South Australian Perinatal Practice Guidelines

Female genital mutilation

Introduction

- The practice of female genital mutilation (FGM) affects an estimated 130 million women and girls worldwide. FGM is most common in African countries, with a small number in the Middle East and Asia. With migration, women and girls from these areas are now living in Europe, Australia, New Zealand, Canada and America (WHO 2001)
- About 80 % of the cases of FGM involve excision of the clitoris and the labia minora (WHO 2001)
- FGM is a medically unnecessary practice sustained by complex social and cultural belief systems. FGM has adverse physical, sexual and psychological consequences (RACOG 1997)
- The origins of this centuries old practice are unclear and predate most contemporary religions. FGM is not a religious practice

Legal considerations

- Female genital mutilation is the term used in law
- In South Australia, FGM is covered by section 26 of the Children's Protection Act, 1993, and section 33 of the Criminal Law Consolidation Act, 1993. FGM has been illegal since April 1997
- It is illegal to do the following types of FGM except as part of treatment of a medical condition
    - Remove or cut out any part of the female genital area (excision)
    - Stitch up the female genital area (infibulation)
    - Cut the clitoris or part of the clitoris (clitoridectomy)
    - Damage the female genital area in other ways. The female genital area refers to the entrance to clitoris, the vagina and vaginal lips (labia minora and majora)
- It is illegal to aid, abet, counsel or procure a person to perform female circumcision or FGM on a woman, girl or female baby
- It is against the law to do FGM even if the woman or girl wants it to be done
- It is also against the law to leave South Australia for the purpose of having FGM performed
- In South Australia, the jail term for performing, aiding or employing another to perform FGM is 7 years
- It is against the law to re-infibulate a girl /woman after birth of a baby or after any other type of gynaecological operation
- Health care professionals are required to report incidents of FGM including situations where they believe a girl to be at risk of FGM (Health care professionals are mandated notifiers and should report via Families SA in South Australia)

Types of female genital mutilation (FGM)

- According to the World Health Organization (WHO 2001), FGM comprises 'all procedures involving partial or total removal of the female external genitalia or other

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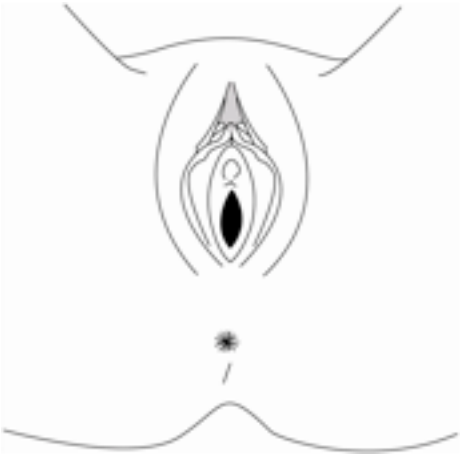
injury to the female genital organs whether for cultural or other non-therapeutic reasons'

Type I

- Excision of the prepuce, with or without excision of part of or the entire clitoris. Other terms used to describe Type I include circumcision, ritualistic circumcision, sunna and clitoridectomy

Figure I: Type I FGM (shaded area denotes the tissue removed)



Type II

- Excision of the clitoris with partial or total excision of the labia minora. Other terms used to describe Type II include clitoridectomy, sunna, excision, circumcision and infibulation

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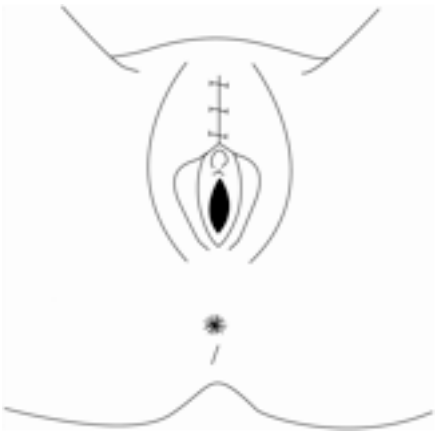
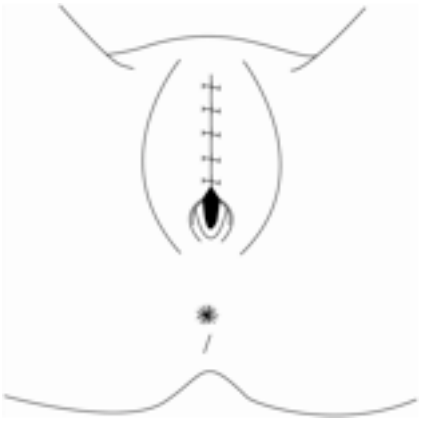
Figure 2: Type II FGM



Type III

- Excision of part or all of the external genitalia and stitching / narrowing of the vaginal opening (infundibulation). Other terms used to describe type III include infibulation, Pharaonic circumcision and Somalian circumcision
- Type III can result in a very small opening which may cause difficulties in urination, menstruation and sexual intercourse, as well as serious problems in childbirth

Figure 3: Type III FGM



Type IV

Unclassified: includes

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- Pricking, piercing or incising of the clitoris and / or labia
- Stretching of the clitoris and / or labia
- Cauterisation by burning of the clitoris and surrounding tissue
- Scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts)
- Introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it

top

Pre-pregnancy counselling

- Pre-pregnancy counselling may be arranged for the couple through the woman's general practitioner, the migrant health service or major tertiary institutions
- Referral for deinfibulation may be offered on request or if there are any complications
- Obtain detailed history and screen for infections / complications associated with type of infibulation (see below)
- Explain law in South Australia related to FGM in the child protection act and criminal law consolidation act

NB: The term female genital mutilation can be offensive to some and its use in consultations may be counterproductive. Women's surgery / operation, cutting and ritual female surgery may be acceptable alternatives

Complications associated with FGM

There are numerous physical, sexual and psychological complications associated with FGM. Not all types are commonly associated with complications; however, most women with type III will experience at least some of the following:

- Difficulties with micturition e.g. urinary retention
- Recurrent urinary tract infections
- Difficulties and pain with menstruation
- Complications in childbirth
- Inability to achieve penetration during sexual intercourse
- Sexual dysfunction

Antenatal considerations

- Recent immigrants may have little knowledge of English. Offer interpreter (preferably female) as required
- The antenatal period may be the first contact for the couple with the Australian health system
- Ask questions in a sensitive way e.g. "Has your vaginal area been changed in any way?"
- Identify and document type of FGM after history and examination
- Detailed history to identify any known complications associated with FGM (see above)
- Sexual issues are very sensitive and women with FGM may feel extremely uncomfortable talking about this issue
- Initiate discussion about de-infibulation / resuturing. Offer antenatal deinfibulation (after 20 weeks)
- The possibility and advantages of de-infibulation should be discussed with women experiencing ongoing health problems related to obstruction

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Counselling

- Health consequences of FGM, rather than legislation, should be stressed when discussing FGM
- Explain to the couple that de-infibulation may be necessary during labour as part of the birth process (anterior episiotomy usually with type III FGM)
- Clarify the woman's expectations about re-suturing and explain that once de-infibulation has been performed, resuturing to re-join the labia is illegal; however the edges of the cut may be oversewn to prevent bleeding, discomfort or accidental rejoining of the labia
- Consider social work referral
- Refer women with Type III or IV FGM for specialist medical care
- Urinalysis / obtain micro specimen urine

De-infibulation

- Vulval scarring varies according to the amount of tissue removed from beneath adhesions
- There may be bands from the surface layer of scarring to the deeper tissues such as clitoris or urethra

Process for de-infibulation

- Depending on clinical context general, regional or local anaesthesia may be used. Topical anaesthetic cream (Emla) may be applied to scar tissue, 1 hour before procedure
- Position the woman in lithotomy and wash vulva with antiseptic solution
- Using a finger feel inside the opening, behind the closed scar tissue for any dense adhesions. Usually the finger slides easily under a free flap of skin
- Infiltrate area with local anaesthetic (xylocaine 1 %)
- Make a straight incision anteriorly with either scalpel or scissors with care near the upper limit as scarring may extend to the urethral meatus (finger guides the incision)
- The cut ends now retract upwards and outwards to reveal the tissues beneath
- Provide advice about vulval / perineal hygiene and healing

NB: Explain that voiding pattern may change (bladder emptying will be quicker and noisier) after deinfibulation

Suturing after de-infibulation

- After de-infibulation oversewing of the raw margins of the anterior incision is required to reduce the chance of raw edges re-joining across the midline. Use continuous suture or 2 – 3 interrupted sutures in absorbable suture material (3/0 or 4/0 monocryl or vicryl rapide)
- Any extension of the anterior incision above the urethra may be repaired at this time

Intrapartum considerations

Assess degree of FGM

- Be aware that pelvic examinations may be difficult, painful or impossible. Stop examination if the woman is unduly uncomfortable
- Catheterisation may be difficult / painful due to scar tissue

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- Parity may affect how the woman copes in labour. There may be heightened pain and fear in first pregnancy
- Discuss legal requirements in relation to FGM with the couple. Explain that re-infibulation of an opened up vulva is equivalent to performing the initial act of female genital mutilation
- During birth the constricted vulva in type II FGM may need to be opened up to allow the passage of the baby to prevent the formation of vesico-vaginal fistula and recto-vaginal fistula. Most infibulated women will require an anterior incision of their scar tissue as the first option before considering the need for a right medio-lateral episiotomy
- Health workers must not, under any circumstances, close up (re-infibulate) an opened vulva in a girl or woman with type III FGM in a manner that makes intercourse and childbirth difficult
- Oversewing of the raw edges of the anterior incision is required to decrease the chance of the raw edges rejoining across the midline. Use continuous suture or 2 – 3 interrupted sutures in absorbable suture material (3/0 or 4/0 monocryl or vicryl rapide)
- Any extension of the anterior incision above the urethra may be repaired at this time

Postpartum considerations

- Offer support and advice on the care of any perineal, vulval or vaginal wounds, or raw surfaces
- Advise the couple to avoid intercourse until healing of deinfibulation is complete and the woman is comfortable
- If the new baby is a girl, discuss the appearance of unaltered female genitalia and ensure the couple have a clear understanding of the law in relation to FGM. Offer pamphlets “What the law say about female circumcision” or “Female Circumcision - We love our culture but our health is important”

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3. The Royal Australian College of Obstetricians and Gynaecologists (RACOG). Female genital mutilation. Information for Australian health professionals The Royal Australian College of Obstetricians and Gynaecologists, 1997. Available from URL: http://www.ranzcog.edu.au/publications/pdfs/FGM-booklet-sept2001.pdf
4. Royal College of Obstetricians and Gynaecologists (RCOG). Female genital mutilation and its management. Green top guideline no 53, May 2009. Available from URL: http://www.rcog.org.uk/files/rcog-corp/GreenTop53FemaleGenitalMutilation.pdf

Useful web sites

RANZCOG College statement on Female Genital Mutilation / cutting:
http://www.ranzcog.edu.au/component/content/article/504-c-gyn/478-female-genital-mutilation-c-gyn-1.html

RANZCOG FGM booklet
Female Genital Mutilation (FGM) Booklet

World Health Organisation – Publications on Female Genital Mutilation
http://www.who.int/reproductivehealth/publications/fgm/en/index.html

Information pamphlet on FGM

Female Genital Mutilation/Female Circumcision information pamphlet is available on the SA PPG Website in English, Arabic, Amharic, Somali and Tigrinya.
http://www.health.sa.gov.au/PPG

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Abbreviations

CTG	Cardiotocograph
e.g.	For example
et al.	And others
FGM	Female genital mutilation
IOL	Induction of labour
LSCS	Lower segment caesarean section
OT	Occipito transverse
PPG	Perinatal Practice Guidelines
USS	Ultrasound

Version control and change history

PDS reference: OCE use only

Version	Date from	Date to	Amendment
1.0	23 Aug 05	30 Jan 08	Original version
2.0	30 Jan 08	20 Mar 12	Review
3.0	20 Mar 12	current	

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