OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Female genital cutting / mutilation (FGC/M)

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH, OPH and home visiting (e.g. Visiting Midwifery Services, Community Midwifery Program and Midwifery Group Practice)

This document should be read in conjunction with this Disclaimer

Contents

Aim

To guide management of women with FGC/M throughout their lifespan and for those that are considered at risk.

Key points

1. If deinfibulation is required to facilitate childbirth, women will be offered the choice of when deinfibulation can occur, either just prior to birth or in the second trimester.
2. WNHS is prevented by law (*Criminal Code Amendment Bill 2003*) from re-suturing the FGC/ M closed (re-infibulation).[1, 2] A woman with FGM should be advised of this legislation..

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. FGM is also the terminology used in the West Australian legal system. When working with affected women and communities it is generally more respectful to use female genital cutting (FGC) or traditional cutting. The hybrid term FGC/M is an attempt to bring policy and community approaches together and will be the terminology utilised in this guideline.

Classification of FGC/M[2, 3]

Type 1 – Partial or total removal of the clitoris and/or the prepuce

Type 2 – Partial or total removal of the clitoris and the labia minora with or without excision of the labia majora

Type 3– Narrowing of the vaginal orifice with creation of a covering seal, formed by cutting and appositioning the labia minora and/or labia majora, with or without excision of the clitoris (also known as infibulation)

Type 4– All other harmful procedures to the female genitalia for non-medical purposes e.g. pricking, piercing, incising, scraping and cauterisation

Definitions

Appositioning- Bringing together

Infibulation – Reducing the vaginal orifice through creation of a covering seal by cutting and appositioning the labia (minora and / or majora), with or without clitoral excision.[2]

Deinfibulation – A surgical procedure to re-open the vaginal introitus in women living with type 3 FGC/M. A health professional performs a mid-line incision along the scar tissue that covers the vaginal introitus The cut edges are then sutured apart, allowing the introitus to remain open.[2]

Re-infibulation – A procedure that narrows the vaginal orifice after deinfibulation.[2]

Background information

The World Health Organisation (WHO) defines female genital cutting/ mutilation (FGC/M) as “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical purposes”.[3] The WHO estimates there are more than 200 million girls and women alive today who have undergone FGC/M;[2, 3] commonly performed between infancy and age 15.[3, 4]

The motivation for communities to practice FGC/M varies widely but includes psychosexual and sociological reasons, hygiene and aesthetic reasons, and myths, and it is a practice that is deeply entrenched in cultural heritage and traditions. It is also important to note that patients who have experienced FGC/M are three times more likely to experience family and domestic violence/ intimate partner violence and any form of gender based violence[5].

FGC/M is illegal in Australia.[2] The Western Australia (WA) Criminal Code Amendment Bill (external website, PDF, 310KB) came into effect in 2004 identifying FGC/M as a crime, stating that a person performing FGC/M or taking a person from Western Australia for the purpose of subjecting a child to FGC/M is liable for imprisonment.[6] FGC/M is a violation of the human rights of girls and women.[2, 3]

Type 1, type 2 and type 4 FGC/M account for approximately 90% of all cases, with the remaining 10% classified as type 3.[4, 7] Women with type 1 and 2 FGC/M are unlikely to experience antepartum, intrapartum or postpartum difficulties unless there is significant scarring; Type 3 usually leads to complications due to narrowing of the introitus.[8].

Communities living in WA whose country-of-origin practice FGC/M

According to the census report 2021, the countries identified below were the birth places of our migrant women with the highest prevalence of FGC/M in their country of origin.

- Somalia; Prevalence of 97.9%[9], mostly type 3
- Sudan; Prevalence of 86.6%[9], mostly type 3
- Ethiopia; Prevalence 65.2%[9], ‘cut flesh removed’
- Eritrea; Prevalence 83%[9], type 1 and type 3
- Egypt; Prevalence 87.2%[9], type 1 and 2 are the most common
- Indonesia; Prevalence 50% (only measured among girls aged 0-11)[9]

Health consequences of FGC/M

There are no known positive health benefits associated with FGC/M.[2] Women who present with complications should receive care that is culturally responsive and non-judgmental.

The health consequences of FGC/M are related to the type of FGC/M. Type 3 is associated with more health consequences of greater the severity.

Long term health issues[10]:

- Genital scarring including epidermal cysts, keloid and neuromas
- Urinary tract problems related to poor flow or urethral damage, such as urinary tract infection, calculi and strictures
- Bladder dysfunction, incomplete emptying from bladder stretch injury
- Sexual dysfunction and /or dyspareunia
- Chronic pelvic pain
- Pelvic floor dysfunction
- Dysmenorrhoea and/or haematocolpos (blood in vagina)
- Pelvic infection and/or infertility (causation uncertain)
- Psychosexual and psychological problems including anxiety, depression and post-traumatic stress disorder (PTSD)
- Obstetric complications including increased risk of prolonged labour, perineal trauma, caesarean section, post-partum haemorrhage and perinatal mortality
- Related- Increased risk of cervical cancer, this may be due to decreased rates of screening

Immediate and short-term health consequences are seldom seen in Australia, if at all but may include severe pain, haemorrhage, infection, urinary retention, death and psychological distress.

Considerations

General considerations

1. Provide a culturally sensitive environment when discussing FGC/M e.g. the presence of a female midwife/doctor during examination when possible.
2. Utilise an interpreter when indicated. It is important to note that many interpreters are part of the community that the patient is from; therefore, it is highly recommended that a phone interpreter be engaged to ensure confidentiality.
3. If a patient discloses that she has experienced some form of FGC/M, it is then recommended for the FGC/M Flip Chart to be used to educate the patient about the type she has experienced and for the clinician to cover all aspects of FGC/M.
4. Consider the increased risk of family domestic violence (FDV), including intimate partner violence and family violence and ensure adequate screening. Refer to Social Work as indicated.
5. All women with FGC/M to be offered support by WNHS Psychological Services, Physiotherapy and Social Work. The roles of each profession will need to be explained.
6. Consider level of health literacy and previous access to health services. It is important to ensure that proposed treatments and the reasons for them have been understood and to provide further opportunities for discussion and explanations.

- Where appropriate the woman's husband or partner should be involved in the discussions. Health professional resource: UNICEF: Engaging boys and men to end FGC/M (external website).

7. When speculum examination is performed the size of the speculum is determined by the size of the introitus. Consider the use of a paediatric speculum.
8. Consider compliance with routine screening of cervical cancer and sexually transmitted infections (STI). See Australian Government, Department of Health and Aged Care National Cervical Screening Program Policy (external website).
9. To have full assessment of bladder function by Urology CNC/NP antenatally and preoperatively if having deinfibulation.

Antenatal considerations

1. All women are asked at booking visit if they or any family members have been "nicked", cut or circumcised.
2. Document in Women-Held Pregnancy Record and patient's medical record.
3. All women who have been identified with FGC/M antenatally are to be **referred to Social Work** to discuss Australian legal requirements.
4. Women who disclose FGC/M, or are unsure if FGC/M has been performed, should have an assessment of the vulva early in the antenatal period.
5. Women attending a midwives' clinic and identified as having undergone FGC/M at the booking visit should have the antenatal visit at 24 weeks gestation with medical staff. If a woman attends late for the booking visit the next appointment should be made with the medical staff to formulate a complete management plan and to provide counselling. Documentation of this visit to be recorded in the medical record.
6. Pregnant women with type 3 FGC/M are to be offered deinfibulation during pregnancy (second trimester) or intrapartum. The timing of the procedure should depend on patient preference, access to health care facilities and health care provider's skill level.[10]
7. Deinfibulation needs to be discussed with team consultant. During the antenatal period, discussion should include potential impacts of FGC/M on pregnancy and birth, such as:
    - potential difficulty in performing vaginal examination in some women[11]
    - the possible need for deinfibulation and/or a medio-lateral posterior episiotomy.[11] Advise the woman that an episiotomy or de-infibulation maybe be required during birth (usually with Type 3).
    - bladder management and increase risk for urinary tract infection[11]
    - difficult application of a fetal scalp electrode or fetal blood sampling, when required[11]
    - risk for perineal tearing, delay in the second stage of labour

Postpartum management

1. Monitor the urine output. See Clinical Guideline, Obstetrics and Gynaecology: Bladder Management.
2. For women who have had intrapartum deinfibulation education needs to include; expected anatomical and physiological changes (e.g. expected labial appearance, potential faster urination, increased vaginal discharge, change to menstrual flow and likely changes to sexual function.[2]
3. All women with FGC/M are seen by a Physiotherapist prior to discharge. Physiotherapy will screen for bladder issues (recurrent urinary tract infections, complete emptying), lower urinary tract symptoms, incontinence, pelvic pain, sexual dysfunction.
4. Document in STORK- free text in Child Health and Discharge summary.
5. Parents, with the birth of a girl, should be seen by Social Work prior to discharge if they have not been seen antenatally. They are to be advised of the legal implications regarding FGC/M in Australia. (If Social Work is unable to review the client and family prior to discharge Social Work are to make a referral to the Child Health Nurse for follow-up education)
    - Education should include advising that FGC/M is illegal, and that a person who takes a child or arranges for a child to be taken from WA with the intention of having them subjected to FGC/M is liable to imprisonment for 10 years. Additionally, a person who performs FGC/M on another person is guilty of a crime and liable to imprisonment for 20 years, and it is not a defence that the person or their parent or guardian consented to the practise..[6]
    - When a child is at risk of being subjected to FGC/M (e.g. a female born to a woman with FGC/M or who has sisters with FGC/M), information on health issues associated with FGC/M should be provided to parents.[1]
    - A health professional who suspects a person has been subjected to, or will be subjected to, FGC/M in Australia should contact Department of Communities
    - For FGC/M screening and response in children under 18- see FGC/M section within Department of Health WA, Protecting Children 2020 (external website).[12]

Gynaecological de-infibulation

1. Women may attend a Gynaecology clinic for de-infibulation to treat complications associated with FGC/M.
2. Woman may attend for deinfibulation to achieve penetrative sexual intercourse or improve sexual arousal.
3. Referrals to the multi-disciplinary team including Social Work, Psychology and Physiotherapy may be indicated. At WNHS, a referral to the Complex Care Gynaecology Coordinator can be considered to coordinate this preoperative care.

4. Pre-operative education and assessment need to include:
    a) Safety: Does seeking this operation put her at an increased risk of family violence? Is she going against family beliefs? How isolated/supported is she?
    b) Education:
        - Deinfibulation is likely to change flow of menstrual blood and they may need different menstrual products.
        - Deinfibulation is likely to change vaginal discharge which is normal.[13]
        - Address what the vulva may look like after de-infibulation as there is evidence that women may not like the look of their vulva after de-infibulation.
        - Deinfibulation may change bladder function and alter urinary flow.[13] Need to ensure bladder emptying and will require education on good bladder habits.
        - Deinfibulation will allow penetrative sex. Sex may still be painful after de-infibulation and education including anatomy of clitoris, arousal, positioning and pelvic floor relaxation may be indicated.
        - Changes to pain, need to be considered in relation to subjective assessment findings pre-operatively.
        - Operative procedure and likely recovery time frames.
        - With all education, need to consider level of health literacy.
        - Consider educating husbands/partners if appropriate.[14]
        - Discussion around beliefs on FGC/M, virginity, sexuality, and genital self-image.
    c) Mental health[13]; trauma / PTSD will need to be addressed prior to surgery and may impact on type of anaesthetic utilised.
    d) Information on anaesthesia (local, locoregional or general), advantages, disadvantages and follow-up.

Deinfibulation technique

For further details with accompanying diagrams, refer to RANZCOG guideline Female Genital Mutilation/Cutting (external website, PDF, 903KB): 'Appendix: Deinfibulation technique (illustration)' (pp30-33).

1. Gently lift the skin flap with a pair of forceps or fingers.
2. Infiltrate with local anaesthetic, along the midline[2] and either side of the fan shape. Allow time for local anaesthesia (LA) to take effect. See 'infiltration' within Perineal Care and Repair and Medication Monograph: 'Lidocaine (Lignocaine)'.
3. Assess the length of the incision by inserting a finger under the skin flap when possible. If not possible use a pair of forceps to guide the posterior blade of the Mayo scissors carefully avoiding the urethral meatus.

4. Perform an anterior incision along the midline of the skin flap until the urethral meatus can be visualised and the anterior flap is opened completely.[2]
5. Apply gentle pressure to control any bleeding.
6. The skin edges are apposed with fine, rapidly absorbable suture, using a small number of interrupted sutures or a continuous suture.[2]
7. Ensure adequate analgesia is prescribed and provided.[2]
8. Provide advice regarding wound management and body changes.[2]

Additional considerations in labour:

a. For LA infiltration use a superficial angle on the needle to protect the baby's head and the clinician.[2]
b. The raw skin edges will retract during the birth.[2] Control the birth, carefully monitoring perineal stretching as scarred tissue may not stretch well and there may be vaginal scarring that is not visible.[2]
c. Prepare and monitor, assessing to see if a mediolateral episiotomy is also required e.g. if tightness or evidence of severe scarring.[2] If a medio-lateral incision is required, the incision should be at 60 degrees to the midline.[2]
d. Repair after birth. Suture to promote haemostasis and prevent re-anastomosis or the raw edges.[2] For repair of a mediolateral episiotomy see Clinical Guideline, Perineal Care and Repair: 'Suturing: Episiotomy and Genital Laceration'.

Identifying a child at risk of FGC/M[1, 12]

- Any female child or adolescent who comes from a country where FGC/M is prevalent or community who practices FGC/M.
- Any newborn female whose mother or sisters have been subjected to FGC/M must be considered at high risk of FGC/M, as must other female children within the extended family.
- The specific age that FGC/M was performed for each female member should be recorded as reference to identifying the risk period for unaffected females within the family.
- Those families less integrated into the community or where children or mothers have limited contact outside the immediate family and have limited access to information on FGC/M are more likely to be subjected to FGC/M.
- Signs that FGC/M is imminent include: a female elder visiting from the country of origin; the child referring to a 'special procedure' she is to undergo; the child requesting help if she suspects she is at imminent risk; parents or the child indicating the child is going out of the country for a prolonged period; the child or family are considered to be a flight risk.

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Related legislation and policies

Legislation: *Criminal Code Amendment Bill 2003* (s306) Parliament of Western Australia.

Department of Health WA:

- Guidelines for Protecting Children (2020)
- National Cervical Screening Program – National Cervical Screening Policy
- Legal and Legislative Services ; Legal policy framework

Related WNHS policies, procedures and guidelines

WNHS Clinical Guidelines, Obstetrics and Gynaecology:

- Bladder Management
- Perineal Care and Repair: Suturing: Episiotomy / Genital Laceration

Useful resources (including related forms)

WNHS:

- Women's Health Strategy and Programs (available to WA Health staff via HealthPoint): Female Genital Cutting and Mutilation (webpage and resources) (available to WA Health staff through HealthPoint)
- Female Genital Cutting / Mutilation Flip Chart: Talking with women: An educational resource
- MyLearning: Female Genital Cutting / Mutilation (WNHS e-learning package for health professionals)

Research & Resources | FGM/C Research Initiative (fgmcri.org) (external webpage)

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Version history

Version number	Date	Summary
1	Dec 2008	First version. Originally titled B1.3.3 'Female Genital Mutilation' DPMS Ref: 5256
2	Sept 2011	Changed to B1.3. Routine review.
3	Sept 2014	Added complications and identifying a child at risk. Ask all women at booking visit. Documentation in medical record and hand-held record; refer to social work. More information around legal implications added to postnatal education section for parents with the birth of a girl.
4	Dec 2015	Amendment- Antenatal culturally sensitive practice- When asking about FGM, it is recommended that a female interpreter be engaged.
5	Feb 2019	To ensure the language used is sensitive and inclusive of all communities, changed to 'Female Genital Cutting / Mutilation' (FGC/M). Background and identifying a child at risk of FGC/M updated. Patients who have experienced FGC/M are three times more likely to experience family and domestic violence/ intimate partner violence and any form of gender-based violence. Interpreters may be part of the community that the patient is from, so it is highly recommended that a phone interpreter is engaged to ensure confidentiality.
6	Feb 2022	• If a patient discloses they have experienced some form of FGC/M, it is recommended the FGC/M Flip Chart be used to educate the patient about the type they experienced and for the clinician to cover all aspects of FGC/M with the patient. • All women with FGC/M can be offered support by WNHS Psychological Services. • Offer the woman referral to Physiotherapy services to assist with voiding changes after de-infibulation. • All postnatal women with FGC/M are seen by a Physiotherapist before discharge.
7	Feb 2024	• Terminology updated, definitions added; updated health consequences of FGC/M; lists communities living in WA whose country-of-origin practice FGC/M • Consider risk of FDV; Consider health literacy during discussions to ensure information about the procedure is understood. Offer and explain WNHS services, including Psychological Services, Physiotherapy and Social Work. • To have full assessment of bladder function by Urology CNC/NP antenatally and preoperatively if having deinfibulation • Maternity patients- The timing (antenatal or intrapartum) of deinfibulation should depend on patient preference, access to

		health care facilities and health care provider's skill level. Additional considerations in labour added and postpartum section updated, including expectations, physiotherapy, and social work. • New Gynaecological de-infibulation chapter- read section