

Health Care in Europe for Women with Genital Mutilation

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The increasing number of immigrants from African countries practicing female genital mutilation (FGM) has raised concern in Europe. Health care professionals have developed three main responses: (1) technical guidelines for clinical management; (2) codes of conduct on quality of care; and (3) specialised health services for medical and psychological care and counselling. Much remains to be done, however, to ensure adequate care in Europe: (1) medico-legal/ethical discussions; (2) development of protocols to assist in making informed decisions; and (3) development of guidelines on counselling, communication strategies, and referral procedures. All agencies working in the field of FGM should be interlinked at the national level, in which members of the affected communities should be included. At the European level, a coordinated approach between all agencies should be developed.

Female genital mutilation (FGM), or female circumcision, includes all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other

Received 30 August 2004; accepted 10 February 2005.

The authors thank Paul Rondelez and Hans Verstraelen for reading earlier drafts of this article and the European Commission, Daphne programme, for funding both research projects.

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TABLE 1 WHO Classification of Femal Genital Mutilation (FGM)

Type 1:	Excision of the prepuce with or without excision of part or all of the clitoris
Type 2:	Excision of the clitoris with partial or total excision of the labia minora
Type 3: Infibulation	Excision of part or all of the external genitalia and narrowing/stitching of the vaginal opening
Type 4: Unclassified procedures	Pricking, piercing, or incision of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterisation by burning of the clitoris and surrounding tissues; scraping of the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to tighten it or to cause bleeding

nontherapeutic reasons (World Health Organisation [WHO], 1998). The WHO classifies four types of FGM (Table 1; WHO, 2001).

The effects of FGM can range from immediate complications (e.g., severe pain, haemorrhage, shock, and infections) to longer-term consequences (e.g., vulvar dermoid cysts, chronic pelvic infections, and with heightened risk of rectovaginal fistulae, among others). In general, the effects of FGM depend on the type performed, the expertise of the circumciser, the hygienic conditions under which the practice is conducted, and the cooperation of the girl at the time of the mutilation (Koso-Thomas, 1987). These effects are more frequent, tend to be more serious, and last longer with infibulations (WHO, 1998).

Worldwide, between 100 and 140 million girls and women have experienced FGM; it is estimated that at least 2 million girls are at risk from FGM every year (WHO, 2001). Type I and II are the most common forms of FGM, accounting for approximately 80% of cases, while infibulation is found in around 15% of cases. Most women and girls with FGM live in 28 sub-Saharan African countries, with some living in Asia and the Middle East (WHO, 2001). Due to the migration of people who follow this tradition, however, FGM is today evident in Australia, Canada, the United States, and the European Union (WHO, 2001).

Estimating the number of girls at risk from, and the number of women with, FGM in the European Union is not easily inferred from existing data on migrant populations (Powell, Leye, Jayakody, Mwangi-Powell, & Morison, 2004). First, although figures on the number of immigrants can be obtained from National Offices of Statistics in each country within the European Union, these rudimentary statistics do not take into account variations in FGM practice within ethnic groups or their differential prevalence within a country's constituent regions. For example, the overall prevalence rate of FGM in Sudan is estimated at 89% (WHO, 2001); yet in the Darfur region and Eastern region, women are less likely to be genitally mutilated (65% and 87%, respectively) as compared with other parts of the country (Carr, 1997).

Second, official statistics do not enumerate illegal immigrants, refugees, and asylum seekers, thereby potentially underestimating its prevalence. Third, statistics also may not be gender specific, further hindering any assessment of the number of girls at risk of being genitally mutilated. Fourth, methodologies for determining the numbers of immigrants, refugees, and asylum seekers vary between countries within the European Union, thereby making intercountry comparisons problematic (Leye, 2001). Fifth, statistics are not updated regularly and might not reflect changes in migration and mobility (Leye, 2001). Table 2 shows estimates of FGM-related figures in eight European countries.

Although reliable national prevalence data and systematic epidemiological data for FGM and its related health problems are unavailable in Europe (Leye, 2001), and the magnitude of the problem in the European Union is difficult to assess, FGM has raised concern in several countries within the European Union and various services (such as health care, social services, and the police) have been confronted with FGM-related issues. In health care, for example, pregnant infibulated women often will present at health services at the time of delivery.

It also has been established that African communities living in European countries continue the practice of FGM, by sending their girls to Africa (Leye & Deblonde, 2004b), by inviting circumcisers to the West, or by requesting Western health care professionals to perform the procedure. There is evidence that FGM has been performed illegally in at least three European countries, including the United Kingdom, Italy, and Switzerland, by medically qualified personnel or by traditional circumcisers (Black & Debelle, 1995; Grassivaro Gallo et al., 1998; Irujo, 2003; Jäger et al., 2002; Reyners, 1993; Sala & Manara, 2001). Girls are suspected of being circumcised in other European countries, including Denmark (Johnsdotter, 2002), Spain (Irujo, 2003), and Belgium (Leye & Deblonde, 2004a). Whether health care professionals in Europe perform the operations for financial motives, because of lack of knowledge about the practice, or because they respect the decision of an adult woman who requests the operation, remains unclear. On the other hand, there is evidence that communities can more easily resist social pressure to have their daughter(s) "circumcised" in Europe than they can in Africa (Johnsdotter, 2002), although this process of cultural reassessment of the practice cannot be generalised and should be interpreted with caution (Johnsdotter, 2002; Powell et al., 2004).

Currently, there is a paucity of literature on the responses to FGM across the European Union. Using data from two projects on FGM among sub-Saharan African immigrants in the European Union, we will highlight some ethical problems European health care professionals can face, review existing health care provisions across the European Union, identify gaps that exist in the care for women with FGM, and suggest possible solutions.

TABLE 2 Female Genital Mutilation (FGM) in Europe

Country	Number of girls at risk	Annual new cases	Number of girls/women with FGM	Number of girls/women from FGM risk countries
France	4,500 (Délégation Régionale aux Droits des Femmes, 1998)		13,000 (Délégation Régionale aux Droits des Femmes, 1998)–27,000 (Gillette, 1997)	40,000 (Gallard, 1995)
Germany	5,500 (Utz, 2000)		21,000 (Gleissner, 2002; Utz, 2000)	
Italy	4,000–5,000 (girls with FGM) (Grassivaro Gallo et al., 1998)		27,000 (Grassivaro Gallo et al., 1995)	30,000 (Bosch, 2001)
Sweden				27,000 (Andersson, 2001)16,000 (Widmark et al., 2002)
Switzerland			(incl.# of girls at risk): 6,711 (Jäger et al., 2002)	
Netherlands				13,313 (Somali women) (Central Bureau voor Statistiek The Netherlands, 2003; Jäger et al., 2002)
UK	10,000 (British Medical Association, 2004; Jager et al., 2002)–15,000 (Levin, 2001)	3,000–4,000 (British Medical Association, 2004; Levin, 2001)	10,000–20,000 (Momoh et al., 2001)	

METHODS

The primarily qualitative data arise from two sources: the first source is a research project undertaken by the International Centre for Reproductive Health in 1998 (Leye et al., 1998), aiming at providing the European Commission with a strategy to address the problem of FGM in the European Union. Central to the proposed strategy was the formulation of recommendations on medical aspects of FGM in the European Union. These recommendations were based on a questionnaire that assessed current knowledge, attitudes, and practices of health care professionals in the European Union, and a discussion paper that reviewed the medical complications of FGM and its medico-ethical aspects (e.g., medicalisation of FGM and resuturing after delivery; Leye et al., 2003). More than 1,880 questionnaires with both open-ended and closed questions were sent to gynaecology/obstetric departments of hospitals in major cities (i.e., from 250,000 to >1,000,000 inhabitants) within the 15 European Union Member States. Although the response rate was disappointing (i.e., 15%), the data provided insight into the opinions of health care professionals on FGM, and gathered valuable information about existing guidelines and codes of conduct for health care providers in the European Union. Prior to submission to the European Commission, the recommendations were discussed at an expert meeting in Ghent, Belgium (1998), attended by 50 African and European FGM experts.

The second data source is a project that was carried out in 2000 again by the International Centre for Reproductive Health, aiming at the creation of a multidisciplinary network for preventing FGM in the European Union. One part of the project (Leye & Githaiga, 2000) focused on providing health care professionals with a framework for the care for women with FGM, to be implemented by each European Union Member State. A review of existing guidelines for health care professionals on the care for women with FGM and the resulting framework subsequently were discussed in a workshop (in Belgium, 2000) with participants from six countries within the European Union (i.e., Belgium, Denmark, Germany, Sweden, the Netherlands, and the United Kingdom).

RESULTS AND DISCUSSION

This section highlights the key findings that arose from both projects and discusses their implications. The key areas follow: ethical problems for Western health care professionals; the responses of European health care providers; and issues of service delivery.

Ethical Problems for Western Health Care Providers

Health care professionals are facing multiple questions regarding women and girls who have FGM-related problems (Grassivaro Gallo & Viviani, 1995; McCaffrey, Jankowska, & Gordon, 1995; Momoh, Ladhani, Lochrie, & Rymer, 2001; Nienhuis & Haaijer, 1995), not only with regard to the clinical management of infibulated women, but also over ethico-legal questions about reinfibulation after delivery, the pricking or incision of the clitoris, and the issue of the cosmetic surgery of female genitalia. Although health care professionals in Europe are increasingly becoming aware of the correct clinical management of FGM, the lack of clear guidelines and legislation leaves them facing these ethical problems.

The WHO and other organisations advise consistently that health care providers in any setting should refrain from any form of FGM. One of the main ethical debating points concerns performing FGM under hygienic and controlled conditions, often referred to as the “medicalisation of FGM.” The WHO’s position rests on the basic underlying ethics of health care: health care providers cannot condone unnecessary bodily mutilation given it conflicts with the Hippocratic Oath (i.e., to act in the interest of the patient; *primum nil nocere*). The International Federation of Gynaecology and Obstetrics, the International Council of Nurses, the Royal Colleges of Obstetrics and Gynaecology in the United Kingdom and Canada, the Council on Scientific Affairs of the American Medical Association, and many others have published similar position statements; the Ghent expert meeting also adopted this position. Despite the adoption of these positions by international and professional organisations, however, the issue of medicalisation is repeatedly emerging in the European Union.

In 1992, two researchers in the Netherlands submitted a report to the Dutch Ministry of Health in which they proposed that as a step toward the total eradication of the practice, incisions of the clitoris be allowed in cases where the parents or family wanted to circumcise a girl (Bartels & Haaijer, 1992). This kind of incision was considered as a nonmutilating form of “female circumcision,” as FGM is commonly referred to in the Netherlands. This report’s recommendation provoked a public debate about the issue that resulted in the total rejection of any form of FGM and, moreover, the rejection of any attempts to differentiate between mutilating and nonmutilating forms of “female circumcision” (Reyners, 1993).

In Germany in 1999, Dr. Groh suggested a “new” technique, “*Incisio Praeputii*”—an incision in the clitoral hood without cutting—as a solution to the problem of FGM (Groh, 1999). He argued that this technique is the only promising strategy to eradicate the practice; given the ritual itself will not change, it is contended that it is better to perform a less invasive type of FGM (Baumgarten & Gahn, 2002). Again, opposition came from nongovernmental organisations (NGOs, i.e., *Terre Des Femmes* [Richter,

2002]) and the German organisation for development cooperation, GTZ [Baumgarten & Gahn, 2002]).

In November 2003, a Somali gynaecologist at Careggi Hospital in Florence, Italy, proposed to practice a “sunna”¹ version of FGM on African women at this public hospital (Turone, 2004), by using a local anaesthetic cream and performing a small cut in the clitoris. The health care service then would provide a certificate to the family to prove that the rite had been performed. The objective of this “sunna” version of FGM was reportedly to prevent illegal infibulations conducted during school holidays. This proposition provoked controversy in Italy and all over the European Union, and was condemned by Italian and European NGOs at an international conference in Florence in February 2004.

The medicalisation of FGM as a harm-reduction strategy also is supported by Shell–Duncan (2001). Arguing that many international associations’ and activists’ opposition to FGM is based on its adverse health outcomes, she contends that medicalisation would protect the health of individual women by having the procedure performed by medically skilled personnel under hygienic circumstances with anaesthetics (Shell–Duncan, 2001).

The main arguments against this proposed medicalisation of FGM follow: (1) it is difficult to avoid damaging the clitoris when performing an incision, especially in genitalia that are not fully developed; (2) complications (such as shock, infections, sepsis, and bleeding) are difficult to avoid, even with an incision; (3) such an incision is performed for cultural/traditional and not for medical reasons; any form of FGM performed is against medical deontology;² (4) an incision remains a violation of the human rights of girls and women (the right to bodily integrity); (5) in some communities, traditional circumcisers will “redo” girls if they notice that only an incision has been made (Baumgarten & Gahn, 2002); (6) promotion of a “light” version promotes the message that FGM is acceptable and thus legitimises the practice (Baumgarten & Gahn, 2002; Richter, 2002); (7) culture is not static, but dynamic, and as such a ritual can be changed over time through, for example, alternative rites of passage; and (8) “sunna” can imply various degrees of cutting, including infibulation, and the terminology “sunna” also means tradition in a religious sense, giving it a religious connotation and suggesting that the practice is accepted as normal and positive (Leye, 2000; Sarkis, 2003).

Another medico-ethical issue that health care providers need to resolve concerns requests for reinfibulation or resuturing of the infibulation after

¹ “Sunna”: practices undertaken or approved by the Prophet and established as legally binding precedents (Al-Sabbagh, 1996).

² Medical deontology refers to the complex of principles, codes of conduct, and practices that every medical doctor must respect and use as a guiding principle in carrying out his or her profession (Nationale Raad van de Orde der Geneesheren, 1998).

delivery, by consenting adult women. Specific criminal law provisions in countries of the European Union (including Austria, Belgium, Denmark, Spain, Sweden, and the United Kingdom) do not mention reinfibulation. In those countries where it is not illegal, tension exists among the attitudes of the health care professionals, his or her practice, his or her own ethical point of view, and the law.

Health care providers need to decide whether they are willing to provide this type of surgery. Moreover, they need to decide the extent of the perineal repair. For example, should it be as tight as the woman requests, or returned to its predelivery state, or repaired as in a normal perineal repair? According to Toubia (1994), a thorough medico-legal debate also must be generated about the similarities and differences between circumcision and other nonessential surgery in adults. Are requests for reinfibulation comparable with requests for female genital cosmetic surgery—such as vaginal tightening, lifting of the labia, hymen reconstructions, and labiaplasty (trimming of the labia minora)—practices that are on the rise in the United States, Canada, and Europe (Jenda, 2001)? In both cases, there are no medical reasons that legitimate these operations. The question remains, why in some cases women can “design” their vagina in the way they want them to look, while others cannot receive resutures after deliveries as they are considered to be “female genital mutilation” and prohibited because there are no medical reasons to justify the procedure.

Obviously, differences exist between the more pragmatic approach of health care professionals and the more ideological discourse of activists at international forums. Nevertheless, medico-legal and medico-ethical discussions should be held in European Union countries, and in collaboration with members of the affected communities, to help health care professionals make informed decisions, especially in those cases where the law remains unclear about what is illegal and what is not. The outcome of such discussions could be guidelines from the European Ministries of Health. If such are not yet present at the national level, protocols from medical associations or guidance from ethics committees in hospitals could help health care professionals make informed decisions.

The Response of Health Care Professionals in the European Union

Following the migratory flow of immigrants and refugees from FGM-practicing countries in sub-Saharan Africa to Europe, an increasing number of health care professionals have been confronted with the health consequences of FGM. The responses of health care providers in the European Union (in Belgium, Denmark, Sweden, the Netherlands, and the United Kingdom) to women with FGM reviewed in the second project are presented below.

BELGIUM

The experience of health care professionals with FGM is relatively new in Belgium, with only a few cases being reported or documented (Richard, 2000). Since June 2000, technical guidelines on delivery procedures for infibulated women have existed (Richard, Daniel, Ostyn, Colpaert, & Amy, 2000), available in French and Dutch and distributed through the Belgian Ministry of Health. These guidelines consist of a brief practical manual for health care providers who are confronted with infibulation during prenatal consultations, delivery, and postpartum care. For each of these phases, the manual offers clinical advice; background information on the practice, counselling guidelines, preventative methods, and training advice are not included.

DENMARK

FGM became of public interest during the 1980s when the first Somali refugees came to Denmark (Danish Board of Health, 1999); in 2000 there were an estimated 14,500 Somalis living in the country (Sörensen Hoff, Aden, & Nybro, 2000). In 1981, the National Board of Health informed Danish medical professionals not to perform FGM. Fifteen years later, at the instigation of the Ministry of Health, an information campaign concerning the circumcision of girls resident in Denmark was initiated (Danish Board of Health, 1999). In 1999, the National Board of Health in Denmark published a reference book for local governments and health professionals, informing them about FGM and the means by which they could address the practice in a culturally sensitive way (Danish Board of Health, 1999).

Currently, a specialist FGM midwife works at the antenatal care clinic of the Frederiksberg hospital, near Copenhagen. This is one of the health care centres in Denmark that deals specifically with infibulated women, and to which various general practitioners in Denmark refer pregnant infibulated Somali women (Sörensen Hoff et al., 2000).

SWEDEN

Somalis began to arrive in Sweden in 1990; today an estimated 19,000 live there, with the largest groups living in Gothenburg and Stockholm (Johnsdotter, 2002). In 1996 the Immigration Services Administration of the City of Gothenburg started a pilot project for both the community and for concerned professionals, and developed several guidelines for medical and health care staff. These guidelines tackled various issues, including the management of genitally mutilated women in antenatal care, the performance of gynaecological examination, and delivery among genitally mutilated women. Some guidelines for paediatricians on the prevention of genital

mutilation among girls and the role of the school health care system in dealing with FGM were also produced (Esken & Aronsson, 2000).

Many Swedish hospitals have their own guidelines concerning care for women with FGM (Leye et al., 1998).

THE NETHERLANDS

Interest in FGM in the Netherlands started in the 1990s as a result of the influx of Somali refugees. Research on FGM within this community revealed that questions regarding FGM and its subsequent sequelae seldom reached health care professionals and that the health care sector was ill prepared to deal with the problems of infibulated women (Bartels & Haaijer, 1992). In 1992, following a vigorous public debate, the Dutch government prohibited all forms of FGM in accordance with the guidelines of the WHO.

One year later, the Dutch Society of Gynaecology & Obstetrics developed a position paper (1993) that rejected requests for infibulation. It also stated that, in those cases where a general practitioner/gynaecologist is confronted with a request for an FGM operation, the request should be rejected. Should this refusal be unsuccessful, the general practitioner/gynaecologist is advised to contact a commission of experts of FGM (established by the Ministry of Health) to find an acceptable solution to each individual case. In 1994, the Chief Medical Inspector of the Department of Public Health developed guidelines concerning the actions to be undertaken when a girl has been genitally mutilated or where there is an assumption that a girl is at risk (Geneeskundige Hoofinspectie van de Volksgezondheid, 1994).

Several centres for refugees and asylum seekers exist in the Netherlands. PHAROS is a national institute, established to contribute to the health and well-being of this client group. Their main objective is to improve the accessibility of Dutch health services to refugees (including girls and women with FGM) by supporting regular health care services in the development of care, prevention, education, and training programs (Geneeskundige Hoofinspectie van de Volksgezondheid, 1994).

UNITED KINGDOM

FGM came to prominence in the United Kingdom in the early 1980s, with stories of women and girls arriving from overseas to have FGM performed in private clinics in London (FORWARD, 1998). The main ethnic groups in the United Kingdom that practice FGM are from Eritrea, Ethiopia, Somalia, and the Yemen (British Medical Association, 2004).

In the United Kingdom, codes of conduct exist for medical doctors, nurses, midwives, gynaecologists, and obstetricians issued by professional organisations, such as the British Medical Association (2004) and the Royal

College of Midwives of England (The Royal College of Midwives, 1998). These codes of conduct outline advice on how to provide ethnically sensitive care, from an ethico-legal point of view, which goes far beyond technical advice on the management of women with FGM.

Information provided to UK hospitals on FGM-related issues usually concerns the extent of the problem and the monitoring of FGM-related health outcomes. The Female Circumcision Prohibition Act in the United Kingdom (1985) was found to be useful for health care professionals as a supportive tool to refuse any FGM requests (Momoh, 2000).

Due to the increasing number of pregnant and nonpregnant women with FGM presenting at delivery suites, and gynaecology and family planning clinics, African Well Women Clinics (AWWC) have been established in the United Kingdom. Examples are located at Northwick Park Hospital in Middlesex established in 1993, and at Guy's and St. Thomas's in London (1997; McCaffrey et al., 1995; Momoh et al., 2001). These AWWC provide appropriate medical care for women with FGM and care for any attendant psychiatric disorders related to FGM. These services also include support, information, advice, and counselling to women and their partners, as well as offering deinfibulation where appropriate to both pregnant and nonpregnant women, and training for health care professionals. These AWWCs work with specialist midwives, often members of the affected African communities themselves (Leye et al., 1998; McCaffrey et al., 1995; Momoh et al., 2001).

Issues in Service Delivery

Experiences from the five countries of the European Union mentioned above show responses to FGM are based primarily on three health interventions: (1) technical guidelines for the clinical management of women with FGM; (2) codes of conduct for health care professionals, published by professional associations, on quality of care issues (e.g., culturally appropriate care); and (3) specialised health services that provide medical care, psychological care, and counselling.

There are several factors that may hamper the provision of adequate clinical care for women with FGM, however, including the unfamiliarity of health care professionals with FGM and their deficient knowledge. In northern Somalia, women are defibulated immediately after marriage, but they may have difficulties obtaining such a facility in Western countries and remain "closed," thus requiring this care in pregnancy and labour (McCaffrey et al., 1995). This situation can result in unnecessary caesarean sections (Elchalal, Ben-Ami, Gillis, & Brzezinski, 1997), or in women not seeking appropriate care during pregnancy, at the time of delivery, or for any FGM-related health problem.

The personal emotions and feelings of health care professionals can play an important role. Some health care providers are reluctant to address the subject out of respect for, or ignorance of, different cultures. Feelings of powerlessness (FGM procedures are irreversible) or anger (cutting genitals is alien to Western practice) may all hamper adequate care for women with FGM (Nienhuis & Haaijer, 1995). Moreover, a qualitative study among a limited number of midwives in three hospitals and two antenatal clinics in Sweden revealed that both obstetric and psychosocial care for women with FGM may be suboptimal, due to communication difficulties among midwives, circumcised women, and their families (Widmark et al., 2002).

A lack of technical guidance for caring for women with FGM hampers the provision of optimal care (Widmark et al., 2002). A similar study in Canada found that Somali women perceived a lack of knowledge and ability by health care professionals to care appropriately for women with FGM during birth (Chalmers & Hashi, 2000). The Swedish study among midwives revealed that the absence of guidelines on what to do in case of a specific request for reinfibulation after delivery forces midwives to refer to the law. They preferred to have supportive guidelines advising them what they could do however, rather than a law instructing them on what they could not do (Widmark et al., 2002).

A lack of knowledge about the health care expectations and needs of affected communities is another issue in delivering appropriate care. In the Netherlands, a small study among Somali women revealed that obstetric care is insufficiently focused on their expectations and needs, and education about obstetric procedures in the Netherlands toward Somali women is necessary (Nienhuis, 1998).

In addition to deficiencies within existing health services, the lack of operational coherence among health and social services, other agencies (such as education, judiciary, police, immigration officials), policymakers and grassroots organisations, further hamper adequate care for those affected by FGM. Powell and colleagues (2004) argue that services develop their own codes of practice in isolation from the multiple other agencies and that the care for women with FGM must be provided collaboratively as part of an integrated approach if it is to be effective. Moreover, until now there has been no coordinated European approach at the health care, legislative, and grassroots levels.

CONCLUSIONS

Ideally, adequate care for women with FGM should focus not only on appropriate clinical care, but also should include culturally sensitive professional counselling.

Because affected communities can be deterred from contact with health care services that are unable to give appropriate and sensitive treatment, it is paramount to assess their health-seeking behaviour and their needs for adequate care with regard to FGM. Those health care providers who take medical care of pregnant infibulated women/girls, or who are in direct contact with girls at risk, need to be identified and provided with adequate and detailed guidelines on how to deliver antenatal care, care at the time of delivery, and postpartum care. They also need to be informed of how to perform gynaecological examinations for the different types of FGM. Health care professionals also need to be informed of how to deal with the provision of counselling services concerning deinfibulation, reversal operations, caesarean sections, and prevention of FGM in newborn girls, and guidance on successful communication strategies. Ethical issues, such as medicalisation and reinfibulation, need to be discussed at a national level, and health care providers need clear guidelines on these issues.

Health care professionals also should receive clear guidelines about referrals when they do not have the adequate skills or time to give appropriate care for a woman with health problems due to FGM, or where to report or refer a girl at risk.

Last but not least, the training needs of health care professionals must be assessed. Training should take into account various levels: clinical care, the prevention of FGM; counselling, communication and attitudes (e.g., open communication skills), and ethical issues (e.g., medicalisation, reinfibulation). In addition, FGM should be included in the curricula of medical students, nurses, and midwives.

In order to establish these guidelines, all agencies working in the field of FGM should be interlinked at the national level, at which members of the affected communities should be included. At the European level, a coordinated approach between all agencies should be developed.

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