HAUTE AUTORITÉ DE SANTÉ

BEST PRACTICE GUIDELINE

Management of female genital mutilation by primary healthcare professionals

Clinical practice guidelines method

GUIDELINE

February 2020

Best practice guidelines (BPGs) are defined in the health field as methodically developed proposals to assist the practitioner and the patient to find the most appropriate care in given clinical circumstances.

BPGs are rigorous summaries of the state-of-the-art and scientific data at a given time, described in the evidence report. They do not exempt health professionals from exercising discretion in the patient's treatment; this must be the treatment considered to be most appropriate depending on their own findings and the patient's preferences.

These best practice guidelines were developed according to the method summarised in the evidence report and in the HAS methodological guide available on-line:
"Development of best practice guidelines – Clinical practice guidelines method".
The objectives of this guideline, the population and the professionals concerned by its implementation are summarised on the last page (information sheet) and described in detail in the evidence report.
The latter and the guideline summary can be downloaded from www.has-sante.fr.

Guideline grades

A	**Established scientific evidence** Based on studies with a high level of evidence (level of evidence 1): randomised controlled trials with high power and without major bias or meta-analysis of randomised controlled trials, decision analysis based on well conducted studies.
B	**Scientific presumption** Based on scientific presumption provided by studies with an intermediate level of evidence (level of evidence 2) such as low power randomised controlled trials, well conducted non-randomised controlled studies, cohort studies.
C	**Low level of evidence** Based on studies with a lower level of evidence such as case-control studies (level of evidence 3), retrospective studies, case-series studies, comparative studies with major biases (level of evidence 4).
EC	**Expert consensus** In the absence of studies, the guidelines are based on agreement between experts in the working group after consultation of the review group. The absence of grading does not mean that the guidelines are not relevant and useful. However, it should prompt additional studies.

The evidence report for these guidelines can be downloaded from
www.has-sante.fr

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Abbreviations and acronyms

ASE	*Aide sociale à l'enfance* (Child welfare services)
ARS	*Agence régionale de santé* (Regional Health Board)
HAS.	French National Authority for Health
CIDFF	*Centre d'information sur les droits des femmes et des familles* (Women's and family rights information centre)
CRIP	*Cellule de recueil des informations préoccupantes du conseil départemental* (Departmental council service responsible for receiving reports giving rise to concern)
DHS	Demographic and Health Surveys
DSM	Diagnostic and statistical manual of mental disorders
GAMS	*Groupe pour l'abolition des mutilations sexuelles, des mariages forcés* (Group for the abolition of genital mutilation, forced marriage)
MICS	Multiple Indicator Cluster Survey
MIPROF	*Mission interministérielle pour la protection des femmes victimes de violences et la lutte contre la traite des êtres humains* (Interministerial mission for the protection of women against violence and the fight against human trafficking)
Ofpra	*Office français de protection des réfugiés et apatrides* (French office for the protection of refugees and stateless persons)
EGO	External genital organs
PMI	*Protection maternelle infantile* (Mother and child welfare)
PTSD	Post-traumatic stress disorder
UMJ	Urgence médicolégale (Abuse consultation team)
HIV	Human immunodeficiency virus

Introduction

This best practice guideline is concerned with improving the treatment and management of children, teenage girls, and women who have undergone or at a risk of undergoing female genital mutilation.

Its objectives are as follows:

- to foster primary healthcare professionals' knowledge of female genital mutilation;
- to prevent the occurrence of female genital mutilation through improved information delivered by healthcare professionals to women, young girls and parents;
- to foster improved management of children, young girls, and women who have been subjected to genital mutilation;
- to harmonise work practices.

This topic concerns all professionals responsible for the welfare and health of children, teenage girls and women.

This guideline relates to the primary management of children, teenage girls, and women who are at a risk or victims of female genital mutilation. Worldwide, 200 million girls and women have been mutilated in at least some forty[1] countries where such mutilation is practised, either through local tradition, or via diasporas. Mutilation is a very old traditional practice which does not correspond to the dictates of any religious belief. In Europe, 500,000 girls and women have undergone mutilation or are exposed to a risk of female genital mutilation.

In France, a first study estimated that, in 2004, between 51,000 and 60,000 women were affected by genital mutilation. A recent study from 2019 estimates that, in the early 2010s[2], there were approximately 125,000 "mutilated" adult women living in France. Approximately 11% of the daughters of these women who have undergone genital mutilation also undergo mutilation.[3]

In 2018, between 12 and 20% (from 0 to 18 years) of these girls continued to be at a threat due to their parents' beliefs, or due to social pressure applied by extended families remaining in the countries of origin[4].

Although currently on an international scale, the majority of victims are under 5 years of age, in the case of France, given its two-pronged approach including prevention (through the PMI network in particular) and repression (through prosecution), potential victims tend to be increasingly older: between 6 and 18 years of age. Female genital mutilation is prohibited, both in France and internationally, including in the countries of origin.

The guideline is based on consensus among working group experts, taking into account the opinion of the stakeholders consulted.

[1] Refer to chapter 1.2.3 of the evidence report "Female genital mutilation worldwide".

[2] http://beh.santepubliquefrance.fr/beh/2019/21/pdf/2019_21_1.pdf

[3] Thirty countries have data from population demographic and health studies. Moreover, other countries concerned have no quantitative data or merely estimations. For example, 70 million for Indonesia alone in terms of female genital mutilation.

[4] Institut national d'études démographiques. Les mutilations sexuelles féminines : le point sur la situation en Afrique et en France. https://www.ined.fr/fichier/s_rubrique/19106/438.fr.pdf.

Recommendations

The term “parents” used in the guideline includes parents and holders of parental responsibility.

1. General data

1.1 Definition of genital mutilation

This term is defined as the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons.

The classification of the different types of female genital mutilation is given below.

Table 1. Classification of genital mutilation based on WHO, 2018

Types	Female genital mutilation
Type I	Partial or total removal of the clitoris (clitoridectomy) and/or the prepuce
Type II	Partial or total removal of the clitoris and the labia minora, with or without removal of the labia majora (excision): • IIa: removal of the labia minora only • IIb: partial or total removal of the clitoris and the labia minora • IIb: partial or total removal of the clitoris, the labia minora and the labia majora
Type III	Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, pulling, piercing, incising, scraping and cauterisation

This classification is descriptive and does not prejudge the severity and health effects for women and minors (from 0 to 18 years of age).

A diagram of the different types of mutilation is provided in Appendix 2 of the evidence report.

Type II and type III female genital mutilation represent approximately 80% and 15% of cases of mutilation in France, respectively.

1.2 Countries where female genital mutilation is practised

The priority information to be taken into account is the parents' origin and/or country of birth, as well as the ethnic group and/or region of origin, including for minors born in France. For the record, worldwide, 200 million women are victims of genital mutilation.

Female genital mutilation is practised on every continent (refer to Table 2 below).

Female genital mutilation can be performed at any age and regardless of socioprofessional category. Children are undergoing mutilation at an increasingly young age. Forty-four million are girls under 15 years of age. In most countries, the majority of young girls undergo mutilation before 5 years of age.

In France, the working group has noted that the risk is present at any age and in particular at milestones of the victim's life:

- after discontinuing follow-up in the PMI network or in the case of a lack of such follow-up;
- before starting primary school;
- before starting middle school;

- before starting high school;
- before marriage;
- when on holiday or visiting family outside France.

In France, the most frequent countries of origin of women and minors who are victims of genital mutilation living in France, are shown in Table 2.[5]

The prevalence of female genital mutilation in Africa is provided in Appendix 1 of the guideline.

Table 2. Nationals of the countries concerned directly and indirectly by female genital mutilation in France

Continents	Nationals of the countries concerned by female genital mutilation present in France (in alphabetical order)
Africa	Cameroon, Central African Republic, Chad, Côte-d'Ivoire, Guinea, Djibouti, Egypt, Eritrea, Gambia, Mali, Mauritania, Nigeria, Somalia, Senegal, Sudan, Togo
Asia	Indonesia India (North-Dawoodi Bohra sect), Malaysia, Thailand (South)
Near and Middle East	Iran, Iraq, Yemen[6]
Oceania	Australia
Europe	Dagestan, Republic of Russia

[5] It is suggested to refer to the following links https://www.unicef.fr/sites/default/files/userfiles/carteexcision.pdf

[6] Only Yemen has quantitatively reliable scientific sources. For the other countries, the data are qualitative.

2. Effects of female genital mutilation

In minors and women, all types of female genital mutilation can have dramatic effects, such as the following:

- immediate potentially life-threatening effects;
- medium- and long-term psychological and somatic effects;
- obstetrical and sexual effects.

The effects are the same, or even more serious, in the case of mutilation procedures performed by healthcare professionals and/or in a medicalised setting.

The working group has requested that the term “minor” replace the terms girl and child, specifying that this is in accordance with the International Convention on the Rights of the Child, aged 0-18.

In view of the health complications among other things, prevention is key. It is recommended that professionals, in liaison with the family and children, assess and prevent the risk of female genital mutilation by any means.

2.1 Immediate medical effects

Immediate medical effects of female genital mutilation
• Death from severe haemorrhaging, septicaemia, neurogenic shock • State of psychotraumatic shock • Bleeding, haemorrhaging • Intense pain • Traumatic lesions of neighbouring organs: urethra, etc. • Urinary disorders: reflex retention of urine, dysuria • Acute internal and external urogenital tract infections • Possible risk factor of transmission of viral and bacterial haematogenous diseases such as tetanus, HIV, hepatitis B and C, herpes simplex virus • Fractured limbs (humerus, femur, collarbones) linked with restraint of the minor or woman, or her attempts to defend herself

2.2 Psychological effects

Psychological after-effects of female genital mutilation are very common and contribute to a greater risk of developing psychiatric and psychosomatic disorders. They are part of a continuum of abuse to women and worsen their circumstances (early marriage, domestic abuse in couples and families, sexual violence, etc.).

Psychological effects of female genital mutilation
• Post-traumatic stress disorders (for example: daytime and nocturnal flashbacks (nightmares), etc. Refer to DSM 5 and to CIMS 11) • Post-traumatic dissociative states (for example: detachment, lack of affect when mutilation is mentioned) • Depression, suicidal behaviour • Behavioural disorders • Anxiety, selective phobias, anxiety about sexual intercourse and childbirth • Withdrawal, loss of self-esteem, sense of being different, abnormal, of shame, sense of injustice, anger

2.3 Medium- and long-term urogynaecological effects

The nature and severity of the urogynaecological complications are dependent on the type of female genital mutilation.

2.3.1 Complications of type I and II female genital mutilation

Complications of type I and II female genital mutilation
• Chronic pain in the vulva and pelvis • Poor wound healing quality due to the lack of aseptic conditions and the lack of suture • Keloid scars, scar neuromas, epidermal cysts, Bartholin's gland cysts • Reduced frequency of sexual intercourse (apareunia, dyspareunia, impaired sexual function) • Dysmenorrhoea of psycho-traumatic origin • Pseudo-infibulation due to appositioning of the labia minora

2.3.2 Complications of type III female genital mutilation

These complications are primarily observed in countries where type III female genital mutilation is practised. In France, these complications are much less common.

Complications of type III female genital mutilation
• Haematocolpos, chronic genital tract infections • Infertility due to an increase in repeated upper genital tract infections • Dysuria and its effects (for example: recurrent urinary tract infections or obstructions potentially resulting in chronic kidney failure, particularly during pregnancy) • Dystocia, vesico-vaginal, recto-vaginal fistulas, with a risk of social exclusion in countries of origin where access to care may be difficult • Increase in pregnancy-related conditions (threat of premature childbirth, intrauterine foetal demise)

2.4 Sexual health effects

Sexual dysfunction is not correlated with the type of mutilation and may be multifactorial (for example: forced marriage, sexual or other abuse, psycho-trauma).

Sexual health effects of female genital mutilation
• Sexual desire disorders (hypoactive), even anaphrodisia (complete absence of desire) • Anorgasmia, reduced frequency of orgasms • Relationship problems • Dyspareunia, sometimes permanent pain (associated with neuromas for example) • Impossible penetration of the vagina (scar tissue, frequently after-effects of traumatic labour), vaginismus

2.5 Obstetrical effects

During pregnancy, female genital mutilation is associated with an increased risk of urinary tract infection, vaginosis and hence a discretely increased risk of late miscarriage and potential premature labour.

During labour, severe obstetrical effects are described in developing countries:

- for the child: obstructed labour associated with vaginal obstruction, with neonatal anoxia, neurological after-effects, peripartum or neonatal death;
- for the mother: vesico-vaginal or recto-vaginal fistulas, increased blood loss, increased risk of Caesarean section and of instrumental deliveries. These complications are most frequently observed in cases of infibulation.

Obstetrical complications of female genital mutilation vary according to:

- the type of mutilation;
- the family's socioeconomic status;
- the healthcare context of the countries where delivery takes place, which can vary considerably in rural or urban areas.

There are many publications with contradictory findings. It is estimated that, if the healthcare situation is not optimal, type III female genital mutilation is accompanied by an increase in the number of peripartum deaths, particularly due to mechanical dystocia. This dystocia can also cause the onset of urogenital and anogenital fistulas due to tissue necrosis.

Complications such as increases in the duration of labour, episiotomies, tears or postpartum bleeding are reported. These complications should be looked at in the context of the age of the woman giving birth (extremely early pregnancies in some cases) and the lack of professional medical assistance trained in this type of complications.

In countries where childbirth is medicalised, deinfibulation of cases of type III female genital mutilation enables women to give birth under near-normal conditions and type II mutilation appears to be primarily associated with an increase in anterior perineal tears.

3. Assessing the level of risk of female genital mutilation

3.1 Risk factors of a patient undergoing female genital mutilation

It is recommended to screen for these factors in order to assess the risk of a patient undergoing female genital mutilation. One of these criteria may be sufficient to warn the healthcare professional and implement preventive measures (refer to chapter 6 of the guideline: “Procedure to follow to protect minors at a risk of female genital mutilation”).

- Minors whose father and/or mother come from a community in which female genital mutilation is performed.
- The family is originally from a community which is known to perform female genital mutilation. A woman may be the victim of pressure from her husband or from other family members or of pressure from her husband and her husband’s family. She may have to allow, or even arrange, her own daughter’s mutilation.
- Girl whose mother, sister, cousin have undergone female genital mutilation. In other cases, a family member (grandmother, aunt, etc.) will take it upon themselves to have female genital mutilation performed, with or without consent from the parents (father and/or mother), based on the principle that the collective prevails over the individual.
- The family states that members of their community have a very high degree of influence or that these individuals are involved in the education of young girls.

When the topic of female genital mutilation is broached with the family:

- the family believes that female genital mutilation is a key aspect of their culture, customs, or religion;
- the parents downplay the health and mortality risks associated with female genital mutilation;
- they are unaware of the legislation in France and the country of origin. The parents believe that the legal risk of performing female genital mutilation on their child is less severe for them if they are outside France.

3.2 Specific indicators in the case of a minor

Being the daughter of a mother who has undergone female genital mutilation is a significant risk factor. Female genital mutilation is performed at any age and in the family context.

Having left the country of origin is not always enough to guarantee the girl’s protection. This situation may, conversely, represent an increased risk due to inward-looking attitudes.

- The parents are planning a trip for their daughter outside the country, including in Europe - various reasons may be given (family celebration, illness of a loved one, etc.) - or indicate that they intend to take their daughter outside the country for a prolonged period.
- The minor tells a healthcare professional that she will be taking part in a celebration, a particular ritual, “*like a baptism*”, where she will be receiving “*gifts*”, “*a pretty dress*”, has a chance to “*become a woman*” or that she is going to be away on a long holiday.
- The family has not ensured that the minor receives regular medical follow-up (for example, blank child health record booklet).
- The parents are planning a trip or to return to the country of origin (the parents request a vaccination, preventive treatment for international travel, the minor has recently been vaccinated against yellow fever). The trip may only apply to the girls in the family.
- A parent, family member or relation expresses their concern about the risk of female genital mutilation for a minor.
- The minor mentions female genital mutilation during a conversation when talking about another child, for example. Never downplay this risk when the child is speaking in confidence or is sharing her concerns.

- A minor requests an adult's help as she has been told or suspects that she may become a victim of female genital mutilation.

4. How to broach the issue of female genital mutilation with female patients (adults, minors)

In the case of a first consultation in which the issue of female genital mutilation is to be brought up, whatever the reason, it is recommended that the patient be seen on her own.

Insofar as possible for a minor patient, and according to her level of discernment, it is recommended to see her on her own for a consultation to discuss FGM.

It is recommended:

- to bring up the issue without fear of offending the person whenever risk factors are present;
- to be acquainted with the topic and make sure that adequate time is available to listen to the patient.

Use an interpreter

An interpreting organisation must be used in cases of language barriers. It is recommended to opt for an interpreter practising in organisations approved by public bodies (hospitals, departmental councils, ARS, etc.) where possible.[7]

The interpreter must never be:

- a family member;
- or known to have an influence on the minor or the woman;
- or belong to the patient's community of origin.

When using an interpreter, it is recommended to note their name and the department with which they are affiliated. If it is not possible to use an interpreter, it is recommended to refer the woman to a specialist care structure or an association[8] working in the area of female genital mutilation.

4.1 Calmly broaching the topic with patients

It is recommended:

- to use the patient's knowledge and vocabulary as a base, learn from her statements;
- to use vocabulary that is appropriate and accessible; try out, with the patient or her family, words to describe female genital mutilation such as: "*tradition*", *"custom"* or *"ritual*", "*genital cutting*", "*circumcision"*, "*excision* "*infibulation"*, or "*cutting down below*" (pointing to the lower abdomen with your hand);
- to try to identify what the patient is ready to talk about, what she wants to talk about, and use that as a starting point for the discussion. Do not pre-empt anything for her;
- to be patient, as it can take some time to establish a relationship of trust given the abuse that she has experienced (female genital mutilation, early and/or forced marriage, rape);
- not to use the terms "*normal*" and "*abnormal*" as the norm is a relative concept;
- to encourage the patient not to feel guilty or responsible;
- not to trivialise, downplay, or justify female genital mutilation;
- not to pass judgement, and to account for the fact that the patient may have a sense of divided loyalty with her parents or her community of origin, which complicates the process for her even further;

[7] Refer to the HAS standard: linguistic interpreting int he healthcare sector. https://www.has-sante.fr/upload/docs/application/pdf/2017-10/interpretariat_dans_le_domaine_de_la_sante_-_referentiel_de_competences....pdf

[8] Refer to Appendix 7 of the guideline "Associations. Reference sites. Tools."

- to acknowledge the patient's feelings in relation to the risk or female genital mutilation undergone (fear, anguish, anger, etc.).

4.2 Advice for conducting a patient interview

Practitioners are liable to encounter a range of situations.

It is recommended not to react too strongly or inappropriately when unaccustomed with this type of abuse to women. Patients may feel humiliated or offended by such attitudes.

It is suggested to start the questions with a question of the following type: "*You come from a country where female genital mutilation can be performed*", *"Do you know whether you have been circumcised*?", "*Do you know any women who have been circumcised in your family? "*.

4.2.1 The patient is aware that she has undergone mutilation

It is recommended:

- to open the dialogue should she so wish;
- to assess the impact of the mutilation on her life and her health;
- to arrange the provision of medical, psychological, social and sexual health care if she so requests;
- to ask her if she has any children and, if so, any daughters living in France or abroad;
- to assess the risks of female genital mutilation for her daughters and future daughters to prevent them from becoming victims in the future.

Based on her responses and those of the father if applicable, set up all necessary prevention and child protection measures.

The patient is unwilling to discuss the matter

If, however, the patient is unwilling to discuss her own mutilation, it is recommended to systematically broach the subject of female genital mutilation in terms of prevention for her daughters and the minors in her family circle.

She may, at her own pace, resume the discussion if she so wishes. It is important to inform her and that she understands that you will be particularly mindful of her daughters (it is recommended to assess the risks of female genital mutilation for her daughters and to arrange prevention).

It is recommended to then advise the patient that the professional remains available and/or to refer her to a specialised unit.

4.2.2 If the patient is not aware that she has undergone mutilation at a gynaecological examination

As female genital mutilation is a criminal offence, prior to any examination, the practitioner must make clear to the patient:

- that if mutilation is discovered, they will be obliged to inform her of the findings of the examination;
- that they are at her disposal to discuss any matters in accordance with her wishes.

The delivery of such information is a major event in the patient's life. It should be done tactfully. The delivery of the information should be followed by sufficient time for discussion, even if this means scheduling the delivery of the information at a later time.

Failure to talk about it is liable to have serious consequences:

- for the patient herself (she may feel ashamed or lacking in confidence in later encounters with healthcare professionals);

- in terms the risk of female genital mutilation for her daughters.

It is recommended to pay special attention to indirect queries.

It may be helpful to refer to educational tools and information on female genital mutilation (refer to Appendix 7 of the guideline “Associations. Reference sites. Tools. ”.

4.3 Specific advice for conducting an interview with a minor

Young girls may confide in someone in an indirect way: “*Not me, but there’s a friend I know*”, as they may feel some subjects are taboo, or have a sense of fear or shame. In this case, it is suggested to respond in an indirect way: “*You can tell your friend that she can come and talk to me about it*”.

4.3.1 Questions on the circumstances of any travel plans

If they are aware of travel to a country where female genital mutilation is performed, the professional should ask questions, particularly about the reasons for the trip, and its details:

“I heard that you were going on a trip to [specify country], do you want to talk to me about it?”, “Who are you going with?”, “What are you going to do when you are there?”, “Do you want to go on the trip?”, “Are you afraid that anything might happen to you while you are away?”, “When are you going? ”.

Without referring to female genital mutilation directly, some of the minor’s answers may indicate that there is a risk of female genital mutilation: *“I have to go to a big celebration or a celebration like a baptism”, “I will get or I have been given gifts, a pretty dress”, “I have to go visit my grandmother, my aunt, who isn’t well”, “I am going to my cousin’s wedding”, “Only my sisters or my cousins will be going with me”.*

4.3.2 In cases of suspected mutilation

The professional may ask about any problems and difficulties observed.

The professional may use the problems and difficulties observed or reported in relation to the minor to start up a discussion with her. It is a matter of providing her with a space allowing her to disclose whether she has been a victim of any abuse, particularly potential or previous female genital mutilation.

- *“I’m worried about you, you seem tired/worried/upset”.*
- *“I’m concerned about your repeated absences from school/the drop in your grades”.*
- *“I have noticed that you find it hard to concentrate, is there anything going on that you want to talk about?”*
- *“Can you tell me about how things are going at home, with your parents?”*

4.4 Broaching the topic of female genital mutilation with a minor’s parents

It is recommended to identify the risk of female genital mutilation at birth, so that preventive and protective measures are taken and maintained. It is important to broach the topic with the parent(s).

In the course of the discussion, a difference in opinion may be detected between the two adults responsible for the child.

When discussing female genital mutilation, it is advised to listen with a considerate attitude from the start, without making any judgement on a family tradition, custom or culture (not only the minor's mother may have been circumcised, but also her father's mother, aunts, etc.).

In the discussion with parents, or parents-to-be, it is recommended to broach the issue of female genital mutilation of the baby girl and any older sisters gradually.

It is recommended:

- to explain the immediate and medium-long-term health effects during the minor's childhood and future adulthood;
- to remind them of the law specifying that, regardless of the country in which it might be committed:
  - minors who are ordinarily resident in France (regardless of nationality) are protected by French legislation,
  - perpetrators or accomplices are subject to French legislation (female genital mutilation is a criminal offence),
  - female genital mutilation is strictly prohibited by law in France and in many countries;
- providing them with information documents. Refer to the site https://stop-violences-femmes.gouv.fr.

It is recommended to subsequently note in the child health record booklet, and in the practitioner's records, "*prevention of female genital cutting with both parents*". In cases of scheduled appointments with an interpreter, this point should also be noted.

It is recommended to broach the topic of female genital mutilation at the minor's milestones:

- for new-born infant girls at their first check-up;
- for any first contact with the child;
- during a medical check-up (vaccine, medical certificate for physical education, etc.);
- before and after a trip abroad, for holidays or outside school holidays.

5. Signs indicating possible recent female genital mutilation in a female patient

A patient may spontaneously report female genital mutilation to a professional.

However, in most cases, this form of abuse is invisible and/or not spoken about. Victims do not talk about it of their own accord. **A combination of the signs** described below should be taken into consideration and lead the professional to envisage the possibility that the patient is a victim of female genital mutilation.

It is recommended to suspect recent female genital mutilation in a patient in the presence of the following signs:

- changes in behaviour and mood: dejection, depression, anxiety, signs of emotional and psychological invasion, poor concentration, drop in academic grades, eating disorder, sadness, fears, rigidity, mutism and withdrawal;
- running away from home;
- aggression to others and self-harming;
- confiding in or asking for help from a healthcare professional but without explaining what the problem is;
- problems walking, sitting down, pain, sense of discomfort between the legs, pain where scar is located;
- period pain, resulting in repeated absences of the minor, frequently unjustified by a medical certificate;
- problems urinating. This may result in repeated requests to go to the lavatory, long periods of time spent in the lavatory;
- fear of or inability to perform some movements: some minors will refuse to take part in sports activities or ask to be excused from physical education without a note from the primary care physician;
- refusal to undergo a medical examination;
- missing sections in the child's health record booklet, or even lack of health record booklet;
- unexpected and prolonged absenteeism from school or regular or drop-in childcare centre; failure to return to school after prolonged school holidays (envisage return to country for genital mutilation and/or potentially early forced marriage).

It is recommended to refer to section 4 of the guideline, "How to broach the issue of female genital mutilation with female patients (adults, minors)"

6. Procedure to follow to protect minors from female genital mutilation

6.1 Means of prevention and protection

6.1.1 Assessing the minor's general circumstances

In the case of a risk of female genital mutilation, the professional must assess the imminence of the danger, based on:

- risk factors (refer to section 3: "Assessing the level of risk of female genital mutilation", and section 3.2: "Specific indicators in the case of a minor");
- discussions with the parents or with the minor herself;
- a potential upcoming trip abroad.

The professional may be assisted by:

  - support services by contacting the number 119 (Childline),[9]
  - the medical officer from the Departmental council service responsible for receiving reports giving rise to concern (CRIP),
  - a professional from the CRIP (if known),
  - or a doctor from the PMI network;

- specialist associations (refer to the list of associations, in Appendix 7 of the guideline).

6.1.2 Protection scenario for minors

Advice given to the minor

The healthcare professional may give the minor at a risk of female genital mutilation, based on her age and capabilities, some simple advice that will help her to react in the event of an emergency:

- contacting emergency services: 17 (police), 114 (SMS contact for the deaf and hard of hearing or those with difficulties expressing themselves);
- contacting:

  - 119 (Childline) which is not an emergency number but a listening and support helpline, based locally, and potentially offering referral to the appropriate child protection services,

- receiving support from the school nurse[10];
- contacting her local PMI centre;
- identifying those of her close contacts (at school, in the neighbourhood, family doctor, etc.) who may be able to offer support;
- finding out whether her sisters may be affected;
- as a last resort at the airport, making herself known to security operatives or the authorities (for example by handing them a note saying "*SOS genital cutting* " (SOS female genital cutting), rolling on the floor, making a scene, etc.) so that she can be taken aside by the authorities and is able to talk.

Advice for parents

It is recommended to provide parents with certificates and a statement that the parents can use as support for protecting their children:

[9] Refer to appendix 6 "Emergency numbers".

[10] Accessible free of charge and without any formalities in all local state-funded teaching establishments.

- a medical certificate confirming the absence of female genital cutting for their daughters, (refer to Appendix 5 “Medical certificate confirming absence of female genital mutilation”) with a review on the indicated return date;
- a statement setting out the legal and financial risks and the health complications for the minor. The more documentation (accompanied by one or more stamps) the parents receive from the professional, the greater the deterrent effect.

It is recommended to place them in contact with specialist associations.

Prevention

Prevention is a key form of leverage in combatting female genital mutilation. Talking about it helps break the taboo and, in some cases, allows people to speak openly. The practitioner is advised to bring the subject up, adapting their discourse to the minor’s and/or woman’s and/or parents’ level of comprehension.

It is important that young people be informed and made aware of the existence of this type of mutilation, the fact that it is illegal and its harmful effects, as well as of the support and care services available for victims and potential victims. The healthcare professional may also receive support from existing structures and let the patient know about them, in order to foster a better support network for her (for example: PMI network, school nurses.

6.2 Procedure for the professional to follow in the event of an imminent risk of female genital mutilation for a minor: reporting to the procureur de la République

The imminent risk of female genital mutilation is an extremely serious situation.

On encountering an imminent risk of female genital mutilation, the professional must first of all, REPORT it as a matter of urgency [11].

This means that the professional **MUST:**

- **notify the procureur de la République** of the high court of the jurisdiction of the patient’s or minor’s residence **by telephone, fax or email** with acknowledgement of receipt (the police force will have the contact details of the magistrates on duty).

If, due to time constraints, the procureur de la République has only been notified by telephone **and** fax, the report shall be confirmed with a dated and signed written document. The professional shall ensure that it is received (refer to Appendix 3: “REPORT forms”);

- **send** a copy of this written document for the attention of the medical officer or head of the Departmental council **service responsible for receiving reports giving rise to concern** (CRIP).

The healthcare professional is advised to keep a copy of this document and to note it in the medical file.

It is recommended at this stage not to notify the parents so as not to put the minor at further risk.

[11] Refer to the section “Reporting requirement for all citizens”, in Appendix 2 “In terms of the legislation” of the guideline. Article 226-14 of the French Penal Code expressly stipulates that professional secrecy is waived for “a person who informs a judicial, medical or administrative authority” on grounds of female genital mutilation. https://www.legifrance.gouv.fr/affichCodeArticle.do?idArticle=LEGIARTI000031428820&cidTexte=LEGITEXT000006070719&dateTexte=20151107

The procureur de la République or a juvenile court judge, where any other prevention method appears to be destined to fail, may issue a prohibition to remove the child out of jurisdiction. They may also contact the police force (juvenile and/or family protection squad) to enforce the law.

Some procureurs may also suggest that an examination of the child's external genitalia be conducted before and after the trip; with penalties in the event of a breach of French legislation.

The procureur de la République is invested with a wide range of powers for child protection, ranging from referral to the juvenile court judge on request, educational support, to a temporary care order ruling to protect the child if deemed necessary.

The referral to the procureur de la République represents the starting point of a judicial review of the circumstances and the investigation.

It is recommended to consider the existence of a similar risk for the girl's sisters.

It is recommended to conduct an examination of the vulvar area.

Mention of this notification of female genital mutilation, as well as the examination of the external genitalia, shall be explicitly recorded in the medical file.

The reporting procedure does not prevent continued follow-up by the healthcare professional, quite the opposite.

It is useful to inform the parents of the need to respect their child's physical integrity and possibly give them a signed and stamped medical certificate confirming the absence of female genital mutilation on the date of the examination, on headed paper.

Writing up such a medical certificate may have a deterrent effect.

The family is then informed that:

- the same medical examination will be conducted on their return (request the planned return date);
- all healthcare professionals are legally required to report any knowledge of female genital mutilation, which is considered a criminal offence in France, and in many countries, to the authorities.

6.3 Procedure for the professional to follow[12] in cases of non-imminent risk of female genital mutilation: report giving rise to concern to the Service responsible for receiving reports giving rise to concern

On encountering a non-imminent risk of female genital mutilation, the professional **must draw up** a **REPORT OF INFORMATION GIVING RISE TO CONCERN to the Departmental council service responsible for receiving reports giving rise to concern** (CRIP).

This means that they must notify **the Service responsible for receiving reports giving rise to concern (CRIP)** by drafting and sending **the medical officer or head of the CRIP** a written document with the information indicating the presence of this risk. Refer to Appendix 4: "form for reporting INFORMATION GIVING RISE TO CONCERN".

Based on this information giving rise to concern, the CRIP (pursuant to the Child Protection law of 14 March 2016) has "*the circumstances* [of the] *minor assessed* […] *by a multidisciplinary team of*

[12] Refer to the section "Reporting requirement for all citizens", in Appendix 2 "In terms of the legislation" of the guideline. Article 226-14 of the French Penal Code expressly stipulates that professional secrecy is waived for "a person who informs a judicial, medical or administrative authority" on grounds of female genital mutilation.

*professional*s […]. At that time, the circumstances of the other minors in the home are also assessed".

The healthcare professional is advised to inform the parents that the information giving rise to concern has been reported.

6.4 In cases where genital mutilation is discovered in a minor: reporting to the procureur de la République

On discovering female genital mutilation, the professional[13] must **first of all, REPORT it as a matter of urgency.**

This means that, without delay, the professional **MUST:**

- **notify the procureur de la République** of the high court of the jurisdiction of the patient's or minor's residence **by telephone, fax or email**, with acknowledgement of receipt (the police force will have the contact details of the magistrates on duty);
- if, due to time constraints, the procureur de la République has only been notified by telephone and fax, the report shall be confirmed with a dated and signed written document. The professional shall ensure that it is received (refer to Appendix 3: "REPORT forms").

It is recommended to contact the procureur de la République by telephone if possible (a member of the procureur de la République's department is systematically on duty), to ascertain the stance to adopt if such a case is detected.

A copy shall be sent to the president of the departmental council so that they are also notified of the existence of a minor at risk in their jurisdiction.

The question of removing the child from the family unit will be posed as a matter of urgency by the investigating department and the procureur de la République's department so as to guarantee the victim's protection.

The professional is advised to check whether any sisters are included among the siblings and to state this in the certificate.

So as not to hinder the judicial investigation, it is recommended not to inform the parents of this reporting process and not to question them on the circumstances (location, date, etc.) of the female genital mutilation.

This report shall not impact the subsequent care of the minor or of the family.

The professional is advised:

- to provide families with information materials (refer to the site https://stop-violences-femmes.gouv.fr);
- to refer the families to associations, if they so wish (refer to Appendix 7 "Associations. Reference sites. Tools".

[13] Refer to the section "Reporting requirement for all citizens", in Appendix 2 of the guideline "In terms of the legislation".

7. Procedure to follow in the case of an adult victim of female genital mutilation

7.1 If the risk concerns an adult patient

It is recommended to refer her to:

- the helpline number 3919 (“Violences femmes info” women’s aid helpline, freephone number);
- a specialist association;
- a member association of the France victimes network;
- a women’s and family rights information centre (CIDFF).

Refer to the list of associations in Appendix 7 of the guideline.

For emergency accommodation, it is recommended to call 115 to refer the patient to the social worker for her local municipality.

In the case of an **imminent risk** of mutilation for an adult woman, assistance measures for at-risk women come into play. It is commended to call 17. [14]

The practitioner should note that they cannot make a report to the authorities without the patient’s consent (unlike minors).

7.2 In the case of known mutilation of an adult patient

The professional should note that:

- if the patient is a “non-vulnerable” adult, there is no obligation to make a report. The professional cannot make a report to the authorities without the patient’s consent (unlike minors);
- if the patient “*is unable to protect themselves because of their age, or physical or psychological state”*[15], there is an obligation to make a report.

It is recommended to inform the victim of her rights.

Female genital mutilation is an offence punished by the French Penal Code. Any woman who has been mutilated while a minor **is entitled to file a report up to 30 years after reaching legal age, i.e. until she is 48 years of age.**

Disclosing such information is always a difficult time for the victim. Therefore, it is essential that she receive support.

It is recommended to refer her:

- to a victims’ aid association accredited by the French Ministry of Justice, capable of guiding her throughout the judicial process;
- to a women’s and family rights information centre (CIDFF);
- or to the helpline number 3919 (Violences femmes info[16]);

[14] Refer to appendix 6 “Emergency numbers”.

[15] Article 226-14 of the French Penal Code expressly stipulates that professional secrecy is waived for “a person who informs a judicial, medical or administrative authority” on grounds of female genital mutilation. Article 226-14 of the French Penal Code amended by Law No. 2015-1402 of 5 November 2015 - art. 1 https://www.legifrance.gouv.fr/affichCodeArticle.do?idArticle=LEGIARTI000031428820&cidTexte=LEGITEXT000006070719&dateTexte=20151107

[16] National helpline number for women who have been victims of abuse, their families and professionals concerned. Freephone, anonymous helpline available 7 days a week, from 9 a.m. to 10 p.m. Monday to Friday and from 9 a.m. to 6 p.m. on Saturday, Sunday and bank holidays.

- or the helpline number 116 006 (victims' aid helpline[17]);
- or to a specialist association who can guide her in filing a report;
- or to the anonymous webchat service for reporting sexual and gender-based violence[18]).

(Refer to the list of associations in Appendix 7 of the guideline).

It is recommended to screen for other forms of abuse. Women who are victims of female genital mutilation are at an increased risk of being victims of other forms of abuse (domestic abuse within a relationship or family, sexual abuse, forced marriage).

The professional is advised to systematically question the woman about the abuse to which she has been subjected in order to screen for the abuse and refer her for protection and appropriate care.

The management of female genital mutilation is covered in section 9.2: "Management of a woman who has undergone female genital mutilation".

[17] Freephone number, open 7 days a week from 9 a.m. to 7 p.m.

[18] https://www.service-public.fr/cmi, 24/7 service.

8. Examination of a patient who has undergone female genital mutilation

Reminder: whenever female genital mutilation is discovered in a minor, the professional is obliged to make a report to the procureur de la République.

The legislation does not require that an examination of the external genitalia be conducted prior to reporting suspected genital mutilation.

All medical certificates must be drafted after a clinical examination fully assessing any injuries or their absence.

The following advice applies to all patients, accounting for specificities related to their age and their circumstances.

Following female genital mutilation, the patient may develop acute stress disorder and post-traumatic stress disorder. In this case, the victim may be confused and unable to recall some or all the events that occurred.

8.1 Examinations of women and young girls

The examination of a female patient must be approached in a sensitive manner, remembering that the subject's consent is required for any examination.

As for any medical examination, the examination must be carried out in a respectful manner, for example:

- respecting the subject's consent;
- it is not necessary for the patient to be completely undressed;
- all actions must be explained;
- not giving the patient cause for concern with an inappropriate reaction (verbal and non-verbal). Patients are not necessarily accustomed to an examination of the genitalia.

The clinical examination of the external genitalia is not a gynaecological examination and does not require digital vaginal examination or the use of a speculum.

The clinical examination is used to confirm the diagnosis of female genital mutilation. It is recommended to assess any after-effects.

It is recommended to suggest that the women or young girl examine themselves with a mirror for explanatory purposes.

It is recommended to use the World Health Organization classification, or to provide a description in the file, specifying:

- presence of the clitoral hood;
- the appearance of the clitoris, labia minora and labia majora, and urinary meatus.

A diagram may be useful in the medical file.

It is recommended to explain the findings of the clinical examination to the patient using educational tools: drawings, diagrams, models[19].

In the event of diagnostic uncertainty, the patient must be referred to a medical specialist or a team specialised in female genital mutilation **without drawing up** a medical certificate.

[19] For example, refer to Appendix 7 "Associations. Reference sites. Tools." and to the following link: "For educational tools: https://federationgams.org/outils-msf/"

It is recommended to refer to the following link which provides an updated list of practices and departments specialised in surgical matters. https://federationgams.org/wp-content/uploads/2019/02/Unit%C3%A9s-de-soins-aux-femmes-excis%C3%A9es-en-2018-1.pdf.

It is also recommended to ascertain whether the patient has daughters and/or sisters who are minors and to bring up female genital mutilation prevention for them with her.

In the case of teenage minors, it is recommended that the doctor remind her:

- that this type of abuse is illegal;
- that she is no way responsible, regardless of the causes and circumstances.

8.2 Examination of a young girl or infant

It is recommended that all minors undergo regular examinations of the external genitalia; the findings of such examinations must be recorded in the child health record booklet.

It is recommended to be mindful of female genital mutilation.

As for any clinical examination, it is necessary to:

- speak to the minor in a manner that is appropriate for her age and her level of comprehension;
- to explain to her what the clinical examination involves (ears, heart, lungs, mouth, eyes and external genitalia);
- to screen for urogenital symptoms when asking about the medical history;
- to take the time to reassure the minor and her parents regarding the examination of the external genitalia as it is a non-invasive examination;
- for infants:
  - to advise on hygiene in respect of the external genitalia and folds while checking the integrity of the external genital organs,
  - an old type I mutilation that has previously healed may go unnoticed in a baby, but infibulation (type III) is clearly visible, on the other hand.

If the child shows resistance (e.g. clenching her legs together, screaming), it is recommended not to insist.

Depending on the context and the risk level assessment, it is recommended to suggest:

- another appointment;
- or call the Departmental council service responsible for receiving reports giving rise to concern (preferably the medical officer).

It should be noted that Article 226-14 of the French Penal Code expressly stipulates that professional secrecy is waived for “a person who informs a judicial, medical or administrative authority” on grounds of female genital mutilation (refer to Appendix 2 of the guidelines “In terms of the legislation”).

It is recommended to record the findings of the clinical examination, including the external genital organs, in the child health record booklet and in the medical file.

Some conditions of the genitalia in young girls may, for unaccustomed clinicians, have a somewhat similar appearance to the after-effects of female genital mutilation (for example, coalescence of the labia minora, lack of formation of a posterior part of the labia minora).

In the event of diagnostic uncertainty, it is recommended to refer the child to an experienced colleague.

Specific example of grounds for clinical examination: request for certificate “confirming absence of female genital mutilation” in the context of an asylum application aimed at protecting the minor from a risk of mutilation in her native country.

In the context of an asylum application (international protection) to the French office for the protection of refugees and stateless persons (OFPRA) or the French court for right of asylum (CNDA), a certificate confirming the absence of mutilation of the minor is requested by these instances. This certificate, and in this specific context, must be drawn up by a medical examiner in an approved department (abuse consultation team).

For such an asylum application, in order to protect her daughter, the mother generally also requests a certificate confirming that she has undergone mutilation. These certificates may be issued by all healthcare professionals with experience in female genital mutilation.[20]

[20] Refer to Appendix 2 of the guideline “In terms of the legislation”.

9. Primary medical care and referral

9.1 Management of a minor who has undergone female genital mutilation

Reminder: any discovery of female genital mutilation in a minor must be reported to the procureur de la République. Failure to make a report is deemed to be a failure to report a criminal offence (refer to section 6.4 “In cases where genital mutilation is discovered in a minor: Reporting to the procureur de la République”).

Reporting also helps protect any sisters among the siblings.

It is recommended to refer the minor for a medical female genital mutilation review to:

- a paediatric surgery department or a multidisciplinary team experienced in the management of female genital mutilation;
- or to a paediatric department.

Do not hesitate to:

- contact the medical officers of specialist associations[21];
- inform the minor of the presence of a school nurse and suggest that she discuss it with her if needed[22].

The multidisciplinary team or department will assess the situation, its causes and effects. The primary objective is offer the child follow-up (diagnosis and early management of complications).

It is recommended:

- that the specialist department and the child’s primary care physician work together;
- to offer psychological follow-up with support from the local child psychiatry service.

How to react when a minor discloses that she has undergone female genital mutilation

It is important to emphasise the minor’s bravery and trust in disclosing female genital mutilation.

What to say: “*You have done the right thing by talking to me about it”, “That is not allowed in France”, “It’s your body, nobody has the right to hurt you”, “That type of abuse is illegal in France and in other countries”,* “*You can come back to see me anytime you like to talk about it*”.

It is recommended to inform the minor that the doctor is obliged to make a report to the competent authorities.

What not to say: *“It’s alright”, “Your secret is safe with me”, “I won’t talk to anyone, this will stay between you and me”, “Everything will be OK”, “Your parents are barbaric”.*

9.2 Management of a woman who has undergone female genital mutilation

It is recommended to take the time to talk with the patient to record her wishes and needs with a view to offering her, if she so wishes, multidisciplinary care (gynaecological, urological, obstetric, surgical, psychological, social).

There are a number of possible choices:

[21] Refer to Appendix 7 of the guideline “Associations. Reference sites. Tools.”

[22] This option is available to her throughout her school years.

- another appointment to see the patient again to continue discussing matters, if she so wishes;
- gynaecological follow-up by gynaecology-obstetrics, surgery, and medico-psychosocial units for multidisciplinary care;
- psychological management;
- sex therapy follow-up with a view to assessing the repercussions of mutilation on the patient's sexuality and the effects on sexual desire and pleasure;
- contact with an association or an institution that organises group therapy around these issues.

As a reminder, it is recommended to assess the risk of female genital mutilation for the patient's daughters.

A woman may report having adult daughters who have undergone female genital mutilation. It is recommended to encourage her daughters to be seen by a doctor themselves.

9.2.1 Psychological management

Girls and women may display a wide range of individual reactions in terms of the psychological and physical internalisation of their mutilation.

In view of the major trauma involved, this wide range should be taken into account by the healthcare professional.

It is recommended to refer patients with disorders such as anxiety, anguish, depression, posttraumatic stress syndrome, etc. to a psychiatrist/child psychiatrist, psychologist, or psychotherapist.

9.2.2 Management of pregnant women

It is recommended to reassure any pregnant women who have undergone female genital mutilation that it will not affect her ability to have a pregnancy and delivery to progress without any complications with appropriate obstetrical follow-up.

It is recommended to refer a victim of female genital mutilation for maternity hospital follow-up from the start of the second trimester of her pregnancy. Indeed, some pregnant women may have a greater risk of urinary tract infections, iron deficiency anaemia, etc.

Deinfibulation may be carried out during pregnancy or during labour immediately before delivery or intraoperatively during a caesarean section.

The procedure to follow during delivery for a patient who has undergone genital mutilation must be discussed and planned from the first antenatal appointments, in order to prepare the patient and her family circle.

As much information as possible must be recorded in the file to prevent the mutilation victim from having to repeat her story.

During obstetrical follow-up, it is recommended to advise the patient:

- that she will not systematically have a caesarean section or episiotomy;
- that in the case of deinfibulation, re-infibulation is strictly prohibited in France.

It is recommended to broach the matter of re-infibulation being illegal with the woman and her family circle.

9.2.3 Sexual dysfunction management

It is recommended to refer women and couples reporting sexual dysfunction for sex therapy.

9.2.4 Surgical management

Clitoral repair is a reparative surgical procedure and not cosmetic surgery. It is covered by French Social Security.

It is suggested to refer to the link below which provides an updated list of practices and departments specialised in surgical matters. https://federationgams.org/wp-content/uploads/2019/02/Unit%C3%A9s-de-soins-aux-femmes-excis%C3%A9es-en-2018-1.pdf

It is important to note that the management of a victim of female genital mutilation is not confined to clitoral reconstruction.

It is recommended that clitoral reparative surgery be accompanied by psychological support and sex therapy.

Injuries that can be treated surgically are, for example:

- for all types of mutilation: sealing of the stumps of the labia minora, neuroma of the dorsal nerve of the clitoris, epidermal inclusion cyst, keloid scars;
- for type II and III female genital mutilation: vaginal occlusion due to vulvar sclerosis;
- for type III female genital mutilation: infibulations;
- for type III and IV female genital mutilation: urinary tract complications (for example, urethral stenosis).

Annexe 1. Prevalence of female genital mutilation in Africa

According to UNICEF, in 2018, the following table shows the prevalence of female genital mutilation in African countries among adolescent girls and women aged 15 to 49 years and among girls from birth up to the age of 15 years [23].

The source of the data in this table was UNICEF global databases, 2018, based on demographic and health surveys (DHS), multiple indicator cluster surveys (MICS) and other nationally representative surveys (Indonesia). UNICEF's map is available on the site https://www.unicef.fr/sites/default/files/userfiles/carteexcision.pdf

The map of the association "Excision, parlons-en" is available at the following link: http://www.excisionparlonsen.org/comprendre-lexcision/cartographie-mondiale-des-pratiques-dexcision/.

Table 3. Prevalence of female genital mutilation in African countries among adolescent girls and women aged 15 to 49 years and among girls from birth up to the age of 15 years

Country	Female genital mutilation prevalence among girls and women aged 15 to 49 years (%)	Female genital mutilation prevalence among girls from birth up to the age of 15 years (%)	Reference year	Data source
Benin	9%	0.2	2014	MICS[24]
Burkina Faso	***76%***	*13%*	2010	DHS[25]/MICS
Cameroon	1%	_	2004	DHS
Côte d'Ivoire	*37%*	*10%*	2016	MICS
Djibouti	**93%**	_	**2006**	**MICS**
Egypt	**87%**	*14%*	2015	DHS
Eritrea	**83%**	*33%*	2010	Population and Health Survey
Ethiopia	**65%**	*16%*	2016	DHS
Gambia	**75%**	**56%**	**2013**	**DHS**
Ghana	4%	1%	2011	MICS
Guinea	**97%**	**45%**	2016	MICS
Guinea-Bissau	**45%**	**29%**	2014	MICS
Indonesia	_	**49%**	2013	RISKESDAS
Iraq	8%	_	2011	MICS
Kenya	21%	3%	2014	DHS
Liberia	*44%*	_	2013	DHS
Mali	**83%**	**73%**	2015	MICS

[23]https://data.unicef.org/topic/child-protection/female-genital-mutilation/ (Updated October 2018)

[24] Multiple Indicator Cluster Study (MICS)

[25] Demographic and Health Surveys (DHS)

Country	Female genital mutilation prevalence among girls and women aged 15 to 49 years (%)	Female genital mutilation prevalence among girls from birth up to the age of 15 years (%)	Reference year	Data source
Mauritania	**67%**	**51%**	2015	MICS
Niger	2%	_	2012	DHS
Nigeria	*18%*	*13%*	2016	MICS
Uganda	0%	1%	2016	DHS
Central African Republic	*24%*	*1%*	2010	MICS
Senegal	*23%*	*14%*	2015-16	DHS
Sierra Leone	**86%**	8%	2017	MICS
Somalia	**98%**	_	2006	MICS
Sudan	***87%***	***30%***	2014	MICS
Tanzania	10%	0.4%	2015-2016	DHS
Chad	*38%*	*10%*	2014-2015	DHS
Togo	5%	0.3%	2013-2014	DHS
Yemen	*19%*	_	2013	DHS
–: Data not available				

*Indicator definition: Percentage of most recently cut daughters among girls and women aged 15 to 49 years with at least one living daughter who has undergone female genital mutilation.

Note: Data for Iraq and Yemen refer to girls and women aged 15 to 49 years who have already been married and with at least one living daughter who has undergone female genital mutilation.

Countries with high prevalence (mothers and/or daughters)**: bold font**

Countries with moderate prevalence (mothers and/or daughters)*: italic font*

Countries with high prevalence for mothers and lower prevalence for daughters: ***bold and italic font***

Countries with low prevalence: light font.

Annexe 2. In terms of the legislation

Reporting requirement for all citizens

Article 434-3 of the French Penal Code

"**Any person** who, having knowledge of maltreatment, deprivations, or sexual assaults inflicted upon a minor or upon a person incapable of self-protection by reason of age, sickness, infirmity, physical or psychological disability or pregnancy, omits to report this to the administrative or judicial authorities and continues to omit to report this to the authorities while the acts are ongoing is punished by three years' imprisonment and a fine of €45,000. "

Where the failure to make a report relates to one of the acts mentioned committed on a minor under fifteen years of age, the penalty is increased to five years' imprisonment and to a fine of €75,000.

For professionals subject to professional secrecy, there are special provisions for: "breach of professional secrecy"

Article 226-13 of the French Penal Code[26] (relating to professional secrecy) is not applicable to the cases where the law imposes or authorises the disclosure of the secret.

Professional secrecy is not applicable:

- if the patient is a minor or "vulnerable adult" (unable to protect themselves because of their age, or her physical or psychological state), the healthcare professional may inform the following authorities of harm observed:
  - judicial (procureur de la République),
  - medical,
  - or administrative (Departmental council service responsible for receiving, processing and assessing reports giving rise to concern)

Article 226-14 of the French Penal Code expressly stipulates that professional secrecy is waived for "a person who informs a judicial, medical or administrative authority" on grounds of female genital mutilation.

- If the patient is a "non-vulnerable" adult, the healthcare professional may disclose the facts with the patient's consent. In these cases, Article 226-14 of the French Penal Code authorises the practitioner to make a disclosure. This provision justifies the breach of professional secrecy.

In both scenarios, the practitioner is not liable to prosecution on grounds of breach of professional secrecy, either in the penal, civil or ordinary courts.

Article 226-14 of the French Penal Code

Article 226-13[27] is not applicable to the cases where the law imposes or authorises the disclosure of the secret. In addition, it is not applicable:

- 1° to a person who informs a judicial, medical or administrative authority of cruelty or deprivation, including sexual abuse or mutilation, of which they have knowledge and which has been inflicted on a minor or a person unable to protect themselves because of their age, or physical or psychological state;

26 https://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006070719&idArticle=LEGIARTI000006417944&dateTexte=&categorieLien=cid

27 https://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006070719&idArticle=LEGIARTI000006417944&dateTexte=&categorieLien=cid

- 2° to a doctor or any other healthcare professional who, with the consent of the victim, brings to the knowledge of the procureur de la République or Team responsible for receiving, processing and assessing reports of concern in relation to endangered or potentially endangered minors, cited in Paragraph 2 of Article L. 226-3 of the French Family and Social Action Code, instances of cruelty or deprivation, either physical or psychological, that they have observed in the exercise of their profession that cause them to believe that physical, sexual or psychological violence of any sort, has been committed.

Where the victim is a minor or a person unable to protect themselves because of their age, or physical or psychological state, their consent is not necessary.

The healthcare professional is a doctor

According to the Code of Ethics (Art. 44) and French Public Health Code (Art. R. 4127-44), the doctor "*must use the most appropriate means to protect the victim demonstrating care and caution. Where a minor or a person unable to protect themselves because of their age or their physical or psychological state is involved, they shall inform the judicial or administrative authorities, other than in special circumstances appraised in good conscience*".

The healthcare professional is a midwife practitioner

Article R. 4127-316 of the French Public health Code stipulates: "*Where a midwife perceives that a woman whom she has been attending or her child is a victim of cruelty, she must use the most appropriate means to protect them*".

The healthcare professional is a nurse practitioner

Article R. 4312-7 of the French Public health Code stipulates: "*Where a nurse practitioner perceives as part of their professional practice that a minor is a victim of cruelty or deprivation, they must use the most appropriate means to protect them, not hesitating, where necessary, to inform the competent medical or administrative authorities in the case of a minor aged [under] 15 years".*

Offences, punishment and criminal proceedings for the perpetrator of mutilation and for those responsible for the mutilated child

The punishment envisaged for the perpetrator of mutilation and for those responsible for the mutilated child are defined by the French Penal Code.

Table 4. Punishment for the perpetrator of mutilation and for those responsible for the mutilated child

Offences	Punishment	Penal Code	Additional information
Acts of violence causing mutilation or permanent disability on a minor under fifteen years of age	15 years' imprisonment	Article 222-10	**FELONY** **Criminal court** **30-year limit (1) to lodge a complaint from the date that the victim reaches legal age (18 years)**
Acts of violence causing mutilation or permanent disability on a minor under fifteen years of age by a legitimate, natural or adoptive ascendant or by any other person having authority over the minor.	20 years' imprisonment	Article 222-10	

Offences	Punishment	Penal Code	Additional information
Acts of violence causing mutilation or permanent disability (without aggravating circumstances)	10 years' imprisonment and a fine of €150,000	Article 222-9	**MISDEMEANOUR** **Magistrates' court** **6-year limit (2) to lodge a complaint from the date of the offence**
Incitement of a minor to undergo genital mutilation, by offers, promises, donations, gifts or advantages of any kind or by using pressure or coercion of any kind	5 years' imprisonment and a fine of €75,000	Article 227-24-1	**MISDEMEANOUR** **Magistrates' court** **10-year limit to lodge a complaint from the date that the victim reaches legal age (18 years)**
Incitement of others to commit genital mutilation on a minor	5 years' imprisonment and a fine of €75,000	Article 227-24-1	

(1) **30-year limit** since the law of August 2018: Law No. 2018-703 of 3 August 2018 reinforcing the combat against sexual and gender-based violence.

https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000037284450&categorieLien=id

(2) **Law No. 2017-242 of 27 February 2017 reforming the statute of limitations for criminal matters (1)**

French criminal law stipulates that the **accomplice to an offence** is punishable as a perpetrator (Article 121-6 of the French Penal Code).

Article 121-7 of the same Code states that: "*the accomplice to a felony or a misdemeanour is the person who knowingly, by aiding and abetting, facilitates its preparation or commission*".

"*Any person who, by means of a gift, promise, threat, order, or an abuse of authority or powers, provokes the commission of an offence or gives instructions to commit it, is also an accomplice*". Those responsible for the child who would be recognised as accomplices of mutilation are therefore punishable in the same way as the perpetrator.

Furthermore, since August 2013, further offences have been added to the French Penal Code concerning cases where mutilation has not been carried out *(Art. 227-24-1 of the Code).* The following offences are punished by five years' imprisonment and a fine of €75,000:

- **inciting a minor to undergo** genital mutilation, with offers or promises or by offering them donations, gifts or advantages of any kind, or by using pressure or coercion of any kind against them, so that they undergo genital mutilation where such mutilation has not been carried out;
- **inciting others to commit** genital mutilation on a minor, where such mutilation has not been carried out.

Legislation on the risk of female genital mutilation and the right of asylum

The law of 29 July 2015 on asylum reform, confirmed by **Law No. 2018-778** of 10 September 2018 for controlled immigration, effective right of asylum and successful integration, acknowledges the need, as part of the asylum application procedure to OFPRA, to furnish a medical certificate confirming absence of genital mutilation.

Similarly, where asylum protection has been granted to a minor, OFPRA requests a certificate at regular intervals (3 to 5 years).

The process for drafting this certificate (certificate template), the practitioners drafting such certificates and the structures where they practice, are set out in the decree of 23 August 2017[28].

This applies to practitioners registered with the French Medical Association, holding a university diploma or qualification in forensic medicine recognised by the French National Medical Association or authorised to practice forensic medicine by the French Medical Association, and occupying a medical role within hospital units specialised in the forensic management of living subjects (Art. 4). And setting out the medical examination process envisaged for persons liable to benefit, or benefitting, from protection with regard to their risks of female genital mutilation.

Decree of 23 August 2017 adopted for the application of **Articles L.723-5 and L.752-3** of the French Code of entry and residence of foreign nationals and right of asylum and setting out the medical examination process envisaged for persons liable to benefit, or benefitting, from protection with regard to their risks of female genital mutilation.

[28] Decree of 23 August 2017 adopted for ***the application*** of Articles L.723-5 and L.752-3 of the French Code of entry and residence of foreign nationals and right of asylum and setting out the process https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000035468390&categorieLien=id

Annexe 3. REPORT forms

Template medical certificates accompanied by instructions are made available to practitioners by professional associations.

- On the French National Medical Association website:

https://www.conseil-national.medecin.fr/sites/default/files/modele_signalement_mineur.pdf (viewed on 5 March 2020).

- On the French National Midwives' Association website:

http://www.ordre-sages-femmes.fr/wp-content/uploads/2015/11/notice-et-modèle-de-certificat-médical1.doc (viewed on 5 March 2020).

Cruelty to a minor: template report

Article 44 for the French Code of Medical Ethics (Art. R. 4127-44 of the French Public Health Code) requires doctors to protect minors and report any cruelty of which they are a victim.

Article 226-14 of the French Penal Code exempts the doctor of professional secrecy and authorises them to inform the procureur de la République (contactable 24/7) or the Service responsible for receiving, processing and assessing reports giving rise to concern (CRIP) (contactable during office hours) of cruelty or deprivation observed and the details relating to the endangered or potentially endangered minor.

In order to assist the doctor in this process, a template judicial report has been prepared in concert between the French Ministry of Justice, Ministry of Health, the Family and the Disabled, the Delegate Ministry for the Family, the French National Medical Association, and child protection associations. This template has been updated.

Reports of cruelty or deprivation observed must be sent directly by the doctor to the procureur de la République or of information giving rise to concern relating to endangered or potentially endangered minors to the medical officer of the departmental council (formerly regional council) CRIP.

If, due to time constraints, the report to the procureur de la République is only made by telephone or fax, it shall be confirmed with a dated and signed written document. The doctor shall ensure that it is received and shall keep a copy.

Template REPORT in the case of KNOWN genital mutilation or of IMMINENT RISK in relation to a MINOR

Doctor's stamp

REPORT

(Please complete in block letters)

I hereby certify having examined today (written out in words):

- date (day of week and month number):

- year:

- time:

- the minor:

- last name:

- first name:

- date of birth (written out in words):

- gender:

- address:

Accompanied by (note whether the person is an adult or a minor, provide the person's contact details where possible and any kinship with the minor):

- the accompanying person has informed us that**:** "

_____
_____
_____
_____
_____ "

- the minor has informed us that: "

_____
_____
_____
_____
_____
_____ "

Doctor’s stamp

Clinical examination conducted in the presence of the accompanying person:

(Delete where inapplicable)

Yes

No

- Description of the minor’s behaviour during the consultation:

- Description of any injuries (note the location and the characteristics without presuming the cause)

-

-

-

-

-

-

-

In view of the above and in accordance with the law, I hereby send you this report.

Report sent to the procureur de la République and copy sent to the Departmental council (formerly regional council) service responsible for receiving reports giving rise to concern (CRIP)

Place: _____, date:

Signature of doctor who examined the minor

Keep a copy of this document.

Template REPORT in the case of KNOWN genital mutilation in relation to an ADULT WOMAN WITH her consent

Prepared by a medical doctor: Art. 226-14 of the French Penal Code

Template report in the case of known genital mutilation in relation to an adult woman
To be sent to the procureur de la République

Subject: report of known genital mutilation committed on an adult woman

LAST NAME:

First name

Age:

Address:

Dear Sir or Madam,

I would like to inform you of the following facts: ……...

……..

……

……

I examined on this day, …… (day, time, month, year) Mrs/Ms: …….

……. (Last name, First name) date of birth ……

(day, month, year) residing at: ……

who has consented to this report.

The following signs cause me to believe that this person has undergone genital mutilation:

……..

……..

Yours faithfully.

Signature/Stamp

Keep a copy of this document

Annexe 4. Medical certificate: form for reporting INFORMATION GIVING RISE TO CONCERN

Sample form for reporting INFORMATION GIVING RISE TO CONCERN

(Department header:) Date:

Enfant(s) concerné(s) par l'information préoccupante

Ces éléments doivent être renseignés pour chacun des enfants concernés par l'information préoccupante

Nom : Prénom : Sexe : ☐ M ☐ F
Date et lieu de naissance :
Adresse du domicile de l'enfant :
Lieu de scolarisation ou assimilé :
Nom du Père : Nom de la Mère :
Titulaires de l'autorité parentale : ☐ Information déclarative ☐ sur justificatif
☐ père ☐ mère ☐ autre ☐ non connu

Nom : Prénom : Sexe : ☐ M ☐ F
Date et lieu de naissance :
Adresse du domicile de l'enfant :
Lieu de scolarisation ou assimilé :
Nom du Père : Nom de la Mère :
Titulaires de l'autorité parentale : ☐ Information déclarative ☐ sur justificatif
☐ père ☐ mère ☐ autre ☐ non connu

Composition de la famille (données d'état civil)

PERE : Nom : Date de Naissance :
Prénom : Lieu de Naissance :
Adresse :
Tel fixe : Tel portable :

MERE : Nom : Date de Naissance :
Prénom : Lieu de Naissance :
Adresse :
Tel fixe : Tel portable :

AUTRE ADULTE VIVANT AU DOMICILE, s'il y a lieu :
Nom : Date de Naissance :
Prénom :

ENFANT(S) DE LA FAMILLE dont les enfants concernés par l'information préoccupante :
Nom : Date de Naissance :
Prénom : Lieu de Naissance :
Lieu de scolarisation ou assimilé :

Nom : Date de Naissance :
Prénom : Lieu de Naissance :
Lieu de scolarisation ou assimilé :

Recipient departments:
☐ Regional head of child welfare services, request for administrative measure
Or ☐ Assessment intended for judicial authorities, at the department's initiative
☐ CRIP or

☐ Response to a CRIP referral, case No.: ……

Or

☐ procureur de la République with copy to the CRIP

Family circumstances of the child/children concerned

Accommodation conditions; family budget information; employment status, other persons residing at home; language spoken; shared custody, etc.

Description and analysis of the situation

L'enfant concerné : on s'attachera à distinguer :

- *Une observation de l'enfant : son état de santé, sa scolarité, son développement (compte tenu de sa classe d'âge). Un bilan est nécessaire pour chacun des enfants concernés par l'information préoccupante*
- *Une observation des relations intrafamiliales, notamment la problématique de l'enfant dans son environnement et le positionnement de chacun des membres de la famille.*

NB : une grille de signaux d'alerte est jointe à la présente notice à titre indicatif (elle n'est pas à reprendre dans le rapport).

Les éléments de l'histoire familiale : *seuls les éléments qui apportent un éclairage à l'évaluation de la situation sont à mentionner.*

La(les) principale(s) problématique(s) repérée(s) : *mise en évidence des éléments de danger.*

Le point de vue de la famille.

Measures initiated

Actions du service auprès de la famille : *dates et durée à préciser, implication des parents, raisons de l'échec s'il y a lieu…*

Autres services intervenant auprès de l'enfant et de sa famille *(préciser leurs coordonnées) ; ex : mesure éducative, CMP, logement, RSA…*

Travail de partenariat : *Synthèse, inscription de la situation en CPPEF, ...*

Notification of parents

Rappel : la règle est d'informer les parents de la transmission d'un écrit (à la CRIP ou à l'ASE). La date et les modalités de celle information sont à préciser.
Si, dans l'intérêt de l'enfant, il a été retenu de différer l'information aux parents, le motif de cette dérogation doit être mentionné.

Department's findings

Rappel : Une orientation vers le Parquet doit répondre à l'un des trois cas suivants :

- danger et échec d'une protection contractuelle ;
- danger et impossibilité d'une protection contractuelle ;
- risque de danger et impossibilité d'évaluer.

+/- Medical certificate

Date: author's signature

The information provided is subject to professional secrecy: it is strictly confidential and intended solely for the recipient concerned. If this report has been received in error, please destroy the document and notify us at: ……

Annexe 5. Medical certificate confirming ABSENCE of female genital cutting

Template medical certificate confirming absence of female genital mutilation for a minor patient (for travel purposes)

Je, soussigné Docteur ……..certifie avoir examiné le……..l'enfant ……..…… en présence de……. (mère, père, parents)

L'examen des organes génitaux externes ne retrouve aucune lésion traumatique au niveau du clitoris, du méat urétral, des petites lèvres, des grandes lèvres.
Cette enfant ne présente ce jour aucun stigmate de mutilation sexuelle féminine.

Cette enfant sera revue en consultation le ……afin de vérifier l'intégrité des organes génitaux externes.

Certificat établi le……..…. et remis en main propre à…….. pour servir et faire valoir ce que de droit.

Date :
Signature / cachet

Garder un double du certificat dans le dossier.

Medical certificates confirming absence of female genital mutilation of a minor within the framework of an asylum application, requested by Ofpra, must be issued in an abuse consultation unit (UMJ).

Template medical certificate confirming ABSENCE or PRESENCE of FEMALE GENITAL MUTILATION for an adult patient

I the undersigned, Dr……..hereby certify having examined on …....., at her request

Mrs/Ms……..... (Last name, first name), date of birth …… (day month

year) residing at ……

Following the examination of her external genitalia, Mrs/Ms…….

- Does not present with any signs, on this day, of female genital mutilation.

Or

- Presents with type (I II III) female genital mutilation. (Description).

Certificate issued on ……..and, given in person

At ……for all legal intents and purposes.

Date:

Signature/stamp

Keep a copy of the certificate in the file

Annexe 6. Emergency numbers

119: French national Childline

The 119 helpline is intended first and foremost for minors who are in danger and is open to anyone wishing to talk about the circumstances of a minor potentially in danger.
This number can be accessed free of charge in Metropolitan France and in French overseas departments 24/7

3919: Violences femmes info women's aid helpline

National helpline number for women who have been victims of abuse, their families and professionals concerned.

This number can be accessed free of charge in Metropolitan France and in French overseas departments 24/7. It is open Monday to Friday from 9 a.m. to 10 p.m., and Saturday, Sunday and bank holidays from 9 a.m. to 6 p.m.

Important: in the case of an emergency, the numbers to call are obviously 17 or 112, or 114 (SMS contact for the deaf and hard of hearing or those with difficulties expressing themselves**)[29].**

Webchat service: on the platform for reporting sexual and gender-based violence: Service-public.fr

A webchat service is now available: to discuss sexual and gender-based violence directly with the police force, via Service-public.fr (24-hour service, 365 days/year).

This new online service enables direct 24/7 communication with a specially trained police officer, in order to establish personalised communication with the officer to report acts of sexual and/or gender-based violence of which you have been a victim and in relation to which you are looking for information, advice or assistance.

This interactive discussion should enable the person, directly from their home, to receive a referral and guidance in respect of the process to a police force department or office or an association capable of providing assistance in a professional and available manner.

116 006: victims' aid helpline number
Freephone number, open 7 days a week from 9 a.m. to 7 p.m.
This helpline is intended for victims of crimes (theft, assault, etc.), and also for victims of road accidents, collective incidents, attacks or natural disasters.
Respecting the caller's anonymity, this helpline listens to victims and refers them to victims' aid association networks and specialised services.
This service is also accessible to French nationals abroad at 00 33 1 80 52 33 76 (normal charging applies).

[29] Samples of posters for the 119 and 3919 helplines are available in Appendix 8 of the guideline

0 800 235 236: "Fil santé jeunes" health helpline for young people (18 to 25 years)

Open every day from 9 a.m. to 11 p.m. (plus chat service). Calls are free from all phone networks.

Annexe 7. Associations. Reference sites. Tools.

Specialist associations

- Commission pour l'abolition des mutilations sexuelles (Commission for the abolition of genital mutilation - CAMS)

Website: http://www.cams-fgm.org/

- Groupe pour l'abolition des mutilations sexuelles (Group for the abolition of genital mutilation - GAMS)

Website: https://federationgams.org/contacts/

- Excision, Parlons-en !

Website: http://www.excisionparlonsen.org/:

- Gynécologie sans frontières, (GSF)

Website: https://gynsf.org/

- Mouvement français pour le planning familial (French family planning movement - MFPF)

Website: https://www.planning-familial.org/fr

Institut Women-Safe (78)

Website: www.women-safe.org

Reference sites, literature, films

Institutional resources

The website Stop violences-femmes.gouv: https://stop-violences-femmes.gouv.fr:

https://stop-violences-femmes.gouv.fr/depliants-et-guides-308 and the leaflet "Female genital mutilation, a crime punishable by the law: https://stop-violences-femmes.gouv.fr/IMG/pdf/Depliant_Mutilations2015_FR.pdf

Training booklet on interviews by professionals of minors who have been a victim or at risk of being a victim of female genital mutilation accompanying the educational short film "Bilakoro". https://stop-violences-femmes.gouv.fr/IMG/pdf/fiche_presentation_kit_bilakoro_2018.pdf.

The short film "Bilakoro" and the accompanying booklet provide a training kit on identifying and managing minors affected by female genital mutilation. This training kit is primarily aimed at social workers and professionals in school and extracurricular settings (teachers, main education counsellors, school psychologists, school nurses and doctors).

The Interministerial mission for the protection of women against violence and the fight against human trafficking (MIPROF):

- training tools: domestic abuse and sexual abuse. https://stop-violences-femmes.gouv.fr/outils-de-formation-violences-au. The tools are available to view and download free of charge on request from the address: formation@miprof.gouv.fr;
- training kits, created by MIPROF with the cooperation of professionals and experts, are also available for other forms of abuse committed against women. The short training films can be viewed on the site stop-violences-femmes.gouv.fr.

The letter from the French National observatory on violence against women dated February 2017 on "female genital mutilation: measuring the extent of the problem worldwide and in France, campaigning to stop the practice, caring for women who are victims" https://stop-violences-femmes.gouv.fr/IMG/pdf/Lettre_ONVF_11_-_mutilation sexuelle féminine_-_fev_17.pdf

The guidance document from the French Ministry of Social Affairs, Health and Women's Rights "Practitioners encountering cases of female genital mutilation": https://ansfl.org/document/guide-le-praticien-face-aux-mutilations-sexuelles-feminines/

The guidance document from the French Ministry of National Education, Higher Education and Research "Sexist behaviour and sexual violence: prevention, detection, action":

http://cache.media.education.gouv.fr/file/11_Novembre/02/9/Violences_sexuelles_Guide-PDF_2014_Canope_370029.pdf

The French Office for the Protection of Refugees and Stateless Persons (OFPRA), "Asylum applications in cases of female genital mutilation": https://www.ofpra.gouv.fr/fr/asile/la-procedure-de-demande-d-asile-et

Practical guide for professionals. French National Prevention and Health Education Institute (Inpes): inpes.santepubliquefrance.fr. : "Practical guide "Migrants/foreign nationals of precarious status, medico-psycho-social management": http://inpes.santepubliquefrance.fr/CFESBases/catalogue/pdf/1663.pdf

Victims' aid associations

The France victimes federation, providing information, advice and support for victims (one national centre and its 130 local associations) which is specialised in criminal law and victim protection in France. The number in France and Europe is 116 006.

The association Centre de victimologie pour mineurs (CVM). This association does not provide personalised support, but offers information for victims who are minors, families and professionals and refers them to appropriate support. The centre provides:

- contact details for departmental council services responsible for receiving reports giving rise to concern in France (CRIP): https://cvm-mineurs.org/public/media/uploaded/pdf/coordonnees-des-crip-de-france-cvm.pdf;
- guidance documents on information giving rise to concern and reporting, issued by the Departments: https://cvm-mineurs.org/page/guides-sur-l-information-preoccupante-et-le-signalement

Other resources, sites, tools, literature, films

The guidance document from the association Gynécologie sans frontières dated 2010 "Guide for practitioners encountering cases of female genital mutilation": https://www.gynsf.org/mutilation sexuelle féminine/praticienfaceauxmsf2010.pdf

The National GAMS (Group for the abolition of genital mutilation, forced marriage and other traditional practices harmful for the health of women and children) Federation: https://federationgams.org/excision/documentation-msf/. This body provides training tools, links to institutional websites, various media (films, music).

- General public: https://federationgams.org/excision/documentation-msf/
- Professionals: https://federationgams.org/outils-msf/
- Teenage girls: http://www.alerte-excision.org/

Tools for professionals are available at the following links:

- https://federationgams.org/outils-msf/
- https://federationgams.org/wp-content/uploads/2019/02/Unit%C3%A9s-de-soins-aux-femmes-excis%C3%A9es-en-2018-1.pdf .
- an updated list of practices and departments specialised in surgical matters: https://federationgams.org/wp-content/uploads/2019/02/Unit%C3%A9s-de-soins-aux-femmes-excis%C3%A9es-en-2018-1.pdf

Commission pour l'abolition des mutilations sexuelles (Commission for the Abolition of Genital Mutilation - CAMS): http://www.cams-fgm.net/index.php/category/documentation:

- the film "Le pari de Bintou", a 17-minute fictional work. An audio cassette containing text in French, Fulani, Bambara, Soninke and Pulaar, four African languages, encourages discussion and demonstrates that female genital cutting is not a requirement of the Muslim faith. http://www.cams-fgm.net/index.php/gallery/Bintou;
- the comic strip**:** "Excision-parlons-en, Agir en réseau pour mettre fin à l'excision" http://www.excisionparlonsen.org/nos-outils/publications/#ficheReflexe, provides tools:

http://www.excisionparlonsen.org/wp-content/uploads/2018/01/Prevention-vacances-scolaires.-Excision-parlons-en-2.pdf

The campaign for prevention and protection of French teenage girls, Alerte Excision: http://www.alerte-excision.org/

Équilibres & populations: http://equipop.org/fr/equipop-2/

Plan international France: https://www.plan-international.fr/

SOS Africaines en danger (75): https://www.sosafricainesendanger.org/

Maison des femmes de Saint-Denis (93): https://www.lamaisondesfemmes.fr/

Marche en corps (Brittany): https://marcheencorps.wordpress.com/

Association Culturelle Zassa d'Afrique (ACZA) (Brittany): http://www.acza-35.fr/

Association Terre de Couleurs (Brittany): http://terres-de-couleurs.blogspot.com/

Les Orchidées rouges (Nouvelle-Aquitaine): https://www.lesorchideesrouges.org/

Association sojaldicienne de promotion de la santé (ASPROS) (Nouvelle-Aquitaine): http://www.aspros-sante.fr/activites/

International resources

European institutions (In English)
https://eige.europa.eu/gender-based-violence/female-genital-mutilation

End FGM European Network: http://www.endfgm.eu/

United Nations (institutions)

UNICEF: https://www.unicef.org/fr/th%C3%A8mes/mgf

UNICEF report from 2013 "Female Genital Mutilation/Cutting: a statistical overview and exploration of the dynamics of change": https://www.unicef.org/french/protection/files/FGM_Report_Summary_French__16July2013.pdf

WHO: https://www.who.int/topics/female_genital_mutilation/fr/

UNFPA: https://www.unfpa.org/fr/mutilations-g%C3%A9nitales-f%C3%A9minines

For more information

28 toomany: https://www.28toomany.org/

"Les mutilations génitales féminines. État des lieux et des connaissances population 2016": https://www.ined.fr/fichier/s_rubrique/27043/mutilationsgenitales.population.2016.2.fr.pdf

“Estimation du nombre de femmes adultes ayant subi une mutilation génitale féminine vivant en France”, Lesclingand M, Andro A, Lombart T. Bull Epidémiol Hebd 2019;21:392-99. http://beh.santepubliquefrance.fr/beh/2019/21/2019_21_1.html

International (associations)

Inter-African Committee on Traditional Practices affecting the Health of Women and Children (English/French):http://iac-ciaf.net/

Latest statistics and reports by country, in English, French and Arabic: https://www.28toomany.org/

For self-directed study (several European languages, including French): *United to END FGM.* United to END FGM is a European knowledge platform intended for professionals dealing with women and girls affected by female genital mutilation. It is a transnational project, co-funded by the European Union and implemented by a consortium of 12 partners and 4 associate partners across the EU. http://uefgm.org/index.php/about/?lang=fr.

Annexe 8. For staff working in the early childhood sector (regular or drop-in childcare centre) and professionals in contact with minors (teachers, instructors), etc.

It is mandatory to[30] display the notice referenced “119 – Enfance en danger” (refer to the following link[31]) in:

- all schools (from preschools to high schools) and facilities in the early childhood sector (regular and drop-in childcare centres) frequented by minors on a daily basis;
- locations where general practitioners, paediatricians, gynaecologists-obstetricians, nurses, midwives, etc. practise; these may also display the notice (referenced 3919 Violences femmes info)[32].

The 119 helpline is intended first and foremost for minors who are in danger and is open to anyone wishing to talk about the circumstances of a minor potentially in danger. This number can be accessed free of charge in Metropolitan France and in French overseas departments 24/7.

A template of these notices is available below.

For staff working in regular and drop-in childcare centres

It is important that staff working in early childhood care centres are aware of the countries with the highest risk of female genital mutilation.

This will enable them, in concert with the team, to target prevention and initiate dialogue with the families concerned. Leaflets explaining female genital mutilation and the risks involved may be distributed to parents originating from countries where female genital cutting is practiced.[33]

In the routine care of babies and children under 3 years of age (changing nappies, intimate hygiene), signs indicating recent genital mutilation may be observed:

- prolonged absenteeism from the regular or drop-in childcare centre;
- change in the child’s manner;
- blood loss;
- pain while receiving care;
- painful urination;
- wound in the region of the external genitalia (inner thighs and/or rectum).

It is important to note that these symptoms may also have a completely different cause, such as an infection or merely nappy rash.

If in doubt, it is recommended that the childcare centre staff notify the referring doctor of the regular or drop-in childcare centre or of the PMI network.

[30] Article L. 226-8 amended by Law No. 2007-293 of 5 March 2007 - Art. 3 JORF 6 March 2007: “The display of the helpline contact details is mandatory in all establishments and departments frequented by minors on a regular basis”.

[31] Available to download and print:

:https://www.allo119.gouv.fr/sites/default/files/upload/content/partenariats/affiche_a4_2_bd_2.pdf.

[32] Available to download and print:

https://stop-violences-femmes.gouv.fr/IMG/pdf/Affiche_finale_40x60_-_Impression.pdf .

[33] Refer to the download and print link (in French): https://stop-violences-femmes.gouv.fr/IMG/pdf/Depliant_Mutilations2015_FR.pdf and in English: https://stop-violences-femmes.gouv.fr/IMG/pdf/Depliant_Mutilations2015_EN.pdf

For professionals in contact with minors: teachers, instructors, etc.

How to assess the risk of female genital mutilation

Being the daughter of a mother who has undergone female genital mutilation is a significant risk factor. Female genital mutilation is performed at any age and in the family context.

Look for the following signs:

- the minor's father and/or mother and/or family come from a community in which female genital mutilation is performed;
- the family has not ensured that the minor receives regular medical follow-up (for example, blank child health record booklet);
- the family states that members of their community have a very high degree of influence, particularly in the education of young girls.

One of the following criteria may be sufficient to indicate a risk of female genital mutilation

The parents are planning:

- a trip for their daughter outside the country, including in Europe - various reasons may be given (family celebration, illness of a loved one, etc.) - or indicate that they intend to take their daughter outside the country for a prolonged period;
- to return to their country of origin. The trip may only apply to the girls in the family.

A parent, family member or relation expresses their concern about the risk of female genital mutilation for a minor.

The minor:

- confides that she will be taking part in a celebration, a particular ritual, "*like a baptism*", where she will be receiving "*gifts*", "*a pretty dress*", has a chance to "*become a woman*" or that she is going to be away on a long holiday;
- mentions female genital mutilation during a conversation, for example when talking about another child;
- requests an adult's help as she has been told or suspects that she may become a victim of female genital mutilation.

Never downplay this risk when the child is speaking in confidence or is sharing her concerns.

If in doubt, it is recommended that the professional contact the school nurse, the school doctor, the PMI network doctor, the primary care physician.

HOW TO DETECT recent female genital mutilation

In most cases, this form of abuse is invisible and/or not spoken about. Victims do not talk about it of their own accord.

A combination of the signs described below should be taken into consideration and lead the professional to envisage the possibility that the minor is a victim of female genital mutilation:

- running away from home;
- unexpected and prolonged absenteeism from school, failure to return to school after prolonged school holidays (envisage return to country for genital mutilation and/or potentially early forced marriage);
- changes in behaviour and mood: drop in academic grades, dejection, depression, anxiety, poor concentration, eating disorder, sadness, mutism, withdrawal;
- aggression to others and self-harming;
- confiding or asking for help but without explaining what the problem is;
- problems walking, sitting down, pain, sense of discomfort between the legs;
- period pain, resulting in repeated absences frequently unjustified by a medical certificate;
- problems urinating. This may result in repeated requests to go to the lavatory, long periods of time spent in the lavatory;
- fear of or inability to perform some movements: some minors will refuse to take part in sports activities or ask to be excused from physical education without a note from the primary care physician;
- refusal to undergo a medical examination;
- missing sections in the child's health record booklet, or even lack of health record booklet.

If in doubt, it is recommended that the professional contact the school nurse, the school doctor, the PMI network doctor, the primary care physician.

Prevention in the context of health education programmes

Prevention is a key form of leverage in combatting female genital mutilation. Talking about it helps break the taboo and, in some cases, allows people to speak openly.
It is important that young people be informed and made aware of the existence of this type of mutilation, the fact that it is illegal and its harmful effects, as well as of the support and care services available for victims and potential victims.
It is recommended to make use of the compulsory health education programmes for students as part of their syllabus (three sessions a year), as well as the expertise of the public school nursing staff, school doctors, etc.

The notice for the 119 helpline: "Children in danger? Parents in difficulty? It's best to talk about it" is available from the following link:

https://www.allo119.gouv.fr/sites/default/files/upload/content/partenariats/affiche_a4_2_bd_2.pdf

The notice for the 3919 helpline "Violences femmes info" (Women's aid helpline). This notice is available at the following link:

https://stop-violences-femmes.gouv.fr/IMG/pdf/Affiche_finale_40x60_-_Impression.pdf

Participants

The following professional bodies and patient and user associations were consulted to propose experts invited individually to take part in working and review groups:

- French national association of childcare assistants (Anap)
- French childbirth association federation (Ciane)
- French college of general medicine (CMG)
- French nursing college (CIF)
- French national college of gynaecologists-obstetricians (CNGOF)*
- French national college of midwives (CNSF)*
- French national council for paediatric medicine professionals (CNPP)
- French national federation for the abolition of genital mutilation (Gams)*
- Ikambere
- French Ministry of National Education - Directorate General of School Education*
- French society for childhood and adolescent psychiatry and associated disciplines (SFPEADA)
- French society of psychoanalytic group psychotherapy (SFPPG)*

(*) This body proposed one or more experts for this project.

► Working group

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(#) Expert in disagreement with the final version of the guide

► Stakeholders

The following stakeholders were consulted for review purposes.

- French national association of childcare assistants (Anap)
- French childbirth association federation (Ciane)
- French college of general medicine (CMG)
- French nursing college (CIF)
- French national college of gynaecologists-obstetricians (CNGOF)*
- French national college of midwives (CNSF)*
- Commission for the abolition of genital mutilation (CAMS)
- French family planning confederation*
- French national council for emergency medicine professionals

- French national council for paediatric medicine professionals (CNPP)*
- French psychiatry federation (FFP)
- French federation of sex therapy and sexual health (FF3S)
- French national federation for the abolition of genital mutilation (Gams)
- Gynécologie sans frontières*
- Ikambere
- French Ministry of National Education - Directorate General of School Education
- Interministerial mission for the protection of women against violence and the fight against human trafficking (Miprof)*
- French society for childhood and adolescent psychiatry and associated disciplines (SFPEADA)
- French society of psychoanalytic group psychotherapy (SFPPG)

(*) This stakeholder responded to the review phase

► Other parties consulted within the scope of this project

Ms Saphia Guereschi, nurse, Paris.

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Information sheet

Title	Management of female genital mutilation by primary healthcare professionals
Work method	Clinical practice guidelines (CPG).
Purpose(s)	The aim is • to foster primary healthcare professionals' knowledge of female genital mutilation; • to prevent the occurrence of female genital mutilation through improved information delivered by healthcare professionals to women, young girls and parents; • to foster improved care for children, young girls, and women who have undergone genital mutilation; • to harmonise work practices.
Patients or users concerned	Children, teenagers and women who are at a risk or victims of genital mutilation.
Professional(s) concerned	This guideline is aimed at general practitioners, paediatricians, PMI network doctors, school doctors, gynaecologists, gynaecologist-obstetricians, midwives, emergency doctors, psychiatrists, psychologists, sexual health consultants, as well as nurses, childcare assistants and all personnel dealing with children and teenagers in a non-hospital setting or in public or private healthcare facilities.
Requested by	See HAS self-referral.
Sponsor	Haute Autorité de santé (HAS - French National Authority for Health), Department for Good Clinical Practice.
Funding	Public funds.
Project management	Coordination: Dr Joëlle Favre-Bonté, project manager, HAS Department for Good Clinical Practice (department manager: Dr Pierre Gabach). Secretarial duties: Ms Sladana Praizovic.
Documentary search	From month year to month year (see documentary search strategy described in Appendix 2 of the evidence report). Performed by Ms Virginie Henry, with the help of Ms Laurence Frigère (head of Documentation-Monitoring department: Ms Frédérique Pagès).
Authors of the evidence report	Dr Joëlle Favre-Bonté, project manager, HAS Department for Good Clinical Practice.
Participants	Professional bodies and patient and service user associations, working group, review group and other parties consulted: see list of participants.
Conflicts of interest	The members of the working group communicate their public declarations of interest to the HAS, which may be consulted on the DPI-Santé website: https://dpi.sante.gouv.fr/dpi-public-webapp/app/home. They were analysed according to the analysis grid of the HAS guidelines for the declaration of interests and management of conflicts of interest. The interests declared by the working group members were considered to be compatible with their participation in this work.
Approval	Adoption by the HAS College in February 2020.
Updates	Updating of the guidelines will be considered on the basis of data published in the scientific literature or significant changes in practice occurring since their publication.
Other formats	Evidence reports of the best practice guideline, and toolkit guides available to download at www.has-sante.fr

Title	Management of female genital mutilation by primary healthcare professionals
Accompanying documents	“Management of female genital mutilation by primary healthcare professionals” best practice evidence report Toolkit guide: “Assessing risk” Toolkit guide: “Detecting and broaching the issue” Toolkit guide: “How to broach the subject with parents” Toolkit guide: “How to protect a minor patient” Toolkit guide: “In cases of mutilation in a minor patient” Toolkit guide: “How to protect an adult patient”

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