1. Purpose
The United Nations identifies FGM as a form of human rights abuse on the female child and supports the eradication of this practice.

This guideline outlines the requirements for management of Female Genital Mutilation (FGM) at the Women's.

Origins of practice
The act of Female Genital Mutilation predates both Christianity and Islam and does not pertain to any specific religion. The practice of infibulation is thought to have arisen out of ancient Egypt. It is also suggested that FGM was associated with patriarchal societies in which men needed assurance of family blood lines. Clitoridectomy, a less extreme form of FGM, was known to be used in Western medicine as late as the 1950s as a treatment for perceived 'female psychiatric illnesses'.

Reasons for the practice
These are complex, arising from a belief system based on cultural and social tradition and impinge on the woman's social acceptance and marriageability within her community. While some people believe FGM to be part of religious requirements, this is not the case.

Prevalence of practice
The WHO (2000) estimates that as many as 100 and 140 million women and girls are affected worldwide. This extrapolates to approximately 3 million girls per year at risk of being circumcised. Regions where various extremes of FGM are practiced include Africa, Asia, South America and the Middle East.

Use of terminology
The term Female Genital Mutilation may cause offence to some who practice or have experienced the procedure. Its use in consultation may have the potential to be counterproductive to forming an effective professional relationship with the client and hence detrimental to the provision of her ongoing care for what is a sensitive issue. Accepted forms of description are traditional female surgery or cutting or female circumcision.

2. Definitions
The World Health Organization (1997) defined Female Genital Mutilation (FGM) as "all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons".

Types of Female Genital Mutilation
The different types of FGM are classified by the extent of the surgery:

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1:</td>
<td>Excision of the prepuce, with or without excision of part or all of the clitoris.</td>
</tr>
<tr>
<td>Type 11:</td>
<td>Excision of the clitoris with part or total excision of the labia minora</td>
</tr>
<tr>
<td>Type 111:</td>
<td>Excision of part or all of the external genitalia and stitching / narrowing of the vaginal opening (infundibulation)</td>
</tr>
<tr>
<td>Type 1V:</td>
<td>Unclassified, but includes: pricking, piercing or incising the clitoris and/ or labia, stretching of the clitoris and/ or labia, cauterization by burning of the clitoris and surrounding tissue, scraping of the tissue surrounding the vaginal orifice or cutting of the vagina, the introduction of corrosive substances or herbs into the vagina to initiate tightening, bleeding or narrowing of the vagina, as well as any other procedure which falls under the WHO definition of FGM.</td>
</tr>
</tbody>
</table>
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 and/or remove a child from the country to have FGM.

Further information is available from the Women's Family and Reproductive Rights program (FARREP) Manager, FARREP workers and the Royal Women's Hospital Corporate Counsel.

4.2 Referrals
Referrals to appropriate healthcare providers should be offered to women, including referral to a FARREP worker.

The Women's offers the de-infibulation procedure to both pregnant and non-pregnant women. Contact may be made via FARREP or WHIC.

4.3 Support and resources for staff
Support/advice can be gained from:

- the Women's Family and Reproductive Rights program (FARREP) Tel: (03) 8345 3058, the FARREP Manager Tel: (03) 8345 3071 or
- FGM Liaison Officers - access information as required from: FGM Liaison Officers: Medical, Nursing/Midwifery and Allied Health Staff (Policy and Procedure Manual - intranet only).

4.4 Health consequences of FGM
There are a number of health problems associated with FGM (listed below).

Short term health issues:
- severe pain
- shock
- haemorrhage
- trauma
- infection
- urinary retention
- damage to adjacent tissues
- death can result from infection or haemorrhage

Long term health issues:
- dysuria
- implantation cysts
- dyspareunia
- recurrent UTIs and vaginal infections
- dysmenorrhoea
- PID / infertility
- surgical reversal of scar tissue in order to achieve intercourse.
FGM may have long term effects on the psychosexual and psychological health of those who have undergone the procedure.

In more recent times concern has been expressed about the possible transmission of human immunodeficiency virus (HIV) due to the use of one instrument for multiple FGM procedures, but as yet is not confirmed by research (WHO, 2000).

### 4.5 Management

Women from regions known to practice the procedure should be asked whether they have undergone female circumcision in their first antenatal appointment at the hospital.

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 and/or migration and resettlement.

The aim needs to be holistic care that is culturally sensitive and non judgemental (RANZCOG, 1997).

The gender provider wishes of the woman should be taken into account in regard to care and referral.

Refer to the Women's Health Professional section of their public website: [Female Genital Mutilation / Cutting](#)

If the woman has been affected by FGM, an appointment should be made for her to see a FGM Liaison Medical Officer, who will discuss with the woman her options regarding de-infibulation during pregnancy or labour (refer to flowcharts under Appendices) or she can be referred to the Well Women’s de-infibulation clinic. A list of FGM Liaison Officers can be found at: [FGM Liaison Officers: Medical, Nursing/Midwifery and Allied Health Staff](#).

**Clinical management**

For details including de-infibulation and re-suturing diagrams and instructions, refer to the [FGM Clinical Management Guidelines](#).

**De-infibulation - gynaecology**

A process has been established to enable women to access two options for de-infibulation: under local anaesthetic or general anaesthetic (refer to FGM Flowchart: De-infibulation Service Pathway under Appendices in this CPG).

A woman should be booked via the Women’s Health Information Centre (WHIC) in to the Well Women’s de-infibulation clinic where an assessment regarding suitability for local or general anaesthetic will be conducted.

**De-infibulation during pregnancy and labour**

De-infibulation is a form of corrective surgery.

The available options should be discussed with the woman early in the pregnancy to facilitate appropriate management.

If de-infibulation is requested by a pregnant woman, the procedure is best performed in the antenatal period between 20 and 34 weeks gestation, to facilitate clinical care during pregnancy and labour.

There are three options available for women and all options should be discussed by an FGM Obstetric Medical Officer with the women so she can make an informed choice (refer to Antenatal flowchart):

1. De-infibulation under local anaesthetic in the Well Women’s De-infibulation clinic. Appointments can be made by contacting WHIC.

2. De-infibulation under general anaesthetic conducted by a FGM Gynaecologist Medical Officer. A FGM Obstetric Medical Officer can book a woman onto an FGM Gynaecologist Medical Officer’s surgery list.

3. A woman may choose to be de-infibulated during labour as part of the birth process.

The woman needs to decide what is the best option for her with her health professional.

**Suturing post de-infibulation**

Guidelines for suturing post de-infibulation:

- following de-infibulation, over-sewing of the raw margins of the anterior incision is required to prevent re-infibulation with potentially poor approximation of wound edges.
Guideline

Female Genital Mutilation Guideline

- any extension of the anterior incision above the urethra may be repaired at that time.
- a routine repair of a medio-lateral episiotomy or perineal tear is also frequently required post labour.

4.6 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: What does Victorian law say about Female Genital Mutilation?

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

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

6. References

- FGM Clinical Management Guidelines
- FGM Liaison Officers: Medical, Nursing/Midwifery and Allied Health Staff
- Family and Reproductive Rights Education Program (FARREP) – internet page
- De-infibulation Clinic – internet page
- Violence Against Women: Assessment, Response and Referral Procedure

7. Legislation/Regulations related to this guideline

Not applicable

8. Appendices

Appendix 1: FGM: De-infibulation Service: Pathway
Appendix 2: FGM Flowchart: Antenatal
Appendix 3: FGM Flowchart: Birth Centre
Appendix 4: FGM Flowchart: Postnatal

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The Royal Women’s Hospital Clinical Guidelines present statements of 'Best Practice' based on thorough evaluation of evidence and are intended for health professionals only. For practitioners outside the Women’s this material is made available in good faith as a resource for use by health professionals to draw on in developing their own protocols, guided by published medical evidence. In doing so, practitioners should themselves be familiar with the literature and make their own interpretations of it.

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Appendix 1

FGM: De-infibulation Service: Pathway

Referral to FGM de-infibulation clinic

Referral sources
1. Self referral – contact WHIC or FARREP to make appointment;
2. Internal (FGM Medical Liaison Officers within the antenatal or gynaecology clinics make referrals to WHIC via internal referral form and the women will be booked in for the procedure and will not need another consultation; all other staff can refer to WHIC);
3. External (GPs fax referral to Access Centre to be recorded on Clinical Referral Management List and then place in a tray for WHIC – Well Women’s to triage and make appointments, community FARREP workers and other health professionals can contact FARREP or WHIC directly)

Appointments
WHIC Receptionist will make all appointments; send letter of appointment and book onsite interpreters if required.

Prior to FGM De-infibulation Clinic appointment
FARREP to telephone all women before their appointment to offer support with access to the hospital and address any other issues. FARREP worker will also inform women of what happens at the clinic. First appointment is consultation and assessment with a nurse and if suitable and the woman consents to de-infibulation in the clinic, this will occur in a fortnight.

FGM De-infibulation Clinic
Consultation with consultant nurse specialist, midwife or nurse practitioner is booked. If assessment already undertaken by Medical FGM Liaison Officer (or Medical practitioner who has consulted with Medical FGM Liaison Officer) who has completed an internal referral form and assessment the woman can be booked for procedure via WHIC without a consultation.

Consultation with FARREP worker with the woman’s consent will occur for all women referred to the Clinic.
- First 6 months clinical support will be provided by FGM Liaison Officers: Gynaecologists and FGM Liaison Officer: Midwifery Educator. A roster will be provided to Well Women’s Clinic Coordinator.
- Post 6 months arrangements to be made for medical back up.

Procedure performed in clinic
- Booked in to clinic for next fortnight
- Post procedure information provided and follow-up appointment in clinic booked for all women undergoing procedure.

Procedure performed under general anaesthetic
- Well Women’s nurses to contact Gynaecology Registrar to book women onto Medical FGM Liaison Officers: Gynaecologists Theatre lists.

Unplanned overnight admission
Please contact the Access Manager on pager: 53473

Referrals and follow up
- 4 week follow up appointment for all women post procedure
- external and/or internal services as required
- confirm women accessing antenatal care have an antenatal appointment booked.

Referrals
- Internal and external services as required, including Allied Health at the Women’s and community agencies
1. First Antenatal Visit
- Identification of FGM during taking of history
- Document type of FGM
- Referral to FGM Liaison Officer
- Referral to FARREP worker
- phone: 8345 3058
- Gender provider discussed.

2. FGM Liaison Officer Appointment
- Grading of FGM type
- Discuss and document management plan (additional visits may be required)
- Initiate discussion re: deinfibulation/re-suturing

3. Plan reviewed at 26 weeks and 36 weeks/Discharge Planning
- Revision of birth plan
- Review plan for deinfibulation/re-suturing
- Referrals as required to other services at the Women’s or to external services


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**Appendix 2**
**FGM Flowchart: Antenatal**

[Diagram of the flowchart is shown here, including the following steps and decision points:

- **Pregnancy (Antenatal) Clinic**
- **TeamCare - initial antenatal appointment**
- **FGM identified by TeamCare Midwife or Doctor**
- **FGM or FGM status unknown**
- **Will degree of FGM inhibit labour? Refer to diagrams:** [http://www.thewomens.org.au/FemaleGenitalMutilationFGMClinicalManagement](http://www.thewomens.org.au/FemaleGenitalMutilationFGMClinicalManagement)
- **Discussion of options/management. Request antenatal de-infibulation.**
- **YES**
- **FGM Obstetric Liaison Officer to discuss with the woman options for surgery and then book suitable women for the procedure under local anaesthetic, via WHIC into Well Women’s de-infibulation clinic. If not suitable for the procedure under local anaesthetic, organise theatre booking on Gynaecology FGM LO day surgery list as a priority booking.**
- **NO**
- **Routine antenatal care**
  - Review woman’s birth plan including labor management of FGM at Pre-Admission Clinic
- **Birth**

Refer to CPG for clinical management and pathways: [http://www.thewomens.org.au/FemaleGenitalMutilationCPG_WomensHealth](http://www.thewomens.org.au/FemaleGenitalMutilationCPG_WomensHealth)

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Refer to Birth plan in medical record and Women’s hand-held record
- Contact FARREP Worker if during business hours (if FARREP involved) or discuss referral with the woman.
- Re-affirm patient’s choices.

**Birth Centre**

- **Woman admitted in labour**
- **FGM previously in antenatal clinic**

**YES**

Degree of FGM as assessed by FGM Liaison Officer or Registrar or experienced midwife. Does FGM inhibit birth?

If NO, explain to woman:
- labour management
- policy at the Women’s regarding re-suturing.

**NO**

- **Mode of birth as per birth plan**
- **Discussion with woman/family. Plan prepared in Birth Centre.**

**Normal Vaginal Birth or Assisted Birth**
- Incision(s) as per management plan
- Repair trauma as required as per FGM Clinical Practice Guideline
- Discuss care
- FGM status recorded as operative procedure on birth summary for MCHN/GP

**Caesarean birth**
- Postnatal Ward
Appendix 4

FGM Flowchart: Postnatal

Postnatal

Woman received into postnatal ward by TeamCare Midwife

Baby girl – referral to FARREP is required for counseling of parents regarding FGM.

Has woman undergone deinfibulation during labour?

YES

For women who have had a caesarean birth, the midwife or medical officer should follow up any requests from the woman for deinfibulation by arranging an appointment with Well Women’s de-infibulation clinic to discuss options and future management. Appointments are made via WHIC (ph: 8345 3037 or 8345 3045) or if the woman prefers, refer her to FARREP (ph: 8345 3058)

NO

If yes, the following needs to be incorporated into normal postnatal care:
- Pain relief
- Hygiene
- Healing of deinfibulation scar
- If required offer debriefing regarding birth experience
- Discuss women’s physical, emotional, cultural and social health needs re: deinfibulation, including impact on her relationships
- Referral to FARREP workers at the Women’s
- Referral to Community services as required and/or requested by the woman, i.e. community midwife, community FARREP workers

Woman discharged