The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

Female Genital Mutilation (FGM)

This statement has been developed and reviewed by the Women's Health Committee and approved by the RANZCOG Board and Council.

A list of Women's Health Committee Members can be found in Appendix A.

Disclosure statements have been received from all members of this committee.

Disclaimer This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: March 1994
Current: November 2017
Review due: November 2020

Objectives: To provide the RANZCOG position on Female Genital Mutilation (FGM).

Target audience: All health practitioners, patients and the public.

Validation: This statement was compared with other guidance on this topic from the RCOG,[1] WHO,[2] and UNICEF.[3]

Background: This statement was first developed by RANZCOG in March 1994 and was revised in July 2010 to provide advice on Female Genital Mutilation (FGM).

Funding: The development and review of this statement was funded by RANZCOG.

1. Patient summary

Female genital mutilation (FGM) is the practice of injuring or removing part or all of the labia, clitoris, and other parts of the female genitals for reasons that are not part of medical treatment. RANZCOG condemns the practice of any form of FGM because these practices violate the human rights of girls and women. Doctors, nurses, and others are asked to be aware of women and girls who are at risk of FGM, and these procedures are illegal in Australia and New Zealand.

It is important to explain the fact that FGM is illegal in Australia and New Zealand to women and their families, especially those with daughters. Measures that aim to prevent FGM, such as community education, information and support, are available. Health care workers who are concerned that a child may be at risk of, or has undergone, FGM have legal obligations to report this.

2. Definition

Female Genital Mutilation (FGM) is defined as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons (WHO).

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) **condemns the practice of any form of FGM as a violation of the human rights of girls and women.**

3. Terminology

The term “mutilation” is problematic when dealing with women who have undergone this procedure. Alternative terminology such as “cutting” or “circumcision” will usually be more appropriate when engaging with communities that perform this practice. The term “infibulation” is used to describe FGM type 3 (see Classification below). “Deinfibulation” is the surgical procedure to restore the vaginal introitus in a woman who has previously undergone type 3 FGM.

4. The law in Australia and New Zealand

Female genital mutilation is prohibited by specific legislation in all States, Territories of Australia and in New Zealand. Moreover, there are provisions for mandatory reporting of children at risk.

Such legislation has been introduced because of the harmful effects of FGM. It must not be performed in any form by doctors, midwives, nurses or any other persons regardless of the apparent persuasiveness of any individual case. Legislation also specifically prohibits providing any assistance with procuring or facilitating the performance of FGM whether within Australia/NZ or overseas where the female being subjected to FGM is an Australian/NZ citizen or permanent resident.

5. Classification of types of FGM procedures (WHO)

Type	Definition
1	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)
2	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)
3	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)
4	All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, a incising, scraping and cauterising

6. WOMEN AT RISK OF FGM

Clinicians should be aware of the countries where FGM is commonly performed. The strongest risk factor for a woman to have undergone FGM is her country of origin, and specifically where she spent her childhood years. FGM is most commonly performed in parts of Africa (especially north-eastern Africa), with migrants from Somalia, Sudan, Ethiopa, and Egypt comprising the majority of affected women seen in Australia and NZ. In Sudan and Somalia more than 80% of women have undergone FGM (mostly Type 3). It is, however, also practised in a few populations in the Middle East and Asia.

7. LONG TERM HEALTH CONSEQUENCE OF FGM

Clinicians in Australia and NZ are unlikely to be called upon to deal with the immediate complications associated with FGM, given that this procedure is illegal in all jurisdictions of both countries.
There are many long term negative health consequences associated with FGM as listed below (WHO 2008). There are no known positive health benefits associated with FGM.

Potential gynaecological consequences of FGM include:

- Impaired sexual function: apareunia, dyspareunia, anorgasmia, reduced sexual pleasure
- Urinary tract: recurrent urinary tract infections, prolonged voiding time, difficulty obtaining a mid-stream urine specimen for analysis
- Recurrent vaginal infections, infertility
- Menstrual problems: haematocolpos, retained menstrual clots, dysmenorrhoea
- Local scar complications: keloid, dermal cysts
- Local pain: chronic neuropathic pain
- Difficulty with minor gynaecological procedures: eg Pap smear, bladder catheterisation
- Psychological: post-traumatic stress disorder, anxiety, and depression

Women presenting with health issues related to FGM should be provided with culturally responsive, non-judgemental health care. It is important for clinicians to demonstrate knowledge and respect. Considering the potential psychological sequelae of FGM, healthcare provision should be holistic with referral for psychological support and counselling where appropriate.

8. FGM AND PREGNANCY

The identification of women who have undergone FGM is an essential part of antenatal care. Identification enables appropriate discussion of antenatal care and management of labour. If needed, antenatal deinfibulation should be offered. Examination findings (including diagrams if appropriate) and management plan should be carefully documented in the patient record in order to reduce the need for unnecessary repeat examinations.

The intrapartum issues related to FGM are directly correlated to the degree of narrowing and scarring of the vaginal introitus. FGM would generally not be an indication for delivery by caesarean section.

Potential pregnancy associated consequences of FGM include:

- difficulty with vaginal examination in pregnancy and labour
- difficulty with intrapartum procedures (eg amniotomy, placement of a fetal scalp electrode)
- difficulty with urethral catheterisation if required
- increased likelihood of severe perineal trauma and vaginal laceration
- increased likelihood of episiotomy
- increased risk of caesarean section
- fear of childbirth

In low income countries, FGM is associated with an increased risk of perinatal death. It is not clear whether this association persists in high income countries with optimal obstetric care.

In women where antenatal assessment indicates that adequate vaginal examination is unlikely to be possible due to introital narrowing, it is advisable to offer antenatal deinfibulation (see below). This is most commonly performed during the second trimester but can be carried out at any time during

pregnancy, or in the first stage of labour if necessary. FGM is not usually an indication for caesarean section.

In women with a history of FGM who have not required antenatal deinfibulation (and even in some who have), anterior episiotomy may be required at the time of delivery, and as such a birth attendant with appropriate knowledge and expertise should be available.
It is not necessary to routinely perform a mediolateral episiotomy in women with a history of FGM, whether or not deinfibulation has been performed, but it will frequently be required due to increased scarring and lack of normal skin elasticity at the vaginal introitus.

Reinfibulation for non-medical purposes related solely to cultural, religious or other social customs is against the law.

9. DEINFIBULATION

Deinfibulation is a minor surgical procedure undertaken to separate the fused midline structures and restore a vaginal introitus that is adequate for sexual function, normal voiding, menstruation and to facilitate vaginal examinations, speculum examinations for Pap smears and intrapartum care. The procedure can usually be performed under local anaesthetic. However the psychological needs of the woman need to be considered and the procedure can be offered under intravenous sedation in the operating theatre. The incision should extend anteriorly enough to allow visualisation of the external urethral meatus but not far enough to injure the buried clitoris or clitoral stump (potential for heavy bleeding). The skin edges should be approximated with a fine absorbable suture.
Reconstructive surgery has been reported with the aim of restoring clitoral sensation and improving sexual pleasure. However, at present there is insufficient evidence to support this practice.

10. PREVENTION OF FGM

The legal status of FGM in Australia and New Zealand should be explained to women and their families, especially those with daughters. Most jurisdictions have support measures directed towards the prevention of FGM through community education, information and support. In the event that clinicians are concerned that a child may be at risk or has undergone FGM, discussion with appropriate services must occur with further referral made as required.

11. Other suggested reading

1. RCOG Statement No. 53, May 2009. Female Genital Mutilation and its management. Available at: |http://www.rcog.org.uk/female-genital-mutilation-and-its-management-green-top-53

2. http://www.fgm.co.nz/fgm-in-nz/

3. Simpson J, Robinson K, Creighton S and Hodes D. Female Genital Mutilation: The role of health professionals in prevention, assessment and management. BMJ 2012; 344:e542

4. Momoh C, editor. *Female Genital Mutilation.* Oxford: Radcliffe Publishing; 2005. ISBN 978-1857756937

5. Mathews B, 'Female genital mutilation: Australian law, policy and practical challenges for doctors' (2011) 194(3) *Medical Journal of Australia* 139-141

6. Jasmine Abdulcadir a, Michel Boulvain a, Patrick Petignat Reconstructive surgery for female genital mutilation.Lancet 2012; 380(9837) 90 - 92.

The WHO website provides information on female genital mutilation. Available at:

http://www.who.int/topics/female_genital_mutilation/en/.

http://www.who.int/mediacentre/factsheets/fs241/en/

FGM legislation in Australia and New Zealand:

FGM in NZ

FGM Law in Australia

Australian Government Review of Australia's FGM legal framework

AMA Position Statement on FGM

12. Links to other College statements

(C-Gen 15) Evidence-based Medicine, Obstetrics and Gynaecology
https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20General/Evidence-based-medicine,-Obstetrics-and-Gynaecology-(C-Gen-15)-Review-March-2016.pdf?ext=.pdf

13. Patient information

A range of RANZCOG Patient Information Pamphlets can be ordered via:

https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets

Appendices

Appendix A Women's Health Committee Membership

Name	Position on Committee
Professor Yee Leung	Chair
Dr Joseph Sgroi	Deputy Chair, Gynaecology
Associate Professor Janet Vaughan	Deputy Chair, Obstetrics
Associate Professor Lisa Hui	Member
Associate Professor Ian Pettigrew	EAC Representative
Dr Tal Jacobson	Member
Dr Ian Page	Member
Dr John Regan	Member
Dr Craig Skidmore	Member
Professor Susan Walker	Member
Dr Bernadette White	Member
Dr Scott White	Member
Associate Professor Kirsten Black	Member
Dr Greg Fox	College Medical Officer
Dr Marilyn Clarke	Chair of the ATSI WHC
Dr Martin Byrne	GPOAC Representative
Ms Catherine Whitby	Community Representative
Ms Sherryn Elworthy	Midwifery Representative
Dr Amelia Ryan	Trainee Representative

Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in March 1994 and was most recently reviewed in November 2017. The Women's Health Committee carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.
- Structured clinical questions were developed and agreed upon.
- An updated literature search to answer the clinical questions was undertaken.
- At the November 2017 face-to-face committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part iii)

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women's Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women's Health Committee

members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines.[17] Where no robust evidence was available but there was sufficient consensus within the Women's Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

Recommendation category		Description
Evidence-based	A	Body of evidence can be trusted to guide practice
	B	Body of evidence can be trusted to guide practice in most situations
	C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
	D	The body of evidence is weak and the recommendation must be applied with caution
Consensus-based		Recommendation based on clinical opinion and expertise as insufficient evidence available
Good Practice Note		Practical advice and information based on clinical opinion and expertise

Appendix B Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.