2016, pp 1-6

This Population Reference Bureau (PRB) policy brief explores the lives of adolescent girls in Egypt. A national response that cuts across development sectors and programs is necessary because of the girls' demographic significance and more importantly because they are vulnerable to harmful practices such as female genital cutting (FGC) and early marriage that violate girls' rights and hinder the country's development.
Girls under age 20-around 19 million of them-make up one-fifth of Egypt's population. In 2015, about 8 million of these girls were adolescents between ages 10 and 19. According to the latest projections from the United Nations (UN) Population Division, this group will grow to 11.5 million in 2030-a 44 percent increase in 15 years.
While adolescent girls' health and well-being have generally improved in Egypt, inequalities remain widespread. Girls' school enrollment has risen significantly over the past few decades, but dropout rates remain high. The rate at which girls undergo FGC has been declining slowly and girls today are less likely to become child brides (married before age 18) than a generation ago-although the rate of child marriage has leveled off in recent years.
Early marriage for girls usually results in early childbearing, because newlyweds are generally expected to have a child soon after marriage, regardless of their age. The proportion of girls who begin childbearing-that is, they are either pregnant or have already given birth-rises rapidly throughout the teenage years as the proportion of girls who are married increases: The 2014 EDHS shows that 1 in 6 girls (16 percent) begin childbearing by the time they reach their 18th birthday. This ratio increases to 1 in 4 girls (27 percent) by the time they reach their 20th birthday. (17 references) (Author, edited) [Full article available online at: http://www.prb.org/pdf16/prb-policy-brief-mena-adolescent-girls-in-egypt-2016.pdf]

Full URL: http://www.prb.org/pdf16/prb-policy-brief-mena-adolescent-girls-in-egypt-2016.pdf

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20160510-14

Perspectives on female genital mutilation/cutting: a literature review. Saunby M, Dean C (2016), MIDIRS Midwifery Digest vol 26, no 2, June 2016, pp 166-171

Female genital mutilation/cutting (FGM/C) refers to all procedures involving partial or total removal of the female external genitalia or injury to the female genital organs for non-medical reasons (World Health Organization (WHO) 2008). The WHO (2008) estimates that up to 140 million girls and women in the world have undergone FGM/C procedures and three million girls are estimated to be at risk every single year. This literature review will focus on the difficulties of providing care to female patients who have experienced or are at risk of FGM/C. (11 references) (ABS)

20160510-13

Female genital mutilation: the role of the midwife. Albert J (2016), MIDIRS Midwifery Digest vol 26, no 2, June 2016, pp 159-165

Caring for a woman with female genital mutilation (FGM) is something that many midwives in the United Kingdom (UK) experience at some stage during their practice. In areas of high prevalence, the management of women with FGM is well-established, but there are some parts of the UK where it may be something that is seen very infrequently, or not at all. All midwives, however, need to be knowledgeable about FGM and the impact that this has on the health of the women and girls who are affected or at risk. (12 references) (Author)

20160421-2*

Compassionate and proactive interventions by health workers in the United Kingdom: a better approach to prevent and respond to female genital mutilation?. Amasanti ML, Imcha M, Momoh C (2016), PLoS Medicine vol 13, no 3, March 2016, e1001982

The United Kingdom government wants to reduce the prevalence of female genital mutilation (FGM) in the country. In order to do this, the UK government has introduced mandatory reporting of all FGM detected as child abuse.
Is this the best first-line approach, or could it drive the problem even further underground or inadvertently harm those who have suffered from FGM?
A more effective first-line intervention to reduce the prevalence of FGM could be a 3-fold approach comprising the following: (1) educating and training health workers about FGM, (2) trained health workers offering information about FGM to females at risk, and (3) antenatal screening.
We hope that by implementing these interventions, it would reduce the necessity for all FGM detected to be mandatorily reported as child abuse.
There is the possibility that these three steps may not be enough and that some form of monitoring of females at risk of FGM may need to be considered. We look at the issues this raises. (22 references) (Author) [Full article available online at: http://journals.plos.org/plosmedicine/article?id=10.1371%2Fjournal.pmed.1001982]

20160413-30*

Position statement: female genital mutilation. Royal College of Midwives (2015), London: Royal College of Midwives July 2015. 5 pages

Sets out the Royal College of Midwives opposition to all forms of female genital mutilation (FGM) and outlines recommendations for identifying, recording and reporting FGM. (11 references) (SB)

Full URL: https://www.rcm.org.uk/media/5520/rcm-position-statement-female-genital-mutilation.pdf

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20160408-5

FGM and midwifery practice. Mitchell M (2016), The Practising Midwife vol 19, no 4, April 2016, pp 13-16

Midwives in the UK should have appropriate education in order to provide optimum care for women with female genital mutilation (FGM) and know how to safeguard any children who could be at risk. In addition to this, women with FGM have a right to progress through their pregnancy and beyond, safely and confidently, in a supportive environment, and must be empowered to do so. Efforts are being strengthened by the government to tackle the issue of FGM and prevent further cases; therefore all those working in maternity care need to ensure they are equipped to deal with this issue. This article focuses on some of the factors that should be considered in the identification and referral of women with FGM, the planning of their maternity care and related safeguarding issues. (16 references) (Author)

20160315-9

United against FGM. Anon (2016), Community Practitioner vol 89, no 3, March 2016, pp 8-10

Community Practitioner reports from the International Day of Zero Tolerance for FGM conference in London. (Author)

20160310-8*

Global threats to child safety. Mace SE (2016), Pediatric Clinics of North America vol 63, no 1, February 2016, pp 19-35

Children have rights, as enumerated in the Declaration of the Rights of the Child, and need protection from violence, exploitation, and abuse. Globalthreats to child safety exist. These threats include lack of basic needs (food, clean water, sanitation), maltreatment, abandonment, child labor, child marriage, female genital mutilation, child

trafficking, disasters, and armed conflicts/wars. Recent disasters and armed conflicts have led to a record number of displaced people especially children and their families. Strategies and specific programs can be developed and implemented for eliminating threats to the safety of children.

20160210-18

Key points for abolishing Female Genital Mutilation from the perspective of the men involved. Jiménez Ruiz I, Almansa Martínez P, del Mar Pastor Bravo M (2016), Midwifery vol 34, March 2016, pp 30-35

Introduction
Female Genital Mutilation is internationally considered an affront on human rights and an act of violence against women and young girls. Furthermore, it hierarchizes and perpetuates inequality and denies the right to bodily and psychosocial integrity of women and young girls.
Aims
to detect the key points for the abolition of Female Genital Mutilation as well as the necessary resources for its eradication.
Material and Method
a qualitative methodology with an ethnonursing perspective, via semi-structured interviews, held both individually and in groups, in 21 men familiar with Female Genital Mutilation.
Results
through the voices of men familiar with this tradition, five key points are presented for its gradual eradication: sensitization and awareness building, team action, abolition-promoting media, focusing action on rural areas and applying educational means before punitive ones.
Conclusion and Practical Implications
awareness-raising via the combined efforts of families, communities and governments, together with the promotion of health education programmes in demonstrating the complications derived from this practice, play a vital part in eradicating Female Genital Mutilation. (23 references) (Author)

20160208-22*

Female genital mutilation/cutting: a global concern. UNICEF (2016), New York: Unicef 5 February 2016. 2 pages

New statistical report on female genital mutilation from UNICEF, which shows that at least 200 million girls and women alive today have undergone female genital mutilation in 30 countries. (7 references) (CI)

Full URL: http://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf

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20160205-4*

Female genital mutilation. World Health Organization (2016), Geneva: World Health Organization February 2016

Updated fact sheet explaining the practice of female genital mutilation (FGM). Describes the four main types of FGM, the cultural and social background behind performing FGM, the health problems, complications and long term consequences that often arise from the procedure, and who is at risk. Reports on the work of the World Health Organization (WHO) and the progress being made in educating communities and eradicating FGM. (JSM)

Full URL: http://www.who.int/mediacentre/factsheets/fs241/en/

20160203-87

The effect of migration on the attitudes of circumcised women to female genital mutilation. Love J, Norton D (2015), Journal of Health Visiting vol 3, no 12, December 2015, pp 666-674

Global migration has led to female genital mutilation/cutting (FGM/C) being seen in many parts of the world, including the UK. The aim of this article is to provide insight into perceptions of FGM/C in migrant communities to inform culturally relevant approaches by specialist community public health nurses working with FGM/C practising families. A review of 10 pieces of primary research found that many women migrating to a European country and coming into contact with health services had a major shift in their attitudes towards FGM/C, from acceptance to rejection of the practice and wanting to protect their daughters. This article will discuss circumcised women's attitudes to FGM/C when living in their home country; their experiences of health care in a European host country and any change in attitudes to FGM/C after migration. (25 references) (Author)

20160114-11

Facilitating birth for women who have experienced genital cutting. Barnawi N, O'Brien B, Richter S, et al (2015), Canadian Journal of Midwifery Research and Practice vol 14, no 3, Fall 2015, pp 30-39

Female genital cutting (FGC) is a traditional practice in parts of Africa, the Middle East, and Asia. Due to increasing migration from these areas to Canada and elsewhere, the care of women who have undergone FGC has become both a national and a global concern. It is widely regarded as a public health and human rights issue affecting at least 140 million women worldwide. In Canada, pregnant women who experienced FGC may face more physical and emotional challenges than their non- pregnant counterparts. Their need to access optimal perinatal care is critical, as FGC, particularly that with more extensive cutting (infibulation), is widely considered to be an indirect cause of/maternal/newborn morbidity. The purposes of this article are (1) to provide a deeper insight into challenges confronting affected women seeking maternity care in Canada and their providers and (2) to recommend the appropriateness of the Canadian midwifery model in providing optimal care for women who have experienced FGC. The goal is to support Canadian health care providers in gaining understanding of the historical, cultural, and physical realities of FGC so that they are able to provide maternity care that meets Canadian standards while being sensitive to cultural values and beliefs. (60 references) (Author)

20160108-1*

A qualitative study exploring how Somali women exposed to female genital mutilation experience and perceive antenatal and intrapartum care in England. Moxey JM, Jones LL (2016), BMJ Open vol 6, no 1, 7 January 2016

Objectives To explore how Somali women exposed to female genital mutilation experience and perceive antenatal and intrapartum care in England. We explored women's perceptions of deinfibulation, caesarean section and vaginal delivery; their experiences of care during pregnancy and labour; and factors that affect ability to access these services, in order to make recommendations about future practice.

Design A descriptive, exploratory qualitative study using face-to-face semistructured interviews. Interviews were audio-recorded, transcribed and data were analysed using a thematic approach. An interpreter was used when required (n=3).

Setting Participants recruited from 2 community centres in Birmingham, England.

Participants Convenience and snowball sample of 10 Somali women resident in Birmingham, who had accessed antenatal care services in England within the past 5 years.

Results 3 core themes were interpreted: (1) Experiences of female genital mutilation during life, pregnancy and labour: Female genital mutilation had a significant physical and psychological impact, influencing decisions to undergo deinfibulation or caesarean section. Women delayed deinfibulation until labour to avoid undergoing multiple operations if an episiotomy was anticipated. (2) Experience of care from midwives: Awareness of female genital mutilation from midwives led to open communication and stronger relationships with women, resulting in more positive experiences. (3) Adaptation to English life: Good language skills and social support networks enabled women to access these services, while unfavourable social factors (eg, inability to drive) impeded.

Conclusions Female genital mutilation impacts Somali women's experiences of antenatal and intrapartum care. This study suggests that midwives should routinely ask Somali women about female genital mutilation to encourage open communication and facilitate more positive experiences. As antenatal deinfibulation is unpopular, we should consider developing strategies to promote deinfibulation to non-pregnant women, to align with current guidelines. Women with unfavourable social factors may require additional support to improve access to English antenatal care services. (Author)

Full URL: http://bmjopen.bmj.com/content/6/1/e009846.full

20151216-7*

Nursing care of women who have undergone genital cutting. Tilley DS (2015), Nursing for Women's Health vol 19, no 5 October/November 2015, pp 445-449

Female genital cutting (FGC), commonly called female genital mutilation, affects millions of women but is poorly understood by many health care providers. FGC procedures intentionally alter the female genital organs for nonmedical reasons and include partial or total removal of female genital organs. These procedures, which have no medical value, are usually done between birth and puberty. Health consequences vary in severity but can be devastating. Women who have experienced FGC may be reluctant to seek health care or to disclose their condition to providers. Suggestions for culturally competent care of women who have experienced FGC are outlined, focusing on understanding the cultural beliefs and values of women who have undergone these procedures and providing informed and sensitive care. [Full article available online at: http://onlinelibrary.wiley.com/doi/10.1111/1751-486X.12237/full] (14 references) (Author)

20151216-58

Female genital mutilation: a practical guide for health visitors and school nurses. Allen B, Oshikanlu R (2015), Community Practitioner vol 88, no 12, December 2015, pp 30-33

Provides guidance on female genital mutilation (FGM) for health visitors and school nurses. Includes discussion of legislation and safeguarding, mandatory reporting, inter-agency working, reasons for families choosing FGM for their daughters, assessment and referral, and health consequences. Also includes case studies for a school nurse and health visitor. (19 references) (SB)

20151215-21

New law on notifying female genital mutilation. Symon A (2015), British Journal of Midwifery vol 23, no 12, December 2015, pp 905-906

Provides an overview of the new legal requirements for police notification of all cases of female genital mutilation. (11 references)

20151202-19*

Female genital mutilation (FGM) enhanced dataset: July to September 2015, experimental statistics. Clinical Audit Support Unit, Health and Social Care Information Centre (2015), Leeds: Health and Social Care Information Centre 2 December 2015. 25 pages

Presents statistics for female genital mutilation from data collected by NHS acute trusts, mental health trusts, GP practices and community services within mental health trusts. (SB)

20151127-5

Caring for women who have experienced female genital cutting. Little CM (2015), MCN - American Journal of Maternal/Child Nursing vol 40, no 5, September/October 2015, pp 291-297

Female genital cutting/mutilation (FGC/M) is a procedure that involves physically altering a woman's/girl's genitals for no health benefits. This is a practice that is deeply rooted in culture, religion, and social tradition primarily in some African and Middle East countries. It is performed by a midwife, barber, traditional healer with no surgical training, or a physician. The practice of FGC/M has been gaining increased attention as womenfrom those countries have been migrating to the United States and Western Europe. The World Health Organization (WHO) has estimated that 125 million women worldwide have undergone FGC/M. The practice has serious short-term and long-term physical, obstetric, and psychological complications. It has been proposed by some healthcare professionals that physicians or other healthcare providers should perform the cutting because it would be done under more sanitary conditions that would reduce complications. However, the WHO and other organizations have condemned the practice by any medical professional. The FGC/M procedure is a human rights violation and has been banned by WHO and other organizations and governments. This article provides an overview of the current issues related to FGC/M and addresses important cultural considerations for nurses caring for women with FGC/M. Nurses are in a unique position to provide holistic, culturally competent care in a respectful, nonjudgmental atmosphere. Nurses have a role in educating women with FGC/M about the complications and care, as education is necessary in the challenge to eradicate the practice of FGC/M. (24 references) (Author)

20151125-18*

Prevalence and predictors of female genital mutilation among infants in a semi urban community in northern Nigeria. Ashimi AO, Amole TG, Iliyasu Z (2015), Sexual & Reproductive Healthcare vol 6, no 4, December 2015, pp 243-248

Objectives

To determine the prevalence, predictors, of female genital mutilation (FGM) among infants and ascertain if their mothers knew what was done to them in Birnin Kudu northern Nigeria.

Methods

Cross sectional study which utilised a pretested interviewer administered semi-structured questionnaire to assess occurrence of FGM with physical examination of the infants. Logistic regression analysis was used to assess the relative effect of determinants, after adjusting for other predictor variables.

Results

Of the 450 infants, 215(47.8%) (95% Confidence Interval [CI]: 43.1%-52.5%) had experienced one form of FGM. The ages at genital mutilation ranged from 1 to 50 days with a median of 4 days and interquartile range of 7 days. Maternal

occupation, education and religion and type of facility accessed were significantly associated with occurrence of FGM in infants ($p \leq 0.05$). After controlling for confounders, having a mother without formal education [AOR = 6.39 and 95% CI = 3.99-10.23] ($p = 0.001$) and one who was employed [Adjusted odds ratio (AOR) = 2.89 and 95% CI = 1.66-5.03] ($p = 0.001$) increased the likelihood of infant FGM remarkably while utilising tertiary institution for health care reduced the risk by about half [AOR = 0.49 and 95% CI = 0.26-0.92] ($p = 0.03$). Of the 215 infants that had undergone FGM, there was correlation between the reported and the observed forms of FGM in 16 (7.4%) of the cases.

Conclusion

The prevalence of FGM is high with mothers' educational status, type of health facility utilised and occupational status being predictors of FGM among infants in Birnin Kudu. Majority of the mothers are not aware of what was done. Strategies aimed at discouraging this dangerous practice in the community should include female education, involvement of the men as husbands, fathers, traditional and religious leaders. (Author)

20151124-27*

The midwife who is trying to save women from FGM. Mundasad S (2015), BBC News 24 November 2015

Presents an interview with a Malian-born midwife, now living in London, whose experiences and memories of undergoing female genital mutilation at the age of six have led her to help other women who have undergone this procedure. (JSM)

Full URL: http://www.bbc.co.uk/news/health-34809550

20151113-48*

Awareness and predictors of female genital mutilation/cutting among young health advocates. Abolfotouh SM, Ebrahim AZ, Abolfotouh MA (2015), International Journal of Women's Health vol 7, 20 February 2015, pp 259-269

Abstract: The act of female genital mutilation/cutting (FGM/C) is considered internationally as a violent act against girls and women and a violation of their human rights. This study sought to assess the awareness and predictors of FGM/C in young Egyptian health advocates. A cross-sectional study of 600 medical students from a total of 2,500 members of the International Federation of Medical Students' Associations (IFMSA)-Egypt, across all Egyptian medical schools, was conducted using a previously validated online Google survey. The overall prevalence of circumcision was 14.7/100 female students, with a significantly higher prevalence in students from rural areas (25%) than in non-rural areas (10.8%, P=0.001), and in those residing in Upper (southern) Egypt (20.6%) than in Lower (northern) Egypt (8.7%, P=0.003). The students' mean percentage score for knowledge about the negative health consequences of FGM/C was 53.50±29.07, reflecting a modest level of knowledge; only 30.5% had a good level of knowledge. The mean percentage score for the overall attitude toward discontinuation of the practice of FGM/C was 76.29±17.93, reflecting a neutral attitude; 58.7% had a favorable attitude/norms toward discontinuation of the practice. Of circumcised students, approximately one-half (46.8%) were unwilling to have their daughters circumcised, and 60% reported no harm from being circumcised. After controlling for confounders, a negative attitude toward FGM/C was significantly (P<0.001 in all cases) associated with male sex, residency in Upper Egypt, rural origin, previous circumcision, and the preclinical medical phase of education. The low level of knowledge among even future health professions in our study suggests that communication, rather than passive learning, is needed to convey the potentially negative consequences of FGM/C and to drive a change in attitude toward discontinuation of this harmful practice. [Full article available free of charge at:
https://www.dovepress.com/awareness-and-predictors-of-female-genital-mutilationcutting-among-you-peer-reviewed-article-IJWH] (53 references) (Author)

Full URL: https://www.dovepress.com/awareness-and-predictors-of-female-genital-mutilationcutting-among-you-peer-reviewed-article-IJWH#

20151113-38

Working together to prevent female genital mutilation. Clarke E (2015), British Journal of Midwifery vol 23, no 11, November 2015, pp 768-770

Highlights the importance of collaborative working in order to end female genital mutilation. (6 references) (SB)

20151113-28*

Intention toward the continuation of female genital mutilation in Bale Zone, Ethiopia. Bogale D, Markos D, Kaso M (2015), International Journal of Women's Health vol 7, 9 January 2015, pp 85-93

Background: Female genital mutilation (FGM) is a harmful traditional practice that is deeply rooted in Africa. It is associated with health complications and human rights violations. Research on intention for the continuation of FGM

and the social determinants underpinning this practice are scarce. Therefore, this study intended to assess the intention of women toward the continuation of FGM among Bale Zone reproductive-age women.
Methods: A community-based cross-sectional study design supplemented by qualitative methods was conducted in 2014. A total of 634 reproductive-age women were involved in the quantitative part of the study. The respondents were drawn from five randomly selected districts of Bale Zone. The total sample was allocated proportionally to each district based on the number of reproductive-age women it has. Purposive sampling method was used for qualitative study. Then, data were collected using a pretested and structured questionnaire. The collected data were analyzed by Statistical Package for Social Sciences for Windows version 16.0. Multiple logistic regressions were carried out to examine the existence of a relationship between intentions for the continuation of FGM and selected determinant factors.
Results: This study revealed that 26.7% of the respondents had intention for the continuation of FGM. Religion, safeguarding virginity, tradition, and social values were the major reasons for the perpetuation of this practice. Circumcised respondents and those who were not able to read and write were ~3 (adjusted odds ratio = 2.89, 95% confidence interval = [1.33, 6.20]) and 7.58 (adjusted odds ratio = 7.58, 95% confidence interval = [3.47, 16.54]) times more likely intending the continuation of FGM than uncircumcised and those who attended secondary-level education and above, respectively.
Conclusion: The study shows that the intention toward the persistence of the practice is high in Bale Zone. Rural residents, those who were not able to read and write, and circumcised respondents were more likely to continue the practice. [Full article available online at: https://www.dovepress.com/intention-toward-the-continuation-of-female-genital-mutilation-in-bale-peer-reviewed-article-IJWH] (22 references) (Author)
Full URL: https://www.dovepress.com/intention-toward-the-continuation-of-female-genital-mutilation-in-bale-peer-reviewed-article-IJWH

20151106-70*

Female genital mutilation: are we winning?. Makinde ON, Elusiyan JBE, Adeyemi AB, et al (2012), East African Medical Journal vol 89, no 6, 2012, pp 193-198
Background: For more than 25 years, efforts have been geared towards curtailing the practice of female genital mutilation (FGM) in countries like Nigeria. This study was designed to see if all these efforts have made any impact in reducing the prevalence of FGM appreciably in the south-West of Nigeria.
Objective: To determine the prevalence of female genital mutilation and profiling the trends of FGM affected patients.
Design: A prospective study based on direct observation of the external genitalia by health-care workers.
Subjects: Five hundred and sixty five females less than 15 years of age.
Setting: The children emergency and gynaecological wards of the Obafemi Awolowo University Teaching Hospitals Complex, Ile-Ife, Nigeria from 1st of January to December 31st 2007.
Results: Forty one point nine percent of the patients examined had female genital mutilation, 93.2% of these had the procedure before attaining the age of one year. Type 2 FGM predominated (58.22%). The procedure was performed predominantly (64.6%) by traditional birth attendants. The decision to have the procedure done was influenced in 78% of cases by mothers and grandmothers. In 35.4% of cases, there were immediate and short term complications. Demands of tradition predominated (59.1%) as the most important reason for the practice of female genital mutilation.
Conclusion: The practice of FGM appears to be still highly prevalent and resistant to change probably due to deep rooted socio-cultural factors. Strategies such as public education campaigns highlighting its negative impact on health and disregard for human rights should be evolved. (Author)
Full URL: http://www.ajol.info/index.php/eamj/article/view/91507/80985

20151102-8*

FGM - supporting girls: information for patients. Department of Health (2015), London: DH 30 November 2015. 2 pages
Patient information explaining the legal position in the UK and the duty of the health care professional in cases where female genital mutilation is known or suspected to have taken place, or where a young girl is considered to be at risk of the procedure. (JSM)
Full URL: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472694/FGM_leaflet.pdf

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20151102-6*

Mandatory reporting of FGM. A new professional duty. Training package for NHS organisations. Department of Health, NHS England, Community Practitioners and Health Visitors Association, et al (2015), London: DH 30 October 2015. 16 pages

From 31st October 2015 the reporting of cases or suspected cases of female genital mutilation will be mandatory for midwives and others involved in the care of young women. This training package introduces the duty to health care professionals.. (JSM)

Full URL: https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare

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20151102-5*

FGM mandatory reporting duty. Department of Health, NHS England, Community Practitioners and Health Visitors Association, et al (2015), London: DH 30 October 2015. 2 pages

Guidelines setting out the procedures that midwives and other health care professionals must follow in cases of known or suspected female genital mutilation in girls under the age of 18, and also in cases where a young girl or woman is thought to be at risk from the practice. (JSM)

Full URL: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472691/FGM_guidance.pdf

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20151102-3*

FGM mandatory reporting duty - what you need to do. Department of Health, NHS England, Community Practitioners and Health Visitors Association, et al (2015), London: DH 30 October 2015. 1 page

From 31st October 2015, it is mandatory for midwives and others caring for young women, to report all cases where female genital mutilation is known or suspected to have taken place. This poster explains what the duty means for health professionals. (JSM)

Full URL: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472690/FGM_poster.pdf

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20151102-2*

'Mandatory reporting is crucial to tackling FGM in the UK' says RCM. Royal College of Midwives (2015), London: RCM 30 October 2015

Reports that from 31st October 2015 all midwives and health care professionals in England and Wales are required by law to report all cases of suspected female genital mutilation (FGM), and it will become the duty of midwives to report all known cases of FGM in girls under the age of 18 to the police. States that resources have been developed by the RCM in collaboration with the Department of Health, NHS England and the other Royal Colleges in order to make staff aware of their responsibilities pertaining to mandatory reporting and to best support those who have undergone FGM but for whom the duty does not apply. Includes comments from RCM CEO Cathy Warwick. (JSM)

20151028-10

Midwives' experiences of caring for women with female genital mutilation: insights and ways forward for practice in Australia. Dawson AJ, Turkmani S, Varol N, et al (2015), Women and Birth: Journal of the Australian College of Midwives vol 28, no 3, September 2015, pp 207-214

BACKGROUND:

Female genital mutilation (FGM) has serious health consequences, including adverse obstetric outcomes and significant physical, sexual and psychosocial complications for girls and women. Migration to Australia of women with FGM from high-prevalence countries requires relevant expertise to provide women and girls with FGM with specialised health care. Midwives, as the primary providers of women during pregnancy and childbirth, are critical to the provision of this high quality care.

AIM:

To provide insight into midwives' views of, and experiences working with, women affected by FGM.

METHODS:

A descriptive qualitative study was undertaken using focus group discussions with midwives from four purposively selected antenatal clinics and birthing units in three hospitals in urban New South Wales. The transcripts were analysed thematically.

FINDINGS:

Midwives demonstrated knowledge and recalled skills in caring for women with FGM. However, many lacked confidence in these areas. Participants expressed fear and a lack of experience caring for women with FGM. Midwives described practice issues, including the development of rapport with women, working with interpreters, misunderstandings about the culture of women, inexperience with associated clinical procedures and a lack of knowledge about FGM types and data collection.

CONCLUSION:

Midwives require education, training and supportive supervision to improve their skills and confidence

when caring for women with FGM. Community outreach through improved antenatal and postnatal home visitation can improve the continuity of care provided to women with FGM. (60 references) (Author)

20151022-1*

Mandatory reporting of female genital mutilation - procedural information [Last updated 22 January 2020]. Home Office (2015), London: Home Office October 2015. pp 1-20

This government guidance provides regulated professionals and the police, with an understanding of the legal requirements required regarding the new female genital mutilation (FGM) mandatory reporting duty. (KM)

Full URL: https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information

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20151020-10*

Sexual and reproductive health and rights: a matter of life and death. Wiklund I (2015), Sexual & Reproductive Healthcare 12 October 2015

Sexual and reproductive ill health is one of the most common health problems for women aged 15-44 in low income countries, where pregnancy, unsafe abortions, childbirth or harmful customs, such as female genital mutilation (FGM), can endanger the lives of girls and women. Despite considerable efforts over the past 20 years, maternal mortality in the world is still high, particularly in Sub-Saharan Africa and South Asia but also in some countries in Europe. Unequal power relations between men and women make it difficult for women and girls to decide over their own bodies and negotiate safer sex. (Author)

20151007-29*

Female genital mutilation (FGM) enhanced dataset April to June 2015, experimental statistics. Health and Social Care Information Centre (2015), London: HSCIC 23 September 2015

Presents a range of data on cases of female genital mutilation, collected by healthcare providers in England from April to June 2015. (JSM)

20150914-15*

Cultural protection against traumatic stress: traditional support of children exposed to the ritual of female genital cutting. Schultz JH, Lien IL (2014), International Journal of Women's Health vol 6, 13 February 2014, pp 207-219

This study explores the factors addressed in folk psychology in The Gambia for protecting the girl-child from the potential traumatic stress of female genital cutting (FGC). The type and quality of the psychological care was analyzed and compared with research on traumatic stress and principles for crisis and trauma intervention. Thirty-three qualitative indepth interviews were conducted with mothers who had supervised their daughters' FGC, women who had been circumcised, and professional circumcisers. The findings indicate that the girls have largely managed to handle the potentially traumatic event of FGC. The event is placed in a meaningful system of understanding, and the stress is dealt with in a traditional way that to a great extent follows empirically-based and evidence-based principles of crisis intervention. However, the approach tends to be culturally encoded, based on the local cultural belief system. This puts circumcised individuals in a potentially vulnerable position if they are living outside the homeland's supportive cultural context, with consequences for psychological and culturally competent FGC health care in exile. [Full article available online at: https://www.dovepress.com/cultural-protection-against-traumatic-stress-traditional-support-of-ch-peer-reviewed-fulltext-article-IJWH] (46 references) (Author)

Full URL: https://www.dovepress.com/cultural-protection-against-traumatic-stress-traditional-support-of-ch-peer-reviewed-fulltext-article-IJWH

20150730-47*

Female genital cutting: A survey among healthcare professionals in Italy. Surico D, Amadori R, Gastaldo LB, et al (2015), Journal of Obstetrics and Gynaecology vol 35, no 4, May 2015, pp 393-396

This study aims to evaluate the knowledge of female genital cutting (FGC) in a tertiary teaching hospital in Italy. A survey questionnaire on FGC was given to paediatricians, nurses, midwives, gynaecologists and residents in paediatrics and gynaecology in a tertiary teaching hospital in Italy. The results of the survey were then analysed. The results showed that 71.5% (73/102) of healthcare professionals dealt with patients presenting with FGC. Gynaecologists (83%) and paediatric nurses (75%) were the only ones who declared to be aware of Italian law on FGC. In detail, 55% of midwives, 50% of paediatricians, 50% of paediatrician residents and 28.5% of gynaecological

residents were aware of this law. The general knowledge of Italian National Guidelines on FGC is even worse: most professionals are not aware of protocols of action. Considering the increasing extension of FGC due to immigration, improvement of care through specialised education of healthcare providers is mandatory. (Author)

20150729-32*

Prevalence of female genital mutilation in England and Wales: National and local estimates. Macfarlane A, Dorkenoo E (2015), London: City University London, Equality Now July 2015. 32 pages

Reports on estimates of the numbers of women with female genital mutilation (FGM) living in England and Wales, the numbers of women with FGM giving birth and the numbers of girls born to women with FGM. Contains estimates at a local authority level. To enable interpretation of these data, it also contains data about the extent to which FGM is practised in the women's countries of origin and about the populations of women born in these countries and living in England and Wales in 2011. Data about the prevalence of FGM were derived from reports of household interview surveys in the countries in which it is practised. (33 references) (Author, edited)

20150723-6*

GIRL Summit: one year on. Department of Health (2015), London: DH 22 July 2015. 32 pages

Summarises progress made in the eradication of female genital mutilation (FGM) and child, early or forced marriage (CEFM) since the first GIRL Summit was held on 22nd July 2014. List key achievements and changes instigated by governments in 36 countries and the European Union, and describes the work undertaken by a number of charitable and professional organisations towards achieving the goal of elimination of FGM and CEFM in a generation. (JSM)

20150723-5*

Declaration on UK government progress since Girl Summit 2014. Department of Health (2015), London: DH 22 July 2015. 2 pages

Summarises the progress made in the eradication of female genital mutilation (FGM) and child, early and forced marriage (CEFM) in the year since the first GIRL Summit was hosted by the Prime Minister and UNICEF on 22nd July 2014. (JSM)

Full URL: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/447578/160722_Cross-Govt_declaration_GS_one_year_on__final___2_.pdf

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20150720-9*

'Fifty girls' taken from UK to Somalia for FGM. Anon (2015), BBC News 17 July 2015

Reports that a criminal investigation is taking place into the transportation of at least 50 young girls from Britain to Somalia to undergo female genital mutilation (FGM). States that this practice, also known as female circumcision, is illegal in Britain, but fears have been raised that 'cutters', people who carry out the procedure for approximately £200 per girl, will try to enter the UK. (JSM)

Full URL: http://www.bbc.co.uk/news/uk-33572428

20150717-31

FGM: dispelling the myths; exploring the facts. Dixon-Wright R (2015), The Practising Midwife vol 18, no 7, July/August 2015, pp 18-20

Female genital mutilation is a process that affects our practice. It is becoming more common in our ever-diversifying population and therefore education is vitally important to be able to put robust care plans in place. Understanding the psychological and physical difficulties experienced by women of childbearing age can help us to improve the care that we, as maternity healthcare professionals, can deliver. Looking at current research, this article examines some of the presumed cultural and societal beliefs behind the procedure and highlights some new evidence that change is welcomed by women and their families. (23 references) (Author)

20150716-1*

Letter from Jane Ellison, Parliamentary Under Secretary of State for Public Health - Female genital mutilation (FGM). Department of Health (2015), London: Department of Health 10 July 2015, 3 pages

Highlights the need for NHS staff to be vigilant over the summer period in order to protect young girls who may be taken overseas for FGM. Includes appendices of resources and safeguarding requirements. (SB)

Full URL: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/443992/PSPH_FGM_letter_acc.pdf

20150714-10*

Female genital mutilation and its management. Low-Beer NM, Creighton SM (2015), London: RCOG July 2015. 2nd ed. 26 pages

Provides evidence-based advice for obstetricians and gynaecologists on the clinical care of women with female genital mutilation (FGM) before, during and after pregnancy, including legal and regulatory responsibilities. It is also relevant for midwives and other healthcare professionals caring for women with FGM. This is the second edition of this guideline, which was previously published under the same title in 2009. Prior to this, a Royal College of Obstetricians and Gynaecologists' statement with the same title was published in 2003. (Author, edited)

Full URL: https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf

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20150702-1*

Mandatory reporting of female genital mutilation by healthcare professionals. Mathers N, Rymer J (2015), British Journal of General Practice vol 65, no 635, pp 282-3

Editorial discussing the UK government's recently proposed mandatory reporting of 'visualised or disclosed' female genital mutilation by health care professionals directly to the police. Considers some of the unintended consequences this may have, and questions whether this new legislative duty will address the problem of lack of identification, simplify referral pathways and deter perpetrators. (CI)

20150623-33

Does the timing of deinfibulation for women with type 3 female genital mutilation affect labour outcomes?. Albert J, Bailey E, Duaso M (2015), British Journal of Midwifery vol 23, no 6, June 2015, pp 430-437

Objective: To determine whether timing of deinfibulation influences obstetric outcomes for women with type 3 female genital mutilation (FGM). Design: A retrospective observational study comprising 94 women with type 3 FGM who gave birth from 2008-2012. Method: Outcomes described in maternity notes of women with deinfibulation performed prior to labour (n=62) compared with 'not deinfibulated before labour' (n=32). Secondary analysis was then performed excluding women who had caesarean sections. Findings: Women who were 'not deinfibulated before labour' had a significantly greater risk of episiotomy (RR 1.67, P<0.05) and prolonged hospital stay of >2 days (RR 1.33, P<0.05). They also had non-significant increased risk of a postpartum haemorrhage (RR 1.15, P=0.58); prolonged second stage (RR 1.77, P=0.16); and required vaginal packing in theatre (RR 2.6, P =0.17). Apgar scores were no different, and both groups had higher than the national average rates for emergency caesarean section and instrumental birth. Conclusion: Type 3 FGM is associated with morbidity in childbirth. When deinfibulation is deferred until labour the risk of morbidity increases. (Author)

20150612-50*

Factors and problems related to female genital mutilation as seen in children at St. Gaspar Hospital, Itigi, Tanzania. Majinge CR, Ngallaba SE (2011), East African Medical Journal vol 88, no 4, 2011, pp 111-118

Objective: To determine the aetiological factors and problems related to female genital mutilation as seen in children at St. Gaspar Hospital.

Data source: Secondary data were obtained from St. Gaspar Hospital, records, registers and patients files or case notes from children ward were retrieved and reviewed, later a special master data sheet was used to collect the required information from the registers.

Data selection: All records of female children who were admitted in the hospital for the past two years were selected however children from outside the region (Singida) were excluded.

Data extraction: A special data sheet was used to collect the required information from the registries, Case note and record, data analysis was done using Dbase IV and SPSS (Version9.0).

Data Synthesis: Retrospective cohort study of 803 female children of which 14.5% had FGM according to statistical confidence review of registers records and case notes. The leading cause of FGM was found to be cosmetic and the performer (expert) of FGM are traditional local people about 92%.

Conclusion: The ratio of FGM was 3:20 women. Nyaturu tribe practice FGM at large and the society have a negative altitude towards girls or women who are not mutilated. Consent for FGM is given by parents and not the child who under go FGM because this is considered to be service to the privileged girls who are expected to undergo FGM, this information was obtained through FGD. (19 references) (Author)

Full URL: http://www.ajol.info/index.php/eamj/article/view/86485/76307

20150428-5*

Joint statement on story about women choosing to be circumcised. The Intercollegiate FGM Group, The International Federation of Gynecology and Obstetrics (FIGO), International Confederation of Midwives (2015), London: RCOG 23 April 2015

Responds to an article which discusses the cultural and traditional reasons why some women choose to undergo female circumcision (1). Expresses great concern over the way in which female genital mutilation (FGM) is depicted in the article and states that the collective view of the Intercollegiate FGM Group, the International Federation of Gynecology and Obstetrics (FIGO) and the International Confederation of Midwives (ICM) is that this practice is child abuse, an extreme form of violence against women and girls, a violation of the rights of the child and of the rights of women and girls and that the medicalisation of FGM must be stopped. 1. Khazan O (2015). Why some women choose to get circumcised. The Atlantic, 8 April. (JSM)

Full URL: https://www.rcog.org.uk/en/news/joint-statement-on-story-about-women-choosing-to-be-circumcised/

20150420-31*

Why some women choose to get circumcised. Khazan O (2015), The Atlantic 8 April 2015

Discusses some common misconceptions about female circumcision, including the notion that men are often responsible for forcing women into undergoing this procedure, when it is often the older women of the tribe who do the most to perpetuate the custom. Includes reference tables showing the incidence of female genital mutilation is on the decline in eight countries: Central African Republic, Chad, Egypt, Ethiopia, Nigeria, Senegal and Sierra Leone. Offers suggestions for the education of those involved in this traditional practice with the aim of helping to eradicate it. (JSM)

Full URL: http://www.theatlantic.com/international/archive/2015/04/female-genital-mutilation-cutting-anthropologist/389640/#disqus_thread

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20150416-2*

Female genital mutilation risk and safeguarding: guidance for professionals [Superseded 2016]. Department of Health (2015), London: FGM Prevention Programme March 2015

NB: This document has now been superseded by the May 2016 guideline.

This document provides guidance to support an NHS organisation when they are developing or reviewing safeguarding policies and procedures around female genital mutilation (FGM).
It can be used by health professionals from all sectors, particularly designated and named safeguarding leads, and local safeguarding children board members. It is based on existing best practice within the NHS.
It has been developed in partnership with health and social care professionals, and professional bodies.
All organisations must ensure that their approach to safeguarding against FGM is multi-agency and multi-disciplinary. They should work with partners in social services and the police. (Author)

Full URL: https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm

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20150408-14*

Commissioning services to support women and girls with female genital mutilation. Department of Health (2015), London: FGM Prevention Programme March 2015

New guidance for England from the Department of Health on commissioning services for women and girls who have undergone female genital mutilation. Issues covered include: scope of service, service standards, and future prevention work. (CI)

Full URL: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418549/2903842_DH_FGM_Commissioning_Accessible.pdf

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20150325-62

Landmark FGM case: doctors found not guilty. Symon A (2015), British Journal of Midwifery vol 23, no 3, March 2015, p 220-1

Reports on the acquittal of two doctors charged with performing and abetting female genital mutilation, and explores the relevance of the case to midwives.
(8 references) (CI)

20150317-24*

'FGM must now be reported but reinfibulation guidance is needed'. Richens Y (2015), Nursing Times vol 11, no 10, 4-10 March 2015, p 7

Gives an overview of the campaign against female genital mutilation (FGM) and gives an update on the progress made by the FGM National Clinical Group in lobbying for a confidential national reporting system, and its future work in seeking clarity for clinicians regarding reinfibulation of FGM. (JSM)

20150316-27

Calls for increased vigilance to root out FGM. (2015), The Practising Midwife vol 18, no 3, March 2015, p 7

As the first figures for the prevalence of FGM in England have now been published, international campaigners redouble their efforts to end the barbaric practice forever. (Author)

20150312-10*

'I screamed so hard I lost my voice for days': victims of female genital mutilation speak out as it's revealed thousands of Brits are STILL planning to cut their daughters. Waterlow L (2015), Daily Mail 11 March 2015

Presents the personal experiences of several young women who have been subjected to the practice of female genital mutilation (FGM). Explains that FGM is illegal in the UK but many families take their daughters out of the country in order for them to undergo the procedure during the school holidays, in what is known as 'the cutting season', (JSM)

Full URL: http://www.dailymail.co.uk/femail/article-2989409/Victims-female-genital-mutilation-speak-s-revealed-thousands-Brits-planning-cut-daughters.html?ITO=1490&ns_mchannel=rss&ns_campaign=1490

20150309-71*

The role of community nurses in preventing female genital mutilation. McCrae N, Bynoe S (2015), Primary Health Care vol 25, no 2, 2015, pp 30-33

Female genital mutilation (FGM) has become a major issue worldwide, including the UK, where the number of women and girls affected has grown. This ritual practice is common in communities originating in parts of Africa and Asia. Although FGM is illegal and causes lasting physical and psychological harm, healthcare services have lacked a robust response until recently. Guided by government policy and clear procedures for detection and reporting, nurses have an important role in preventing FGM and in providing sensitive care for those who have undergone the procedure. (Author)

20150225-57*

Perception and attitude of pregnant women in a rural community north-west Nigeria to female genital mutilation. Ashimi AO, Amole TG (2015), Archives of Gynecology and Obstetrics vol 291, no 3, 2015, pp 695-700

PURPOSE:

Nigeria has the highest absolute number of residents who have undergone female genital mutilation (FGM) and most are carried out during infancy; however most reports on FGM are from urban based facilities hence we sought to know the perception and attitude of pregnant women residing in a rural community in northern Nigeria to FGM.

METHODS:

A descriptive cross sectional study utilized a pretested structured interviewer administered questionnaire to assess the types of FGM known, reasons for performing it and willingness to support or perform FGM among 323 pregnant women attending antenatal care in two different health facilities.

RESULTS:

Of the 323 respondents, 256 (79.3 %) were aware of the practice and the common varieties of FGM known to them were Gishiri cut in 137 (53.5 %) and Angurya cut 113 (44.1). The notable reasons for carrying out FGM in the community were tradition 88 (34.4 %), to ease difficulty in childbirth 69 (26.9 %) and better marriage prospect in 55 (21.5 %). Of the respondents that were aware of FGM; 100 (39.1 %) have experienced it and 55 (21.5 %) of those aware of it would subject their daughters to the procedure. There was statistically significant association between willingness to mutilate daughters by the respondents type of education (p = 0.014) and the type of facility they were receiving antenatal care (p = 0.001).

CONCLUSION:

FGM is prevalent in this community with Gishiri cut being the commonest variety. It is often associated with difficult childbirth and many women would subject their daughters to this practice. Female education and empowerment is crucial to discontinuation of this practice.

(Author)

20150216-19*

Surgeon acquitted of carrying out FGM in a prosecution criticised by obstetricians. Dyer C (2015), BMJ vol 350, no 7995, 14 February 2015, p 4

Brief news item reporting that a trainee obstetrician who was accused of female genital mutilation (FGM), has been acquitted by a jury. The doctor's lawyers had argued that he was being made a 'scapegoat' for systematic failures at the hospital and that the woman, who underwent genital mutilation as a child, should have been referred to a specialist FGM team months before her due date. (CI)

20150209-76*

International day of zero tolerance for female genital mutilation. United Nations (2015), New York: UN 6 February 2015

Announces International Day of Zero Tolerance for Female Genital Mutilation (FGM) on 6th February 2015. Explains the history of FGM and argues that the practice is 'an extreme form of discrimination against women and girls'. Suggests that, despite the fact that FGM has been practised for over a thousand years, there is evidence to indicate it could be abolished in one generation. (JSM)

Full URL: http://www.un.org/en/events/femalegenitalmutilationday/

20150206-28*

New measures to end FGM on International Day of Zero Tolerance. (2015), London: Department of Health, Home Office and Department for Education 6 February 2015

News item reporting on a series of measures to be brought in by the government to better protect women and girls at risk of female genital mutilation. (CI)

Full URL: https://www.gov.uk/government/news/new-measures-to-end-fgm-on-international-day-of-zero-tolerance

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20150127-1*

Birmingham's Heartlands Hospital treats 1,500 victims of female genital mutilation in just five years. McCarthy N (2015), Birmingham Mail 26 January 2015

Reports that a hospital in Birmingham has dealt with 1,500 cases of FGM in five years, the number of cases peaking in 2013, even though the practice has been illegal in the UK since 2014. Most of those seen had been mutilated as a child outside the UK and although the practice of taking a child out of the UK in order to undergo FGM has been illegal since 2003, no one has been prosecuted. (JR)

Full URL: http://www.birminghammail.co.uk/news/midlands-news/birminghams-heartlands-hospital-treats-1500-8506599

20150120-2*

Doctor 'performed FGM on new mother in hospital'. Anon (2015), BBC News 20 January 2015

Reports that, in the first prosecution of its kind in the UK, a court has heard how a British doctor performed female genital mutilation on a mother after she gave birth in hospital. The doctor is accused of carrying out the procedure at the Whittington Hospital in north London. (CI)

Full URL: http://www.bbc.co.uk/news/uk-30886077

20141217-51*

Female genital mutilation: Knowledge, attitude and practices of Flemish midwives. Sien C, L'Ecluse C, Clays E, et al (2014), Midwifery 8 December 20104 Online version ahead of print

Background

Health professionals in Belgium are confronted with female genital mutilation (FGM). To date, no survey to assess knowledge, attitudes and practices on FGM was conducted among midwives in the Northern region of Belgium.

Objective

The objective of this study was to assess the knowledge, attitude and practices of Flemish midwives regarding female genital mutilation (FGM).

Design

We used a quantitative design, using KAP study (semi-structured questionnaire)

Setting

labour wards, maternity wards and maternal intensive care units (MIC) in 56 hospitals in Flemish region of Belgium

Participants

820 midwives, actively working in labour wards, maternity wards and maternal intensive care units (MIC)
Findings
Eight hundred and twenty valid questionnaires (40.9%) were returned. More than fifteen percent of the respondents were recently confronted with FGM. They were mostly faced with the psychological and sexual complications caused by FGM. Few respondents were aware of existing guidelines regarding FGM in their hospitals (3.5%). The results also showed that only 20.2% was aware of the exact content of the law. The majority of midwives condemned the harmful traditional practice: FGM was experienced as a form of violence against women or a violation of human rights. Only 25.9% declared that FGM forms a part of their midwifery program. The vast majority of respondents (92.5%) indicated a need for more information on the subject.
Key conclusions
This study indicated that midwives in Flanders are confronted with FGM and its complications and highlighted the gaps in the knowledge of Flemish midwives regarding FGM. This may interfere with the provision of adequate care and prevention of FGM for the new-born daughter.
Implications for practice
There is an important need for appropriate training of (student)midwives concerning FGM as well as for the development and dissemination of clear guidelines in Flemish hospitals. (Author)

20141217-34*

Research gaps in the care of women with female genital mutilation: an analysis. Abdulcadir J, Rodriguez MI, Say L (2015), BJOG: An International Journal of Obstetrics and Gynaecology vol 122, no 3, February 2015, pp 294-303

Female genital mutilation (FGM) includes procedures involving the partial or total removal of the external female genitals for non-therapeutic reasons. They can have negative psychosexual and health consequences that need specific care. In this paper, we review some key knowledge gaps in the clinical care of women with FGM, focusing on obstetric outcomes, surgical interventions (defibulation and clitoral reconstruction), and the skills and training of healthcare professionals involved in the prevention and management of FGM. We identify research priorities to improve the evidence necessary to establish guidelines for the best multidisciplinary care, communication, and prevention, and to improve health-promotion measures for women with FGM. (59 references) (Author)

20141125-9*

Effects of female genital cutting on physical health outcomes: a systematic review and meta-analysis. Berg RC, Underland V, Odfgaard-Jensen J, et al (2014), BMJ Open vol 4, no 11, 21 November 2014

Objective Worldwide, an estimated 125 million girls and women live with female genital mutilation/cutting (FGM/C). We aimed to systematically review the evidence for physical health risks associated with FGM/C.
Design We searched 15 databases to identify studies (up to January 2012). Selection criteria were empirical studies reporting physical health outcomes from FGM/C, affecting females with any type of FGM/C, irrespective of ethnicity, nationality and age. Two review authors independently screened titles and abstracts, applied eligibility criteria, assessed methodological study quality and extracted full-text data. To derive overall risk estimates, we combined data from included studies using the Mantel-Haenszel method for unadjusted dichotomous data and the generic inverse-variance method for adjusted data. Outcomes that were sufficiently similar across studies and reasonably resistant to biases were aggregated in meta-analyses. We applied the instrument Grading of Recommendations Assessment, Development and Evaluation to assess the extent to which we have confidence in the effect estimates.
Results Our search returned 5109 results, of which 185 studies (3.17 million women) satisfied the inclusion criteria. The risks of systematic and random errors were variable and we focused on key outcomes from the 57 studies with the best available evidence. The most common immediate complications were excessive bleeding, urine retention and genital tissue swelling. The most valid and statistically significant associations for the physical health sequelae of FGM/C were seen on urinary tract infections (unadjusted RR=3.01), bacterial vaginosis (adjusted OR (AOR)=1.68), dyspareunia (RR=1.53), prolonged labour (AOR=1.49), caesarean section (AOR=1.60), and difficult delivery (AOR=1.88).
Conclusions While the precise estimation of the frequency and risk of immediate, gynaecological, sexual and obstetric complications is not possible, the results weigh against the continuation of FGM/C and support the diagnosis and management of girls and women suffering the physical risks of FGM/C. (Author) [The full text of this article is available free of charge via http://bmjopen.bmj.com]

Full URL: bmjopen.bmj.com/content/4/11/e006316.short?rss=1

20141125-85*

The psychological impact of Female Genital Mutilation/Cutting (FGM/C) on girls/women's mental health: a narrative

literature review. Mulongo P, Martin CH, McAndrew S (2014), Journal of Reproductive and Infant Psychology vol 32, no 5, 2014, pp 469-485

Background: Female Genital Mutilation/Cutting (FGM/C) is the procedure of removing healthy external genitalia from girls/women for socio-cultural reasons. There is much scientific literature on the adverse physical health complications that can result from having FGM/C, but little is known about its psychological impact and treatment. Objective: To identify psychological problems that may follow from a woman having FGM/C and success of treatment herein, and relate findings to the role of the maternity care professional. Study design: A structured narrative review, which identified 10 studies, was carried out. Findings: Eight of ten studies reported psychological consequences, such as Post-Traumatic Stress Disorder (PTSD) and affective disorders. Also identified were socio-cultural differences in the meaning of perceived consequences for different individuals. Two studies reported inconclusive results regarding the psychological impact of FGM/C on women's lives. Key conclusion: While these findings provide an indication of adverse psychological effects of women/girls having FGM/C, more studies are needed. In particular, studies that focus on the role that cutting extent, circumstances surrounding the cutting, and girls' level of knowledge of what was going to take place, and their relationships to psychological outcomes. Implications for Practice: Raising awareness of the risk of negative psychological consequences is important, with maternal health care professionals requiring training on how to treat and care for women/girls who are suffering problems that result from having FGM/C. (Author)

20141119-79

Female genital mutilation: raising awareness to safeguard children. (2014), Journal of Health Visiting vol 2, no 10, October 2014, p 531

The Institute of Health Visiting has published a practical fact sheet on FGM, and the FGM National Clinical Group has produced a short film to raise the issue's profile. (Author)

20141105-12*

Prevalence of female genital mutilation and its effect on women's health in Bale zone, Ethiopia: a cross-sectional study. Bogale D, Markos D, Kaso M (2014), BMC Public Health vol 14, no 1076, 16 October 2014

Background
Females' genital mutilation (FGM) is one of the harmful traditional practices affecting the health of women and children. It has a long-term physiological, sexual and psychological effect on women. It remains still a serious problem for large proportion of women in most sub-Saharan Africa countries including Ethiopia. Methods
A community based cross sectional study design which is supplemented by qualitative method was conducted in 2014. A total of 634 reproductive age women were involved in the quantitative part of the study. The respondents were drawn from five randomly selected districts of Bale zone. The total sample was allocated proportionally to each district based on the number of reproductive age women it has. Purposive sampling method was used for qualitative study. Then, data were collected using pre-tested and structured questionnaire. The collected data were analyzed by SPSS for windows version 16.0. Multiple logistic regressions were carried out to examine the existence of relationship between FGM and selected determinant factors. Variables significant in the bivariate analysis were then entered into a multiple logistic regression analysis. Results
In this study, 486 (78.5%) of women had undergone some form of FGM with 75% lower and 82% upper confidence interval. To get married, to get social acceptance, to safeguard virginity, to suppress sexual desire and religious recommendations were the main reasons of FGM. The reported immediate complications were excessive bleeding at the time of the procedure, infection, urine retention and swelling of genital organ. Muslim women and women from rural areas were significantly more likely to have undergone the procedure. In addition to these, compared to women 15-20 years old older women were more likely to report themselves having undergone FGM. Conclusions
Although younger women, those from urban residence and some religions are less likely to have had FGM it is still extremely common in this zone. Deep cultural issues and strongly personally held beliefs which are not simple to predict or quantify are likely to be involved in the perpetuation of FGM. Efforts to eradicate the practice should incorporate a human rights approach rather than rely solely on the damaging health consequences. (Author) [Please note: BMC initially publish articles in a provisional format. If there is a note on the document to indicate that it is still provisional, it may undergo minor changes]

Full URL: http://www.biomedcentral.com/content/pdf/1471-2458-14-1076.pdf

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20141104-73*

Female genital mutilation/cutting in The Gambia: long-term health consequences and complications during delivery and for the newborn. Kaplan A, Forbes M, Bonhoure I, et al (2013), International Journal of Women's Health vol 5, 17 June 2013,

no 323-331

Background: Female genital mutilation/cutting (FGM/C) is a harmful traditional practice deeply rooted in 28 Sub-Saharan African countries. Its prevalence in The Gambia is 76.3%. The objective of this study was to gain precise information on the long-term health consequences of FGM/C in The Gambia as well as on its impact on delivery and on the health of the newborns.

Methods: Data were collected from 588 female patients examined for antenatal care or delivery in hospitals and health centers of the Western Health Region, The Gambia. The information collected, both through a questionnaire and medical examination, included sociodemographic factors, the presence or not of FGM/C, the types of FGM/C practiced, the long-term health consequences of FGM/C, complications during delivery and for the newborn. Odds ratios, their 95% confidence intervals, and P values were calculated.

Results: The prevalence of patients who had undergone FGM/C was 75.6% (type I: 75.6%; type II: 24.4%). Women with type I and II FGM/C had a significantly higher prevalence of long-term health problems (eg, dysmenorrhea, vulvar or vaginal pain), problems related to anomalous healing (eg, fibrosis, keloid, synechia), and sexual dysfunction. Women with FGM/C were also much more likely to suffer complications during delivery (perineal tear, obstructed labor, episiotomy, cesarean, stillbirth) and complications associated with anomalous healing after FGM/C. Similarly, newborns were found to be more likely to suffer complications such as fetal distress and caput of the fetal head.

Conclusion: This study shows that FGM/C is associated with a variety of long-term health consequences, that women with FGM/C are four times more likely to suffer complications during delivery, and the newborn is four times more likely to have health complications if the parturient has undergone FGM/C. These results highlight for the first time the magnitude of consequences during delivery and for the newborn, associated with FGM/C in The Gambia. [The full text of this article is available free of charge at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3702244/] (38 references) (Author)

Full URL: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3702244/

20141027-75

Female genital mutilation/cutting - towards abandonment of a harmful cultural practice. Varol N, Fraser IS, Ng CHM, et al (2014), Australian and New Zealand Journal of Obstetrics and Gynaecology (ANZJOG) vol 54, no 5, October 2014, pp 400-405

Globally, the prevalence of, and support for, female genital mutilation/cutting (FGM/C) is declining. However, the entrenched sense of social obligation that propagates the continuation of this practice and the lack of open communication between men and women on this sensitive issue are two important barriers to abandonment. There is limited evidence on the role of men and their experiences in FGM/C. Marriageability of girls is considered to be one of the main driving forces for the continuation of this practice. In some countries, more men than women are advocating to end FGM/C. Moreover, men, as partners to women with FGM/C, also report physical and psychosexual problems. The abandonment process involves expanding a range of successful programs, addressing the human rights priorities of communities and providing power over their own development processes. Anecdotal evidence exists that FGM/C is practised amongst African migrant populations in Australia. The Australian Government supports a taskforce to improve community awareness and education, workforce training and evidence building. Internationally, an African Coordinating Centre for abandonment of FGM/C has been established in Kenya with a major global support group to share research, promote solidarity, advocacy and implement a coordinated and integrated response to abandon FGM/C. (41 references) (Author)

20141013-5*

Africa can end 'child abuse' of FGM by 2035: activists. Migiro K (2014), Yahoo! News 10 October 2014

Reports the launch of 'the Girl Generation campaign', which aims to facilitate cultural and behavioural change in 10 African countries including Kenya, Burkina Faso and Nigeria and to end the practice of female genital mutilation (FGM) in Africa within 20 years. (JSM)

Full URL: http://news.yahoo.com/africa-end-child-abuse-fgm-2035-activists-151019722.html

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20141002-14

Evidence to inform education, training and supportive work environments for midwives involved in the care of women with female genital mutilation: A review of global experience. Dawson A, Turkmani S, Fray S, et al (2015), Midwifery vol 31, no 1, January 2015, pp 229-238

Objective: to identify how midwives in low and middle income countries (LMIC) and high income countries (HIC) care for women with female genital mutilation (FGM), their perceived challenges and what professional development and workplace strategies might better support midwives to provide appropriate quality care. Design: an integrative review

involving a narrative synthesis of the literature was undertaken to include peer reviewed research literature published between 2004 and 2014. Findings: 10 papers were included in the review, two from LMIC and eight from HIC. A lack of technical knowledge and limited cultural competency was identified, as well as socio-cultural challenges in the abandonment process of the practice, particularly in LMIC settings. Training in the area of FGM was limited. One study reported the outcomes of an education initiative that was found to be beneficial. Key conclusions: professional education and training, a working environment supported by guidelines and responsive policy and community education, are necessary to enable midwives to improve the care of women with FGM and advocate against the practice. Implications for practice: improved opportunities for midwives to learn about FGM and receive advice and support, alongside opportunities for collaborative practice in contexts that enable the effective reporting of FGM to authorities, may be beneficial and require further investigation. (Author)

20140915-3*

Female genital mutilation [written answers]. House of Commons (2014), Hansard vol 585, no 32, 4 September 2014, col 309W

Mr Timpson responds to a written question by Steve McCabe asking the Secretary of State for Education (1) how many cases of female genital mutilation have been reported by teachers and staff in school in the latest period for which figures are available; (2) whether her Department offers guidance to teachers and staff on addressing cases of female genital mutilation amongst female students. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201415/cmhansrd/cm140904/text/140904w0001.htm#14090443000013

20140904-82*

This abuse must stop. Cecilia Anim argues that nurses and midwives must identify and challenge cases of female genital mutilation. (2014), Nursing Standard vol 28, no 49, 2014, p 26

No abstract available.

20140811-4

From the editor. Ashwin C (2014), MIDIRS Midwifery Digest vol 23, no 4, September 2014, p 276

In this September 2014 editorial, MIDIRS principal editor Cathy Ashwin pulls together the different strands featuring in this issue of the Digest. These range from the Hot Topic exploring the role of the supervisor of midwives, to the issues surrounding female genital mutilation and the first ever prosecution in a UK court of law, The editor also discusses some of the health issues facing asylum seekers and reports back from the recent ICM conference in Prague at the beginning of June 2014. (ABS)

20140807-8

Information paralysis regarding female genital mutilation. McCormick C, Raynor MD (2014), MIDIRS Midwifery Digest vol 24, no 3, September 2014, pp 311-313

Globally, female genital mutilation (FGM), also known as genital cutting/female circumcision, is recognised as a form of sexual violence against women and girls, and is therefore a human rights issue. Yet paradoxically and almost universally it is under-reported due to the perceived cultural sensitivity of the subject matter. Nevertheless, the literature is replete with information that provides a global overview of the definition, types, physical, emotional, social and psychosexual consequences of FGM. This paper will not revisit these areas but aim to discuss the legal and wider professional ramifications that midwives need to consider during pregnancy, labour and puerperium, when screening for or caring for a woman with, FGM, regardless of its type. (7 references) (Author)

20140805-118

Nursing and midwifery at the crossroads - new challenges, new successes. Richens Y (2014), African Journal of Midwifery and Women's Health vol 8, no 3, July-September 2014, pp 152-153

Yana Richens, Professional Advisor to the RCM, shares three presentations given at the first International Nursing Conference held at Stellenbosch University, South Africa. The presentations were on the subject of midwifery students' experiences of mother-child HIV prevention; experiences of pregnant women regarding health education in the antenatal period; and a midwives' guide to management of FGM. (2 reference) (MB)

20140716-41

Closing in on FGM. Ewers H (2014), Midwives vol 17, no 4, 2014, pp 42-44

Almost 30 years after FGM was made illegal in the UK, the Crown Prosecution Service announced the first UK prosecutions over FGM. Hollie Ewers looks at the latest efforts being made in the anti-FGM campaign. (Author)

20140704-42*

Gender differences in support for the discontinuation of female genital cutting in Sierra Leone. Sagna ML (2014), Culture, Health & Sexuality vol 16, no 6, 2014, pp 603-619

Despite decades of policies, interventions and legislation, many girls and women are being subjected to female genital cutting (FGC) across the African continent. Because FGC has profound implications for women's wellbeing and reproductive health rights, an examination of behavioural changes toward the practice is imperative to reinforce strategies directed at eradicating it. Using a nationally representative survey, this study examines support for discontinuation of FGC and its associated predictors among both women and men in Sierra Leone. Findings reveal gender differences in attitudes toward the elimination of the practice across most of the socioeconomic predictors. Interestingly, beliefs about and perceived benefits of FGC emerge as important determinants of the support for the elimination of FGC, both genders considered. The findings highlight the importance of achieving gender equality and women's empowerment, and the necessity for a more contextualised approach to FGC eradication. (Author)

20140703-9*

Female genital mutilation: the case for a national action plan. Second report of session 2014-15. House of Commons Home Affairs Committee (2014), London: The Stationery Office Limited 25 June 2014, 59 pages

A report and the formal minutes relating to the report on FGM ordered by the House of Commons including: key facts and an overview of FGM in the UK with recent developments; information on prosecuting FGM, cases considered by the Crown Prosecution Service, problems in securing a prosecution and comparisons with France; how to safeguard those at risk, including training, guidelines and the roles of different organisations; changes in law that need to be made and working with communities. (JR)

Full URL: http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/201/201.pdf

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20140530-18*

Female genital mutilation: a violation of the human rights of girls and women a call for concrete policies and renewed actions. Karunamoorthi K (2013), Journal of Socialomics vol 2, no 2, April 2013, pp 1-5

Gives an overview of the history and culture surrounding the practice of female genital mutilation (FGM) and discusses its prevalence and the negative outcomes for girls and women who have undergone this procedure, and also looks at preventative strategies. [The full text of this article is available free of charge at: http://omicsgroup.org/journals/female-genital-mutilation-a-violation-of-the-human-rights-of-girls-and-women-a-call-for-concrete-policies-and-renewed-actions-2167-0358.1000e121.pdf] (24 references) (Author)

Full URL: http://omicsgroup.org/journals/female-genital-mutilation-a-violation-of-the-human-rights-of-girls-and-women-a-call-for-concrete-policies-and-renewed-actions-2167-0358.1000e121.pdf

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20140530-11*

Perceptions of obstetrical interventions and female genital cutting: insights of men in a Somali refugee community. Johnson-Agbakwu CE, Helm T, Killawi A, et al (2014), Ethnicity and Health vol 19, no 4, 2014, pp 440-457

Objectives. Somali women are at increased risk of adverse pregnancy outcomes. Anxiety and perceived stigmatization toward female genital cutting (FGC) further fuels an atmosphere of miscommunication and distrust, contributing to poorer health outcomes. While the attitudes and experiences of Somali refugee women toward healthcare are widely known, the views of Somali refugee men are largely unknown. This study examines the perspectives of Somali men toward FGC and women's childbirth experiences in one refugee community in the USA. Design. Community-based participatory research partnerships with key stakeholders within the Somali refugee community incorporated qualitative methods comprising semi-structured focus groups and individual interviews to elicit male participants' perspectives on FGC, experiences during childbirth, and the perception of increased cesarean deliveries among Somali women. Qualitative analyses involved a framework and team-based approach using grounded theory and conventional content analysis. Results. Acculturation influenced changes in traditional gender roles fostering new dynamics in shared decision-making within the household and during childbirth. Participants were aware of FGC-related morbidity, ongoing matriarchal support for FGC, and were generally not supportive of FGC. They perceived health-care providers as being unfamiliar with caring for women with FGC fueling profound aversion to cesarean deliveries, miscommunication, and distrust of the health-care system. Conclusion. Our work yields new

insights into Somali reproductive healthcare through Somali men, namely: strong matriarchal support of FGC, discomfort in men's presence during delivery, and a strong aversion to cesarean delivery. Our findings support the need for advocacy to engage Somali women, their partners/spouses, and health-care providers in facilitating greater continuity of care, building greater trust as men become engaged throughout the spectrum of care in the decision-making process while respecting traditional norms. Cultural health navigators should bridge communication and support between providers and patients. Our work provides foundational knowledge to inform culturally appropriate health interventions within a Somali refugee community. (Author)

20140528-42

Combating female genital cutting in the UK: The role of the health visitor. Dike P, Umoren I (2014), Journal of Health Visiting vol 2, no 5, May 2014, pp 260-265

Over the past 30 years, the prevalence of female genital cutting (FGC) in the UK has increased, despite legislation making the practice illegal. The Government has recognised the need for health professionals to become knowledgeable in both the health implications and the cultural aspects of this practice. Health visitors are well placed, given their proximity to families during the early years of a child's life, to identify girls at risk of FGC and enact interventions and strategies that will help to reduce its prevalence in affected communities. It is necessary to examine how the current role of the health visitor can be developed to aid the prevention and reporting of FGC in the UK if the aim of eradicating the practice is to be achieved. (29 references) (Author)

20140522-52*

Missed opportunities for diagnosis of female genital mutilation. Abdulcadir J, Dugerdil A, Boulvain M, et al (2014), International Journal of Gynecology & Obstetrics vol 125, no 3, 2014, pp 256-260

OBJECTIVE:

To investigate missed opportunities for diagnosing female genital mutilation (FGM) at an obstetrics and gynecology (OB/GYN) department in Switzerland.

METHODS:

In a retrospective study, we included 129 consecutive women with FGM who attended the FGM outpatient clinic at the Department of Gynecology and Obstetrics at the University Hospitals of Geneva between 2010 and 2012. The medical files of all women who had undergone at least 1 previous gynecologic exam performed by an OB/GYN doctor or a midwife at the study institution were reviewed. The type of FGM reported in the files was considered correct if it corresponded to that reported by the specialized gynecologist at the FGM clinic, according to WHO classification.

RESULTS:

In 48 (37.2%) cases, FGM was not mentioned in the medical file. In 34 (26.4%) women, the diagnosis was correct. FGM was identified but erroneously classified in 28 (21.7%) cases. There were no factors (women's characteristics or FGM type) associated with missed diagnosis.

CONCLUSION:

Opportunities to identify FGM are frequently missed. Measures should be taken to improve FGM diagnosis and care. (Author)

20140519-3*

Collecting data on female genital mutilation. Erskine K (2014), BMJ vol 348, no 7958, 17 May 2014, p 9

Editorial which comments that the introduction by the government of mandatory reporting of female genital mutilation and related procedures, without funding and without additional training for staff, is likely to result in inaccurate data collection, could be a waste of clinical time and a distraction from the crucial campaign to identify and protect girls at risk. (CI)

20140514-23*

Female genital mutilation [Last updated 2017]. International Confederation of Midwives (2017), The Hague, The Netherlands: International Confederation of Midwives 2017. 4 pages

ICM position statement on female genital mutilation. Reviewed and endorsed at Durban International Council meeting in 2011. (5 references) (SB)

Full URL: https://internationalmidwives.org/assets/files/statement-files/2018/04/eng-fgm.pdf

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20140513-29*

Egypt: deadly risks, but female genital mutilation persists. Guerin O (2014), BBC News 13 May 2014

Describes the events behind the first trial in Egypt, of a girl's father and a doctor following the death of a 13 year old girl soon after she had undergone female genital mutilation. (JR)

Full URL: http://www.bbc.com/news/world-middle-east-27322088

20140409-69

Female genital mutilation. Winter GF (2014), British Journal of Midwifery vol 22, no 4, April 2014, p 236

Considers contradictions in law and practice relating to female genital mutilation and 'cosmetic' genital surgery. (8 references) (CI)

20140408-32*

Prosecution for female genital mutilation raises concerns among doctors. Dyer C (2014), BMJ vol 348, no 7952, 5 April 2014, p 2

Briefly reports on concerns expressed by obstetricians that the first criminal prosecution in the UK for female genital mutilation (FGM) could lead doctors to fear that they are liable for prosecution if they treat the tearing that can occur during childbirth in women who have undergone the procedure. (CI)

20140408-3

Management of type III female genital mutilation in Birmingham, UK: A retrospective audit. Paliwal P, Ali S, Bradshaw S, et al (2014), Midwifery vol 30, no 3, March 2014, pp 282-288

OBJECTIVES: to audit clinical management of women with type III female genital mutilation (FGM) according to local guidelines. Secondary objectives were to describe the population that uses the service and compare obstetric outcomes of intrapartum deinfibulation and antenatal deinfibulation. DESIGN: retrospective audit. SETTING: a hospital midwifery-led FGM specialist service in Birmingham, UK. PARTICIPANTS: 253 women with type III FGM who gave birth between January 2008 and December 2009 METHODS: retrospective case analysis using patient records. MAIN OUTCOME MEASURES: proportion of women managed according to locally agreed criteria for the management of FGM; obstetric outcomes including perineal tears, episiotomy rates, estimated blood loss, infant APGAR scores and indications for caesarean section. FINDINGS: 91 (36%) women booked into antenatal care after 16 weeks gestation. Only 26 (10.3%) were managed fully according to guidelines. The area with poorest performance was child protection, where the presence of normal genitalia was documented in only 52 (38.8%) of medical notes following birth of a female infant. The majority of women (214, 84.6%) had been deinfibulated in a previous pregnancy. Of the 39 infibulated at booking, only 9 (23.1%) were deinfibulated antenatally, the rest opted for intrapartum deinfibulation. Women who had intrapartum deinfibulation had a higher average blood loss and more tears than those deinfibulated antenatally, although this was not statistically significant. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: alternative systems should be considered to improve documentation of child protection related information. Further research is needed to confirm or refute the adverse findings among those that delayed deinfibulation. (41 references) (Author)

20140324-6*

FGM: UK's first female genital mutilation prosecutions announced. (2014), BBC News 21 March 2014

Reports that the Crown Prosecution Service has announced the first prosecutions connected with Female Genital Mutilation (FGM) since the practice was banned in the UK in 1985. States that Dr Dhanuson Dharmasena will stand trial for an offence allegedly committed while he was working at the Whittington Hospital in London, and Hasan Mohamed is charged with intentionally encouraging FGM. Includes audio-visual footage featuring a specialist midwife speaking about how FGM affects women. (JSM)

Full URL: http://www.bbc.co.uk/news/uk-26681364#

20140324-11*

Children, families and maternity e-bulletin. Department of Health (2014), London: DH Edition 79, March 2014, pp 1-8

Topics covered in this issue include: Friends and Family Test for Maternity Services; Consultation on changes to specialised services specifications; Child Health Clinical Outcome Review Programme; Mid-Staffs Inquiry - Criminal Offence of Ill-Treatment or

Wilful Neglect; Child Health Profiles 2014 published; Female Genital Mutilation (FGM) mandatory data collection from acute trusts; National Institute for Health and Care Excellence (NICE) Guidance on Domestic Violence; Violence Against Women and Girls Action Plan;

Ensuring quality services (Ill children and children with disabilities); Health Select Committee Inquiry into Children and Young People's Mental Health and CAMHS; MindEd e- learning to support healthy young minds. (JSM)
Full URL: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/295103/CFM_ebulletin_No__79_2014_FINAL.pdf

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20131227-5*

Decline of supportive attitudes among husbands toward female genital mutilation and its association to those practices in Yemen. Al-Khulaidi GA, Nakamura K, Seino K, et al (2013), PLoS ONE vol 8, no 12, 18 December 2013, e83140

Objectives: To elucidate the attitudes of women and their husband's towards female genital mutilation (FGM) and their associations with the continuation of FGM upon their daughters. Methods: Subjects were 10,345 (in 1997) and 11,252 (in 2003) ever married women aged 15 to 49 years from the Yemen Demographic Health Surveys. Performances of FGM on the most-recently-born daughters were investigated. Attitudes of women and their husbands were assessed by their opinions on the continuation of FGM. The association between the attitudes of women and their husbands and performance of FGM on the most-recently-born daughters were investigated after adjusting for age and education of the women. Findings: The percentage among the most-recently-born daughters who received FGM of women who had undergone FGM declined from 61.9% in 1997 to 56.5% in 2003 ($p<0.001$). The percentages of women who had undergone FGM and who supported the continuation of FGM and of husbands who also supported its continuation decreased from 78.2% and 60.1% in 1997 to 70.9% and 49.5% in 2003, respectively (both $p<0.001$). When the women or the husbands did not agree with FGM, it was less likely to be performed on their daughter than when the women or the husbands agreed in 1997 (odds ratio=0.11, 95% confidence interval 0.07-0.16 and odds ratio=0.07, 95% confidence interval 0.04-0.12, respectively) and in 2003 (odds ratio=0.12, 95% confidence interval 0.09-0.16 and odds ratio=0.11, 95% confidence interval 0.07-0.16, respectively). Conclusion: Non-supportive attitudes of women and their husbands towards the continuation of FGM have become common and were associated with their decision not to perform FGM upon their daughters. [The full text of this article is available free of charge at: http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0083140] (30 references) (Authors)
Full URL: http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0083140

20131218-3*

Female genital mutilation [written answers]. House of Commons (2013), Hansard vol 572, no 94, 16 December 2013, col 521W

Jane Ellison responds to a written question by Helen Jones asking the Secretary of State for Health what steps he has taken to implement the recommendations in the report, Tackling FGM in the UK; and if he will make a statement. (VDD)
Full URL: http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131216/text/131216w0005.htm#1312174001204

20131212-70

A united fight against FGM. (2013), Midwives no 6, 2013, p 13

As a new report launches around the recognition and treatment of FGM victims by healthcare professionals, Midwives looks at the key recommendations. (Author)

20131204-6*

Female genital mutilation [written answers]. House of Commons (2013), Hansard vol 571, no 28, 26 November 2013, col 177W

Norman Baker responds to a written question by Gavin Shuker asking the Secretary of State for the Home Department, pursuant to the answer to the hon. Member for Bishop Auckland of 11 September 2013, Official Report, column 744W, on female genital mutilation, when the Home Office Inter-Ministerial Group on Violence against Women and Girls has met since May 2010; and which (a) Government Ministers and (b) civil servants attended each such meeting. (VDD)
Full URL: http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131126/text/131126w0001.htm#13112670000263

20131129-4

FGM: a hidden crime. Naughton L (2013), Community Practitioner vol 86, no 12, December 2013, pp 22-23

A new report into female genital mutilation (FGM) highlights that, despite the barbaric practice being illegal in the UK, not one single person has been held to account for their involvement in the act. (Author)

20131125-5*

Female genital mutilation [written answer]. House of Lords (2013), Hansard vol 749, no 73, 20 November 2013, col W213

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe) responds to a written question by Baroness Scotland of Asthal asking Her Majesty's Government (a) what assessment they have made of the report Tackling Female Genital Mutilation in the UK, and in particular its assertion that 66,000 women in England and Wales have undergone Female Genital Mutilation and more than 24,000 girls under 15 are at risk of it; (b) what plans they have to implement the recommendations made in the report Tackling Female Genital Mutilation in the UK. (VDD)

Full URL: http://www.publications.parliament.uk/pa/ld201314/ldhansrd/text/131120w0001.htm#13112085000316

20131125-4*

Female genital mutilation [written answers]. House of Commons (2013), Hansard vol 570, no 78, 20 November 2013, col 910W

Norman Baker responds to a written question by Gavin Shuker asking the Secretary of State for the Home Department pursuant to the answer to the hon. Member for Bishop Auckland of 11 September 2013, Official Report, column 744W, on female genital mutilation, when the Home Office Inter-Ministerial Group on Violence against Women and Girls has met since May 2010; and which (a) Government Ministers and (b) civil servants attended each such meeting. (VDD)

20131125-107*

Female genital cutting. Perron L, Senikas V, Burnett M, et al (2013), JOGC [Journal of Obstetrics and Gynaecology Canada] vol 35, no 11, November 2013, pp 1028-1045

Objective: To strengthen the national framework for care of adolescents and women affected by female genital cutting (FGC) in Canada by providing health care professionals with: (1) information intended to strengthen their knowledge and understanding of the practice; (2) directions with regard to the legal issues related to the practice; (3) clinical guidelines for the management of obstetric and gynaecological care, including FGC related complications; and (4) guidance on the provision of culturally competent care to adolescents and women with FGC. Published literature was retrieved through searches of PubMed, CINAHL, and The Cochrane Library in September 2010 using appropriate controlled vocabulary (e.g., Circumcision,Female) and keywords (e.g., female genital mutilation, clitoridectomy, infibulation). We also searched Social Science Abstracts, Sociological Abstracts, Gender Studies Database, and ProQuest Dissertations and Theses in 2010 and 2011. There were no date or language restrictions. Searches were updated on a regular basis and incorporated in the guideline to December 2011. Grey (unpublished) literature was identified through searching the websites of health technology assessment and health technology-related agencies, clinical practice guideline collections, clinical trial registries, and national and international medical specialty societies. Values: The quality of evidence in this document was rated using the criteria described in the Report of the Canadian Task Force on Preventive Health Care (Table 1). Summary Statements 1. Female genital cutting is internationally recognized as a harmful practice and a violation of girls' and women's rights to life, physical integrity, and health. (II-3) 2. The immediate and long-term health risks and complications of female genital cutting can be serious and life threatening. (II-3) 3. Female genital cutting continues to be practised in many countries, particularly in sub-Saharan Africa, Egypt, and Sudan. (II-3) 4. Global migration patterns have brought female genital cutting to Europe, Australia, New Zealand, and North America, including Canada. (II-3) 5. Performing or assisting in female genital cutting is a criminal offense in Canada. (III) 6. Reporting to appropriate child welfare protection services is mandatory when a child has recently been subjected to female genital cutting or is at risk of being subjected to the procedure. (III) 7. There is concern that female genital cutting continues to be perpetuated in receiving countries, mainly through the act of re-infibulation. (III) 8. There is a perception that the care of women with female genital cutting is not optimal in receiving countries. (III) 9. Female genital cutting is not considered an indication for Caesarean section. (III) Recommendations 1. Health care professionals must be careful not to stigmatize women who have undergone female genital cutting. (III-A) 2. Requests for re-infibulation should be declined. (III-B) 3. Health care professionals should strengthen their understanding and knowledge of female genital cutting and develop greater skills for the management of its complications and the provision of culturally competent care to adolescents and women who have undergone genital cutting. (III-A) 4. Health care professionals should use their knowledge and influence to educate and counsel families against having female genital cutting performed on their daughters and other family members. (III-A) 5. Health care professionals should advocate for the availability of and access to appropriate support and counselling services. (III-A) 6. Health care professionals should lend their voices to community-based initiatives seeking to promote the elimination of female genital cutting. (III-A) 7. Health care professionals should use interactions with patients as opportunities to educate women and their families about female genital cutting and other aspects of women's health and reproductive rights. (III-A) 8. Research into female genital cutting should be undertaken to explore women's perceptions and experiences of accessing

sexual and reproductive health care in Canada. (III-A) The perspectives, knowledge, and clinical practice of health care professionals with respect to female genital cutting should also be studied. (III-A). 9. Information and guidance on female genital cutting should be integrated into the curricula for nursing students, medical students, residents, midwifery students, and students of other health care professions. (III-A) 10. Key practices in providing optimal care to women with female genital cutting include: a. determining how the woman refers to the practice of female genital cutting and using this terminology throughout care; (III-C) b. determining the female genital cutting status of the woman and clearly documenting this information in her medical file; (III-C) c. ensuring the availability of a well-trained, trusted, and neutral interpreter who can ensure confidentiality and who will not exert undue influence on the patient-physician interaction when providing care to a woman who faces language challenges; (III-C) d. ensuring the proper documentation of the woman's medical history in her file to minimize the need for repeated medical histories and/or examinations and to facilitate the sharing of information; (III-C) e. providing the woman with appropriate and well-timed information, including information about her reproductive system and her sexual and reproductive health; (III-C) f. ensuring the woman's privacy and confidentiality by limiting attendants in the room to those who are part of the health care team; (III-C) g. providing woman-centred care focused on ensuring that the woman's views and wishes are solicited and respected, including a discussion of why some requests cannot be granted for legal or ethical reasons; (III-C) h. helping the woman to understand and navigate the health system, including access to preventative care practices; (III-C) i. using prenatal visits to prepare the woman and her family for delivery; (III-C) j. when referring, ensuring that the services and/or practitioners who will be receiving the referral can provide culturally competent and sensitive care, paying special attention to concerns related to confidentiality and privacy. (III-C). (Author) [Superseded by SOGC Clinical Practice Guideline No. 395]

20131111-20*

Doctors are key to securing the UK's first conviction for FGM. Hives-Wood S (2013), BMJ vol 347, no 7932, 9 November 2013, p 3

Reports that a coalition of health organisations has recommended that doctors who find evidence of female genital mutilation should treat it as a crime and report it the police. (CI)

20131104-43*

Tackling FGM in the UK: intercollegiate recommendations for identifying, recording, and reporting. Royal College of Midwives, Royal College of Nursing, Royal College of Obstetricians and Gynaecologists, et al (2013), London: RCM November 2013. 30 pages

The recommendations contained in this report from the Intercollegiate Group and its partners demonstrate solidarity to raise awareness of the need for early intervention in order to prevent female genital mutilation (FGM). Calls for health and social care agencies, the Department of Education and the police to integrate FGM prevention into national and local strategies for safeguarding children from FGM abuse. (42 references) (Author, edited)

20131104-42*

Health professionals must screen for genital mutilation. Dreaper J (2013), BBC News 4 November 2013

States that guidelines (1), produced collaboratively by the Royal College of Midwives (RCM), the Royal College of Nursing (RCN), the Royal College of Obstetricians and Gynaecologists (RCOG), trade unions and Equality Now, have called for midwives, nurses and GPs to screen for female genital mutilation and to treat it as child abuse, referring all cases to the police and other services. 1. 1. RCM et al (2013), Tackling FGM in the UK: Intercollegiate recommendations for identifying, recording and reporting. London: RCM http://www.rcog.org.uk/files/rcog-corp/FGM_Report%20v10%20a~final%20forwebsite.pdf (JSM)

Full URL: http://www.bbc.co.uk/news/health-24765956#

20131104-40*

Intercollegiate group draws up ground-breaking recommendations for tackling female genital mutilation. Royal College of Obstetricians and Gynaecologists (2013), London: RCOG 4 November 2013

Announces the launch of a collaborative report (1) on Female Genital Mutilation (FGM) by several Royal Colleges, trade unions and Equality Now, in the House of Commons today. Reports that recommendations made in 'Tackling FGM in the UK: Intercollegiate recommendations for identifying, recording and reporting' include:

1. Treat FGM as Child Abuse: FGM is a severe form of violence against women and girls. It is child abuse and must be integrated into all UK child safeguarding procedures in a systematic way.
2. Implement an awareness campaign: The Government should implement a national FGM awareness campaign,

similar to previous domestic abuse and HIV campaigns.
3. Hold frontline professionals accountable: The NHS and local authorities should systematically measure the performance of frontline health professionals against agreed standards for addressing FGM and publish outcomes to enable effective benchmarking. 1. RCM et al (2013), Tackling FGM in the UK: Intercollegiate recommendations for identifying, recording and reporting. London: RCM http://www.rcog.org.uk/files/rcog-corp/FGM_Report%20v10%20a~final%20forwebsite.pdf (Author)
Full URL: https://www.rcog.org.uk/en/news/intercollegiate-group-draws-up-ground-breaking-recommendations-for-tackling-female-genital-mutilation/

20131104-24*

Female genital mutilation [written answer]. House of Lords (2013), Hansard vol 748, no 60, 28 October 2013, col W212

The Parliamentary Under-Secretary of State, Home Office (Lord Taylor of Holbeach) responds to a written question by Lord Judd asking Her Majesty's Government what estimate they have made of the number of female genital mutilation operations carried out in the United Kingdom in each of the last three years. (VDD)
Full URL: http://www.publications.parliament.uk/pa/ld201314/ldhansrd/text/131028w0001.htm#1310282000294

20131028-2*

NHS: migrant access [written answer]. House of Lords (2013), Hansard vol 748, no 54, 17 October 2013, col WA104

The Parliamentary Under-Secretary of State, Home Office (Lord Taylor of Holbeach) responds to a written question by Lord Touhig asking Her Majesty's Government (a) what provision they intend to make under proposals to regulate migrant access to health services for non-European Economic Area migrants who are victims of (1) violent crime, (2) sexual assault, or (3) female genital mutilation; (b) what provisions they intend to make under proposals to regulate migrant access to health services for non-European Economic Area migrants experiencing complications in pregnancy; (c) what assessment they have made of the compatibility between their proposals to regulate migrant access to health services and their strategy to end violence against women and girls, in particular with regard to victim support. (VDD)
Full URL: http://www.publications.parliament.uk/pa/ld201314/ldhansrd/text/131017w0001.htm#13101775000348

20131014-5*

Female genital mutilation [written answers]. House of Commons (2013), Hansard vol 568, no 53, 10 October 2013, col 328-329W

Lynne Featherstone responds to a written question by Helen Goodman asking the Secretary of State for International Development in which countries he assesses female genital mutilation to be (a) widespread and (b) tolerated by the authorities. (VDD)
Full URL: http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131010/text/131010w0001.htm#13101077000120

20131011-51

FGM helpline. (2013), Midwives no 4, 2013, p 10

News item reporting that the Royal College of Midwives has welcomed the launch of a new NSPCC helpline providing confidential and independent advise to young girls at risk of female genital mutilation, their parents and other relatives, and health professionals working with at-risk families. (CI)

20131003-26

The fight against FGM. (2013), British Journal of Midwifery vol 21, no 10, October 2013, p 688

Highlights the prevalence of female genital mutilation (FGM) in the UK, despite the introduction of legislation in 1985 which made the practice illegal. Although much has been done to raise awareness of FGM, to safeguard those at risk and to support women living with the consequences, there has not been a single prosecution in the UK in the past 30 years. (4 references) (CI)

20130916-41*

Female genital mutilation [written answers]. House of Commons (2013), Hansard vol 567, no 49, 12 September 2013, col 841W

Mr Lidington responds to a written question by Helen Goodman asking the Secretary of State for Foreign and

Commonwealth Affairs what recent discussions he has had with the Secretary of State for the Home Department on the practice of female genital mutilation. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130912/text/130912w0002.htm#130912w0002.htm_sbhd24

20130916-40*

Female genital mutilation [written answers]. House of Commons (2013), Hansard vol 567, no 49, 12 September 2013, col 814-815W

Lynne Featherstone responds to a written question by Helen Goodman asking the Secretary of State for International Development what recent discussions she has had with the Secretary of State for the Home Department about those at risk of female genital mutilation seeking asylum in the UK. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130912/text/130912w0001.htm#130912w0001.htm_sbhd58

20130916-37*

Female genital mutilation [written answers]. House of Commons (2013), Hansard vol 567, no 47, 10 September 2013, col 675-676W

Mrs Grant responds to a written question by Helen Goodman asking the Minister for Women and Equalities what recent discussions she has had with the Secretary of State for the Home Department on the practice of female genital mutilation in the UK. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130911/text/130911w0002.htm#13091164000921

20130916-33*

Female genital mutilation [written answers]. House of Commons (2013), Hansard vol 567, no 48, 11 September 2013, col 722-723W

Jeremy Browne and Mr Harper respond to a written question by Helen Goodman asking the Secretary of State for the Home Department (a) what funding the Government has allocated to tackling the practice of female genital mutilation at home and abroad; (b) (1) in how many cases asylum was granted on the grounds of the risk of female genital mutilation in each year since 2010; (2) in how many cases asylum was applied for on the basis of the risk of female genital mutilation but subsequently rejected since 2010; (c) what training is given to police officers on tackling and prosecuting instances of female genital mutilation; (d) what the policy is on granting asylum to women and girls at risk of female genital mutilation. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130911/text/130911w0001.htm#13091164000494

20130916-23*

Female genital mutilation [written answers]. House of Commons (2013), Hansard vol 567, no 47, 10 September 2013, col 675-676W

The Solicitor-General responds to a written question by Helen Goodman asking the Attorney-General how many convictions for committing female genital mutilation there were in (a) 2010-11, (b) 2011-12 and (c) 2012-13. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130910/text/130910w0001.htm#13091059000659

20130912-55

Increasing certified nurse-midwives' confidence in managing the obstetric care of women with female genital mutilation/cutting. Jacoby SD, Smith A (2013), Journal of Midwifery & Women's Health vol 58, no 4, July/August 2013, pp 451-456

INTRODUCTION:

In response to an increase in the number of women who immigrate to the United States from countries that practice female genital mutilation/cutting (FGM/C; infibulation), US clinicians can expand their knowledge and increase confidence in caring for women who have experienced infibulation. This article describes a comprehensive education program on FGM/C and the results of a pilot study that examined its effect on midwives' confidence in caring for women with infibulation.

METHODS:

An education program was developed that included didactic information, case studies, a cultural roundtable, and a hands-on skills laboratory of deinfibulation and repair. Eleven certified nurse-midwives (CNMs) participated in this pilot study. Participants completed a measure-of-confidence survey tool before and after the education intervention.

RESULTS:

Participants reported increased confidence in their ability to provide culturally competent care to immigrant women with infibulation when comparisons of preeducation and posteducation survey confidence logs were completed. DISCUSSION:
Following the education program and the knowledge gained from it, these midwives were more confident about their ability to perform anterior episiotomy and to deliver necessary care to women with FGM/C in a culturally competent context. This education program should be expanded as more women who have experienced infibulation immigrate to the United States. (23 references) (Author)

20130909-16*

Female genital mutilation [written answers]. House of Commons (2013), Hansard vol 567, no 42, 3 September 2013, col 330W

Mr Jeremy Browne responds to a written question by Toby Perkins asking the Secretary of State for the Home Department how many convictions for (a) carrying out female genital mutilation (FGM) in the UK and (b) transporting women or girls abroad for the purposes of FGM have been secured in each year since the passage of the Female Genital Mutilation Act 2003. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130903/text/130903w0002.htm#13090455001657

20130906-43*

Female genital mutilation in Iraqi Kurdistan: description and associated factors. Saleem RA, Othman N, Fattah FH, et al (2013), Women and Health vol 53, no 6, 2013, pp 537-551

The high prevalence of female genital mutilation has been a concern in Iraqi Kurdistan. This study was undertaken to estimate its prevalence and describe factors associated with its occurrence. A cross-sectional survey was undertaken from March to April 2011 of females aged up to 20 years using interviews and clinical examination. The survey included 1,508 participants with mean age of 13.5 years (SD 5.6). Overall female genital mutilation prevalence was 23%, and the mean age at which it had been performed was 4.6 years (SD 2.4). Type I (partial or total removal of the clitoris) comprised 76% of those who had had female genital mutilation; in 79% of cases the decision to perform it was made by the mother; and in 54% of cases it was performed by traditional birth attendants/midwives. Women aged 16 years and over were more likely to have had female genital mutilation compared to children aged below 6 years (OR 11.9, $p < .001$). Children of uneducated mothers were eight times as likely to have had genital mutilation compared to children of mothers with over nine years of education (OR 8.0, $p < .001$). Among women aged 17 years and younger, 34% of those who were married had been circumcised versus 17% of those who were not married ($p < .001$). Participants residing in the northeast of Kurdistan region were more likely to have been circumcised. The study results show that female genital mutilation is a frequent practice in Iraqi Kurdistan. Attention and intervention is needed to address this aspect of the well-being of girls and women. (Author)

20130906-1*

First female genital mutilation prosecution 'close', says CPS. Anon (2013), BBC News 6 September 2013

The Crown Prosecution Service has reported that a new strategy is helping them to track down those responsible for female genital mutilation in the UK, and that the likelihood of a prosecution in is much higher than ever before. There has not been a successful prosecution in the UK since criminalisation 28 years ago. (CI)

Full URL: http://www.bbc.co.uk/news/uk-23982767

20130812-5*

Quality of obstetric and midwifery care for pregnant women who have undergone female genital mutilation. Zenner N, Liao LM, Richens Y, et al (2013), Journal of Obstetrics and Gynaecology vol 33, no 5, 1 July 2013, pp 459-462

Despite the availability of professional guidelines for the pregnancy management of women affected by female genital mutilation (FGM), this study demonstrated major deficits in identification, management and safeguarding. (Author)

20130805-2*

Female genital mutilation [written answer]. House of Lords (2013), Hansard vol 747, no 45, 30 July 2013, col W282

The Advocate-General for Scotland (Lord Wallace of Tankerness) responds to a written question by Baroness Cox asking Her Majesty's Government what progress has been made by the Crown Prosecution Service in implementing its action plan on female genital mutilation. (VDD)

Full URL: http://www.publications.parliament.uk/pa/ld201314/ldhansrd/text/130730w0001.htm#13073035000561

20130730-24*

Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change. UNICEF (2013), New York: Unicef July 2013. 194 pages

This report is a comprehensive statistical overview of female genital mutilation/cutting (FGM/C) in the 29 countries where the practice is concentrated. Analysis of the data reflects current perspectives on FGM/C, informed by the latest policy, programmatic and theoretical evidence. The purpose of the report is to generate an in-depth understanding of FGM/C that can be applied to the development of policies and programmes, with the ultimate aim of eliminating the practice. (180 references) (CI)

Full URL: https://data.unicef.org/resources/fgm-statistical-overview-and-dynamics-of-change/

20130710-14

Female genital mutilation: Being aware of the laws against it. Griffith R (2013), British Journal of Midwifery vol 21, no 7, July 2013, pp 525-526

Provides an overview of current UK law relating to female genital mutilation. (4 references) (SB)

20130703-17*

Maternity services [written answers]. House of Commons (2013), Hansard vol 565, no 22, 24 June 2013, col 48W

Mr Jeremy Browne responds to a written question by Dr Huppert asking the Secretary of State for the Home Department whether she has set up a national register of girls at risk of female genital mutilation (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130624/text/130624w0002.htm#1306253000200

20130625-2*

Female genital mutilation victim was 'aged just seven'. Burns J (2013), BBC News 24 June 2013

Reports that new data released by the NHS show that the youngest girl to be treated during the last two years for the effects of female genital mutilation (FGM), also known as female circumcision, was just seven years old; about 1,700 girls were treated at specialist FGM clinics. Announces that a helpline run by NSPCC child protection experts is to be launched on 1st July 2013, and will offer support and protection to girls at risk from this practice, which still exists among some African, Middle Eastern and Asian communities. (JSM)

Full URL: http://www.bbc.co.uk/news/education-23001119#

20130614-4*

MPs urge more action on female genital mutilation. Anon (2013), BBC News 13 June 2013

Reports that MPs have warned that cultural and political sensitivities are preventing female genital mutilation (FGM) from being tackled properly in the UK. Ministers have called for a cross-agency approach to prevent FGM and secure convictions. (CI)

Full URL: http://www.bbc.co.uk/news/uk-politics-22880152

20130605-42*

Female genital mutilation/cutting: knowledge, attitude and training of health professionals in inner city London. Relph S, Inamdar R, Singh H, et al (2013), European Journal of Obstetrics & Gynecology and Reproductive Biology vol 168, no 2, 2013, pp 195-198

OBJECTIVES:

To assess the knowledge, attitude and training on female genital mutilation/cutting (FGM/C) amongst medical and midwifery professionals working in an area of high prevalence of the condition.

STUDY DESIGN:

Prospective observational study using a questionnaire designed to assess knowledge, attitude and training received by health care professionals on the practice of FGM/C. Factors which may affect knowledge, attitude and training were compared between groups.

RESULTS:

92.9% (n=79) questionnaires were returned. All respondents were aware of FGM/C but only 27.8% correctly identified the grade from a simple diagram. Three quarters (72.4% and 77.2% respectively) were aware of the complications of FGM/C and of the legislation in the United Kingdom. Of the respondents, 13.9% agreed that a competent adult should be allowed to consent to FGM/C if requested but only 8.9% agreed that the procedure should be medicalised to

reduce the associated morbidity. Less than 25% of respondents had received formal training in recognising or managing this condition.
CONCLUSION:
Although the majority of respondents were aware of FGM/C, their ability to identify the condition and its associated morbidity remain suboptimal; more training is recommended in larger cities with a higher prevalence of this condition. (Author)

20130605-26*

Female genital mutilation and infections: a systematic review of the clinical evidence. Iavazzo C, Sardi TA, Gkegkes ID (2013), Archives of Gynecology and Obstetrics vol 287, no 6, 2013, pp 1137-1149

AIM:
Female genital mutilation (FGM) is a common practice especially performed in women with no anaesthesia or antibiotics and in absence of aseptic conditions. The aim of this systematic review is to explore and analyze for first time in the current literature, the clinical evidence related to the presence of infections in the practice of FGM.
METHOD:
A systematic search of PubMed and Scopus was performed. A combination of the terms 'female circumcision', 'genital mutilation', 'genital cutting' and 'infection' were used. Studies reporting data on the infections related to patients with FGM were included.
RESULTS:
A total of 22,052 patients included, in the study, from African countries. The age ranged from 10 days to 20 years. The procedure was done by physicians, paramedical staff, and other specialties. Type I FGM was performed in 3,115 women while 5,894, 4,049 and 93 women underwent Type II, Type III and unknown type of FGM, respectively. Different types of infections were identified including UTIs, genitourinary tract infections, abscess formation and septicemia or even HIV infection. Moreover, most infections were identified in Type III FGM. The isolated pathogens in the different type of infections, were HIV, Clostridium tetani, Chlamydia trachomatis, Neisseria gonorrhoeae, Treponema pallidum, Candida albicans, Trichomonas vaginalis, HSV-2, Pseudomonas pyocyanea, Staphylococcus aureus. The univariate risk of infection ranged from 0.47 to 5.2.
CONCLUSION:
A variety of infections can occur after FGM. The management of these complications in a low-income economy can be a great burden for the families. (Author)

20130605-15

The cruellest cut of all!. Fyle J (2013), Essentially MIDIRS vol 4, no 6, June 2013, pp 46-48

Discusses the current situation in the UK regarding female genital mutilation (FGM) which, despite changes to law in 2003 and 2005, still continues to affect an estimated 24,000 girls under the age of 15. Highlights a lack of support for midwives in dealing with FGM and calls for improvements to data collection of cases of the practice. (16 references) (MB)

20130531-15*

Meaning-making of female genital cutting: children's perception and acquired knowledge of the ritual. Schultz JH, Lien IL (2013), International Journal of Women's Health vol 5, 15 April 2013, pp 165-175

Abstract: How do girls who have undergone female genital cutting understand the ritual? This study provides an analysis of the learning process and knowledge acquired in their meaning-making process. Eighteen participants were interviewed in qualitative indepth interviews. Women in Norway, mostly with Somali or Gambian backgrounds, were asked about their experiences of circumcision. Two different strategies were used to prepare girls for circumcision, ie, one involving giving some information and the other keeping the ritual a secret. Findings indicate that these two approaches affected the girls' meaning-making differently, but both strategies seemed to lead to the same educational outcome. The learning process is carefully monitored and regulated but is brought to a halt, stopping short of critical reflexive thinking. The knowledge tends to be deeply internalized, embodied, and morally embraced. The meaning-making process is discussed by analyzing the use of metaphors and narratives. Given that the educational outcome is characterized by limited knowledge without critical reflection, behavior change programs to end female genital cutting should identify and implement educational stimuli that are likely to promote critical reflexive thinking. [The full text of this article is available free of charge at http://www.dovepress.com/meaning-making-of-female-genital-cutting-childrenrsquos-perception-and-peer-reviewed-article-IJWH] (29 references) (Author)

Full URL: http://www.dovepress.com/meaning-making-of-female-genital-cutting-childrenrsquos-perception-and-peer-reviewed-article-IJWH

20130423-91

A survey on knowledge of female genital mutilation guidelines. Purchase TCD, Lamoudi M, Colman S, et al (2013), Acta Obstetricia et Gynecologica Scandinavica vol 92, no 7, July 2013, pp 858-861

The increase in immigration from countries with a high prevalence of female genital mutilation (FGM) has highlighted the need for knowledge and sensitivity in this area of healthcare in high-resource countries. We have surveyed with an online questionnaire 607 members, fellows and trainees of the Royal College of Obstetricians and Gynaecologists (RCOG) on knowledge about the RCOG guidelines for FGM. Completed training and more practical experience with women affected by FGM significantly increased knowledge. Many respondents were not aware of specialist services locally (22.9%) or how to access them (52.3%). Some areas of insufficient knowledge were identified, in particular in relation to psychiatric morbidity, HIV, hepatitis B and pelvic infection. More specialised training efforts might improve this aspect. (8 references) (Author)

20130423-110*

Adult recall of childhood female genital cutting and perceptions of its effects: A pilot study for service improvement and research feasibility. Liao LM, Elliott C, Ahmed F, et al (2013), Journal of Obstetrics and Gynaecology vol 33, no 3, April 2013, pp 292-295

This study aimed to gather information from service users of an African Women's Clinic for the purposes of planning service improvement and estimating research feasibility. The report is based on 17 interviews with Somali speaking women who had experienced female genital cutting in childhood. With language barriers removed, a high percentage of clinic attendees responded positively to the invitation to participate in research. They willingly discussed their experiences of FGM and expressed their negative viewpoints about the practice of FGM, suggesting that psychosocial and psychosexual research may be feasibly carried out in specialist contexts. The results also point to the need for psychological and educational input for service improvement.
(Author)

20130325-1*

Female genital mutilation [written answer]. House of Lords (2013), Hansard vol 744, no 124, 12 March 2013, col W56

The Parliamentary Under-Secretary of State, Home Office (Lord Taylor of Holbeach) responds to a written question by Lord Lester of Herne Hill asking Her Majesty's Government how they ensure in asylum decisions that the risk or presence of female genital mutilation is recognised and given adequate weighting. (VDD)

Full URL: http://www.publications.parliament.uk/pa/ld201213/ldhansrd/index/130312.html#contents

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20130319-28

A qualitative study of women's lived experience after deinfibulation in the UK. Safari F (2013), Midwifery vol 29, no 2, February 2013, pp 154-158

Objective: to explore women's experiences of deinfibulation and its aftermath. Design: a qualitative study using semi-structured interviews with data collection via audio-recording and field notes. The audio-recorded interviews were transcribed verbatim and analysed using Interpretive Phenomenological Analysis (IPA) method for qualitative data analysis. Setting: recruitment for the study was carried out in an African Well Women Clinic in London, United Kingdom. Participants: there were nine women participants of Somali and Eritrean origin who had Female Genital Mutilation (FGM) type III previously and underwent deinfibulation between January 2008 and September 2009. Findings: key themes identified were the cultural meaning and social acceptability of deinfibulation; the consequences of deinfibulation within marital relationships; feelings about the appearance of genitalia post deinfibulation and thoughts on reinfibulation. Conclusions: marital factors and stability of the relationship influence the experience of deinfibulation. Those women who said they had discussed deinfibulation with their husband in advance, and that he had agreed to the procedure, reported less problems afterwards. Single women who had deinfibulation before marriage may face more difficulties in terms of social acceptability within their community. Implications for practice: sensitivity to social consequences of deinfibulation is important as well as recognition that these consequences vary. When deinfibulation is carried out for medical purposes some women may appreciate the offer of an official letter from a health-care practitioner confirming the medical nature of the procedure. The data suggests that deinfibulated women may dislike the new appearance of their genitalia; therefore, the practicality of performing a concurrent minor cosmetic surgery with deinfibulation procedure may need to be examined. The need

for further research conducted in women's primary language is pressing and should explore issues such as the situation of single women, men's knowledge of the complications associated with FGM and the benefits of deinfibulation for infibulated women. (17 references) (Author)

20130311-10*

Interventions for improving outcomes for pregnant women who have experienced genital cutting (Cochrane Review). (Review content assessed as up-to-date: 8 Jan 2013). Balogun OO, Hirayama F, Wariki WMV, et al (2013), The Cochrane Database of Systematic Reviews Issue 2, 2013

Background

Female genital cutting (FGC) refers to all procedures that involve the partial or total removal of the external female genitalia, or other injury to the female genital organs for cultural or other non-therapeutic reasons. There are no known medical benefits to FGC, and it can be potentially dangerous for the health and psychological well-being of women and girls who are subjected to the practice resulting in short- and long-term complications. Health problems of significance associated with FGC faced by most women are maternal and neonatal mortality and morbidity, the need for assisted delivery and psychological distress. Under good clinical guidelines for caring for women who have undergone genital cutting, interventions could provide holistic care that is culturally sensitive and non-judgemental to improve outcomes and overall quality of life of women. This review focuses on key interventions carried out to improve outcome and overall quality of life in pregnant women who have undergone FGC.

Objectives

To evaluate the impact of interventions to improve all outcomes in pregnant women or women planning a pregnancy who have undergone genital cutting. The comparison group consisted of those who have undergone FGC but have not received any intervention.

Search methods

We searched the Cochrane Pregnancy and Childbirth Group's Trials Register (31 December 2012) and organisations engaged in projects regarding FGC.

Selection criteria

Randomised controlled trials (RCTs), cluster-randomised trials or quasi-RCTs with reported data comparing intervention outcomes among pregnant women or women planning a pregnancy who have undergone genital cutting compared with those who did not receive any intervention.

Data collection and analysis

We did not identify any RCTs, cluster-randomised trials or quasi-RCTs.

Main results

There are no included studies.

Authors' conclusions

FGC research has focused mainly on observational studies to describe the social and cultural context of the practice, and we found no intervention trials conducted to improve outcomes for pregnant women presenting with complications of FGC. While RCTs will provide the most reliable evidence on the effectiveness of interventions, there remains the issue of what is considered ethically appropriate and the willingness of women to undergo randomisation on an issue that is enmeshed in cultural traditions and beliefs. Consequently, conducting such a study might be difficult.. (Author)

20130211-38

Infibulated women have an increased risk of anal sphincter tears at delivery: a population-based Swedish register study of 250 000 births. Berggren V, Gottvall K, Isman E, et al (2013), Acta Obstetricia et Gynecologica Scandinavica vol 92, no 1, 2013, pp 101-108

Objective. To investigate the risk for anal sphincter tears (AST) in infibulated women. Design. Population-based cohort study. Setting. Nationwide study in Sweden. Population. The study population included 250 491 primiparous women with a vaginal singleton birth at 37-41 completed gestational weeks during 1999-2008. We only included women born in Sweden and in Africa. The African women were categorized into three groups; a Somalia group, n = 929, where over 95% are infibulated; the Eritrea-Ethiopia-Sudan group, n = 955, where the majority are infibulated, compared with other African countries, n = 1035, where few individuals are infibulated but had otherwise similar anthropometric characteristics. These women were compared with 247 572 Swedish-born women. Methods. Register study with data from the National Medical Birth Registry. Main outcome measures. AST in non-instrumental and instrumental vaginal delivery. Results. Compared with Swedish-born women, women from Somalia had the highest odds ratio for AST in all vaginal deliveries: 2.72 (95%CI 2.08-3.54), followed by women from Eritrea-Ethiopia-Sudan 1.80 (1.41-2.32) and other African countries 1.23 (0.89-1.53) after adjustment for major risk factors. Mediolateral episiotomy was associated with

a reduced risk of AST in instrumental deliveries. Conclusion. Delivering African women from countries where infibulation is common carries an increased risk of AST compared with Swedish-born women, despite delivering in a highly technical quality healthcare setting. AST can cause anal incontinence and it is important to investigate risk factors for this and try to improve clinical routines during delivery to reduce the incidence of this complication. (33 references) (Author)

20130204-1*

Midwife 'role' as NHS targets female genital mutilation. Anon (2013), BBC News 2 February 2013

Reports that the Department of Health are considering plans to ask midwives to raise the subject of female genital mutilation (FGM) among pregnant women from communities where it is known the procedure is carried out. States that this moves comes after an action plan to target FGM was launched by the Crown Prosecution Service in November 2012, and after the Royal College of Midwives pledged to improve their monitoring of the practice. (JSM)

Full URL: http://www.bbc.co.uk/news/uk-21306861#

20130107-18

Crown Prosecution Service to crack down on female genital mutilation. (2013), The Practising Midwife vol 16, no 1, January 2013, p 9

Brief news item reporting that the Crown Prosecution Service has published an action plan to tackle the problem of female genital mutilation in the UK, where it is estimated that up to 24,000 girls under the age of 15 are at risk. (MB)

20130103-54

Female genital mutilation/cutting (FGM/C): Survey of RANZCOG Fellows, Diplomates & Trainees and FGM/C prevention and education program workers in Australia and New Zealand. Moeed SM, Grover SR (2012), Australian and New Zealand Journal of Obstetrics and Gynaecology (ANZJOG) vol 52, no 6, December 2012, pp 523-527

Background

Female genital mutilation/cutting (FGM/C) is traditionally practised in parts of Africa, the Middle East and South-East Asia. Migration has brought FGM/C to the attention of health practitioners in industrialised nations. It is not known whether FGM/C procedures are being performed in Australia and New Zealand, where legislation has been passed banning the practice.

Aims

To survey RANZCOG Fellows, Trainees and Diplomates, and FGM/C education and prevention program workers, about their experience with women and children affected by FGM/C, specifically to identify whether FGM/C is being performed in Australia or New Zealand.

Methods

Electronic survey distributed via e-mail to RANZCOG Fellows, Trainees and Diplomates and FGM/C program workers in Australia and New Zealand between November 2010 and February 2011.

Results

530 responses were received from RANZCOG Fellows, Trainees and Diplomates, with an overall response rate of 18.5%. Thirty-four responses were received from FGM/C program workers. Five RANZCOG respondents and two FGM/C program workers cited anecdotal evidence that FGM/C is being performed in Australia and New Zealand. 21.2% (82) of RANZCOG respondents had been asked to re-suture following delivery, and 11 respondents had done so at least once. Two RANZCOG respondents had been asked to perform FGM/C on a baby, girl or young woman.

Conclusions

There is no conclusive evidence of FGM/C being performed in Australia and New Zealand, either from direct reports or children presenting with complications, although re-suturing post-delivery is occurring. Anecdotal evidence suggests that it is most likely that people other than registered health practitioners are performing FGM/C. (11 references) (Author)

20130103-30

Have you been mutilated...? How should we ask women if they have undergone female genital cutting?. Esegbona-Adeigbe S (2013), Essentially MIDIRS vol 4, no 1, January 2013, pp 32-36

Explores the importance of using sensitive language and terminology when working with women who have undergone female genital mutilation (FGM). Proposes that midwives should use the term 'cutting' rather than 'mutilation', as women who have undergone FGM may feel further demoralised and alienated when hearing the word mutilated. Considers the debate surrounding the appropriate terminology for FGM, and concludes by describing the

communication skills that midwives will need to deploy in such a situation. (25 references) (TC)

20121217-25*

Female genital mutilation [written answer]. House of Commons (2012), Hansard vol 555, no 85, 12 December 2012, col 353W

Anna Soubry responds to a written question by Karl Turner asking the Secretary of State for Health what training (a) health professionals, (b) education professionals and (c) social care professionals receive in respect of female genital mutilation. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121212/text/121212w0002.htm#12121272001503

20121206-2*

The African villages declaring an end to female genital mutilation. Ford L (2012), The Guardian 5 December 2012

Molly Melching, founder and executive director of the non-governmental organization Tostan, explains how empowering communities in West Africa to understand their human rights has led villages in Guinea-Bissau to make public declarations of intent to end the practice of female genital mutilation (FGM). The declarations follow three years of education and discussion with the community about people's rights, particularly those of women and girls. The approach is proving successful, with almost 6000 villages across the continent having abandoned FGM since 1991 as a result of Tostan's work. (CI)

Full URL: http://www.guardian.co.uk/global-development/2012/dec/05/african-villages-female-genital-mutilation

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20121205-65

Female circumcision: double standards. Adikibi A (2012), The Practising Midwife vol 15, no 11, December 2012, pp 27-28

Female circumcision is an emotive subject condemned by all and thought to be practised by less developed countries than the United Kingdom (UK) and United States of America (USA). However, this is now a growing business among western cosmetic surgeons as these two nations become entangled in the search for the `perfect body'. The difference lies only in the who, why, where and by whom the operations are performed in these two distinct worlds. The most frightening observation is the rate at which this business is growing in the National Health Service (NHS) and public sector. (8 references) (Author)

20121128-17*

UN resolution on female genital mutilation (FGM) welcomed. (2012), Amnesty International UK 27 November 2012

Reports that Amnesty International have praised the United Nation's General Assembly human right's committee's adoption of a resolution against female genital mutilation (FGM). States that it is expected that the UN's General Assembly will endorse the resolution in December 2012. Gives background information on the incidence of FGM, which is common in 28 African countries, and also Yemen, Iraq, Malaysia, Indonesia and among some ethnic groups in South America. Stresses that while the resolution is not legally binding, UN General Assembly resolutions are seen as influential, and Amnesty International hope that it will serve to remind governments of the need to develop and monitor national action plans in order to raise awareness. Includes comments from Amnesty International UN representative, José Luis Díaz. (JSM)

Full URL: http://www.amnesty.org.uk/news_details.asp?NewsID=20473

20121126-1*

Female genital mutilation [written answer]. House of Commons (2012), Hansard vol 553, no 73, 22 November 2012, col 564-565W

Jeremy Browne responds to a written question by Lindsay Roy asking the Secretary of State for the Home Department what estimate her Department has made of the number of female genital mutilation operations carried out in the UK in each of the last three years. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121122/text/121122w0001.htm#12112248000038

20121116-7*

Female genital mutilation [written answer]. House of Commons (2012), Hansard vol 552, no 64, 6 November 2012, col 536W

Jeremy Brown responds to a written question by Karl Turner asking the Secretary of State for the Home Department what estimate she has made of the number of girls being taken out of the country to have female genital mutilation performed. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121106/text/121106w0002.htm#121106w0002.htm_sbhd2

20121116-23*

Female genital mutilation [written answer]. House of Commons (2012), Hansard vol 553, no 69, 13 November 2012, col 197-198W

Anna Soubry responds to a written question by Karl Turner asking the Secretary of State for Health if he will consider including a mandatory data collection question about female genital mutilation on GP registration forms. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121113/text/121113w0004.htm#121113w0004.htm_sbhd36

20121116-17*

Female genital mutilation [written answer]. House of Commons (2012), Hansard vol 552, no 65, 7 November 2012, col 630W

Jeremy Brown responds to a written question by Karl Turner asking the Secretary of State for Justice how much funding the Government has made available for engaging with communities affected by female genital mutilation. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121107/text/121107w0001.htm#121107w0001.htm_sbhd47

20121116-16*

Female genital mutilation [written answer]. House of Commons (2012), Hansard vol 552, no 65, 7 November 2012, col 625W

Damien Green responds to a written question by Karl Turner asking the Secretary of State for the Home Department what responsibilities police and crime commissioners will be given on tackling female genital mutilation-related crimes. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121107/text/121107w0001.htm#121107w0001.htm_sbhd34

20121113-2*

Female genital mutilation: time for a prosecution. Gerry F (2012), The Guardian 13 November 2012

Reports that a joint seminar between the Association of Women Barristers (AWB) and the Crown Prosecution Service (CPS) has been held to ascertain why not one successful conviction of perpetrators of female genital mutilation (FGM) has been brought about in this country, despite the fact that FGM has been illegal in the UK for 27 years. States that it is estimated by the Home Office that there are approximately 24, 000 girls under the age of 15 at risk of FGM in the UK, and worldwide there are thought to be between 100 million to 140 million women and girls who have undergone the procedure and are now living with the resulting complications, which include haemorrhaging, chronic pain, menstrual problems, and adverse psychological effects. (JSM)

Full URL: http://www.guardian.co.uk/law/2012/nov/13/female-genital-mutilation-prosection-uk

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20121105-4*

Female genital mutilation [written answer]. House of Commons (2012), Hansard vol 552, no 60, 31 October 2012, col 242W

Jeremy Brown responds to a written question by David Wright asking the Secretary of State for the Home Department what assessment she has made of the powers available to tackle the practice of female genital mutilation. He also responded to a question from Jim McGovern asking how many complaints of female genital mutilation have been recorded by the police in the UK over the last 10 years; how many such complaints resulted in criminal investigation; and how many such investigations led to prosecutions. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121031/text/121031w0002.htm#121031w0002.htm_sbhd6

20121105-3*

Female genital mutilation [written answer]. House of Commons (2012), Hansard vol 552, no 61, 1 November 2012, col 359-360W

Anna Soubry responds to a written question by David Wright asking the Secretary of State for Health what assessment he has made of the number of cases of female genital mutilation in the UK in the latest period for which figures are available; and what strategy he has put in place to eradicate this practice. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121101/text/121101w0002.htm#121101w0002.htm_sbhd31

20121029-46*

Female genital mutilation [written answer]. House of Lords (2012), Hansard vol 740, no 52, 22 October 2012, col W14

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe) responds to a written question by Baroness Tonge asking Her Majesty's Government whether they will consider minimal mandatory antenatal data gathering, including on female genital mutilation and cutting. (VDD)

Full URL: http://www.publications.parliament.uk/pa/ld201213/ldhansrd/text/121022w0001.htm

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20121024-75*

Knowledge and attitudes of female genital mutilation among midwives in Eastern Sudan. Ali AAA (2012), Reproductive Health vol 9, no 23, 10 October 2012

BACKGROUND: Female Genital Mutilation (FGM) or cutting caries legal and bioethical debates and it is practiced in many developing countries. METHODS: Random selection of 154 midwives was used for the study during June 2012 and through July 2012 aiming to assess knowledge and attitudes of the midwives towards FGM in Eastern Sudan. RESULTS: A total of 157 midwives enrolled in this study. They had been practicing for 3 - 44 years (mean SD 19.2 +/- 10.3). More than two third of them experienced practicing FGM sometime in their life (127/157, 80.9%). There was low level of awareness of types of FGM practice since only 7% (11/157) identified the four types correctly. 53.5% (84/157) identified type 1 correctly while 18.5% (29/157), 17.8% (28/157) and 15.9% (25/157) identified type 2, 3 and 4 as correct respectively. While 30 (19.1%) of the midwives claimed that all types of FGM are harmful, 76.4% (120/157) were of the opinion that some forms are not harmful and 7 (4.5%) reported that all types of FGM are not harmful. Likewise while 74.5% (117/157) of the interviewed midwives mentioned that the FGM is a legal practice only 25.5% (40/117) were of the opinion that FGM is illegal practice. The vast majority of the respondents (64.3%, 101/157) have an opinion that FGM decreases the sexual pleasure. More than half (53.5%, 84/157) of the participants affirmed that FGM does not increase the risk of HIV transmission. High proportion of the respondents (71.3%, 112/157) did not know whether or not infertility could complicate FGM. CONCLUSIONS: Thus a substantial effort should be made to discourage the continuation of FGM practice among midwives in Sudan. This might be achieved by improving knowledge and awareness among the midwives and the community. [Please note: Reproductive Health initially publish articles in a provisional format. If there is a note on the document to indicate that it is still provisional, it may undergo minor changes]

Full URL: http://www.reproductive-health-journal.com/content/9/1/23/abstract

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20121019-7*

Female genital mutilation [written answer]. House of Lords (2012), Hansard vol 739, no 47, 15 October 2012, col W437

The Parliamentary Under-Secretary of State, Home Office (Lord Taylor of Holbeach) responds to a written question by Baroness Tonge asking Her Majesty's Government (1) whether they will make it mandatory for health, education and social service professionals to report knowledge or suspicion of female genital mutilation and cutting to the police; whether parents have a duty to report suspected female genital mutilation and cutting to Government officials. (VDD)

Full URL: http://www.publications.parliament.uk/pa/ld201213/ldhansrd/text/121015w0001.htm#12101560000421

20121019-3*

Female genital mutilation [written answer]. House of Commons (2012), Hansard vol 551, no 48, 15 October 2012, col 28W

The Solicitor-General responds to a written question by Ann Clwyd asking the Attorney-General what plans he has to review the rate of prosecutions of offences involving female genital mutilation; and if he will make a statement. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121015/text/121015w0002.htm#121015w0002.htm_sbhd7

20121019-2*

Africa [written answer]. House of Commons (2012), Hansard vol 551, no 48, 15 October 2012, col 17W

Lynne Featherstone responds to a written question by Mr Spellar asking the Secretary of State for International Development with reference to the answer of 30 April 2012, Official Report, column 1348W, on female genital mutilation, what recent progress has been made in discussions with African countries on the prevention of female

genital mutilation. (VDD)
Full URL: http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121015/text/121015w0001.htm#121015w0001.htm_sbhd25

20121001-1*

UK looks at failure to try genital mutilation crimes. Batha E (2012), TrustLaw 28 September 2012

Reports that the Director of Public Prosecutions, Keir Starmer, has called for greater efforts to be made in prosecuting those responsible for arranging or carrying out female genital mutilation (FGM) in this country. Explains that FGM has been illegal in the UK for 30 years, but not one case has gone to court. States that Mr Starmer has suggested mounting undercover operations in order to bring those responsible to trial, as it is unrealistic to expect victims of this crime to report their parents. (JSM)

20120921-7*

Doctors not to be charged following female genital mutilation investigation. (2012), The Guardian 20 September 2012

Reports that Ali Haji Mao-Aweys and Omar Sheikh Mohamed Addow, two doctors who were arrested in May (1) over claims that they were offering to perform female genital mutilation in this country, have been released without charge. 1. Dwyer D (2012). Two men held in inquiry into female genital mutilation. The Independent, 5 May 2012. (JSM)
Full URL: http://www.guardian.co.uk/uk/2012/sep/20/doctors-not-charged-female-genital-mutilation

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20120914-4*

Charges over genital mutilation of girls in Australia. (2012), Medical Xpress 14 September 2012

Reports that two men and two women have been charged over the alleged female genital mutilation of two young girls aged six and seven in Australia. States that this practice, which is often carried out for religious or cultural reasons, is illegal in Australia. Includes comments from Pru Goward, New South Wales state Minister for Family and Community Services. (JSM)
Full URL: http://medicalxpress.com/news/2012-09-genital-mutilation-girls-australia.html

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20120912-12*

Female genital mutilation [written answer]. House of Commons (2012), Hansard vol 550, no 40, 10 September 2012, col 45W

The Solicitor-General responds to a written question by Mark Pritchard asking the Attorney-General how many people were prosecuted for carrying out female genital mutilation in the latest period for which figures are available. (VDD)
Full URL: http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm120910/text/120910w0002.htm#12091037000012

20120906-40

A new service for women affected by female genital mutilation. Thomas K (2012), Perspective issue 16, September 2012, p 11

Chelsea & Westminster NHS Trust has won an All Party Parliamentary Group on Maternity (APPGM) award for its new service for women who have experienced female genital mutilation. Consultant gynaecologist Naomi Low-Beer talked to Kim Thomas about why the service is needed and what is offers. (Author)

20120813-38*

Health complications of female genital mutilation in Sierra Leone. Bjälkander O, Bangura L, Leigh B, et al (2012), International Journal of Women's Health vol 4, 5 July 2012, pp 321-331

Abstract: Sierra Leone has one of the highest rates of female genital mutilation (FGM) in the world, and yet little is known about the health consequences of the practice. Purpose: To explore whether and what kind of FGM-related health complications girls and women in Sierra Leone experience, and to elucidate their health care-seeking behaviors. Patients and methods: A feasibility study was conducted to test and refine questionnaires and methods used for this study. Thereafter, a cross-section of girls and women (n = 258) attending antenatal care and Well Women Clinics in Bo Town, Bo District, in the southern region and in Makeni Town, Bombali District, in the northern region of Sierra Leone were randomly selected. Participants answered interview-administrated pretested structured questionnaires with open-ended-questions, administrated by trained female personnel. Results: All respondents had undergone FGM, most between 10 and 14 years of age. Complications were reported by 218 respondents (84.5%), the

most common ones being excessive bleeding, delay in or incomplete healing, and tenderness. Fever was significantly more often reported by girls who had undergone FGM before 10 years of age compared with those who had undergone the procedure later. Out of those who reported complications, 187 (85.8%) sought treatment, with 89 of them visiting a traditional healer, 75 a Sowei (traditional circumciser), and 16 a health professional. Conclusion: The high prevalence rate of FGM and the proportion of medical complications show that FGM is a matter for public health concern in Sierra Leone. Girls who undergo FGM before 10 years of age seem to be more vulnerable to serious complications than those who are older at the time of FGM. It is important that health care personnel are aware of, and look for possible complications from FGM, and encourage girls and women to seek medical care for their problems. (27 references) (Author)

Full URL: http://www.dovepress.com/health-complications-of-female-genital-mutilation-in-sierra-leone-peer-reviewed-article-IJWH

20120810-28*

Female genital mutilation: prevalence, perceptions and effect on women's health in Kersa district of Ethiopia. Yirga WS, Kassa NA, Gebremichael MW, et al (2012), International Journal of Women's Health vol 4, 13 February 2012, pp 45-54

Background: Female genital mutilation (FGM) is nontherapeutic surgical modification of the female genitalia. It is an ancient tradition in large parts of Africa, including Ethiopia, especially in the eastern part of the country. This study aimed to identify the prevalence, perceptions, perpetuators, reasons for conducting FGM, and factors associated with this practice with regard to women's health.

Methods: Community-based cross-sectional house-to-house interviews were conducted during 2008 among 858 females of reproductive age (15-49 years), in Kersa district, East Hararge, Oromia region, Ethiopia. Proportions and Chi-square tests were used to describe the data and logistic regression was used to describe statistical associations. Statistical significance was set at $P < 0.05$.

Results: FGM was reported to be known by 327 (38.5%) of the interviewees. The majority (n = 249, 76.1%) reported that local healers were the main performers of FGM, and 258 (78.9%) respondents stated that the clitoris was the part removed during circumcision. The main reason for the practice of FGM was reduction of female sexual hyperactivity (reported by 198 women [60.3%]). Circumcision of daughters was reported by 288 (88.1%) respondents, and this showed a statistically significant association with the Christian religion ($P = 0.003$), illiteracy ($P = 0.01$), and Amhara ethnicity ($P = 0.012$). The majority of the respondents (792, 92.3%) were themselves circumcised and 68.8% did not know of any health-related problems associated with FGM. Conclusion: In spite of FGM being a common practice in the study area, only one third of the respondents stated that they knew about it. Local healers were the main performers of FGM. Some of the women knew about the negative reproductive health effects of FGM and some had also experienced these themselves. However, only a few had tried to stop the practice and the majority had taken no steps to do so. This may be attributable to the fear of becoming alienated from the cultural system and fear of isolation. (31 references) (Author)

Full URL: http://www.dovepress.com/female-genital-mutilation-prevalence-perceptions-and-effect-on-women39-peer-reviewed-article-IJWH

20120809-14*

Attitudes toward female circumcision among Somali immigrants in Oslo: a qualitative study. Gele AA, Kumar B, Hjelde KH, et al (2012), International Journal of Women's Health vol 4, 20 January 2012, pp 7-17

Abstract: Due to its negative impact on public health, female circumcision (FC) has gained increased attention from international communities and the Norwegian public in recent decades. In 1995, the Norwegian government outlawed the practice and simultaneously developed a package of measures aimed at preventing and ultimately eradicating FC in Norway. Like many other Western countries, immigrants of Somali descent constitute the largest immigrant group in Norway from countries with FC traditions. Although this immigrant group is often perceived as a cultural society that supports FC generally as a practice, there appears to be a lack of studies that explore the impact of acculturation and the Western social context on Somali immigrants' attitudes toward the practice. Against this background, this paper explores the attitudes of Somalis living in Oslo, Norway to the practice of FC. Findings from this qualitative study indicate that Somalis in Oslo have, to a large extent, changed their attitude toward the practice. This was proven by the presence in Oslo of a large number of Somali parents who left their daughters uncut as well as Somali girls, boys, men, and women who attribute being uncircumcised a high status. This study adds to the knowledge of the process of abandonment of FC among immigrants in the Western countries. The study highlights the success that has been achieved in improving attitudes toward the practice of the Somali community in Oslo, Norway, as well as emerging challenges that need to be addressed further. (46 references) (Author)

Full URL: http://www.dovepress.com/attitudes-toward-female-circumcision-among-somali-immigrants-in-oslo-a-peer-reviewed-article-IJWH

20120727-70*

Reconstructive surgery after female genital mutilation: a prospective cohort study. Foldes P, Cuzin B, Andro A (2012), The Lancet vol 380, no 9837, 2012, pp 134-141

BACKGROUND: Women who have undergone female genital mutilation rarely have access to the reconstructive surgery that is now available. Our objective was to assess the immediate and long-term outcomes of this surgery. METHODS: Between 1998 and 2009, we included consecutive patients with female genital mutilation aged 18 years or older who had consulted a urologist at Poissy-St Germain Hospital, France. We used the WHO classification to prospectively include patients with type II or type III mutilation. The skin covering the stump was resected to reveal the clitoris. The suspensory ligament was then sectioned to mobilise the stump, the scar tissue was removed from the exposed portion and the glans was brought into a normal position. All patients answered a questionnaire at entry about their characteristics, expectations, and preoperative clitoris pleasure and pain, measured on a 5-point scale. Those patients who returned at 1 year for follow-up were questioned about clitoris pain and functionality. We compared data from the 1-year group with the total group of patients who had surgery. FINDINGS: We operated on 2938 women with a mean age of 29·2 (SD 7·77 years; age at excision 6·1, SD 3·5 years). Mali, Senegal, and Ivory Coast were the main countries of origin, but 564 patients had undergone female genital mutilation in France. The 1-year follow-up visit was attended by 866 patients (29%). Expectations before surgery were identity recovery for 2933 patients (99%), improved sex life for 2378 patients (81%), and pain reduction for 847 patients (29%). At 1-year follow-up, 363 women (42%) had a hoodless glans, 239 (28%) had a normal clitoris, 210 (24%) had a visible projection, 51 (6%) had a palpable projection, and three (0·4%) had no change. Most patients reported an improvement, or at least no worsening, in pain (821 of 840 patients) and clitoral pleasure (815 of 834 patients). At 1 year, 430 (51%) of 841 women experienced orgasms. Immediate complications after surgery (haematoma, suture failure, moderate fever) were noted in 155 (5%) of the 2938 patients, and 108 (4%) were briefly re-admitted to hospital. INTERPRETATION: Reconstructive surgery after female genital mutilation seems to be associated with reduced pain and restored pleasure. It needs to be made more readily available in developed countries by training surgeons. (Author)

20120727-59*

Prevalence of female genital mutilation among female infants in Kano, Northern Nigeria. Garba ID, Muhammed Z, Abubakar IS, et al (2012), Archives of Gynecology and Obstetrics vol 286, no 2, 2012, pp 423-428

OBJECTIVES: To determine the prevalence and type of female genital mutilation (FGM) among female infants, reasons and attitude of the mothers to the practice. DESIGN: A cross sectional descriptive study. SETTING: Tertiary centre in Kano Northern Nigeria. METHOD: A Pretested questionnaire was administered for mothers of female infants presenting for routine immunization in Aminu Kano Teaching Hospital (AKTH). A total of 250 questionnaires were administered, but only 200 were properly filled and this was used for the analysis. MAIN OUTCOME MEASURES: Prevalence and type of FGM, reason for and attitude of mothers towards FGM. RESULTS: Twenty-six infants had FGM during the period of study, giving a prevalence rate of 13 %. The mean age at cutting was 8 days ± 7.3. The commonest type of FGM was type I accounting for 96.2 % of the cases. Tradition/culture was the commonest reason for mutilation accounting for 73.1 %, other reasons included; religious in 11.5 %, hygienic in 11.5 % and to preserve virginity in 3.8 %. Traditional barbers were the commonest operators in 80.8 % of cases, followed by the nurse/midwife in 15.4 % of cases. The fathers were the main decision makers in 46.2 %, followed by both parents in 26.9 % and grandparents in 15.4 % of the cases. 84 % of mothers were not in support of the practice. Thirteen percent of the clients would circumcise all their daughters. Forty-eight percent of the clients were of the opinion that FGM cause harm to the victims. Four percent of those whose daughters were yet to be circumcised will do so later. CONCLUSION: Female genital cutting is still practiced in our environment. Educational enlightenment is fundamental in changing public opinion as well as in offering reasonable alternative to FGM. Campaign against the practice of FGM should be encouraged to eradicate its practice. (Author)

20120710-19

Defibulation During Vaginal Delivery for Women With Type III Female Genital Mutilation. Rouzi AA, Al-Sibiani SA, Al-Mansouri NM, et al (2012), Obstetrics & Gynecology vol 120, no 1, July 2012, pp 98-103

OBJECTIVE: To assess the routine practice of defibulation during vaginal delivery for women who have undergone female genital mutilation or cutting. MATERIALS AND METHODS: A case-control study was conducted on women from Sudan, Somalia, Ethiopia, Egypt, and Yemen who delivered at King Abdulaziz University Hospital, Jeddah, Saudi Arabia, from January 1, 2000, to November 30, 2011. Women who had defibulation were identified, and their records were examined. For each woman who had defibulation, a woman from the same nationality who delivered without defibulation on the same day or the next days was chosen as a control. Data collected included demographics, mode

of delivery, blood loss, intraoperative and postoperative complications, and labor outcome. RESULTS: During the study period, 388 women underwent defibulation during vaginal delivery. Women who did not have defibulation were chosen as a control group (n=388). In the defibulation group, 300 (77.3%) women were registered during pregnancy; 88 (22.7%) women were unregistered. Defibulation during vaginal delivery was successfully performed by residents and senior residents under the care of the attending on call. No cesarean delivery was performed because of female genital mutilation or cutting, and no spontaneous rupture of the scar occurred. There were no statistically significant differences between women who had defibulation with those who did not or between infibulated registered and unregistered women in the duration of labor, episiotomy rates, blood loss, Apgar score, or fetal birth weight. CONCLUSION: Defibulation during vaginal delivery is a valid management option. Labor attendants should be trained to perform it. (24 references) (Author)

20120702-6*

Female genital mutilation [written answer]. House of Commons (2012), Hansard vol 547, no 21, 27 June 2012, col 268W

Lynne Featherstone responds to a written question by Guy Opperman asking the Minister for Women and Equalities what steps she is taking to tackle cases of female genital mutilation (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm120627/text/120627w0001.htm#120627w0001.htm_sbhd23

20120612-26

Safeguarding against FGM: everyone's issue. Gardner S (2012), British Journal of Midwifery vol 20, no 6, June 2012, p 384

Briefly discusses issues relating to female genital mutilation (FGM) and outlines the role midwives have in safeguarding those women who have been subject to FGM or who are at risk. (5 references) (SB)

20120611-9*

Predictors of female genital cutting among university students in northern Nigeria. Iliyasu Z, Abubakar IS, Galadanci HS, et al (2012), Journal of Obstetrics and Gynaecology vol 32, no 4, May 2012, pp 387-392

Female genital cutting (FGC) is a harmful cultural practice that is perpetrated against women and children. Little is known about the extent of this custom among university students in northern Nigeria. Using self-administered questionnaires, we studied the prevalence and determinants of FGC among female university students in Kano, Nigeria (n =359). The prevalence of FGC was 12.1% (95% confidence interval =8.8-15.8%). Awareness and disapproval of FGC among the study population was very high (96% and 91%, respectively). In multivariate regression models, ethnicity and geographic origin were significant predictors of female circumcision. A comprehensive legal and educational framework and the support of civil society, governments and development partners is required to address this form of gender discrimination. (35 references) (Author)

20120601-5*

North Africa and Middle East [written answer]. House of Commons (2012), Hansard vol 545, no 7, 21 May 2012, col 452W

Mr Duncan responds to a written question by Helen Goodman asking the Secretary of State for International Development what programmes his Department supports in North Africa and the Middle East on (a) women's social and political participation, (b) women's health and (c) reduction of female genital mutilation. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm120521/text/120521w0003.htm#12052136000063

20120521-2*

Female genital mutilation [written answer]. House of Commons (2012), Hansard vol 545, no 5, 16 May 2012, col 131W

Lynne Featherstone responds to a written question by Simon Kirby asking the Secretary of State for the Home Department what steps her Department is taking to prevent female genital mutilation being carried out on British citizens. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm120516/text/120516w0001.htm#12051648000006

20120509-22*

Female genital mutilation [written answer]. House of Commons (2012), Hansard vol 543, no 296, 30 April 2012, col 1348W

Mr Bellingham responds to a written question by Mr Spellar asking the Secretary of State for Foreign and Commonwealth Affairs what discussions his Department has had with countries in sub-Saharan Africa on the

prevention of female genital mutilation of girls from the UK (VDD)
Full URL: http://www.publications.parliament.uk/pa/cm201212/cmhansrd/cm120430/text/120430w0009.htm#12050215000035

20120508-27*

Two men held in inquiry into female genital mutilation. Dwyer D (2012), Independent 5 May 2012

Briefly reports on the arrest of two men, in connection with claims that female genital mutilation is being offered in the UK. (CI)
Full URL: http://www.independent.co.uk/news/uk/crime/two-men-held-in-inquiry-into-female-genital-mutilation-7715774.html

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20120423-32*

Female genital mutilation [written answer]. House of Commons (2012), Hansard vol 543, no 291, 19 April 2012, col 458W

Lynne Featherstone responds to a written question by Mr Spellar asking the Secretary of State for the Home Department how many people have been (a) charged and (b) convicted under the Female Genital Mutilation Act 2003. (VDD)
Full URL: http://www.publications.parliament.uk/pa/cm201212/cmhansrd/cm120419/text/120419w0001.htm#120419w0001.htm_sbhd8

20120423-2*

Female genital mutilation 'offered by UK medics'. Anon (2012), The Guardian 22 April 2012

Reports that a doctor, dentist and alternative practitioner have been filmed offering to carry out female genital mutilation (FGM), a traditional practice in parts of Africa, which is illegal in the United Kingdom. States that those performing the procedure in this country are liable to a 14-year prison term, and it is also illegal to arrange for FGM to take place. (JSM)
Full URL: http://www.guardian.co.uk/uk/2012/apr/22/female-genital-mutilation-uk-medics

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20120417-105

Female genital cutting/mutilation. Perron L, Senikas V (2012), JOGC [Journal of Obstetrics and Gynaecology Canada] vol 34, no 2, February 2012, pp 197-200

A policy statement from the Society of Obstetricians and Gynaecologists of Canada concerning female genital mutilation. (15 references) (PR)

20120326-9*

Female genital mutilation: the role of health professionals in prevention, assessment, and management. Simpson J, Robinson K, Creighton SM, et al (2012), BMJ vol 344, no 7848, 17 March 2012, p 37-41

Presents an overview of female genital mutilation (FGM) and provides health professionals with a practical approach to the assessment and management of women and girls with FGM, together with strategies aimed at prevention. (CI)

20120326-46*

Female Genital Mutilation: Report of a survey on midwives' views and knowledge. Royal College of Midwives (2012), London: RCM. 2012. 23 pages

The aim of this study was to elicit the views and opinions of practising midwife members of the RCM on a range of issues relating to Female Genital Mutilation, including their understanding of the law, the practice, knowledge of the communities they work with and their response to FGM, with the purpose of identifying educational, training and support needs relevant to the prevention of FGM and care of women with FGM. (Author)

20120216-25*

Female genital cutting: current practices and beliefs in western Africa. Sipsma HL, Chen PG, Ofori-Atta A, et al (2012), Bulletin of the World Health Organization vol 90, no 2, February 2012, pp120-127E

Objective To conduct a cross-national comparative study of the prevalence and correlates of female genital cutting (FGC) practices and beliefs in western Africa. Methods Data from women who responded to the Multiple Indicator Cluster Surveys between 2005 and 2007 were used to estimate the frequencies of ever having been circumcised, having had a daughter circumcised, and believing that FGC practices should continue. Weighted logistic regression using data for each country was performed to determine the independent correlates of each outcome. Findings The

prevalence of FGC was high overall but varied substantially across countries in western Africa. In Sierra Leone, Gambia, Burkina Faso and Mauritania, the prevalence of FGC was 94%, 79%, 74% and 72%, respectively, whereas in Ghana, Niger and Togo prevalence was less than 6%. Older age and being Muslim were generally associated with increased odds of FGC, and higher education was associated with lower odds of FGC. The association between FGC and wealth varied considerably. Burkina Faso was the only country in our study that experienced a dramatic reduction in FGC prevalence from women (74%) to their daughters (25%); only 14.2% of the women surveyed in that country said that they believe the practice should continue. Conclusion The prevalence of FGC in western Africa remains high overall but varies substantially across countries. Given the broad range of experiences, successful strategies from countries where FGC is declining may provide useful examples for high-prevalence countries seeking to reduce their own FGC practices. (39 references) (Author)

Full URL: http://www.who.int/bulletin/volumes/90/2/11-090886.pdf

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20120206-6*

Senegalese hip hop artist Sister Fa calls for an end to the mutilation of girls. Boseley S (2012), The Guardian 6 February 2012

Looks at the efforts being made to eradicate the practice of female circumcision, to coincide with the UN International Day of Zero Tolerance of Female Genital Mutilation. Reports that many British girls are taken overseas in order to undergo this procedure, and asks why no prosecutions have taken place, despite a law to protect young girls from this happening coming into force in 2003. Highlights the campaigning work of Senegalese hip hop artist Sister Fa, who will be addressing the House of Commons on this topic. (JSM)

Full URL: http://www.guardian.co.uk/society/sarah-boseley-global-health/2012/feb/06/women-feminism

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20120125-71*

Female genital mutilation [written answer]. House of Lords (2012), Hansard vol 734, no 254, 24 January 2012, col WA208-10

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe), responds to a written question by Baroness Gould of Potternewton asking Her Majesty's Government (1) what current support they are providing to specialist services dealing with female genital mutilation that are experiencing funding cuts as a result of NHS reforms: (2) what support they are giving to girls under 18 years old who are affected by female genital mutilation; (3) whether they have established a full-time appointment working on the issues surrounding female genital mutilation; (4) who will take on the commissioning responsibility for specialist services and community programmes in respect of female genital mutilation under the new structure for health and social care services. (AEP)

Full URL: http://www.publications.parliament.uk/pa/ld201212/ldhansrd/text/120124w0001.htm#12012455000492

20120105-3

Somali immigrant women's perceptions of cesarean delivery and patient-provider communication surrounding female circumcision and childbirth in the USA. Ameresekere M, Borg R, Frederick J, et al (2012), International Journal of Gynecology & Obstetrics vol 115, no 3, December 2011, pp 227-230

OBJECTIVE: To explore perceptions of cesarean delivery and patient-provider communication surrounding female circumcision and childbirth through interviews with Somali women residing in the USA. METHODS: Semistructured in-depth interviews were conducted with 23 Somali immigrant women living in Boston who had given birth in the USA and Africa. Interviews asked about birth experiences in the USA and Africa, as well as norms and attitudes surrounding childbirth practices. Interview transcripts were coded and themes identified through an iterative process. RESULTS: Participants were aged 25-52 years and had been living in the USA for an average of 7 years. All women had experienced circumcision. Five women had undergone a cesarean delivery. Women feared having a cesarean because of their perception that it could result in death or disability. Women also highlighted that providers in the USA rarely discussed female circumcision or how it could affect childbirth experiences. CONCLUSIONS: Previous experiences and cultural beliefs can affect how Somali immigrant women understand labor and delivery practices in the USA and can explain why some women are wary of cesarean delivery. Educating providers and encouraging patient-provider communication about cesarean delivery and female circumcision can ease fears, increase trust, and improve birth experiences for Somali immigrant women in the USA. (21 references) (Author)

20120104-38*

FGM campaign gains momentum in CRR. Anon (2012), Daily Observer [Gambia] 3 January 2012

Reports on the range of training activities and information campaigns organised by The Gambia Committee on Traditional Practices affecting the health of Women and Children (GAMCOTRAP), with the aim of raising awareness

about the practice of female genital mutilation (FGM) and eradicating the procedure. (JSM)

20111101-4*

Crown prosecution service to strengthen support to victims of female genital mutilation. (2011), Crown Prosecution Service 7 September 2011

On 7 September 2011, the Crown Prosecution Service (CPS) issued new guidance that sets out the legal elements of female genital mutilation (FGM) and the challenges prosecutors may face in bringing a case to court, particularly when a victim may retract her evidence due to social and cultural pressures. It is hoped that the new guidance will raise awareness of FGM and help prosecutors to hold perpetrators accountable. (AEP)

20111031-4*

Female genital mutilation [written answer]. House of Commons (2011), Hansard vol 534, no 214, 26 October 2011, col 273W

Mr O'Brien responds to a written question by Valerie Vaz asking the Secretary of State for International Development what his Department's policy is on steps to eradicate female genital mutilation in developing countries. (VDD)

Full URL: http://www.publications.parliament.uk//pa/cm201011/cmhansrd/cm111026/text/111026w0002.htm#11102670000266

20111019-89

Genital trauma in prepubertal girls and adolescents. Merritt DF (2011), Current Opinion in Obstetrics and Gynecology vol 23, no 5, October 2011, pp 307-314

PURPOSE OF REVIEW: To look critically at recent research articles that pertain to children and adolescents who present with genital injuries.

RECENT FINDINGS: Emerging evidence supports links to long-term psychological sequelae of child sexual abuse. Parents should be educated to instruct their children regarding types of child abuse and prevention. 'Medicalization' of female genital mutilation (FGM) by health providers, including 'cutting or pricking', is condemned by international organizations. SUMMARY: Genital injuries whether accidental or intentional need to be reported with standardized terminology to allow for comparisons between reported outcomes. Motor vehicle accidents associated with pelvic fractures may result in bladder or urethral trauma. Adverse long-term psychosocial behaviors may be sequelae of child sexual abuse. FGM is willful damage to healthy organs for nontherapeutic reasons, and a form of violence against girls and women. Healthcare providers should counsel women suffering from the consequences of FGM, advise them to seek care, counsel them to resist reinfibulation, and prevent this procedure from being performed on their daughters. (30 references) (Author)

20111018-47*

Dynamics of change in the practice of female genital cutting in Senegambia: testing predictions of social convention theory. Shell-Duncan B, Wander K, Hernlund Y, et al (2011), Social Science and Medicine vol 73, no 8, 2011, pp 1275-1283

Recent reviews of intervention efforts aimed at ending female genital cutting (FGC) have concluded that progress to date has been slow, and call for more efficient programs informed by theories on behavior change. Social convention theory, first proposed by Mackie (1996), posits that in the context of extreme resource inequality, FGC emerged as a means of securing a better marriage by signaling fidelity, and subsequently spread to become a prerequisite for marriage for all women. Change is predicted to result from coordinated abandonment in intermarrying groups so as to preserve a marriage market for uncircumcised girls. While this theory fits well with many general observations of FGC, there have been few attempts to systematically test the theory. We use data from a three year mixed-method study of behavior change that began in 2004 in Senegal and The Gambia to explicitly test predictions generated by social convention theory. Analyses of 300 in-depth interviews, 28 focus group discussions, and survey data from 1220 women show that FGC is most often only indirectly related to marriageability via concerns over preserving virginity. Instead we find strong evidence for an alternative convention, namely a peer convention. We propose that being circumcised serves as a signal to other circumcised women that a girl or woman has been trained to respect the authority of her circumcised elders and is worthy of inclusion in their social network. In this manner, FGC facilitates the accumulation of social capital by younger women and of power and prestige by elder women. Based on this new evidence and reinterpretation of social convention theory, we suggest that interventions aimed at eliminating FGC should target women's social networks, which are intergenerational, and include both men and women. Our findings support Mackie's assertion that expectations regarding FGC are interdependent; change must therefore be coordinated among interconnected members of social networks. (Author)

20111017-1*

Female genital mutilation [written answer]. House of Commons (2011), Hansard vol 533, no 203, 10 October 2011, col 163-4W

Mr Blunt responds to a written question by Meg Munn asking the Secretary of State for Justice how many prosecutions there have been under the provisions of the Female Genital Mutilation Act 2003; and if he will make a statement. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm111010/text/111010w0006.htm#111010w0006.htm_sbhd50

20111005-6*

Kenyan Maasai seek to end female circumcision. Anon (2011), Africasia 5 October 2011

Explains different attitudes towards female genital mutilation in the Maasai tribe in Kenya where an increasing number of girls are turning their back on the tradition (JR)

20111005-1*

Female genital mutilation [written answer]. House of Lords (2011), Hansard vol 730, no 197, 3 October 2011, col WA95

The Parliamentary Under-Secretary of State for Schools (Lord Hill of Oareford) responds to a written question by Baroness Tonge asking Her Majesty's Government whether they will support projects enabling schoolgirls to make films about female genital mutilation, in order to raise awareness of the subject in schools. (VDD)

Full URL: http://www.publications.parliament.uk/pa/ld201011/ldhansrd/text/111003w0001.htm#1110031001018

20110923-9*

Female genital mutilation [written answer]. House of Lords (2011), Hansard vol 730, no 195, 14 September 2011, col WA57

The Minister of State, Ministry of Justice (Lord McNally) responds to a written question by Baroness Tonge asking Her Majesty's Government whether they have discussed with the relevant authorities in other European countries their successful prosecution of cases involving female genital mutilation. (VDD)

Full URL: http://www.publications.parliament.uk/pa/ld201011/ldhansrd/text/110914w0001.htm#11091483000289

20110923-8*

Female genital mutilation [written answer]. House of Lords (2011), Hansard vol 730, no 194, 13 September 2011, col WA47

The Minister of State, Home Office (Baroness Browning) responds to a written question by Baroness Tonge asking Her Majesty's Government a) what support services are available for those who have undergone female genital mutilation; and where they are located; and b) what assistance they are providing to non-governmental organisations in disseminating information about female genital mutilation, through distribution of leaflets and other means. (VDD)

Full URL: http://www.publications.parliament.uk/pa/ld201011/ldhansrd/text/110913w0001.htm#11091381000150

20110923-4*

Female genital mutilation [written answer]. House of Commons (2011), Hansard vol 532, no 197, 9 September 2011, col 875W

Mr Bellingham responds to a written question by Mr MacShane asking the Secretary of State for Foreign and Commonwealth Affairs what recent reports he has received on the prevalence of female genital mutilation in Gambia; and if he will make a statement. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110909/text/110909w0002.htm#110909w0002.htm_sbhd30

20110923-3*

Female genital mutilation [written answer]. House of Commons (2011), Hansard vol 532, no 197, 9 September 2011, col 847W

Damian Green responds to a written question by Mr MacShane asking the Secretary of State for the Home Department what her policy is on returning girls to countries which are known to practise female genital mutilation. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110909/index/110909-x.htm

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20110923-10*

Female genital mutilation [written answer]. House of Lords (2011), Hansard vol 730, no 196, 15 September 2011, col WA85-86

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe) responds to a written question by

Baroness Tonge asking Her Majesty's Government a) what action they have taken to ensure standardisation of specialist female genital mutilation services across the United Kingdom; and b) whether they will guarantee funding for the 16 specialist female genital mutilation clinics in the United Kingdom. (VDD)

Full URL: http://www.publications.parliament.uk/pa/ld201011/ldhansrd/text/110915w0001.htm#11091557000171

20110909-2*

Female genital mutilation [written answer]. House of Lords (2011), Hansard vol 730, no 189, 5 September 2011, col WA22-21

The Parliamentary Under-Secretary of State for Schools (Lord Hill of Oareford) responds to a written question by Baroness Tonge asking Her Majesty's Government whether they have plans to encourage teachers to raise awareness of female genital mutilation amongst girls in schools; and, if so, how. (VDD)

Full URL: http://www.publications.parliament.uk/pa/ld201011/ldhansrd/text/110905w0001.htm#1109052000142

20110909-19*

Female genital mutilation [written answer]. House of Lords (2011), Hansard vol 730, no 192, 8 September 2011, col WA33

Baroness Browning, Minister of State,Home Office, responds to a written question by Baroness Tonge asking Her Majesty's Government a) whether they have plans to prepare a strategy on female genital mutilation; and, if so, what arrangements they will put in place to fund such a strategy and to co-ordinate it across government; b) whether they plan to reinstate the role of female genital mutilation co-ordinator; and, if so, when; c) what they are doing to encourage awareness of and debate on female genital mutilation; and d) what steps they are taking to promote outreach in communities regarding female genital mutilation. (VDD)

Full URL: http://www.publications.parliament.uk/pa/ld201011/ldhansrd/text/110908w0001.htm#11090840000074

20110907-9

Female genital cutting: addressing the issues of culture and ethics. Ibe C, Johnson-Agbakwu C (2011), The Female Patient vol 36, no 8, August 2011, pp 28-31

Understanding female genital cutting will help the clinician gain insight into providing culturally competent care. (12 references) (Author)

20110819-2*

Female genital mutilation becomes less common in Egypt. Zuckerman W (2011), New Scientist 18 August 2011

Reports that new research has indicated that the practice of female genital mutilation (FGM) is becoming less common in Egypt. FGM was banned by the Egyptian government in 2007, but as the annual incidence had begun to drop before this law was introduced, it is unclear whether the decline is a result of government actions or greater general awareness surrounding the issue. (CI)

Full URL: http://www.newscientist.com/article/dn20808-female-genital-mutilation-becomes-less-common-in-egypt.html

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20110816-21

Female circumcision: obstetrical and psychological sequelae continues unabated in the 21st century. Chibber R, El-Saleh E, El Harmi J (2011), Journal of Maternal-Fetal and Neonatal Medicine vol 24, no 6, June 2011, pp 833-836

OBJECTIVES: To assess the incidence of female circumcision/female genital cutting (FGC) among pregnant women and describe the obstetrical and psychological sequelae of female circumcision. METHOD: Four thousand eight hundred pregnant women over a 4-year period were assessed for female circumcision. Odd ration (OR) and 95% confidence interval (CI) were calculated to measure association between female circumcision, maternal morbidity, and birth outcome. Variables included prolonged maternal hospitalization, low birth weight, prolonged labor, obstructed labor, cesarean section, and fetal outcome. Assessment measures to determine cognitive and emotional effects included the Mini international Neuro-psychiatric interview and Rey memory test. RESULTS: The prevalence of female circumcision was 38%; women who were circumcised were more likely have extended hospital stay. There was a positive association between such women and prolonged labor, cesarean section, post-partum hemorrhage, early neonatal death, and hepatitis C infection. Psychiatric sequelae included: 80% continued to have flashbacks to the FGC event; 58% had a psychiatric disorder (affective disorder); 38% had other anxiety disorders, and 30% had post-traumatic stress disorder. CONCLUSION: Female circumcision is associated with adverse materno-fetal outcome and psychiatric sequelae. Many will need psychiatric as well as gynecological care. (9 references) (Author)

20110729-1*

Men 'must help stop female genital mutilation'. Onyanga-Omara J (2011), BBC News 29 July 2011

Reports that Detective Chief Inspector Dave McCallum of the Avon and Somerset Police has urged men to put an end to the practice of female genital mutilation (FGM) by speaking out to protect their daughters and future wives from being subjected to the procedure, traditional in many cultures, where it is believed to maintain hygiene and preserve virginity and marital fidelity. States that although it is illegal to perform FGM in the UK or to take British nationals or permanent residents to another country to undergo the procedure, some young girls and women are sent abroad covertly. (JSM)

Full URL: http://www.bbc.co.uk/news/uk-england-bristol-14216808

20110725-5*

Female genital mutilation [written answer]. House of Lords (2011), Hansard vol 729, no 187, 20 July 2011, col WA309-10

Baroness Browning, Minister of State,Home Office, responds to a written question by Baroness Tonge asking Her Majesty's Government whether they plan to collate statistics on the levels of female genital mutilation in the United Kingdom; what plans they have to prosecute those who perform female genital mutilation in the United Kingdom; what plans they have to protect temporary United Kingdom residents from female genital mutilation; what they are doing to combat female genital mutilation in the United Kingdom; what assessment they have made as to whether to launch a nationwide campaign highlighting the dangers of female genital mutilation in the United Kingdom. (VDD)

Full URL: http://www.publications.parliament.uk/pa/ld201011/ldhansrd/index/110720.html#contents

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20110725-4*

Female genital mutilation [written answer]. House of Lords (2011), Hansard vol 729, no 185, 18 July 2011, col WA233

Baroness Browning, Minister of State,Home Office, responds to a written question by Baroness Tonge asking Her Majesty's Government what programme of public education is undertaken for refugees who arrive in the United Kingdom from countries where female genital mutilation is prevalent. (VDD)

Full URL: http://www.publications.parliament.uk/pa/ld201011/ldhansrd/index/110718.html#contents

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20110708-7*

Does gum disease delay conception?. Anon (2011), NHS Choices. Behind the Headlines 6 July 2011

Critically assesses a recent study into a link between fertility and oral health that made the newspapers, examines how reliable the research is and how it was reported on. (JR)

20110707-51*

Female genital mutilation/cutting: data and trends. Population Reference Bureau (2010), Washington, DC: Population Reference Bureau 2010, 9 pages

An estimated 100 million to 140 million girls and women worldwide have undergone female genital mutilation/cutting (FGM/C) and more than 3 million girls are at risk for cutting each year on the African continent alone. This report describes the different forms it takes, the prevalence and trends in the procedure in different African countries. (JR)

Full URL: http://www.prb.org/pdf10/fgm-wallchart2010.pdf

20110704-20*

UK girls at risk of mutilation abroad. Elgot J (2011), Independent 4 July 2011

Briefly reports that British girls as young as 8 years of age are at risk of experiencing female genital mutilation as family members take them abroad to undergo painful procedures. (MB)

Full URL: http://www.independent.co.uk/news/uk/home-news/uk-girls-at-risk-of-mutilation-abroad-2306288.html

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20110615-34

Female genital mutilation in Upper Egypt in the new millennium. Rasheed SM, Abd-Ellah A, Yousef FM (2011), International Journal of Gynecology & Obstetrics vol 114, no 1, July 2011, pp 47-50

OBJECTIVE: To estimate the influence of the 2007 criminalization law on the prevalence and yearly incidence of female genital mutilation (FGM) in Upper Egypt and assess the attitudes of both the population and their health providers toward FGM. METHODS: Between September 15, 2008, and September 15, 2010, all girls and young women presenting

at the Departments of Gynecology and Obstetrics or Pediatrics of Sohag and Qena University Hospitals were invited to answer a questionnaire, which was also presented to their parents. Another questionnaire was presented to all nurses, young physicians, and senior physicians working at either hospital. RESULTS: The prevalence of FGM was 89.2%. The incidence was 9.6% in 2000, began to decrease in 2006, and had reached 7.7% at the end of the study period in 2009 (P=0.05). In their vast majority, the procedures were performed by general practitioners. In total, 88.2%, 34.3% and 14.9% of nurses, young physicians, and senior physicians, respectively, approved the practice. CONCLUSION: The incidence of FGM is still very high in Upper Egypt in spite of the criminalization law. While general practitioners perform most procedures, most nurses are in favor of preserving the practice. (19 references) (Author)

20110613-11*

Developing countries: female genital mutilation [written answer]. House of Commons (2011), Hansard vol 529, no 167, 10 June 2011, col 546W

Andrew Mitchelll responds to a written question by Harriet Harman asking the Secretary of State for International Development what steps his Department is taking to reduce the incidence of female genital mutilation in the developing world. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110610/text/110610w0004.htm#11061051000122

20110603-11*

KENYA: Legislation failing to curb FGM/C. Anon (2011), IRIN 2 June 2011

Relates the story of a girl who was recently circumcised, a woman who carries out the practice and says she will continue to do so and a woman who runs a refuge for girls who run away rather than undergo such mutilation, in order to illustrate the depth of the tradition in Kenya. (JR)

Full URL: http://www.irinnews.org/report.aspx?reportID=92869

20110516-1*

Female genital mutilation [written answer]. House of Lords (2011), Hansard vol 727, no 150, 13 May 2011, colWA252

Lord Howell, Minister of State, Foreign and Commonwealth Office, responds to a written question by Lord Jones of Cheltenham to the Secretary of State for the Home Department asking Her Majesty's Government whether they will encourage the Government of Kenya to outlaw female genital mutilation following recent protests by young women in Kenya against this practice. (VDD)

Full URL: http://www.publications.parliament.uk/pa/ld201011/ldhansrd/text/110513w0001.htm#11051343000727

20110420-43

Obstetric and neonatal outcomes for women with reversed and non-reversed type III female genital mutilation. Raouf SA, Ball T, Hughes A, et al (2011), International Journal of Gynecology & Obstetrics vol 113, no 2, May 2011, pp 141-143

OBJECTIVE: To record and compare obstetric and neonatal complication rates in women with reversed and non-reversed type III female genital mutilation (FGM). METHODS: A retrospective observational study comparing cesarean delivery rates and neonatal outcomes of primiparous and multiparous women who had or had not undergone reversal of FGM III. RESULTS: Of the 250 women, 230 (92%) had an FGM reversal. Of these, 50 (21.7%) were primiparous (cesarean delivery rate 17/50; 34%) and 180 (78.3%) were multiparous (cesarean delivery rate 28/180; 15.6%). Of the 20 women who had not had an FGM reversal, 7 (35%) were primiparous (cesarean delivery rate 5/7; 71.4%) and 13 (65%) were multiparous (cesarean delivery rate 7/13; 53.8%). The cesarean delivery rates for primiparae and multiparae were 32.9% and 25%, respectively. Multiparous women with FGM III reversal had a lower possibility of cesarean delivery compared with the hospital multiparous population (P=0.003) and multiparae who had not undergone FGM III reversal (P=0.007). There was no significant association between Apgar scores or blood loss at vaginal delivery and FGM reversal. CONCLUSION: Reversal of FGM III significantly reduced the increased risk of cesarean delivery seen with multiparae who have FGM III. (14 references) (Author)

20110419-15*

Kenyan girls fight back against genital mutilation. (2011), The Guardian 18 April 2011

A video which documents the attempts of two teenage girls in rural Kenya to refuse female genital mutilation. Depicts how the custom embeds itself in social expectations and the emotional and social conflicts they face in challenging this convention. (CI)

Full URL: http://www.guardian.co.uk/global-development/poverty-matters/2011/apr/18/kenyan-girls-rebel-against-fgm

20110415-6*

The midwife on a mission to stop female genital mutilation. Moorhead J (2011), The Guardian 15 April 2011

Describes how Cath Holland, a midwife from Lancashire, is campaigning to eradicate female genital mutilation (FGM) in Kenya, after having witnessed the consequences of this practice while working as a midwifery tutor at a nursing school in Pokot. (JSM)

Full URL: http://www.guardian.co.uk/lifeandstyle/2011/apr/15/female-genital-mutilation-midwife-kenya

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20110408-28*

What the law says on female genital mutilation. Griffiths R (2011), British Journal of School Nursing vol 6, no 3, April 2011, p146-47

Many girls and young women in the UK are at risk of female genital mutilation (FGM). Suspected cases might come, or be brought to the attention of school nurses and it is therefore vital that they are up to date with current legislation on FGM. (Author)

Full URL: http://www.internurse.com/cgi-bin/go.pl/library/article.cgi?uid=83134

20110408-27*

Female genital mutilation: What can school nurses do about it?. Robinson E (2011), British Journal of School Nursing vol 6, no 3, April 2011, p113-114

In the UK over 24000 girls are at risk of female genital mutilation. Estelle Robinson comments on the new multi-disciplinary guidelines that have recently been published as well as the important role school nurses can play in addressing FGM. (Author)

Full URL: http://www.internurse.com/cgi-bin/go.pl/library/article.cgi?uid=83127

20110317-33

Awareness is key, says new guideline to tackle FGM. Anon (2011), Midwives vol 14, no 2, 2011, p 8

Announces new NICE guidelines on female genital mutilation and includes some signs to look out for which may indicate that a woman or girl has undergone the procedure. (JR)

20110315-8*

African communities against female circumcision. (2011), Medindia 15 March 2011

The non-governmental organization Tostan has reported that representatives in villages in Sengal and Mali have agreed to ban the practice of female genital mutilation. Tostan campaigns for an end to the procedure in Africa. (CR)

Full URL: http://www.medindia.net/news/African-Communities-Against-Female-Circumcision-82235-1.htm

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20110310-92*

Female genital mutilation: Australian law, policy and practical challenges for doctors. Mathews B (2011), Medical Journal of Australia vol 194, no 3, 2011, pp 139-141

The issue of whether medical practitioners should perform 'ritual nicks' as a method of meeting demand for female genital mutilation (FGM) has recently been debated in the United States and Australia. Due to increasing numbers of people arriving and settling in Australia from African nations in which FGM is customary, demand for FGM in Australia is present and may be increasing. Australian law clearly prohibits performance of any type of FGM. FGM is also prohibited by the most recent policy of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). For legal, medical and social reasons, the RANZCOG policy is sound, and medical practitioners should not administer FGM in any form. Development of an evidence base regarding incidence of and attitudes towards FGM, and the need for post-FGM treatment, would help inform sound policy and practical responses. Strategies adopted in African nations to abolish FGM may assist in refining educational and supportive efforts. (Author)

20110225-26*

Multi-agency practice guidelines: female genital mutilation. Foreign and Commonwealth Office (2011), London: Foreign and Commonwealth Office 24 February 2011, 50 pages

New, multi-agency practice guidelines on tackling and preventing female genital mutilation are now published.

Awareness among healthcare practitioners across all sectors, but particularly in GP practices, and midwifery, gynaecology, neo-natal and anti-natal [sic] services, is crucial to creating the joined-up approach needed to safeguard girls and women from harm; and ensuring those affected receive the physical and mental health care they need. (Author)

20110215-11

International agency calls for end to 'inhuman practice' of female genital mutilation. Cui W (2011), BMJ vol 342, no 7793, 12 February 2011, pp 354-355

Highlights the spread of the practice of female genital mutilation and briefly describes what it involves. (JR)

20110209-5*

Solid Foods Before 4 Months Can Raise Obesity Risk For Bottle-Fed Babies. Paddock C (2011), Medical News Today 8 February 2011

Reports research published in Pediatrics journal (1) which suggests that bottle fed babies who are given solid foods prior to four months of age are six times more likely to be obese at the age of three, but that this is not the case for breastfed babies for whom the timing of the introduction of solids made no difference. 1. Huh SY et al. Timing of Solid Food Introduction and Risk of Obesity in Preschool-Aged Children. Pediatrics. 7th February [published online ahead of print]. (JR)

20110208-9*

Africa shows signs of winning war against female genital mutilation. McVeigh T (2011), Observer 6 February 2011

Describes how Senegalese hip-hop star, Sister Fa, is reaching out to African communities through her music in a campaign to bring about voluntary abandonment of female genital mutilation (FGM). Reports that by demonstrating an understanding of local culture, initiatives such as her 'Education Against Mutilation' tour, and drives by other cultural ambassadors, have helped to discourage FGM in some countries, including Ethiopia, Kenya and Egypt which have all shown decreases in the number of girls being subjected to the procedure. (JSM)

Full URL: http://www.guardian.co.uk/global-development/2011/feb/06/female-circumcision-sister-fa

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20110208-4*

Top UN officials call for abolishing female genital mutilation. (2011), UN News Centre 6 February 2011

Reports that to mark the International Day of Zero Tolerance to Female Genital Mutilation/Cutting (FGM/C), UNFPA Executive Director Babatunde Osotimehin and UNICEF Executive Director Anthony Lake have issued a joint statement calling for the abolition of FGM/C, a cultural practice which has affected up to 140 million women and girls worldwide, and is still carried out on approximately 3 million girls in African countries every year. States that Egypt, Ethiopia, Kenya and Senegal are among 6, 000 communities in Africa that have already banned the practice. (JSM)

Full URL: http://www.un.org/apps/news/story.asp?NewsID=37478&Cr=women&Cr1=health

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20110127-13*

ETHIOPIA: Pastoralists battling FGM/C. (2011), IRIN 26 January 2011

Reports that the practice of female genital mutilation has been outlawed by pastoralist communities in Amibara and Awash-Fentale in the Afar region of Ethiopia because of the resulting health problems to women and because it goes against their culture. States that the decision has been welcomed by the Head of Women's Affairs in Amibara district, Fatuma Ali, who has pledged to fight for region-wide abandonment of the procedure. (JSM)

Full URL: http://www.irinnews.org/report.aspx?ReportID=91732

20110121-2*

50,000 girls under threat of circumcision. (2011), Europe News 20 January 2011

Reports that the Association of German Criminal Officers has warned that 50,000 girls in the country are at risk of female genital mutilation. (CR)

20110107-27*

Care of women with female genital mutilation/cutting. Abdulcadir J, Margairaz C, Boulvain M, et al (2011), Swiss Medical Weekly vol 140, 6 January 2011, w13137

In multi-ethnic European society medical professionals are faced with an increasing number of women originating from countries where female genital mutilations/cuttings (FGM/C) are practised. Recent studies, however, emphasise the lack of knowledge on this subject. This review article aims to present FGM/C as a complex socio-healthcare and multidisciplinary issue, outlining the definition, classification, epidemiology and anthropologico-legal aspects of FGM/C. It explains the approach to be adopted to FGM/C women, focusing on defibulation, clitoral restoration/repair and re-infibulation. Finally, it reports on the discussions surrounding pricking/nicking and the proposals for alternative rituals in recent years. (47 references) (Author)

Full URL: http://www.smw.ch/content/smw-2010-13137/

20101123-15*

New report offers breakthrough to ending female genital mutilation. Medical News Today (2010), Medical News Today 21 November 2010

Reports that a new publication from Unicef's Innocenti Research Centre - The dynamics of social change: towards the abandonment of female genital mutilation/cutting in five African Countries - is providing evidence on how African countries are working towards putting an end to the practice of female genital cutting, despite prevailing social norms that entrench female circumcision deep in their societies. The report examines the conditions that would be necessary to fully abandon to the practice, including involving respected community members such as religious and local leaders, and engaging social networks and institutions. (MB)

20101122-2

More current issues for midwives. Edmondson L (2010), Journal of Family Health Care vol 20, no 5, 2010, pp 166-168, 170-173

Linda Edmondson reports on Current Issues in Midwifery, the Learning Curve study day that took lace in Birmingham in June 2010. Four excellent presentations focused on female genital mutilation, managing obesity in pregnancy, setting up a weight-management service for pregnant women, and CTG monitoring. (Author)

20101119-38*

The dynamics of social change. Towards the abandonment of female genital mutilation/cutting in five African countries. UNICEF (2010), Florence: UNICEF Innocenti Research Centre October 2010

Examines the social dynamics of the abandonment of female genital mutilation/cutting (FGM/C) in Egypt, Ethiopia, Kenya, Senegal and the Sudan, and seeks to inform policies and programmes aiming to abolish this practice in countries where it forms part of local tradition, and also among disporate communities in countries of immigration. Demonstrates progress towards effective abandonment of the practice of FGM/C in intervention areas and, in some cases, beyond. Also provides evidence of significant changes in attitudes towards FGM/C over a relatively brief period of ten years. Concludes with reflections on the remaining challenges of FGM/C abandonment and offers recommendations for future research and programme interventions. (Author, edited)

20101118-24*

UNICEF: Support needed to end female genital mutilation. Foulkes I (2010), BBC News 18 November 2010

UNICEF is to release a report on female genital mutilation and the ways in which communities can be encouraged to end this practice. It is to say that interventions can only succeed if they address the needs and wishes of the community. (CR)

Full URL: http://www.bbc.co.uk/news/world-europe-11783203

20101116-17*

Leaders call for genital mutilation ban. (2010), Official Wire 15 November 2010

Briefly reports that an international appeal has urged the United Nations to adopt a resolution banning female genital mutilation worldwide. (CR)

20101110-26*

Leaders from 10 countries gather for two-day meeting in New York to discuss progress, barriers to reducing violence against women. (2010), Medical News Today 9 November 2010

Reports on a meeting hosted by the United Nations Population Fund (UNFPA), and attended by representatives from ten countries with the aim of reducing violence against women; issues discussed included female genital mutilation

and cutting, and involving men and boys in putting an end to gender based violence (GBV). States that pilot programmes have been launched in Burkina Faso, Chile, Fiji, Jamaica, Jordan, Kyrgyzstan, Paraguay, Philippines, Rwanda and Yemen. (JSM)

20101108-1*

Female Genital Mutilation Act 2003: Prosecutions [written answer]. House of Commons (2010), Hansard vol 517, no 64, 3 November 2010, col 833W

Mr Blunt responds to a written question by Richard Fuller to the Secretary of State for Justice regarding how many prosecutions have been brought under the provisions of the Female Genital Mutilation Act 2003 in each year since its entry into force; and if he will make a statement. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm101103/text/101103w0002.htm#qn_91

20101027-7*

Female genital mutilation [written answer]. House of Commons (2010), Hansard vol 517, no 58, 25 October 2010, col 61W

The Attorney-General responds to a written question by Valerie Vaz asking how many prosecutions have been brought in respect of offences relating to female genital mutilation in each of the last five years. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm101025/text/101025w0003.htm#qn_118

20101020-27*

Female genital mutilation [written answer]. House of Commons (2010), Hansard vol 516, no 54, 19 October 2010, col 636W

Lynne Featherstone responds to a written question by Jo Swinson to the Secretary of State for the Home Department asking (1) how many cases of female genital mutilation have been reported to UK police in each year since 2003; (2) what estimate her Department has made of the number of girls resident in the UK who have been taken overseas to undergo female genital mutilation in each of the last three years. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm101019/text/101019w0001.htm#10101950000008

20100917-21

12 months later..... Albert J (2010), Midwives September 2010, pp 40-41

Specialist midwife Juliet Albert reflects on the first year of a new community-based, midwifery-led, de-infibulation clinic for women with female genital mutilation in the heart of West London. She began her report in A ray of light in the FGM darkness, published in Midwives in September last year. (Author)

20100915-76*

Female genital mutilation [written answers]. House of Commons (2010), Hansard vol 515, no 45, 14 September 2010, col 909W

James Brokenshire responds to a written question by Valerie Vaz to the Secretary of State for the Home Department regarding whether she will take steps to strengthen enforcement of legislation prohibiting female genital mutilation; and if she will make a statement. (VDD)

Full URL: http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm100914/text/100914w0001.htm#qn_11

20100915-4

Obstetric care at the intersection of science and culture: Swedish doctors' perspectives on obstetric care of women who have undergone female genital cutting. Widmark C, Leval A, Tishelman C, et al (2010), Journal of Obstetrics and Gynaecology vol 30, no 6, August 2010, pp 553-558

Providing healthcare for women having undergone female genital cutting can present challenges. The women might require special obstetric care, including an anterior episiotomy (defibulation) for infibulated women. This paper explores how Swedish doctors caring for these women describe, explain and reason about their care and relevant policies in a Swedish context. A qualitative study was carried out with 13 chief/senior obstetricians and seven senior house officers. There was little consensus among the interviewed doctors on what constitutes good obstetric care for women with FGC or how care should be provided. Major problems include: inconsistent policy and praxis; uncoordinated care trajectories; diffuse professional role responsibilities; difficulties in monitoring labour and fetal status; and inhibited communication. The data highlight the need for increased awareness and reflective praxis both on the part of individual practitioners, and on an organisational level, which takes account of the special needs of

different users. (29 references) (Author)

20100823-1*

'Rise in female genital mutilation' in London. (2010), BBC News 22 August 2010

Reports that the number of cases of female genital mutilation reported in London is rising; however, despite the procedure being illegal in the UK, there have been no prosecutions to date. (CR)

Full URL: http://www.bbc.co.uk/news/uk-england-london-11053375

20100820-24

Ritual genital cutting of female minors. American Academy of Pediatrics, Committee on Bioethics (2010), Pediatrics vol 125, no 5, May 2010, pp 1088-1093

The traditional custom of ritual cutting and alteration of the genitalia of female infants, children, and adolescents, referred to as female genital mutilation or female genital cutting (FGC), persists primarily in Africa and among certain communities in the Middle East and Asia. Immigrants in the United States from areas in which FGC is common may have daughters who have undergone a ritual genital procedure or may request that such a procedure be performed by a physician. The American Academy of Pediatrics believes that pediatricians and pediatric surgical specialists should be aware that this practice has life-threatening health risks for children and women. The American Academy of Pediatrics opposes all types of female genital cutting that pose risks of physical or psychological harm, counsels its members not to perform such procedures, recommends that its members actively seek to dissuade families from carrying out harmful forms of FGC, and urges its members to provide patients and their parents with compassionate education about the harms of FGC while remaining sensitive to the cultural and religious reasons that motivate parents to seek this procedure for their daughters. (36 references) (Author)

20100805-65

Late complications of childhood female genital mutilation. Hamoudi A, Shier M (2010), JOGC [Journal of Obstetrics and Gynaecology Canada] vol 32, no 6, June 2010, pp 587-589

BACKGROUND: Canada's immigrants are increasingly from non-English-speaking countries with different medical issues. Female genital mutilation (FGM) is a procedure performed for non-medical reasons that is not traditionally encountered in Canada and that has serious health implications for women. CASE: A 36-year-old woman, who underwent FGM at the age of four, presented to our colposcopy unit with increasing swelling of the vulva. Examination revealed a large cystic mass in the midline of the vulva, and MRI identified two well-defined cystic lesions. The mass was excised, and histologic examination confirmed an epidermal inclusion cyst. CONCLUSION: An epidermal inclusion cyst can develop as a long-term consequence of FGM. Although it grows slowly and usually without symptoms, it may require excision because of inflammation, secondary infection, or, in rare cases, malignancy developing within the cyst. (16 references) (Author)

20100726-5*

British girls undergo horror of genital mutilation despite tough laws. McVeigh T, Sutton T (2010), Observer 25 July 2010

Reports on the issue of female genital mutilation (FGM) and highlights that although up to 2000 British schoolgirls are expected to undergo the procedure during the school summer holidays, either in the UK or after being taken abroad, there have been no prosecutions against the practice since it was made illegal in 1985. Includes accounts from women who have undergone female circumcision and interviews with experts who have encountered FGM in the course of their work. (CR)

Full URL: http://www.guardian.co.uk/society/2010/jul/25/female-circumcision-children-british-law

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20100726-3*

Female circumcision growing in Britain despite being illegal. McVeigh T (2010), Observer 25 July 2010

Reports that experts believe that female circumcisions are likely to be carried out on between 500 and 2000 girls in Britain this summer, despite the practice being illegal. The practice was criminalised in 1985 and taking children out of the country to have it performed was made illegal in 2003. (CR)

Full URL: http://www.guardian.co.uk/society/2010/jul/25/female-circumcision-health-child-abuse

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20100706-2*

The razor and the damage done: female genital mutilation in Kurdish Iraq. Chulov M (2010), The Guardian 5 July 2010

Discusses female genital mutilation in Kurdish Iraq from the points of view of those who perform the procedure, the girl who undergoes the procedure, and the families of girls who have been subjected to it. Looks at the history and culture behind this controversial practice, which many now believe should be made illegal. (JSM)

Full URL: http://www.guardian.co.uk/world/2010/jul/05/female-genital-mutilation-kurdish-iraq

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20100705-13*

Congress should act 'quickly' on female genital mutilation bill, New York Times editorial states. (2010), Medical News Today 2 July 2010

Calls on the United States government to pass a law, the 'Girls Protection Act', which would prevent young girls being taken out of the country to undergo female genital mutilation (FGM). Explains that FGM has been illegal in the United States since 1996. (JSM)

20100630-34

Female genital mutilation. Bewley S, Creighton S, Momoh C (2010), BMJ vol 340, no 7760, 19 June 2010, pp 1317-1318

Examines the progress made worldwide in reducing the practice of female genital mutilation (FGM) and queries why the American Academy of Paediatrics recently amended an earlier policy on FGM which would allow doctors to 'nick' female genitalia as a cultural compromise. Argues that such a statement has undermined local, national, regional and international initiatives against FGM. (13 references) (TC)

20100624-57*

Views of women and men in Bobo-Dioulasso, Burkina Faso, on three forms of female genital modification. Jirovsky E (2010), Reproductive Health Matters vol 18, no 35, 2010, pp 84-93

This paper is about how female circumcision/female genital mutilation (FC/FGM) was viewed by women and men aged 18-89 in Bobo-Dioulasso, Burkina Faso, now that it has been against the law for almost 15 years. The findings come from 11 months of field research, participant observation and interviews in 2008. The practice of FC/FGM was an important issue in Bobo-Dioulasso, even though prevalence seems to be falling. The most important argument for continuing it was not a traditional role, but the need to control female sexuality - regarded as very active - not to negate it, but to ensure morally acceptable behaviour. When I talked about female genital cosmetic surgery it emerged that Bobolaise women used various substances to enhance sexual pleasure for men, both to keep the relationship and to protect the gifts and money many women needed to survive and for their children. FC/FGM was seen as a socio-cultural obligation, necessary to achieve a respectable status. Other forms of genital modification were seen as a means of satisfying male sexual needs, though vaginal tightening to hide sexual experience was also a way of demonstrating respectability. What emerged overall is that Bobolaises had their own perspectives about all the forms of female genital modification that were discussed. (Author)

20100622-5*

Human rights watch calls on Kurdish regional government to ban female genital mutilation. Anon (2010), National Partnership for Women and Families 18 June 2010

A report from the human rights group Human Rights Watch has revealed that most girls in the Kurdish region of northern Iraq undergo female genital mutilation; authorities have failed to address the issue because of cultural concerns. (CR)

20100603-5*

American Academy Of Pediatrics Retracts Policy Statement On Female Genital Mutilation. (2010), National Partnership for Women and Families 1 June 2010

News item reporting that the American Academy of Pediatrics has withdrawn its recommendation that doctors may consider 'pricking' or 'nicking' the clitoris of a newborn girl to prevent families from sending the child abroad for a more severe form of female genital mutilation. (JR)

20100601-9*

COTE D'IVOIRE: Zero tolerance of FGM/C. Anon (2010), ReliefWeb 31 May 2010

Reports that a campaign in Cote d'Ivoire to eliminate the practice of female genital mutilation by the end of 2010 is

stalling because of worsening levels of health and education resulting from a lack of resources and a movement of skilled staff from outlying areas to the capital city. The practice is particularly prevalent in the north and the west of the country despite the fact that it is illegal. (JR)

Full URL: http://www.reliefweb.int/rw/rwb.nsf/db900SID/ASHU-85YTQA?OpenDocument

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20100527-5*

Some Immigrants Face Pressure To Perform Female Genital Mutilation, Advocates Say. Anon (2010), National Partnership for Women and Families 25 May 2010

News item reporting that some immigrants to the United States are being pressured into female circumcision despite the fact that it is illegal in the States. There is only anecdotal evidence for many aspects of this topic because many families are not willing to answer questions on the subject, but there has been some discussion about making it illegal to take someone abroad for the purposes of female circumcision. (JR)

20100526-39

Promoting female reproductive and sexual health: The importance of attitude. Grenman S (2010), International Journal of Gynecology & Obstetrics vol 109, no 3, June 2010, pp 183-184

Gives an overview of the work of the International Federation of Gynecology and Obstetrics (FIGO) in promoting female reproductive and sexual health across the world, including the reduction of maternal mortality, and the abolition of female genital mutilation. Stresses the importance of collaboration and common aims (6 references) (JSM)

20100526-16*

US pediatricians to condone FGM, sort of. (2010), Independent 26 May 2010

Reports that strong criticism has been levelled against the American Academy of Pediatrics (AAP), following their policy statement (1) recommending that pediatricians in the United States make 'ritual nicks' in the genitalia of young girls in an attempt to display cultural sensitivity, while at the same time discourage families from performing full female genital mutilation. 1. American Academy of Pediatrics (2010). Policy statement ritual genital cutting of female minors. Available at: http://pediatrics.aappublications.org/cgi/reprint/peds.2010-0187v1 (JSM)

20100525-46*

Sierra Leone: female genital mutilation [written answer]. House of Commons (2010), Hansard vol 508, no 68, 7 April 2010, col 1434W-1435W

Mr Thomas responds to a written question by Mr McShane to the Secretary of State for International Development pursuant to the answer of 29 March 2010, Official Report, columns 739-40W, on Sierra Leone: overseas aid, regarding what estimate he has made of the effect of the programme funded by his Department to improve the reproductive health of women in Sierra Leone on the level of female genital mutilation of women aged between 15 and 49 years old in that country, and pursuant to the answer of 29 March 2010, Official Report, columns 739-40W, on Sierra Leone: overseas aid, what proportion of the £16 million his Department is providing for women's reproductive health in Sierra Leone is spent on reducing the incidence of female genital mutilation. (CR)

Full URL: www.publications.parliament.uk

20100525-4

UK colleges criticise US advice on female genital mutilation. Kmietowicz Z (2010), BMJ vol 340, no 7756, 22 May 2010, p 1103

News item reporting that the Royal College of Obstetricians and Gynaecologists and the Royal College of Paediatrics and Child Health have raised concerns about guidance issued by the American Academy of Paediatrics on female genital mutilation (FGM) which suggested that, while opposing all forms of FGM, doctors could offer families 'a ritual nick as a possible compromise'. (CR)

20100520-44

Special commentary on the issue of reinfibulation. Cook RJ, Dickens BM (2010), International Journal of Gynecology & Obstetrics vol 109, no 2, May 2010, pp 97-99

Policy on reinfibulation exposes the interface between individual or micro-ethics and population-wide or macro-ethics. If, following childbirth, an infibulated woman requests reinfibulation, a gynecologist may respectfully advise her of its negative implications, but would not act in breach of ethical or usually legal requirements in

undertaking the procedure. However, as a matter of health policy and professional responsibility, physicians should refuse to initiate infibulation, and advise their patients and communities that the procedure is harmful, not required by religious or other ordinance, and frequently if not always unlawful. Reinfibulation is not genital cutting (or 'mutilation') in itself, but when undertaken by a physician may appear to condone infibulation. This is contrary to medical professional ethics, which condemn medicalization of infibulation and generally of reinfibulation, even as a harm-reduction strategy to spare women the risks of injury and infection from unskilled interventions. (13 references) (Author)

20100520-43

The issue of reinfibulation. Serour GI (2010), International Journal of Gynecology & Obstetrics vol 109, no 2, May 2010, pp 93-96

Reinfibulation is resuturing after delivery or gynecological procedures of the incised scar tissue resulting from infibulation. Despite the global fight against female genital mutilation/cutting (FGM/C), reinfibulation of previously mutilated or circumcised women is still performed in various countries around the world. A good estimate of the prevalence of reinfibulation is difficult to obtain, but it can be inferred that 6.5-10.4million women are likely to have been reinfibulated worldwide. Women who undergo reinfibulation have little influence on the decision-making and are usually persuaded by the midwife or birth attendant to undergo the procedure immediately following labor or gynecological operation. Although medicalization of reinfibulation may reduce its immediate risks, it has no effect on the incidence of long-term risks. Reinfibulation is performed mainly for the financial benefit of the operator, and cultural values that have been perpetuated for generations. Reinfibulation has no benefits and is associated with complications for the woman and the unborn child. Its medicalization violates the medical code of ethics and should be abandoned. International and national efforts should be combined to eradicate this practice. (30 references) (Author)

20100517-10*

Policy statement renews controversy over U.S. efforts to address female genital mutilation. Anon (2010), Medical News Today 14 May 2010

Reports that a recent policy statement from the American Academy of Pediatrics on female genital mutilation, which suggests that a 'ritual nick' could be offered as a potential compromise 'to avoid greater harm', has drawn criticism from human rights activists and renewed the debate about how the issue should be addressed. (CR)

20100514-9*

Joint RCOG/RCPCH statement on the AAP policy statement on FGM. Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health (2010), London: RCOG 12 May 2010

The Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Paediatrics and Child Health (RCPCH) respond to the publication of the American Academy of Paediatrics (AAP) Committee on Bioethics policy statement on female genital mutilation. While they support the main recommendations of the AAP, the RCOG and RCPCH express concern at the suggestion in the AAP paper that it might be possible to offer a 'ritual nick' to families as a compromise. (CR)

Full URL: www.rcog.org.uk/what-we-do/campaigning-and-opinions/statement/joint-rcogrcpch-statement-aap-policy-statement-fgm

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20100512-7*

Why are US doctors allowing genital mutilation?. Anantnarayan L (2010), The Guardian 11 May 2010

Calls upon the American Academy of Pediatrics (AAP) to retract its policy statement issued last month on female genital mutilation (FGM) which suggested federal and state law in the United States should give paediatricians the right to offer a ritual 'nick' to the genitalia of young immigrant girls in order to meet their cultural needs of their families. States that the move has met with outrage from International women's rights organisations in the United States, Africa, and Europe. Refers to the protocol to the African charter on human and people's rights on the rights of women in Africa which specifically prohibits all forms of female genital mutilation. (JSM)

Full URL: http://www.guardian.co.uk/commentisfree/2010/may/11/female-genital-mutilation-us-nicking

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20100510-3*

African Lawmakers Appeal For U.N. Resolution Banning Female Genital Mutilation. Anon (2010), Kaiser Family Foundation 5 May 2010

Reports an appeal to the United Nations to ban Female Genital Mutilation because it is contrary to human rights.

Provides a brief description of the practice and briefly outlines some of the possible resulting complications. (JR)
Full URL: https://khn.org/morning-breakout/gh-050510-fgm/

20100422-31

Female genital mutilation: a global and local concern. Momoh C (2010), Practising Midwife vol 13, no 4, April 2010, pp 12-14

The devastating consequences of FGM are increasingly evident in the UK. (7 references) (Author)

20100422-26

Female circumcision: standing in their shoes. Adikibi A (2010), Practising Midwife vol 13, no 4, April 2010, pp 4-5

Comments on the history and practice of female genital mutilation, more often known as female circumcision, around the world and considers the role of men in preventing the practice. Argues that successful cultural change will only occur from within communities where female circumcision is practiced, through changes in government policy and education. (11 references) (TC)

20100406-34*

Estimating the obstetric costs of female genital mutilation in six African countries. Adam T, Bathija H, Bishai D, et al (2010), Bulletin of the World Health Organization vol 88, no 4, April 2010, pp 281-88

Objective: To estimate the cost to the health system of obstetric complications due to female genital mutilation (FGM) in six African countries. Methods: A multistate model depicted six cohorts of 100 000 15-year-old girls who survived until the age of 45 years. Cohort members were modelled to have various degrees of FGM, to undergo childbirth according to each country's mortality and fertility statistics, and to have medically attended deliveries at the frequency observed in the relevant country. The risk of obstetric complications was estimated based on a 2006 study of 28 393 women. The costs of each complication were estimated in purchasing power parity dollars (I$) for 2008 and discounted at 3%. The model also tracked life years lost owing to fatal obstetric haemorrhage. Multivariate sensitivity analysis was used to estimate the uncertainty around the findings. Findings: The annual costs of FGM-related obstetric complications in the six African countries studied amounted to I$ 3.7 million and ranged from 0.1 to 1% of government spending on health for women aged 15-45 years. In the current population of 2.8 million 15-year-old women in the six African countries, a loss of 130 000 life years is expected owing to FGM's association with obstetric haemorrhage. This is equivalent to losing half a month from each lifespan. Conclusion: Beyond the immense psychological trauma it entails, FGM imposes large financial costs and loss of life. The cost of government efforts to prevent FGM will be offset by savings from preventing obstetric complications. [A full text version of this article can be accessed online at http://www.who.int/bulletin/volumes/88/4/09-064808.pdf] (Author) (21 references)

20100318-74*

Egyptian ever-married women's attitude toward discontinuation of female genital cutting. Afifi M (2010), Singapore Medical Journal vol 51, no 1, January 2010, pp 15-20

Introduction: This study aimed to examine Egyptian ever-married women's beliefs and attitude toward the discontinuation of female genital cutting (FGC) . We also examined the significant sources of information which the women with positive attitude were exposed to the year prior to the survey. Methods : In a national representative community-based sample of 15,573 evermarried Egyptian women, the intention to continue the practice of FGC and other sociodemographical variables were collected from the 2000 Egypt Demographic and Health Survey data. A secondary in-depth analysis was conducted on the data in order to investigate the women's attitude and its associated factors. Results : Only 12.4 percent of the sample intended to discontinue the practice. The logistic regression models showed that women with a positive attitude to discontinue the practice believed that FGC was not an important part of religious traditions, that husbands did not prefer a cut wife, and that FGC reduced sexual desire. The most significant sources of information related to a positive attitude to discontinue the practice were community discussions, the mosques or churches and the newspapers. Conclusion: The aforementioned sources of information are related to the social and religious aspects of women in the Egyptian community. In order to change women's attitude toward the discontinuation of this unhealthy practice, communication rather than passive learning is needed. [The full text of this article can be accessed at: http://smj.sma.org.sg/5101/5101a1.pdf] (24 references) (Author)

20100317-66

The relationship between female genital cutting and obstetric fistulae. Browning A, Allsworth JE, Wall LL (2010), Obstetrics & Gynecology vol 115, no 3, March 2010, pp 578-583

OBJECTIVE: To evaluate any association between female genital cutting and vesicovaginal fistula formation during obstructed labor. METHODS: A comparison was made between 255 fistula patients who had undergone type I or type II female genital cutting and 237 patients who had not undergone such cutting. Women were operated on at the Barhirdar Hamlin Fistula Centre in Ethiopia. Data points used in the analysis included age; parity; length of labor; labor outcome (stillbirth or not); type of fistula; site, size, and scarring of fistula; outcomes of surgery (fistula closed; persistent incontinence with closed fistula; urinary retention with overflow; site, size, and scarring of any rectovaginal fistula; and operation outcomes), and specific methods used during the operation (use of a graft or not, application of a pubococcygeal or similar autologous sling, vaginoplasty, catheterization of ureters, and flap reconstruction of vagina). Primary outcomes were site of genitourinary fistula and persistent incontinence despite successful fistula closure. RESULTS: The only statistically significant differences between the two groups (P=.05) were a slightly greater need to place ureteral catheters at the time of surgery in women who had not undergone a genital cutting operation, a slightly higher use of a pubococcygeal sling at the time of fistula repair, and a slightly longer length of labor (by 0.3 day) in women who had undergone genital cutting. CONCLUSION: Type I and type II female genital cutting are not independent causative factors in the development of obstetric fistulae from obstructed labor. (34 references) (Author)

20100223-20

DVD highlights healthier future without FGM. (2010), Midwives February/March 2010, p 06

Brief news item reporting the launch of a DVD to support midwives, doctors and nurses working with sufferers of female genital mutilation (FGM) and their families. Includes comments from Baroness Ruth Rendell, a prominent campaigner against FGM, and provides a web address for further information - www.fgmnationalgroup.org. (TC)

20100217-27*

Life after female genital mutilation. Gould M (2010), The Guardian 17 February 2010

Recounts the experience of a woman in the UK who underwent female genital mutilation (FGM) in Sierra Leone at the age of 12. Explains that there are now a handful of medical professionals in the UK who can carry out FGM reversals, known as deinfibulation. (CR)

Full URL: http://www.guardian.co.uk/society/2010/feb/17/reversing-female-genital-mutilation

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20100215-4*

Female circumcision ban urged. Khidhir Q (2010), Institute for War and Peace Reporting 11 February 2010

News item reporting that a survey has found that the majority of women in Iraqi Kurdistan have undergone genital mutilation. Although the results suggest that the practice is falling out of favour amongst younger parents and that local media, non-government organisations and women's groups have raised public awareness about female genital mutilation, the topic is still considered taboo and many Kurdish politicians are reluctant to address it. (CR)

Full URL: http://www.iwpr.net/index.php?apc_state=hen&s=o&o=l=EN&p=icr&s=f&o=360088

20100128-7

Knowledge of female genital cutting and experience with women who are circumcised: a survey of nurse-midwives in the United States. Hess RF, Weinland JA, Saalinger NM (2010), Journal of Midwifery & Women's Health vol 55, no 1, January/February 2010, pp 46-54

Thousands of women with a history of female genital cutting (FGC) have immigrated to the United States. The purpose of this study was to assess certified nurse-midwives' (CNMs') knowledge of FGC and to explore their experiences caring for African immigrant women with a history of genital cutting. A descriptive survey design was used. A random sample of 600 CNMs from the member list of the American College of Nurse-Midwives was surveyed. Two hundred forty-three CNMs completed a survey of FGC knowledge and provider experience. The respondents exhibited more correct medical knowledge about FGC than knowledge of cultural and legal issues. Differences in correct or incorrect knowledge were statistically significant based on provider experience. Almost 70% of respondents could identify infibulation. Less than 20% knew that both Muslim and Christian women are circumcised. Fifty-seven percent knew that it is illegal in the United States to circumcise women younger than 18 years of age. We found that discussions between CNMs and clients who were circumcised regarding FGC-related concerns and complications were minimal. Women with a history of FGC want female providers. Reinfibulation poses an ethical dilemma for some CNMs. Nurse-midwives in the United States need to learn more about FGC and the cultures of their clients in order to provide culturally competent care. (36 references) (Author)

20100114-73

Female genital mutilation and the law. Griffith R (2010), British Journal of Midwifery vol 18, no 1, January 2010, pp 58-59

Examines the legal issues relating to female genital mutilation in the UK, including an outline of the Female Genital Mutilation Act 2003, the exemptions to this act, and the issues surrounding child protection. Considers the role of the midwife in referring cases of female genital mutilation. (6 references) (TC)

20100111-9*

Independent Appeal: saved from the agony of female circumcision. Vallely P (2010), Independent 9 January 2010

Describes how a project, run by the British development agency ActionAid, has brought about a change in social attitudes towards female genital mutilation and how the practice is slowly disappearing in that region of Ethiopia. (CR)

Full URL: http://www.independent.co.uk/news/appeals/indy-appeal/independent-appeal-saved-from-the-agony-of-female-circumcision-1862416.html

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20100108-13*

Ending the culture of FGM. al-Sultan B (2010), The Guardian 7 January 2010

Describes the author's experience of female genital mutilation as a young girl in Sudan, and argues that the best way to end this practice is through education so that those who carry out female circumcisions are made aware of the adverse health and social consequences of the procedure. (JSM)

Full URL: http://www.guardian.co.uk/commentisfree/2010/jan/07/female-genital-mutilation-sudan

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