Policy Statement
All Southern Health patients will receive clinical care that reflects best practice and is based on the best available evidence.

Purpose and Rationale
Health professionals must be culturally and gender sensitive to the needs and concerns of women with female genital mutilation providing education and counselling in pregnancy to reduce the risk of intrapartum complications and the long term complications associated with the practice of female genital mutilation. Women with female genital mutilation (FGM) are significantly more likely than those without FGM to have adverse maternity outcomes. Risks seem to be greater with more extensive FGM.  

Definitions
Female genital mutilation (FGM) is defined by World Health Organisation (WHO) 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. There are 4 different types of FGM:

1. **Type I** – Excision of the prepuce with or without excision of part or the entire clitoris. This is the most common procedure.
2. **Type II** – Excision of the clitoris with partial or total excision of the labia minora.
3. **Type III** – Excision of part or all of the external genitalia and stitching or narrowing of the vaginal opening (infibulation). The raw area of the labia majora are brought together to create fusion. The healed scar creates a hood of skin that covers the urethra and part or most of the vaginal opening. A small opening is left at the bottom of the incision to allow drainage of urine and menstrual blood flow.
4. **Type IV** – Unclassified. This includes pricking, piercing or incising of the clitoris or labia, stretching of the clitoris or labia, cauterization by burning of the clitoris and surrounding tissue, scraping of the tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts), introduction of corrosive substance or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it and any other procedures that falls under the definition given above.


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1. The history of female genital mutilation

Female genital mutilation is practised in many countries and cultures around the world. It is a cross-cultural and a cross-religious ritual. The origin of FGM is unclear as the practice is centuries old and predates most contemporary religions.

It has been estimated that more than 120 million women and girls have undergone this ritual. The age at which girls undergo FGM varies between communities. Most FGM is performed on girls aged 8-9 years old and is seen as a rite of passage to womanhood. However, FGM can be performed just prior to marriage or as early as a few days old.

Although the practice of FGM is more prevalent in African countries there are also reports of it being practised in Asia (Indonesia, India and Malaysia) and the Middle East (Oman, UAE, Yemen). African countries where this tradition is commonly practised are Somalia, Sierra Leone, Ethiopia, Eritrea and Sudan.


The practice of FGM is accepted as vital for the maintenance of valued social structure. It is the belief that the practice is performed in the best interest of the child in order to provide her with a future as an honourable wife and mother. Therefore, there is potential ostracism of children in this community who wish to discontinue the practice. Some known reasons for the practice of FGM are tradition, preservation of dignity of family, as a guarantee of virginity and fidelity to the husband, to dampen or remove a woman’s sexual pleasure, hygiene and aesthetics.

Of all women who have undergone some form of FGM, it has been estimated that only about 15% have **Type III** (infibulation). Most infibulated women will see deinfibulation as a normal and expected part of pregnancy and the woman’s expectations should be discussed.

2. Complications of female genital mutilation

**Immediate complications** are not likely to be seen here in Australia. It includes severe haemorrhage, trauma to surrounding structures (the urethra, bladder, anal sphincter and others), acute urinary retention, infection (wound, sepsicaemia, tetanus, urinary tract infections, pelvic inflammatory disease, and possibly HIV), pain, shock and death.

**Long-term complications** include the following:

- **Genitourinary complications** – Incontinence, recurrent urinary tract infections, vesicovaginal fistula.
- **Local effect** – keloid scar formation, chronic abscess and cyst formations, general tenderness and sensitivity in the vulva, perineum or vagina and dyspareunia.
- **Gynaecological complications** – dysmenorrhoea, haematocolpos, infertility.
- **Sexual difficulty** – vaginismus, non consummation due to obstruction, impaired sexual response and enjoyment.
- **Pregnancy and childbirth complications** – difficulty of vaginal assessment in labour due to difficult access and excessive pain associated with scar tissue, prolonged and obstructed labour, laceration and haemorrhage during birth.
- **Psychological complications** – post traumatic stress disorder, anxiety, depression and fear of sexual intercourse. Some women may have flash backs of their circumcisions during labour or examination.
3 The Australian legal stance

In Australia, it is a criminal offence to perform female genital mutilation and is punishable by imprisonment.¹ Female Genital Mutilation in this act means all or any of the following:

- infibulation
- excision or mutilation of the whole or part of the clitoris
- excision or mutilation of the whole or a part of the labia minora or labia majora
- any procedure to narrow or close the vaginal opening
- sealing or suturing together of the labia minora or labia majora
- removal of the clitoral hood.

4 Deinfibulation

Deinfibulation is an obstetric surgical procedure to reverse infibulation (FGM type III) and open the vaginal introitus.

Deinfibulation is best done before pregnancy to reduce lacerations and avoid deinfibulation or anterior episiotomy in labour.

Deinfibulation may be done following counselling at around 20 weeks gestation as a quick elective day procedure, on a caesarean list at the booked hospital.

After counselling in pregnancy and with consent it is commonly performed in second stage labour with the head descending.

References.

Female Genital Mutilation (FGM) in pregnancy

Background

Document Management

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Disclaimer

The maternity clinical practice procedures and guidelines have been developed having regard to general circumstances. It is the responsibility of every clinician to take account of both the particular circumstances of each case and the application of these procedures and guidelines. In particular, clinical management must always be responsive to the needs of the individual woman and particular circumstances of each pregnancy.

These procedures and guidelines have been developed in light of information available to the authors at the time of preparation. It is the responsibility of each clinician to have regard to relevant information, research or material which may have been published or become available subsequently. Please check this site regularly for the most current version.