

Female Genital Mutilation / Cutting – Guideline for Care



1. Purpose

This guideline outlines the appropriate care of women and girls who have previously undergone female genital mutilation/cutting (FGM/C).

This care is provided in the knowledge that:

- The practice of FGM/C is internationally recognised as a form of human rights abuse
- The practice of FGM/C is illegal in Australia
- The removal of an Australian resident from Australia for the purpose of FGM/C is illegal in Australia
- Affected women and girls in Australia will generally have undergone FGM/C prior to arrival in Australia
- The provision of good quality care and health information to members of affected communities supports changing attitudes locally and international efforts to eradicate FGM/C
- FGM/C comprises a set of practices of complex background which have been considered essential to belonging to the communities within which it is practised; cultural change is necessary to change attitudes and is supported by knowledge and understanding of the harms caused by FGM/C

2. Definitions

Female Genital Mutilation (FGM): The World Health Organization (1997) defines this as "all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons".

Terminology

Female genital mutilation (FGM) is a term adopted by the World Health Organization in 1991, which reflects the harms caused and violation of human rights represented by the practices. When working with affected women and communities it is generally more respectful to use female genital cutting (FGC) or traditional cutting or their own preferred terms. The hybrid term FGM/C has been adopted by UNICEF in an attempt to bring policy and community approaches together.

Types of Female Genital Mutilation

The different types of FGM are classified by the nature and extent of the damage to and removal of tissue:

Type	Definition
Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
Type III	Narrowing of the vaginal orifice with 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, piercing, incising, scraping and cauterization.

Refer to [appendix 1](#) for details.

FARREP – Family and Reproductive Rights Education Program. A service of the Women's employing staff to provide psycho social and practical support to women and girls affected by FGM/C, including community liaison and health education. The FARREP program was established by the Victorian Department of Human Services in the late 1990s.

African Women's Clinic

Clinical service for women with any health problems or concerns relating to a history of FGM/C. Includes facility to perform deinfibulation under local anaesthetic.

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3. Responsibilities

Staff caring for a woman with genital mutilation should follow this guideline.

4. Guideline

4.1 Legal issues

Staff are expected to be aware of specific legislation in the State of Victoria and elsewhere in Australia which makes it a **criminal offence to perform FGM** (which includes reinfibulation after birth) and/or remove a child from the country to have FGM.

Further information is available from the FARREP Manager, FARREP staff and the Royal Women's Hospital Legal Counsel.

4.2 Referrals and resources

FARREP team: accept direct referrals of women and provide advice and support to clinicians regarding FGM/C. Where possible they will see women on the day of their clinic appointment. FARREP staff will assist women to understand and negotiate care options. Contact 8345 3058.

African Women's Clinic: nurse/midwife-led service with medical support; will see women with any health problems or concerns relating to a history of FGM/C. Deinfibulation when needed can usually be undertaken in the AWC for pregnant women not > 34/40 gestation and non-pregnant women using local anaesthetic. Referrals; via the Internal Referral form OP/20, via external referral from treating clinician or via self-referral by contacting 8345 3037

4.3 Health consequences of FGM/C

Many health problems may be associated with FGM/C, although some women do not consider their health has been affected:

Long term health issues:

- Genital scarring including epidermoid cysts, keloid and neuromas
- Urinary tract problems related to poor flow or urethral damage, such as urinary tract infection, calculi, stricture
- Sexual dysfunction and/or dyspareunia
- Dysmenorrhoea and/or haematocolpos
- Pelvic infection and/or infertility (causation uncertain)
- Psychosexual and psychological problems
- Transmission of bloodborne viruses is at least theoretically possible when instruments are not sterile and used for multiple FGM procedures; not proven to occur
- Obstetric complications including increased risk of prolonged labour, perineal trauma, Caesarean section, postpartum haemorrhage and perinatal mortality are suggested by epidemiological studies

Immediate and short term health consequences are seldom if at all seen in Australia, but may include severe pain, damage to vulva and adjacent structures, haemorrhage, infection, urinary retention, shock, death and of course distress and other psychological consequences.

4.4 Management

General

The aim is to provide holistic care that is culturally sensitive and non judgmental.

Countries where FGM/C is known to be practiced, which have substantial Victorian resident populations include

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Egypt (91% prevalence), Ethiopia (74% prevalence), Eritrea (89% prevalence), Somalia (98% prevalence) and Sudan (88% prevalence). See footnote¹ for other countries.

Women from countries known to practice FGM/C should be asked at their first appointment whether they have undergone female genital cutting or circumcision and if so whether they have experienced any health consequences. Consideration should be given to whether infibulation is likely or possible and whether this is likely to affect health and/or health care. This information should be recorded in the medical record.

With discussion and consent, inspection of the vulva should be performed (sometimes at a subsequent visit if the woman prefers) to assess how much tissue has been removed or damaged and whether infibulation has been performed. Staff member should record findings in detail to assist future health professionals and to minimise the likelihood of needing repeat examinations.

Staff should be aware that women affected by the practice may also be experiencing a range of psychosocial issues that have arisen from their experience of FGM/C and/or war, family separation, migration and resettlement.

It may be during adolescence that girls or young women realise or understand that FGM/C has occurred and they may start to wonder how it will affect them in their evolving sexual and reproductive lives; opportunities must be provided to ask and address these questions.

The gender provider wishes of the woman should be taken into account in regard to care and referral, see [Responding to Requests for Female or Other Health Care Providers](#) guideline.

As well as assessing and responding to the presenting problem, clinicians should:

- consider any impact of FGM/C on the presenting problem
- explore any other symptoms which might arise from FGM/C
- consider/discuss any likely future health implications of FGM/C

Affected women should be offered the opportunity to discuss their history and health care needs relevant to FGM/C with a FARREP worker and/or the African Women's Clinic (AWC). FARREP and the AWC team are available to discuss any general or specific aspects with clinical staff. Specific issues may warrant referral to the Psychosexual Service, gynaecology clinic or other services, such as Choices Clinic or Reproductive Services.

Women who have had infibulation performed (See also guideline on [Deinfibulation Timing and Technique](#) (intranet only))

For women who have a narrowed vaginal introitus as a result of infibulation, the impact on their health and wellbeing should be discussed and consideration should be given to deinfibulation.

Infibulation may cause pain and difficulty with micturition, menstruation and sexual activity, difficulty with vaginal examination when needed (including for cervical screening) and birthing difficulties and complications, specifically delay and tearing.

The degree of narrowing of the introitus and the woman's preference will determine whether and when deinfibulation is necessary.

Deinfibulation may be undertaken when non-pregnant, during pregnancy or at the time of birth, with the timing

¹ >80% prevalence: Djibouti, Guinea, Mali, Sierra Leone

50-80% prevalence: Gambia, Burkina Faso, Mauritania, Liberia

25-50% prevalence: Guinea Bissau, Chad, Cote d'Ivoire, Kenya, Nigeria, Senegal

<25% prevalence: Central African Republic, Yemen, United Republic of Tanzania, Benin, Iraq, Ghana, Togo, Niger, Cameroon, Uganda (source UNICEF report)

Prevalence unknown: Malaysia, India, Indonesia

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determined by clinical, cultural and psychological features, ultimately a woman's choice.

Elective deinfibulation (pregnant or non-pregnant) can usually be undertaken in the African Women's Clinic **Maternity care**

If a woman is from a country where FGM/C is practised, ask about history of FGM/C and any perceived effects:

1. If a woman has had FGM/C, in consultation with FARREP and/or AWC clinic staff and/or an interpreter as appropriate/needed, assess the nature and degree of FGM/C; record in the medical record
2. Consider the likely impact on pregnancy and birth. Consider any other symptoms possibly related to FGM/C and refer for review to AWC Clinic or other service during or following the pregnancy
3. If infibulation has occurred, as early as possible in pregnancy assess the need for deinfibulation, discuss possible timing and make a management plan for antenatal or intrapartum deinfibulation
4. Ensure that the plan is understood and agreed with the woman and clearly documented in her medical record
5. Discussion should include that reinfibulation will not be done due to its potential for harm and its illegality, but suturing such as oversewing of raw edges may be done to support healing
6. Ensure that antenatal discussion occurs regarding the illegality of FGM/C if the baby is a girl, because of the harm caused
7. Even in the absence of infibulation, the presence of scarring after FGM/C may increase the risk of vaginal and/or vulval tearing at birth
8. Be aware of possibly increased risks of prolonged labour, caesarean section and perinatal mortality in the presence of FGM/C
9. Because women with a history of FGM/C are often from countries with very different health systems and services they may be very unfamiliar with the nature, frequency and reasons for interventions such as induction of labour and caesarean section. It is important to take particular care to ensure that proposed treatments and the reasons for them have been understood and to provide further opportunities for discussion and explanation after birth
10. Following delivery of a baby girl, there should be discussion about FGMC, if necessary providing information about its illegality and the harms it causes; arrange follow up and inform eg maternal and child health nurse and/or GP

Women or girls thought to be at risk of FGM/C

If a health professional believes a person to be at risk of FGM/C or to have undergone FGM/C in Australia or to have been removed from Australia for that purpose, there is a responsibility under mandatory reporting provisions to make a report. Social Work staff and/ or FARREP should be consulted about assessing risk and making a report if indicated.

4.5 Additional information for health professionals

Additional information for health professionals can be located on the following page:

- [Female Genital Mutilation / Cutting](#) contains the following information:
 - [FGM Fact Sheet](#) for Health Professionals
 - FGM Fact Sheet: [Female Circumscision and The Law in Australia](#)

5. Evaluation, monitoring and reporting of compliance to this guideline

Compliance to this guideline will be monitored by review of incidents reported through VHIMS.

6. References

1. [Deinfibulation Timing and Technique Guideline](#)
2. [Family and Reproductive Rights Education Program \(FARREP\)](#) – internet page

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3. [Identifying and Responding to Family Violence Policy](#)
4. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). (2010). *Female Genital Mutilation (FGM)*. Retrieved from [https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Female-Genital-Mutilation-\(C-Gyn-1\)-Nov17.pdf?ext=.pdf](https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Female-Genital-Mutilation-(C-Gyn-1)-Nov17.pdf?ext=.pdf) – Copy And Paste in to Browser to View
5. Royal College of Obstetricians and Gynaecologists (RCOG). (2015). *Female Genital Mutilation and its Management (Green-top Guideline No. 53)*. Retrieved from <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg53/>
6. UNICEF (2013). *Female genital mutilation/cutting: A statistical overview and exploration of the dynamics of change*. New York, UNICEF. http://www.unicef.org/media/files/FGCM_Lo_res.pdf
7. World Health Organization (2008). *Eliminating female genital mutilation: an interagency statement*. UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO. Geneva, WHO http://apps.who.int/iris/bitstream/10665/43839/1/9789241596442_eng.pdf – Copy And Paste in to Browser to View
8. Vaughan, C., White, N., Keogh, L., Tobin, J., Ha, B., Ibrahim, M. & Bayly, C. (2014). *Listening to North Yarra Communities about female genital cutting*. Melbourne, The University of Melbourne. <http://newsroom.melbourne.edu/sites/newsroom.melbourne.edu/files/Listening%20to%20North%20Yarra%20Communities%20-%20Final%5B1%5D.pdf>
9. Vaughan, C., White, N., Keogh, L., Tobin, J., Murdolo, A., Quiazon, R. & Bayly, C. (2014). *Female genital cutting/mutilation in regional Victoria: Research to practice*. Melbourne, The University of Melbourne <http://netfa.com.au/downloads/FGMC-in-Regional-Victoria-Report-WEB.pdf>
10. Costello, S., Quinn, M., Tatchell, A., Jordan, L. & Neophytou, K. (2013). *A Tradition in Transition: Female genital mutilation/cutting* (A Literature review, an overview of prevention programs, and demographic data for Victoria, Australia). Melbourne, Family Planning Victoria. <https://www.fpv.org.au/professional-learning-support/resources/publications-research/fgmc>
11. Jordan L, Neophytou K and James C (2014). *Improving the health care of women and girls affected by female genital mutilation/ cutting: A national approach to service coordination*. Melbourne, Family Planning Victoria. <https://www.fpv.org.au/assets/resources/FGM-ServeCoOrdinationGuideNationalWeb.pdf>
12. For RANZCOG trainees and Fellows: Climate e-learning units on female genital mutilation.
13. Cohealth website including a training video 'starting conversations about female circumcision' <http://cohealth.org.au/fgc/>
14. National Education Toolkit for Female Genital Mutilation in Australia: includes a range of resources and links for health professionals. <http://www.netfa.com.au/index.php>

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7. Legislation/Regulations related to this guideline

Crimes Act 1958.

8. Appendices

Appendix 1: [Types of FGM](#)

Appendix 2: [Plan of Care for Women with FGM in Pregnancy](#)

Appendix 3: [Plan of Care for Non-Pregnant Women with FGM](#)

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Types of FGM



Normal female genitalia with clitoris, labia minora and labia majora intact.



Type 1 FGM involves partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

It may be subtle and hard to identify, as genitalia may look intact at first glance.

Even in cases where minimal tissue damage has occurred, there may still be sensory nerve damage, and psychological sequelae.



Type 2 FGM involves partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

This is the form of female circumcision most commonly seen.

A Type 2 presentation can be quite subtle and may be missed by some practitioners when undertaking an examination.

There may be general or periurethral scarring or nerve damage, which may make penetrative procedures uncomfortable.



Types of FGM



Type 3 FGM involves narrowing of the vaginal orifice with 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).

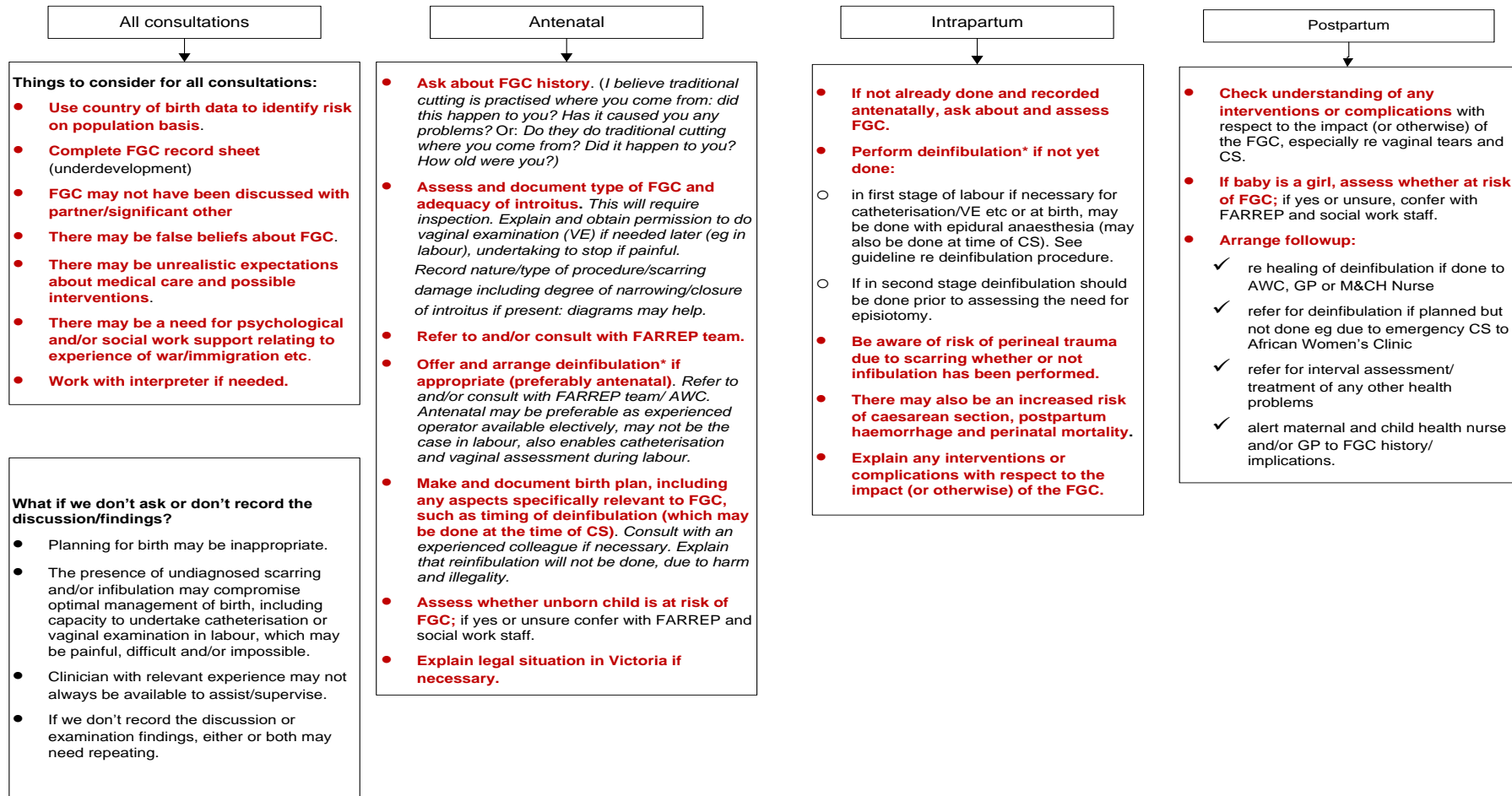
There will be anterior midline scar tissue.

The infibulation may obscure underlying dermatological problems such as abscesses, dermoid and sebaceous cysts, and other scarring. It may predispose to both short and long term health consequences for women.

With Type 3 FGM, the extent to which underlying genital tissue has been removed varies.

The appearance of type 4 FGM will vary according to what has been done, from normal appearance after pricking or piercing through incision scarring to extensive scarring of the vulva and/or vagina.

Plan of Care for Women with FGM in pregnancy



*Refer to [Deinfibulation Timing and Technique Guideline](#) for details

Plan of Care for Non-Pregnant Women with FGM



All consultations

Things to consider for all consultations:

- Use country of birth data to identify risk on population basis.
- Complete FGC record sheet (underdevelopment)
- FGC may not have been discussed with partner/significant other
- There may be false beliefs about FGC.
- There may be unrealistic expectations about medical care and possible interventions
- There may be a need for psychological and/or social work support relating to experience of war/immigration etc.
- Work with interpreter if needed.

Plan of Care for Non-Pregnant Women with FGM

- **Assess and respond to presenting symptoms/concerns.**
- **Ask about FGC history.** (*I believe traditional cutting is practised where you come from: did this happen to you? Has it caused you any problems? Or: Do they do traditional cutting where you come from? Did it happen to you? How old were you?*)
- **Assess and document type of FGC and adequacy of introitus.** *This will require inspection. Explain and obtain permission to do vaginal examination (VE) if needed, undertaking to stop if painful.*
- **Record nature/type of procedure/scarring/damage** including degree of narrowing/closure of introitus if present: diagrams may help.
- **Discuss possible/likely/actual impacts on sexual and reproductive health according to life stage.**
- **Offer and arrange deinfibulation* if appropriate** (prior to sexual intercourse or otherwise as requested).
- **Consider referral** to FARREP, AWC, psychosexual, mental health, contraception, fertility and/or other services depending on symptoms and/or concerns.
- **Explain legal situation** in Victoria if necessary.

What if we don't ask and record?

- Symptoms may be neglected or misinterpreted.
- Woman may avoid cervical screening.
- Vaginal examination in an urgent situation may be unexpectedly painful difficult or impossible.
- As vaginal examination is not routinely done, clinicians may discover at the time of a booked procedure, even after anaesthesia, that catheterisation, curettage for miscarriage or abortion and other gynaecological procedures are not possible without prior deinfibulation, for which consent has not been obtained.
- If we don't record discussion or examination findings, either or both may need repeating.

*Refer to [Deinfibulation Timing and Technique Guideline](#) for details