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 antenatal, intrapartum and postnatal management of a women with FGC/M.

Key points

1. If deinfibulation is required to facilitate childbirth, it is usually performed just prior to birth, but may be performed late in the second trimester.[9]
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 during the antenatal period.

Background information

The World Health Organisation (WHO) defines Female Genital Cutting/ Mutilation (FGC/M) as “all procedures involving partial or total removal of the female external 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 who have undergone FGC/M;[4] commonly performed between the ages of 4 to 10 years.[5] In some communities the procedure is performed just before marriage[5], during pregnancy, or post birth.[6]

The motivation for communities to practice FGC/M varies widely but includes psychosexual and sociological reasons, hygiene and aesthetic reasons, and myths,[3] 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[7].

FGC/M is illegal in Western Australia.[8] The WA Criminal Code amendment bill came into effect in 2004 identifying FGC/M as a crime, and states “a person performing FGM or taking a person from WA for the purpose of subjecting a child to FGM is liable for imprisonment”.[9] RANZCOG condemns the practice of FGM as a violation of the human rights of girls and women.[8]

Type I, type II and type IV FGC/M account for approximately 90% of all cases, with the remaining 10% classified as type III.[6] A recent study revealed that women with FGC/M are at higher risk for caesarean section, postpartum haemorrhage (PPH), episiotomies, longer hospital stays, increased resuscitation of the infant, and inpatient perinatal death.[10] Women with type I and II FGC/M are unlikely to experience antepartum, intrapartum or postpartum difficulties unless there is significant scarring Type III usually leads to complications due to narrowing of the introitus.[11]

It is also important to note that the WNHS altered the use of the terminology by referring to the practice as female genital cutting/mutilation, to ensure that the language used by health professionals is sensitive and inclusive of all communities.

Communities practicing FGC/M

- Western, eastern and north-eastern regions of Africa[4, 8]
- Some countries in Asia and the Middle-East[4, 8]
- Type l FGC/M is more commonly performed in Ethiopia, Eritrea and Nigeria.[11]
- Type II FGC/M is performed mainly in Sierra Leone, Gambia and Guinea.[11]
- Type III FGC/M is predominantly performed in Somalia and Northern Sudan,[11] Djibouti, parts of Egypt, Ethiopia, Eritrea, Kenya, Mali, Mauritania, Niger and Senegal.[9]

Classification of FGC/M[3]

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

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

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

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

Complications of FGC/M

There are no known positive health benefits associated with FGC/M.[8] Women who present with complications should receive care that is culturally responsive and non-judgmental.[8] Referral to Psychological Services or counselling may be required depending on the individual clinical situation.[8]

Acute complications	Long-term complications
• Severe pain[4, 12] • Shock[4] • Haemorrhage[4, 12, 13] • Urinary retention[4, 12] • Bony fractures[5] • Injury to nearby genital tissue[4] • Death[12, 13] • Infection[12, 13]; Sepsis or tetanus[4]	• Bladder dysfunction and urinary tract infections[4, 5, 8] • Chronic localised neuropathic pain[8] • Menstrual problems (e.g. retained menstrual clots)[8] • Infertility[4, 5] and increased risk for obstetric complications[4, 5] • Increased uro-gynaecological surgical procedures[4] • Difficulty with minor gynaecological procedures (e.g. Cervical Screening Test)[8] • Abscess and fistula formation[5] • Chronic pelvic infections[5], Hepatitis and HIV[12] • Sexual dysfunction[5, 8] • Recurrent vaginal infections[5, 8] • Keloid scar formation[5, 8] and cysts[4, 8, 12] • Psychological disorders e.g. post-traumatic stress[12], anxiety, depression[8]

Identifying a child at risk of FGC/M[2]

- Any female child or adolescent who comes from a 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.

Antenatal management

1. Provide a culturally sensitive environment when discussing FGC/M e.g. the presence of a female midwife/doctor during examination when possible. It is recommended that a female interpreter be engaged. 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.
2. All women are asked at booking visit if they or any family members have been "knicked", cut or circumcised.
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 with the patient.
4. Document in the National Women-Held Pregnancy Record and patients notes including special instruction sheet.
5. All women who have been identified with FGC/M are to be **referred to Social Work** to discuss Australian legal requirements.
6. All women with FGC/M can be offered support by WNHS Psychological Services.
7. Women who disclose FGC/M, or are unsure if FGC/M was performed, should have an inspection of the genitalia early in the antenatal period to determine the type.

8. Women attending a midwives' clinic at the booking visit with FGC/M should have the antenatal visit at 24 weeks gestation with the medical staff. If a woman attends late for the booking visit the next appointment should be made with the medical staff to formulate a management plan and to provide counselling. Documentation of this visit is recorded on the MR004.
9. Women who are considered to have an inadequate vaginal introitus for childbirth may be offered the option of antenatal de-infibulation late in the second trimester[8] after consultation with the team consultant. It is essential that the woman's husband or partner is involved in the discussions. If de-infibulation is performed the woman should be warned about voiding changes that may result i.e. a direct stream of urine rather than dribbling, and also of sexual changes.[14] Offer the woman referral to Physiotherapy services to assist with voiding changes after de-infibulation.
10. During the antenatal period discussion should include FGC/M maternal consequences, such as:
    - potential difficulty in performing vaginal examination in some women[12]
    - the possible need for an anterior episiotomy and/or a medio-lateral posterior episiotomy.[12] Advise the woman that anterior episiotomy or de-infibulation will normally be required during birth (usually with Type III).[14]
    - bladder management and increase risk for urinary tract infection[12]
    - difficult application of a fetal scalp electrode or fetal blood sampling, when required[12]
    - risk for spontaneous laceration, including possible fistula formation
    - delay in the second stage of labour
11. 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.[5, 11]

Intrapartum management

Intrapartum epidural can be offered[12] to women who find vaginal examinations difficult to tolerate.

Performing an anterior episiotomy

When an anterior episiotomy is required it should be performed before the presenting part distends the perineum.[14] The timing to perform an anterior episiotomy may be determined by the ability to perform procedures e.g. catheterisations and vaginal examinations. The decision to perform an early anterior episiotomy earlier in labour shall be done in consultation with the medical team.

An anterior episiotomy shall be performed by midwifery or medical personnel familiar with the procedure, or by an accoucheur supervised by personnel competent in performing the procedure.

1. Gently lift the skin flap with a pair of forceps or fingers.
2. Infiltrate with local anaesthetic along the midline and either side of the fan shape. Allow time for local anaesthesia to take effect.[14] 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.[14]
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.[14]
5. Apply gentle pressure to control any bleeding.[14]
6. Assess to see if a mediolateral episiotomy is also required.[14]
7. After the birth the skin edges are apposed with fine interrupted sutures or a continuous subcuticular suture.[14]
8. For repair of a mediolateral episiotomy see Clinical Guideline, Perineal Care and Repair: 'Suturing: Episiotomy and Genital Laceration'
9. Provide advice regarding vulval/ perineal hygiene and healing.[14]

Postpartum management

1. Monitor the urine output. See Clinical Guideline, O&G: Bladder Management.
2. Advise the woman who has had an anterior episiotomy of changes in the voiding stream.[14] All women with FGC/M are seen by a Physiotherapist before discharge.
3. Parents, with the birth of a girl, should be advised of the legal implications regarding FGC/M in Western Australia (WA) and throughout Australia.
    - This 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 mutilation.[15]
    - 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.[2]
    - A health professional who suspects a person has been subjected to or will be subjected to FGC/M in Australia should contact 'Legal and Legislative Services' for information.[16]
    - Women should be seen by a Social Worker prior to discharge.
    - Document in STORK- free text in Child Health and Discharge summary.

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Related legislation and policies

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

Department of Health WA:

- Guidelines for Protecting Children (2015)
- Legal and Legislative Services

Related WNHS policies, procedures and guidelines

WNHS Clinical Guidelines, Obstetrics & 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)
- NMHS Moodle: Female Genital Cutting / Mutilation (e-learning package for health professionals)

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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.

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