



Female
genital
mutilation

Information for Australian health professionals

Credits

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Preface



This booklet attempts to provide a step towards the improvement of health care provision for women who have been affected by female genital mutilation (FGM), by raising the awareness of health professionals about this subject and the issues that surround it and providing information to assist their response. It is our intention that this booklet be accessible not only to medical practitioners but to any health professional likely to encounter affected women including midwives, nurses, community health workers, social workers, psychologists and any other interested professionals. This booklet does not attempt to be, and should not be seen as, an authoritative or comprehensive account of FGM. It should be recognised that reliable epidemiological information about the practices is very limited. Much of the available material is essentially qualitative, based on estimates and subject to revision.

The subject of FGM can be very emotive, political and controversial. The production of this booklet has therefore meant weaving a path through various views, positions and philosophies. The authors have attempted to avoid giving particular support, or bringing attention, to any one viewpoint, group or position other than those prescribed in the operating framework (see below). One of the challenges has been to balance the issues relevant to the transcendence of cultural boundaries. Writing from within our culture about those of others, we are aware of the potential to be ethnocentric in our approach. However, in avoiding this bias we need also to avoid lending support to the cultural relativist view that allows cultural self-determination even when the violation of human rights is evident to others. Rather than entering this debate explicitly we have restricted comment to where it relates directly to our primary aims. That is, in aiming to provide adequate health care to those from different communities, there is a need for knowledge of, sensitivity to and understanding of the cultural background and expectations of health care of those for whom we are caring. Further, due to the known health consequences of FGM, the eradication of this practice and therefore a questioning of the beliefs, structures and milieu that sustain it, is necessary for the future health of women and children.

As this booklet has been produced under the sponsorship of the Commonwealth Department of Health and Family Services National Education Program on Female Genital Mutilation¹, it has also been guided by the Operating Framework developed for this program which includes the following relevant passages:

Program Objectives

The National Education Program on Female Genital Mutilation aims to:

Prevent the occurrence of female genital mutilation in Australia and its territories through an emphasis on community education, information and support; and assist those women and girls living in Australia who are at risk of, or have already been subjected to, genital mutilation to minimise adverse health outcomes and psychosocial harm.

It further aims to promote the development of a consistent, holistic health approach in working with communities and facilitating supports and access to health services for women and girls affected by or at risk of the practice.

Section 7.2.2: Health Care

Health practitioners need training to identify and respond to the health and psychosocial needs of women and girls who have undergone genital mutilation including understanding of the cultural underpinnings of the practices and legal and ethical implications which may impact on health care provision.

Good practice involving sensitive care for these women and girls should be promoted to facilitate better health care and support services.

Protocols and procedures should be developed by health care providers particularly around the provision of antenatal, delivery, and post partum care in childbirth; around management of specific procedures such as deinfibulation; and for the care of women with complications which may arise from the practices, eg around menstrual and sexual health. The psychosocial needs of women who have undergone genital mutilation should be recognised and culturally sensitive and skilled practitioners who can provide counselling and support identified and networks established.

The psychosocial needs of children and adolescents who have undergone genital mutilation should be specifically recognised and appropriate counsellors and support networks identified.

Section 8: Uniqueness of Female Genital Mutilation

Female genital mutilation is acknowledged as a unique, deeply rooted cultural practice. Strategies to combat female genital mutilation need to be appropriately focused on the specific complexities of the issue.

¹ Operating Framework for the National Education Program on Female Genital Mutilation. Commonwealth Department of Health and Family Services, 1997



The practice of female genital mutilation (FGM) affects an estimated 130 million women and girls worldwide² and continues within a complex web of social, cultural and economic justification. It is medically unnecessary and has adverse physical, sexual and psychosocial consequences.

Increasing numbers of women are migrating to Australia from countries where FGM is practised. Yet, many Australian health care practitioners have little knowledge or experience of the cultural and health issues relevant to FGM. The provision of appropriate health care for women who have been affected by FGM needs to be based in an understanding of the issues and beliefs which have accommodated the continuation of the practices. Health care and promotion for these women may involve addressing long held beliefs about FGM, including those relating to health, hygiene, personal philosophy and traditional practices.

Female genital mutilation has been legislated against in most States and Territories of Australia. However, prevention of the practice in this country must also involve education about the negative consequences. Health care professionals have an important contribution to make through the provision of health information and health promotion. Health care professionals need also to be aware of the potential for women to be evasive of, or alienated from, the Australian health care system as a result of insensitivity to individual needs, communication barriers and unfamiliarity with the system.

The booklet has been produced to increase awareness and understanding of some of the issues around FGM and, where possible, to provide guidance about the provision of appropriate health care and health promotion for affected women, girls and their families. The information provided here is intended only to alert the uninformed to some of the possible issues surrounding FGM. Within the scope, the authors cannot claim to have addressed anywhere near all of the issues, or to have represented all affected women. As with all care provision, and with reference to FGM in particular, it is important that time and effort is taken to allow for a trusting exchange of information about the individual's unique experiences and needs.

² Female genital mutilation. A joint WHO/UNICEF/UNFPA statement. Geneva: World Health Organisation 1997.

PART ONE

BACKGROUND AND CONTEXT





1. What is female genital mutilation?

Summary

The World Health Organisation (WHO) has defined *female genital mutilation* as comprising '*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*' (1).

The term *female genital mutilation* can be offensive to some and its use in consultations may be counterproductive to the establishment of effective caring relationships.

Many different communities practise FGM in many countries around the world. Increasing numbers of people from these communities are migrating to Australia.

It is unclear where FGM originated, the practice is centuries old, predating most contemporary religions.

FGM is culturally based and practised by people from a number of religious backgrounds: it is not practised universally by any religious group.

The practice of FGM is sustained by complex and potent belief systems.

FGM is performed with the belief that it is in the best interests of the girl child; that it will ensure health, chastity, hygiene, societal cohesion, family honour, marriageability, fertility and successful childbirth.

Definition and Classification

Definition

The World Health Organisation (WHO) has defined *female genital mutilation* (FGM) as comprising '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' (1).

This definition encompasses the diversity of procedures performed by different cultural groups. The classification of FGM (see Table 1.1) provides a technical description of the types of procedures that this definition covers. Within each of the types of FGM there will be variation with respect to the amount of tissue removed.

The term *female genital mutilation* will be used throughout this booklet as defined by WHO. Many other terms have been used to describe FGM but they can be ambiguous and euphemistic and hold different meanings for different cultural groups. *Female circumcision* is a term previously used widely but this term is anatomically inaccurate in most situations and its further generic use is discouraged.

Use of terminology

The term *female genital mutilation* may cause offence to some who practise or have experienced it. Although Western societies may view the practice as mutilation, within the cultures who practise FGM it is performed with the good of the child in mind (see *Beliefs about FGM* below). The use of the term *female genital mutilation* in consultations therefore has the potential to be counterproductive to the establishment of effective caring relationships. Without the development of such relationships, it may not be possible to meaningfully address the difficult and sensitive issues with which a woman affected by these practices may need assistance.

It is therefore important when discussing FGM that some care is taken to establish what terms the woman and her family use, and to use these where possible. In one to one encounters, it is recommended that the woman be allowed to indicate her own preferred description, by asking her how she describes it. If it is necessary to introduce terminology, phrases such as traditional *female surgery*, *cutting* and *ritual female surgery* are suggested. *Female circumcision* is also a term with which many women are likely to be familiar. The use of this term at a policy level is generally discouraged, as it does not adequately describe the practice, however, if it assists communication it may be a useful term.

The WHO classifications are not necessarily general knowledge and are unlikely to be useful in consultations.

It is important to avoid endorsing the practices through choice of terminology. One important example is the term Sunna. The Muslim Welfare Board of Victoria states that

...the term 'Sunna' is a term used in Islam to cover religious values and requirements. Although some women may feel that FGM is a religious obligation this is not in fact the

case, because the mainstream teaching of the Sunna has neither commanded, prohibited nor recommended (strongly) the practice of female circumcision [sic] let alone FGM. The use of this term should therefore be avoided as it has the potential to reinforce feelings of religious obligation, which are unfounded (2).

Further, health care professionals need to be aware that a single term may be used by different women to describe different procedures. For example, *sunna* is used by some to describe a relatively minor ritualistic nicking of the clitoral prepuce, while others will use the same term to describe clitoridectomy. If an accurate understanding of the extent of a woman's FGM is necessary this should depend on examination, rather than terminology used. The use of the WHO definition and classification (see Table 1.1) is recommended for clarity and comparison. However, to unambiguously describe the extent of FGM in an individual case it may be necessary to use anatomically descriptive terms such as *clitoridectomy* and *excision*.

Table 1.1: World Health Organisation classification of female genital mutilation (1).

Definition	<i>'Female genital mutilation comprises 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.'</i>
Type I	Excision of the prepuce, with or without excision of part or all of the clitoris; (see Figure 1.2) Other terms used to describe Type I procedures include <i>circumcision, ritualistic circumcision, sunna, clitoridectomy</i>
Type II	Excision of the clitoris with partial or total excision of the labia minora; (see Figure 1.3) Other terms used to describe Type II procedures include <i>clitoridectomy, sunna, excision and circumcision</i> .
Type III	Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation); (See Figure 1.4) Other terms used to describe Type III procedures include <i>infibulation, Pharaonic circumcision and Somalian circumcision</i> .
Type IV	Unclassified: includes <ul style="list-style-type: none"> • 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;

- and any other procedure which falls under the definition of female genital mutilation given above.

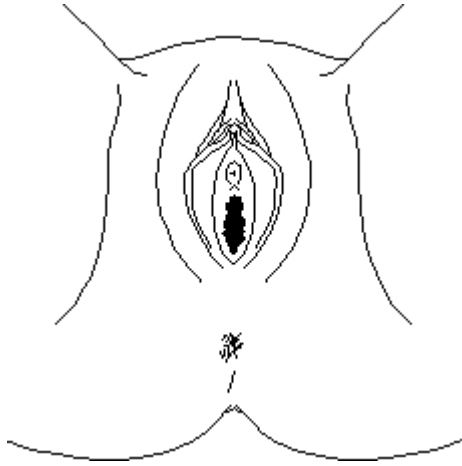


Figure 1.1: Unaltered female genitalia

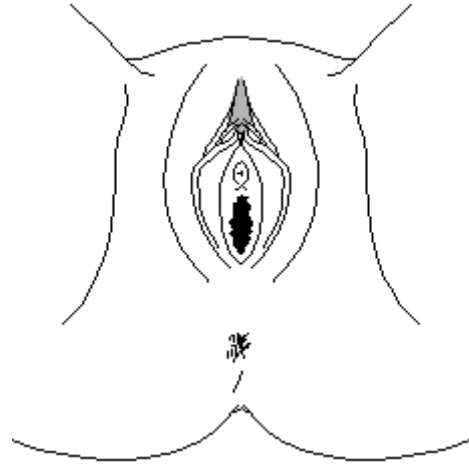


Figure 1.2: Area of tissue removed - Type I FGM

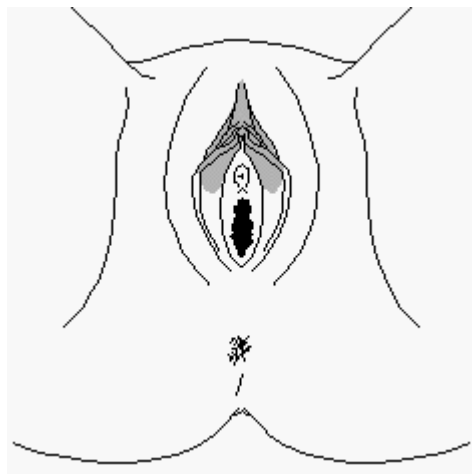


Figure 1.3.1: Area of tissue removed - Type II FGM

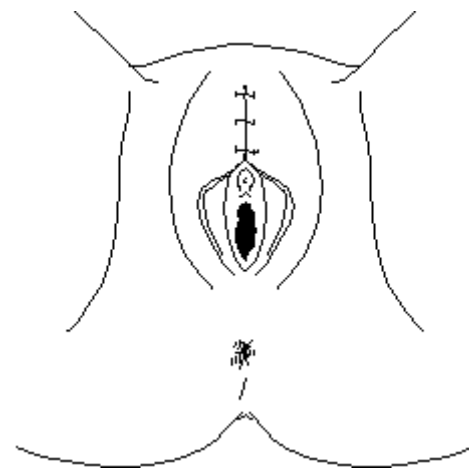


Figure 1.3.2: Appearance of Type II after suture

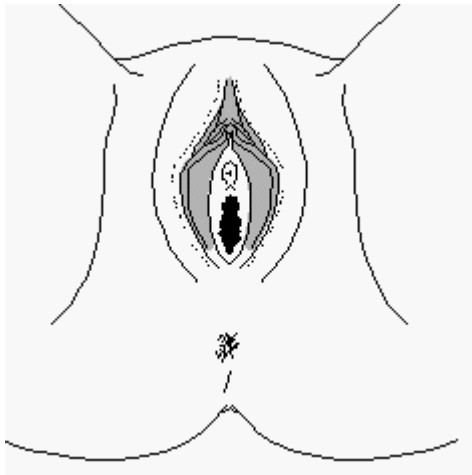


Figure 1.4.4: Area of tissue removed - Type III FGM

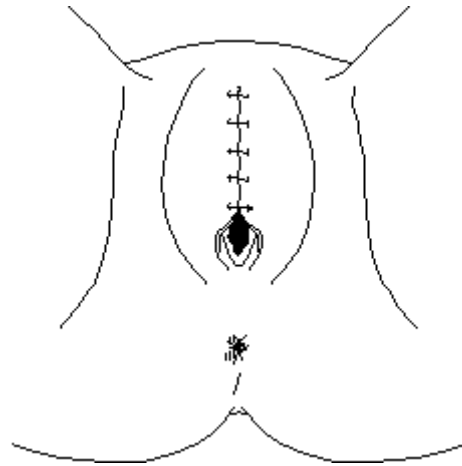


Figure 1.4.2: Appearance of Type III after suture

N.B. These figures are examples only, considerable variations occur within FGM types.

Communities that practise female genital mutilation

While there is no direct evidence that FGM is being practised in Australia, there are increasing numbers of immigrants who come from ethnic groups who practise FGM and therefore, increasing numbers of women who have been affected are being seen in the Australian health care system. The 1996 Census indicated that there were over 120,000 women in Australia who were born in countries where the practice of FGM has been reported. There is, however, no information regarding the likely proportion of the women in Australia who will have been affected by the practice.

There are many communities known to practise FGM, and possibly many unknown. Table 1.2 includes a list of the countries of origin of communities who are known to perform FGM. An awareness of these countries will be an important tool for health care professionals to anticipate whether FGM may be a consideration for the women they see. However, it should not be assumed that because a woman is from one of the countries listed that she will have undergone FGM. The prevalence estimates included in the table provide an indication of the proportion of women from each country who may have undergone FGM.

Each woman should be approached individually with awareness that she may have undergone FGM but no assumption that this has occurred.

Table 1.2: Countries where communities are known to practice FGM.

Region	Countries	Prevalence estimates* (3,4,5,6,7)
Asia	Indonesia, Malaysia	practice has been reported but no data is available

	India	less than 10%
Africa	Djibouti, Sierra Leone, Somalia, Egypt	90% and over
	Eritrea, Ethiopia, Gambia, Sudan	80-89%
	Burkina Faso, Chad, Guinea, Liberia, Mali	60-79%
	Ivory Coast, Central African Republic, Ghana, Benin, Guinea Bissau, Kenya, Nigeria, Togo	30-59%
	Senegal, Niger, Mauritania, Cameroon	10-29%
	Congo, Tanzania, Uganda, Zaire	less than 10%
Middle East	Oman, United Arab Emirates, Yemen	practice has been reported but no data is available

* Research on the prevalence of FGM is very limited and estimates are generally the only data available. These estimates incorporate those made within a number of different sources which are widely cited. However, the data are, and should be used as, a rough guide only. There has been no comprehensive research carried out in Australia and the appropriateness of generalising these figures has not been investigated. These figures are presented here in the absence of more accurate information and are subject to revision.

Background

Origin

The exact origin of female genital mutilation is unknown. There are many theories of the origin and reported documentation of the practice as long as six thousand years ago (8). Infibulation (Type III FGM) is thought to have been practised by Egyptian Pharaohs (9, 10) and clitoridectomy was used in Western medicine up to the late 1950s as a treatment for nymphomania, promiscuity and masturbation (8,11).

Prevalence

The exact prevalence of FGM is difficult to estimate as limited research has been undertaken. The WHO estimates that 130 million women world-wide have undergone some form of FGM, with an annual incidence of 2 million (12).

The most common types of FGM are Type I and Type II (see Table 1.1) which account for up to 80% of all cases. Type III FGM, the most extreme form of FGM (commonly known as *infibulation*) constitutes approximately 15% of all procedures (10).

The procedure

As there are a number of different types of FGM and much diversity between the different practising communities there is huge variety in the way the procedures are performed.

Many of the descriptions available describe the procedure as primitive and performed in unsterile conditions (4, 9, 13). The practice has traditionally been performed by women without formal training, known as *traditional birth attendants*, who may have used primitive instruments, razor blades or pieces of glass. Women who underwent FGM in traditional settings are unlikely to have had an anaesthetic and may have been held down by a number of older women to restrict struggling. This may have resulted in more extensive physical damage than was intended. With the more extreme procedure of infibulation (Type III FGM) the raw edges of the labia majora will have been sutured using catgut or possibly thorns and the legs bound together to encourage healing.

However, while some may still undergo the procedure in traditional settings, in some communities FGM is now performed in modern clinical settings by medically trained individuals (6, 13, 14).

Reports of the practice being performed in Western countries such as France and the UK suggest that the practice has migrated with the practising communities (4).

Age

The age at which girls undergo FGM varies between communities. For example, in some communities FGM is understood as a passage to womanhood and is therefore performed on girls of 8 or 9 years of age as part of an 'initiation' ceremony (6, 14). In other communities FGM is performed just prior to marriage and in others when the girl is only a few days old

(4, 15). It is thought that the age at which FGM is being performed is reducing and that the association with initiation into adulthood is diminishing (8).

Beliefs about female genital mutilation

Health care practitioners need to understand the complexity and potency of the belief systems that sustain the practice of FGM. Health care initiatives, education about health consequences and any other efforts to eradicate the practice need to be placed in context of the understanding held by the individual and her family, and the complex web of influences that maintain this understanding.

Female genital mutilation is practised in many vastly different communities. However, there is a tendency for these communities to be both patrilineal and patriarchal. Paradoxically, within many of these communities the tradition of FGM is often upheld and supported by women. The practice is understood as vital for the maintenance of valued social structures including patrilineage, family honour and social position. FGM is sustained by the belief that it is in the best interest of the child, providing her with a future as an honourable wife and mother. Failure to participate is considered by many to place the child at risk.

Some of the reasons that may be given for FGM are listed below. They are only intended to give an indication of the possible beliefs held by those who practise FGM and there will be marked variety from community to community and also at an individual level.

There is potential for victimisation and ostracism of members of affected communities who wish to discontinue the practices and health professionals who oppose FGM may be seen as racist. It may also be helpful to understand that both opponents to and proponents of legislation against FGM have the interests of the welfare and successful future of girls and women in mind.

Tradition

Tradition is one of the more common reasons given for performing FGM. For many, FGM is a normal part of a woman's life, experienced by all women. It is an expected and anticipated step in a girl's development to adulthood. The practice may be associated with cultural celebrations of the passage of the young girl to womanhood and this can involve present giving and feasting. This tradition is upheld by social pressure to the extent that girls may be stigmatised and ostracised for non-compliance (5).

Social cohesion

The tradition of FGM is also linked to the understanding of family honour, a vital component of community position and of community cohesion. Honour is jealously guarded by a family and can be lost through the actions of its members, in particular the female members (10). FGM is considered to be a normal precaution to ensure the morality of girls and the preservation of virginity (13) and in times of war FGM has been considered to protect women against rape. The practice of FGM is perpetuated within the social system, as deviation from the norm implies immorality and therefore can cause loss of honour ('son of an uncircumcised mother' is reported to be an extreme term of abuse in some communities). This is particularly detrimental for females as marriageability will

often be the only opportunity for status and economic support beyond their family.

Female genital mutilation is also thought to foster social cohesion between groups of girls who are operated on in the same time period, as girls will affiliate with those who have undergone the same experience at the same time (5).

Religion

Female genital mutilation has been reported to be practised by Christians (Protestants, Catholics and Copts), Muslims, Jews, Animists, and atheists (5, 14). Religious requirement may be understood by the individual as the reason that FGM is performed. However, FGM is not included within the formal teachings of any religion. The association of FGM with religious belief and obligation is assumed to be the result of historic concurrence and incorrect teaching and/or understanding of religious texts.

Female genital mutilation pre-dates most modern religions, including Christianity and Islam.

One commonly held misconception about FGM is that it is prescribed within the Islamic religion. However, there are many Islamic people around the world who do not practise FGM, notably those of predominantly Islamic Middle Eastern countries, such as Saudi Arabia. For some women the procedure is understood to be *sunna*, a religious requirement prescribed within teachings of the Prophet Mohammed. However, there is considerable debate on this issue within the religion (16).

Marriageability

Female genital mutilation is practised in communities where, in general, women will have limited access to economic or social resources and must be eligible for marriage to secure a means of future support (14). FGM is thought to increase marriageability by ensuring virginity, which is almost always considered a prerequisite for marriage. FGM may also be thought to ensure the lineage of any children by limiting pre-marital sex and encouraging fidelity during marriage (as FGM will lessen sexual desire). Others believe that FGM enhances fertility and/or increases a man's sexual pleasure, both of which enhance a woman's attractiveness as a wife (17).

Economics

In some societies the practice of FGM provides the traditional birth attendants with power, status and money not usually accessible to women outside of the private domestic sphere (6,16). Traditional birth attendants, or excisors, have traditionally performed not only the FGM operations, but also the opening of the vaginal introitus to prepare for marriage and childbirth and any repetition of the procedure after childbirth. Each stage provides a source of income.

In addition, in some communities FGM is considered in the negotiation of bride price and therefore further contributes to the local economy (6).

Female genital mutilation is also known to be practised in modern clinical settings,

including private clinics, which may foster the continuation of the practice as it provides a profitable source of income. Clinicians may also hold the belief that if the procedures will inevitably take place, it is better that they be done in circumstances where anaesthesia and appropriately clean surgical techniques may be used. This medicalisation is a further factor potentially contributing to the perpetuation of the practices.

It is assumed that in Western countries where communities may be continuing the practice illegally there is the potential for backyard operators to perform FGM procedures (18).

Gender roles and sexuality

In some groups FGM functions as a way of marking the girl so that she is able to fulfil her role as a woman, a wife and a mother. The practice may be understood as the determinant of gender identity (17) which may be closely related to the concepts of chastity, the safeguarding of the purity of women and the control of female sexuality, all of which may be pre-conditions for the ability to marry and have children (6).

In some cultures it is believed that the clitoris is a masculine feature which must be excised to create true femaleness (19), some also believing that the clitoris is an infant penis whose growth must be forestalled by surgery (13). Women who have not undergone FGM are thought to maintain, or have the potential to develop, characteristics thought to be appropriate only for men, such as sexual desire, aggressive behaviour and promiscuity.

Feminist commentary cites FGM as evidence of the continued oppression of women. The removal of the clitoris is seen as an attempt to control the sexual activities of women; a denial of the freedom of sexual desire and expression. FGM is seen as a misogynistic message about the expectation of the behaviour appropriate for the female gender, including the prohibition of sexual pleasure and freedom and the expectation that women should exhibit behavioural characteristics such as compliance and docility.

Aesthetics and hygiene

Within different cultures various aspects of FGM are seen to enhance beauty. Female genitalia are considered by some to be ugly and impure and FGM is thus associated with beautification. In some communities genitalia are thought to be most desirable when smooth to touch and with no evidence of a cleft (4, 20).

In some communities where the clitoris is thought to produce an offensive discharge and/or exude a rank odour (13), FGM may be considered to be associated with cleansing. This is illustrated by the Arabic word for FGM, *tahur*, which literally means purity and cleanliness. Some also believe the clitoris discharges 'pollutants' which are a danger to the health of the foetus during childbirth.

There is also a belief that if a woman has not undergone infibulation air will enter through the vagina and cause infection.

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2. Legal and ethical aspects of female genital mutilation

Summary

There are many active organisations throughout the world working to prevent and eradicate female genital mutilation (FGM).

It has been recognised that, in isolation, legislation is unlikely to prevent the practice of FGM. Australia has implemented a two-part strategy to prevent the practice of FGM in this country involving:

National Education Program on FGM, focussing on health promotion within a community development context.

Legislation against the practice in most States and Territories.

The health professional has an important role in the prevention of FGM including the provision of health promotion information and support to affected community members.

Health care professionals need to be aware of the implications of legislation relevant to them. This includes the prohibition of procedures considered to be FGM and mandatory reporting.

There are many active organisations throughout the world working to prevent and eradicate female genital mutilation (FGM) including the World Health Organisation (WHO), the United Nations Children's Fund (UNICEF), the Inter-Africa Committee on Harmful Traditional Practices (IAC), and the United Nations Population Fund (UNFPA). Furthermore, many health, social and religious organisations worldwide have issued statements or are working to support the eradication of FGM. This includes The World Medical Association, the International Federation of Gynaecology and Obstetrics (FIGO), the American College of Obstetricians and Gynaecologists (ACOG), the Australian Medical Association (AMA), and the Foundation for Women's Health Research and Development (FORWARD).

Australia's response to female genital mutilation

Australia is signatory to a number of international conventions which are relevant to the eradication of FGM. These include:

The Universal Declaration of Human Rights (1948)

The Convention on the Elimination of All Forms of Discrimination Against Women (1979)

The Convention on the Rights of the Child (1990)

The Declaration on Violence Against Women (1993: includes specific reference to FGM).

In 1994 the Family Law Council prepared a report on FGM for the Attorney-General in which it recommended Australia undertake a two part strategy involving education and legislation to prevent the practice of female genital mutilation in this country (1).

The national education program on female genital mutilation

The National Education Program on Female Genital Mutilation is funded by the Commonwealth Department of Health and Family Services. Responsibility for carrying out the education program is at the State and Territory level. It is recognised that the most effective way to eradicate the practice is through community development, education and health promotion. The education program has a focus of health promotion within a community development context and aims to promote the development of a consistent, holistic health approach in working with communities and facilitating support and access to health services for women and girls affected by, or at risk of, the practice (2).

There have also been a number of educational and preventative initiatives from within the affected communities.

The State/Territory based programs will be an ongoing source of support, referral, information and advice for health professionals, who are encouraged to contact personnel at the relevant government departments if the need arises. Contact details are supplied in Appendix B.

Legislation

Specific legislation banning FGM has been enacted in all States and Territories except Queensland and Western Australia. Queensland will not be legislating as it prefers to rely on general offences in relation to assault. Western Australia is developing legislation.

Where legislation has been passed it has the following features:

a person who intentionally performs female genital mutilation on a person is guilty of a serious offence with a maximum penalty of at least 7 years imprisonment;

a person must not take a child from a jurisdiction, or arrange for a child to be taken from it with the intention of having female genital mutilation performed on the child. A child is defined as someone under the age of 18 years. Again there is a maximum penalty of at least 7 years imprisonment;

there are exceptions for the performance of medical procedures that have a genuine therapeutic purpose.

Those who wish to examine the legislation in detail should obtain a copy from their relevant State or Territory Department.

The legislation was introduced as a deterrent and to make clear that the procedure is illegal. However it is recognised that legislation will not work in isolation. The legislation provides a legal framework for guidelines and protocols to assist community workers and health care providers to deal with at risk situations.

The role of the health professional

Health care professionals have an important role in the prevention of FGM in Australia and the care of affected women. They are in a unique position to provide information about FGM because of their expertise, the respect in which they are held, the relevance of health issues to FGM and the frequency with which they are likely to interact with the affected communities. Health promotion information provided by health professionals can give convincing support to arguments against FGM, as information in a health context provides a relatively objective criticism of FGM, for which there is tangible evidence. However, Dorkenoo stresses the need to place information in context, stating that

Medical facts, carefully explained, may be one way to discourage the practice since these facts are almost the opposite of what is believed, and can be demonstrated and proved...However, this approach presented out of context ignores the force of the societal pressures which drive women to perform these operations, regardless of risk, in order to guarantee marriage for their daughters, and to conform to severe codes of female behaviour... (3).

Health care professionals are likely to find themselves in situations where they will need to provide information, counselling and support concerning issues relevant to FGM. In many instances this may involve explanations about the health and legal consequences of the

practice. The following are some issues of which health care professionals may need to be aware when discussing these matters with individuals and their families (4);

Considerable time, and possibly many consultations, may be needed to discuss issues associated with FGM.

Discussions will be facilitated by established relationships and the development of good rapport. Knowledge about FGM and the cultural and social issues related to it will assist in the establishment of trust.

Health care professionals should be aware of, and prepared for, the possible reactions which discussions about FGM may incite, for example;

Some members of affected communities view arguments against FGM, including legislation, as racist and ethnocentric. Health consequences, rather than legislation, should be stressed. Current health campaigns pitched at the eradication of practices harmful to health, such as anti-smoking and diet and exercise initiatives, may provide a useful context in which FGM prevention strategies can be placed.

Others may perceive a 'double standard' in the attitudes of critics some of whom they know participate in body piercing, trans-gender surgery, breast implants and other forms of cosmetic surgery. It may be necessary to stress arguments about consent if this issue is raised and it may be useful to be knowledgeable about other damaging practices which have been abandoned such as foot-binding, witch burning and chastity belts.

... It may be our hubris as anthropologists that we cannot or dare not imagine ourselves so immersed in any culture that we would buy its multiplex rationalisations – its meanings – however subtle and persuasive and coherent they may be. And yet we submit ourselves to caesarean sections and mechanised childbirth to produce that 'perfect' baby; inculcate in our daughters, albeit implicitly, that they must diet, exercise, dye, and depilate to achieve the 'perfect' body; we tweeze and pluck and colour and conceal to attain the 'perfect' face. We work hard at being a woman, spend considerable sums of money, subject ourselves to bunions and bulimia and worse. Clearly a central question epitomised so horribly by the practice of female 'circumcision' is why female bodies in virtually every society should be subject to alteration, maiming, mutilation, control ... (5)

Legal implications for health professionals

Health professionals need to educate themselves about their responsibilities with respect to legislation. As there are some differences in legislation from State to State the following is only general information; individuals should refer to the legislation relevant to them when more information is required with respect to legal obligation.

Requests to perform female genital mutilation

There is potential for health professionals to be approached to perform FGM on a child. There is evidence of this in Western countries such as the UK (3, 6) and in Australia a

survey conducted by The Royal Australian College of Obstetricians and Gynaecologists in 1994 reported that ten doctors had been approached to perform FGM and ten reported anecdotal evidence of FGM being carried out in this country (7).

In refusing to perform FGM it is important that health practitioners counsel the parents and their families about the harmful effects of FGM and take responsibility for ensuring that the child is not at risk. If concerns remain that a child is at risk, health professionals are mandated to report this to the relevant authorities (see Appendix C).

Practitioners may also be asked to resuture a previously infibulated introitus (Type III FGM) for a woman after delivery. Depending on the circumstances and the particular legislation, this may be illegal. However, for someone to be convicted a jury would need to be convinced that the resuturing was a form of mutilation (when it is arguable the mutilation had been done previously) or that it was not necessary for therapeutic purposes. It has been reported that effective antenatal counselling will discourage most women from requesting resuture.

Illegality may be a useful explanation for unwillingness to perform a requested procedure that a practitioner believes to be covered by the relevant legislation.

Other procedures

Procedures such as hymenal reconstruction prior to marriage or cosmetic surgery to the genital region could be interpreted as coming under the legislative provisions. Again, a jury would need to be convinced that any procedure is done for other than therapeutic reasons and could be considered mutilation. Cultural, religious or other social customs are not in themselves regarded to constitute genuine therapeutic reasons.

Child protection

In most States/Territories the legislation extends existing mandatory reporting provisions to FGM. Health care professionals are therefore required to report incidents of FGM including situations where they believe a girl to be at risk. Reports should be made to the relevant child welfare authority (see Appendix C). The appropriate State/Territory authorities are working to develop appropriate interventions designed to protect the child, while keeping the child in the family if possible.

Health care professionals should be conscious of the potential for children from affected communities to be at risk of FGM. They should take responsibility to discuss the issue of FGM with parents who may wish to continue the practice and to educate them about the health consequences and the relevant legal restrictions. However, it is important not to alienate the woman and her family from the health care system through fear of having their child taken away. Suspicion of intent to perform FGM should also be addressed immediately.

Mandatory reporting would not apply to women with an old history of FGM, although some members of affected communities have mistakenly believed that they are liable to imprisonment if it is discovered that they have had FGM in

the past.

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PART TWO

HEALTH CARE





3. Health consequences of female genital mutilation

Summary

A wide range of complications of female genital mutilation (FGM) is documented, including short and long term physical, sexual and psychosocial problems.

Immediate complications include pain, bleeding, infections, injuries, urinary obstruction and death.

Longer term complications of FGM can include:

- vulval scarring and pain
- pelvic and urinary tract infection
- obstructed menstrual and urinary flow
- urinary and faecal fistulae
- obstructed miscarriage and childbirth
- vaginal and perineal damage at childbirth
- sexual difficulties including non-consummation and painful intercourse

There is a wide range of severity of symptoms, while some women do not experience any problems which they attribute to FGM.

A wide range of complications of female genital mutilation (FGM) is documented, including short and long term physical, sexual and psychosocial problems.

There are limited epidemiological data to provide a reliable indication of the relative prevalence of different forms of FGM or of the incidence of complications. This is in part because women may not associate the health problems they experience with FGM or may simply accept them as part of life. Hence they may present with a condition possibly related, either directly or indirectly, to FGM, but not know of, or accept, the connection. In addition, in some communities the practices have been subject to strong taboos such that they are matters of great sensitivity and privacy to many women who may find them difficult to discuss. Furthermore, some of the reported complications of FGM (for example dysmenorrhoea) are common in the general population and the possible part that genital mutilation plays in these has not been defined.

There is very little information about the experiences of older women who have had FGM, but it might be expected that cutting and resuture of the vulva, especially if repeated with many pregnancies, would lead to worsening symptoms such as dyspareunia and incontinence accompanying vulval atrophy after menopause.

Complications experienced will vary at the individual level. While many women will not experience complications, others may experience the impact of the procedure on a daily basis. Many of the less severe forms of FGM (eg Types I and II) may be less physically obvious so may be overlooked or assumed to be associated with fewer complications. This is not necessarily the case, especially with respect to the psycho-sexual impact of the practice.

Immediate complications

The immediate complications of FGM are not likely to be commonly seen in Australia. They are included here for reference, but may not necessarily be relevant to the assessment and treatment of women who have undergone FGM many years ago. Some women arriving in Australia will have undergone the procedure in modern hospital settings under appropriate anaesthesia and therefore may have avoided some of the more extreme early consequences. Others, however, will have experienced FGM in unsterile conditions and may therefore have been more vulnerable to the immediate complications.

Immediate physical complications may include:

- haemorrhage (primary and secondary, even to the point of exsanguination)
- fractures, dislocations or other injuries due to restraining a struggling child
- acute urinary retention
- infection (wound, septicemia or tetanus, pelvic inflammatory disease, urinary tract, blood borne diseases due to sharing of implements)
- injury to adjacent structures such as the urethra

- pain
- shock

Long term complications

The long term complications of FGM may be encountered in women in our community, although they may not be the reason for presenting. Obstructive problems are more likely to be seen after infibulation (Type III FGM) although scarring may also be severe in women who have undergone some Type II procedures.

The following complications have been associated with FGM:

Local vulval problems

- scarring with or without keloid
- retention cysts, abscesses
- neuromas
- bleeding due to recurrent trauma, possibly resulting in anaemia
- aggravated atrophic symptoms after menopause

Urinary tract problems

- voiding difficulties due to urethral damage, scarring or obstruction (bladder emptying may take as long as 15 minutes for infibulated women, which may be seen as normal if it has happened throughout life)
- painful micturition
- recurrent upper or lower urinary tract infection due to stasis or obstruction
- incontinence due to urethral damage or fistula formation

Other gynaecological complications

- pain due to chronic pelvic inflammatory disease
- infertility due to tubal damage
- contraceptive difficulty eg with use of intra-uterine contraceptive device (IUCD)
- dysmenorrhoea, especially with genital tract obstruction
- haematocolpos
- vesicovaginal or rectovaginal fistula resulting from FGM, deinfibulation, reinfibulation or obstructed labour

Problems in pregnancy and childbirth

- obstructed miscarriage
- excessive pain associated with scar tissue
- restricted examinations resulting in inaccurate assessment and difficult bladder management
- prolonged and obstructed labour
- lacerations and haemorrhage at delivery

Sexual difficulties

- non-consummation due to obstruction, vaginismus or painful scar tissue
- trauma on deinfibulation by partner or traditional birth attendant
- dyspareunia
- vaginismus with or without introital scarring
- impaired sexual response and enjoyment
- if vaginal intercourse is precluded, sexual expression may be problematic and/ or a source of relationship conflict.



4. Psychosocial issues around female genital mutilation

Summary

There is very limited research on the psychosocial consequences of female genital mutilation (FGM).

Psychological stress may be experienced as a direct consequence of FGM or may be related to other experiences including those around immigration and settlement.

Some causes of psychosocial stress explored in the chapter:

- *reactions to the trauma of FGM itself*
- *anxiety and depressive symptoms*
- *effects on sexuality*
- *war, famine, immigration issues*
- *conflict within family and community*
- *responses of host communities, including health professionals*
- *inter-generational issues regarding continuity of the practice*
- *post-immigration anxiety and regret regarding FGM.*

Health care practitioners should be aware of the psychological health of women and refer (where necessary and possible) to culturally appropriate support.

Possible sources of psychosocial stress

In a small study conducted in the Northern suburbs of Melbourne in 1995 mental health was highlighted by health professionals as one of the key issues for women they had seen from communities affected by FGM. Many of the specific issues raised were associated with pre- and post-settlement experiences while others might be considered to be the result of experiences related directly to FGM (1).

There is very limited information available on the impact of FGM on psychological health. The research which has been conducted is sparse and is likely to have been limited by reduced self-awareness about these issues resulting from cultural and social restrictions on the discussion or exploration of this topic.

For women from affected communities living in Australia many issues relevant to psychological health will not be directly related to FGM. The impact that these issues may have on the health and welfare of the individual can be significant and they are therefore explored below alongside issues related more specifically to FGM.

Reaction to the event of FGM

In many instances the event of FGM will have been a traumatic experience for the woman (2). When performed in traditional rural settings, where the use of anaesthesia is unlikely, FGM will have meant extreme physical pain. Pain will also have been experienced during the healing period, in which the girl may have had her legs strapped together to immobilise her. Complications such as haemorrhage and shock may have caused further distress related to the experience.

Girls may have been fearful of the impending painful operation and the procedure may have been preceded by acts of deception, intimidation and coercion by trusted parents, relatives and friends (3). The experience may have left a lasting effect on psychological well being, with reports of girls experiencing disturbances in eating, sleeping, mood and cognition which may be manifested in sleeplessness, nightmares, appetite or weight loss, post-traumatic stress, panic attacks, mood instability and difficulties in concentrating (3).

However, within the social context, where the girl and the community see FGM as a positive step, that is a rite of passage, which may be celebrated with gifts and feasting, psychological trauma may have been less acute. In all cases of FGM the intention is not of violence, but rather to ensure the future welfare of the child (see *Beliefs about FGM*). FGM may have been an anticipated event which was associated with initiation into the adult world and in some instances may have been instigated by a girl anxious to be considered a woman. The girl's understanding of the procedure and her beliefs about its function may have been long established and the psychological impact may have been mediated by her beliefs (4).

There is also the argument that FGM functions as a message to girls that, as females, they are expected to behave in gender-defined ways, including being docile and compliant. The experience of FGM may be accompanied by the strong message that women are expected

to suppress their thoughts and feelings.

Sequelae to physical complications

Women may experience considerable psychological reaction to the physical complications associated with FGM. Women have reported feelings of incompleteness, loss of self-esteem, depression, irritability, chronic anxiety, phobia and panic disorders (3, 4).

Women may have few opportunities to express their feelings in culturally appropriate or sanctioned forums and may have suppressed their feelings.

Sexuality

The psycho-sexual implications of FGM are poorly documented as this subject is taboo in many cultures, and as one of the many justifications for performing these procedures is to decrease female sexual pleasure in order to keep women chaste, it is difficult to investigate the effects.

Sexual difficulties experienced as sequelae to FGM may cause considerable distress to some women.

Some of the possible complications include painful intercourse and reduced sensitivity. Some women may be concerned that their ability to please their husbands may be affected (4, 5).

The ability of other sensory tissues and fantasy to compensate for loss of the clitoris is not well documented but the few studies reported suggest that the orgasmic frequency in women who have undergone FGM is about the same as women who have not (4, 5).

Gender identity

Some women may understand their gender identity in relation to the physical appearance of their body and the possibility of not being resutured after delivery may represent an assault on their understanding of being a woman. This may be analogous to the reaction that some women experience to mastectomy or hysterectomy.

Other past experiences

Some women arriving in Australia from affected communities will be refugees and will have experienced war and famine in their home countries. They may have been victims of torture and may have lost family, livelihood, homes and home countries; some having witnessed the killing of relatives and/or friends. In these cases FGM will not be seen as a cause of psychological distress, and attention to it may seem insensitive in light of these other experiences.

The immigration experience

Women may also experience difficulties associated with relocation, adjustment to a new culture, and experiences of racism and marginalisation. Priorities on arrival in a new country are settlement issues, including orientation, language, accommodation and employment. The perception that the focus of the host community is on the genitalia, as

exemplified by sensationalised media reports and the introduction of legislation, may be distressing, intrusive, humiliating, embarrassing and confusing. A perceived lack of consultation about educational and legislative approaches to FGM in Australia may have exacerbated feelings of alienation and marginalisation in the host community.

Women who have practised FGM in politically isolated regions may have difficulty accepting and understanding the negative reaction to FGM in Australia. Knowledge that women who have not undergone FGM can lead successful lives, and exposure to evidence of the negative impact of FGM may force women to question long held beliefs. This may be a time of confusion and isolation. Some women may feel betrayed by their parents, family and friends. Others may respond by rejecting the views of the host community and may seek the security and familiarity provided by those from their own culture.

Some women may find that they are torn between their knowledge of the consequences of FGM and the pressures exerted from their communities to continue the practice. They may find themselves not wanting to perform FGM on their children but fearful of rejection by their community and family because of this view. The degree of knowledge about FGM will vary greatly and will be changing constantly, especially as education programs and other initiatives around the country grow in number. Both women and men are likely to experience some degree of confusion and depression associated with the process of questioning their long held beliefs. Particular support may be necessary in these circumstances and, again, referral to local community groups active in the campaign against FGM may be appropriate.

For some women who have experienced FGM, confronting associated issues may mean reliving trauma experienced before coming to Australia in terms of remembered pain and suffering. Consequently attention to FGM may cause further distress (6).

Inter-generational conflict

Young women who come from communities and cultures where FGM is commonly performed are likely to face conflicting cultural messages about the meaning of FGM as they grow up in Australia. These conflicting messages may be a potential source of significant confusion, conflict and distress.

Young women who reject their parents' request for FGM to be performed may face difficulties within the family. The parents are likely to view FGM as vital to the maintenance of valued social structures. The young woman may experience considerable pressure from her parents who may believe that she will be unable to live a normal life, including the opportunity for marriage, without FGM. There may also be differences in values and beliefs with respect to many other issues. The young woman will often have a hard task communicating her views as she may have had very different experiences to those of her family. The health care worker may be required to facilitate communication between the young woman and her family. The family may be concerned primarily about the social consequences of non-compliance with the tradition. A compromise may be appropriate, such as providing the parents with a medical certificate stating that FGM could not be performed on their daughter for medical reasons, which they can then use as an

official exoneration should their family and friends inquire about the girl's FGM status.

Those who have undergone FGM and are growing up in Australia may suffer a range of emotions about the procedure, including acceptance, confusion, embarrassment and anger. Providing an opportunity for young women to discuss the meaning of this procedure may be helpful for some, but considered culturally inappropriate by others.

Provision of psychological support

In many areas of Australia there will be limited facilities for skilled, culturally appropriate psychological care of those affected by FGM. The development of culturally appropriate support services is one of the objectives of the State/Territory Education programs who should be contacted for current information (see Appendix B). While in some areas community support groups may exist, some may wish to support continuation of the practices. Therefore, attitudes should be clarified prior to referral.

Access to expert psychological support and care may be limited and health care practitioners are likely to meet situations where immediate attention is required. In particular, health care practitioners may need to counsel women about the harmful affects of FGM especially when concerned about prevention (see Chapter 2). Further, there will be instances where distress is caused by discussion of FGM and health care practitioners should be prepared to offer a woman appropriate support and understanding.

While some women may not have any concerns, others may have a need for support in relation to various psychological issues. Some women may be unable to articulate their concerns or to discuss them. Opportunities should be provided to raise and discuss concerns, but there should be no pressure for women to do so.

In many instances, knowledge about FGM and the issues surrounding it will increase the capacity of the health care practitioner to understand the concerns of the woman. The information in Chapters 1 and 2 of this booklet will provide a grounding on which to base such knowledge. Further, health care practitioners should be aware of the contextual issues covered in this and the following chapter. Awareness of the possible sources of distress may be useful if the woman is experiencing difficulty in articulating or expressing her concerns. It follows that using appropriate terminology will facilitate the process and avoid additional stress for the woman. Some women will be hesitant to discuss issues in front of others.

Psychological support for adolescents

Adolescence is a time when sexuality develops greater relevance for young people and as a consequence any issues affecting sexual and reproductive health are of particular significance. It is a time that many young people find it especially difficult to talk to health professionals about any aspect of their sexual or reproductive health. Similarly, many health professionals find it difficult talking to young people about common health issues (7) let alone the more complex issues that FGM raises for young people and their families.

Gaining a true understanding of the young woman's perspective will be difficult if her

parents are present during all interactions. As with all adolescents, ensuring that at least part of the consultation takes place with the girl on her own provides an opportunity to encourage discussion of any potentially sensitive topics, such as FGM. Questions or discussions by Australian health professionals about FGM may initially be treated with suspicion by the girl and her family. However, identifying whether a young girl has had, or is at risk of, any FGM procedure that places her physical and sexual health at risk is an important part of the complete provision of health care.

Explicitly highlighting the confidential nature of health care in Australia is an important aspect of all medical consultations with adolescents, whatever the topic. This is especially important when FGM is known to be a source of conflict within a family.

It is important that practitioners do not apportion blame to a girl's parents in their discussions about FGM as this may serve to create tension and anger between the child and her parents. Young people are often at risk of alienation from their parents as in the process of accommodation to a new society they must develop a bi-cultural identity for social and personal survival.

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5. Practice guidelines

Summary

In their approach to clinical care, health care practitioners should:

Aim to provide holistic care with attention to psychosocial factors in a culturally sensitive non-judgmental manner

Be aware of communities who may practise FGM in order to be alert to the possibility, while making no assumptions on the basis of country of origin, race or religion

Be aware of the practices which constitute FGM, their background and their consequences including medical, social and psychological aspects (see Chapters 1, 3 and 4)

Be aware of the influence of the Australian context including experiences relevant to immigration

Be aware of likely divergence between expectations and functioning of the health care system; explanation of the system is likely to be necessary

Be aware of, and deal with, provider's own feelings and responses

Involve interpreters if possible/appropriate

Understand that husbands may play an important role in decision making; explore and respect the woman's wishes

Use terminology which is acceptable to the woman and which avoids endorsing the practices

Respect difficulties discussing intimate matters and take time to develop a trusting professional relationship

Explain and illustrate normal anatomy and the woman's own situation according to her needs and wishes and explain reasons for examinations and procedures

Be aware that pelvic examination may be difficult, painful or impossible and do not persevere if unduly uncomfortable/painful; careful angulation of instruments and one finger examination may be necessary

Document findings in detail to minimise need for repeat examinations and so that future difficulties such as catheterisation problems may be anticipated and planned for

If infibulation has been performed, consider place and timing of deinfibulation

Manage other symptoms as usual, provided that obstruction is relieved if contributing.

Approach to clinical care

Women who have been affected by FGM are vulnerable to adverse experiences in the Australian health care system. This vulnerability may relate to the possible reactions of 'others' to FGM, but is more likely to be related to general difficulties which stem from cultural barriers such as communication difficulties and differences in expectations of health care. It is important for health care practitioners to be sensitive to the potential for these experiences and to provide assistance where possible to minimise the adverse impact.

The following are some areas where health care practitioners may be able to assist in the improvement of the quality of care extended to those from different cultural backgrounds including those affected by FGM.

All practitioners involved in the care of women should be able to respond to the needs of women and girls who may have experienced FGM. While it may be appropriate to refer for relevant experienced specialist care in an at risk situation, for complex counselling or if surgery is required, primary care issues should remain the province of usual carers. The State and Territory Education programs (Appendix B) are working on listings of contacts and resources for information and referral when needed.

The health care provider should be aware of the communities that are likely to practise FGM and its prevalence within these communities so that the possibility of FGM can be anticipated.

Communication

Interpreters

Women from communities affected by FGM are likely to be recent immigrants and may have little or no knowledge of English. Health care practitioners are encouraged to ask women if they would like an interpreter. Interpreters need to be involved sensitively. In many instances male interpreters will not be acceptable to the woman, who may be reluctant to discuss personal issues. Further, in some of the small immigrant communities the woman may know the interpreter socially and so there may be fears related to confidentiality. These fears must be recognised, addressed and allayed. There may be limited numbers of interpreters available who speak the relevant language and alternatives such as telephone interpreters could be explored.

Practitioners who do not have ready access to interpreters or who are not familiar with working with interpreters may wish to consider referral to a centre with this service and expertise, if available and indicated. It may be necessary to consider the personal views of the interpreter about FGM in some circumstances, but this is clearly a very delicate issue.

Use of husbands as interpreters

Some women will prefer to have their husbands or children interpreting for them, or this

may appear to be the only option available. Women may feel more comfortable discussing personal issues in front of family members and may be accustomed to their husband's involvement in decision making. However, some concern has been raised about the involvement of husbands as interpreters as it is believed that there is potential for them to have undue influence on decision making and possibly inhibit women from expressing their true feelings or preferences. It may be useful to record the presence of the husband and note any concerns the health carer may have. Directly addressing this issue will be a delicate matter, but it may be important to encourage the couple to accept the involvement of a trained interpreter. On the other hand it is also important not to exclude the husband entirely. Education about the practices and the negative impact that they can have on women is likely to be just as persuasive to a man who loves his wife and children, as to a woman herself.

Terminology

The use of appropriate terminology to describe FGM may be a fundamental component of effective communication. The term female genital mutilation is likely to be counter-productive to the establishment of good rapport as it can be offensive to those who see the practice as in the best interests of the child. The use of terminology which is acceptable to the woman, and which avoids endorsing the practice is discussed in Chapter 1 and readers are advised to refer this section.

Care is needed in describing infections of any kind; terms which imply impurity or poor hygiene may be offensive and confusing, particularly since FGM is believed to improve hygiene and cleanliness.

Medical terminology

Women who are otherwise proficient in their use of English may be unfamiliar with anatomical terms such as vulva, vagina, labia minora/majora. There may be a need for explanation in simple terms with the use of visual aids of the parts of the body which were affected by the practice. When working with interpreters it may be equally important to establish the interpreter's level of understanding of the terms used.

Affected women may never have seen unaltered adult female genitalia and have no clear idea of what is 'normal' nor what has been done to them anatomically, so explaining their own anatomy should take this into account.

Discussing FGM

Some health care professionals will have had limited experience discussing subjects such as FGM and many women are also diffident about discussing it. This may cause some discomfort for both parties.

It is important to be mindful of whether a woman is presenting for reasons related to FGM. If the woman is from a community in which FGM is practised and is experiencing health problems that may be related, raising the issue may be warranted. If the woman is pregnant it will also be important to address the issue in some detail (see Chapter 7).

There may be instances when the woman will present for unrelated reasons but will be experiencing difficulty associated with FGM. Health care practitioners need to provide ample opportunity for the woman to raise the subject and should be sensitive to signs that indicate the possibility that she may have such concerns. However, raising the subject when there is no apparent reason to do so may be very intrusive, embarrassing and distressing.

One of the important components in effective communication about this issue will be the establishment of good rapport and a trusting relationship. This may be facilitated by the health practitioner being informed about the likelihood of the woman being affected (Chapter 1), aware of the possible complications (Chapter 3), non-judgmental in approach and willing to listen. In addition an awareness that some time, and possibly several consultations, may be needed to develop trust and to explore the subject.

It has been the experience of some that including a question about FGM in routine history taking has been helpful.

Institutional response

Institutions or practices in which many women from the affected communities are seen, may benefit from setting up protocols to facilitate the care of these women. These may include ways to facilitate continuity of care, which will be beneficial to the development of trusting relationships and will reduce the number of times that the woman will need to discuss the issue of FGM.

Experiences and expectations of health care

Women may have experiences and expectations of medical practice and health care delivery that are very different from the operation of the Australian health care system. Other women who have experienced genital mutilation may be part of more established communities within Australia and will have a better understanding of the local system. Their needs, generally and with respect to FGM, may be less obvious to the health care worker.

One priority for women will be the maintenance of privacy; they may be very inhibited about being undressed and should be covered as much as possible during examination. Some women report being subjected to multiple examinations and inspection when practitioners unfamiliar with FGM have consulted colleagues or asked others to come and look at the woman. This experience can be very traumatic for the woman for whom privacy and modesty are paramount. Explanation of, and prior consent to, the involvement of any additional staff or student is essential.

Some women may request female health practitioners as it may be extremely difficult to talk about sensitive issues and, especially, to be physically examined by male practitioners for cultural or religious reasons. Women will seek out practitioners, male or female, who have a reputation in their communities for being sensitive and helpful.

Women may have different expectations about health outcomes. For example, often maternal and peri-natal mortality rates are higher in their countries of origin than in

Australia and caesarean section rates much lower. The communities that practise FGM may perceive caesarean section as a last resort rather than a procedure performed on the basis of a number of clinical indications.

There may also be limited awareness of preventative tests and initiatives such as Pap smear tests, immunisation and breast screening. It may be necessary to provide information about these procedures and the benefits that they may carry with them.

Birth control may also be unfamiliar to some women and the options should be discussed. Some methods of birth control, such as barrier methods or those which involve touching the genitalia, may be inappropriate for cultural or religious reasons.

The experience of FGM

The following points are some issues raised by affected women about their experience of FGM and the health care system. They may be important for the provision of appropriate care.

Affected women may not know which part of their organs are missing, or their normal functions. Some women will be curious about the appearance of unaltered female genitalia, as all their friends and relatives may look like themselves.

Most affected women believe that there are no major health complications associated with FGM apart from the shock and bleeding experienced at the time of the operation. The ongoing infections some women suffer are seen as a normal part of women's lives.

Australian health workers should not assume that all affected women are abnormal and have health complications because they have been affected by FGM. The majority of women have not had major health problems as a result of the practice. Problems that result from the practice may not be seen to be associated with the practice and this association may need to be explained.

In their own countries it will have been normal to have undergone FGM and women cope with it for their whole lives.

Women from the affected communities who request information regarding FGM for the first time may suffer shock. Health care practitioners should consider referring the woman for cultural support (see Appendix B).

Young affected women may be concerned about having sex without pain and may request information.

Sexual issues are extremely sensitive. Women from affected communities feel extremely uncomfortable talking about this issue.

Some women may not be aware that they have undergone any form of FGM, others may deny it.

Awareness of cultural differences

Health care practitioners should be conscious of their own views and prejudices when caring for those from different ethnic backgrounds. Stereotyping is a fairly normal mechanism used to understand and organise information about people. This can result in judgements that are, however, potentially very harmful if they are based on ignorance or incorrect assumptions. In particular a woman should not be assumed to have undergone FGM based on her country of origin or her religion.

Health care workers should also be aware that their own beliefs and prejudices may at times make the issues surrounding FGM difficult to understand and to deal with. It can be easy to forget that the understanding and experience of others will be very different from their own. For example, feminists may view FGM as further evidence of the oppression of women; a view that may be completely rejected by the woman who believes FGM is performed in the best interest of the child.

Health care practitioners may experience distress on hearing stories of FGM and performing physical examination. It is important to recognise this distress and to understand that the issues around FGM may stir personal concerns and conflicts in relation to sexuality, which may influence and colour responses to the women for whom one is caring. It is important not to alienate women by conveying distress to them, remembering that each woman's experience and physical appearance are normal to her. Peer support and debriefing should be sought if necessary to assist providers in dealing with their own feelings.

Health care practitioners should at all times be aware of the limitations which exist because of cultural differences. When available, referral to health care practitioners of the same ethnic background as the woman, or to culturally appropriate support groups should always be considered. The State and Territory based education programs will be developing referral networks and they should be contacted if referral points are needed (see Appendix B).

Well-woman/gynaecological care

Pelvic examination and Pap smear tests

For women from affected communities, pelvic examinations and Pap smear tests are likely to seem strange and intrusive. Some women will need to be educated about the reason for preventative or screening tests and this can also provide an opportunity for general education about the effects of FGM. Routine examinations such as Pap smear tests should only be done with consideration of the following points.

There is a need for careful explanation about the examination and consent should be obtained. In some cultures it is usual for a husband to consent before his wife undergoes any form of treatment or investigation. Although it may not be usual procedure there may be a need to involve men in pre-examination discussions.

Female health care providers may be the only ones permitted to do intimate examinations for some women.

Pelvic examination and Pap smears may be restricted by FGM, particularly Type III.

Be aware that it may be the first such examination and reassure that you will stop at any time if she becomes uncomfortable.

Observe the external genitalia. Minor degrees of FGM may not be obvious and appear just as a smooth, hairless anterior vulva. There may, however, be tenderness or scarring. Making a record of the appearance may help avoid unnecessary future examinations or highlight when procedures (eg. catheterisation) may be difficult.

Women vary considerably in their desire to discuss their own anatomy. In some cultures it would be improper to dwell on details, while other women may wish to use a mirror to have structures (or the absence of them) pointed out.

Speculum examination may be difficult or impossible. If there is much of an anterior closure the instrument may need to be angled carefully so as not to press on scar tissue too much. This may be the case also with other procedures such as trans-vaginal ultrasound.

Digital vaginal examination may be uncomfortable and one finger only may be preferable.

Difficulty with examinations may be alleviated with deinfibulation. The possibility and advantages of deinfibulation should be raised with women experiencing ongoing health problems related to obstruction.

Urinary tract infections

Urinary tract infections may be recurrent and caused by urinary retention. This may not be immediately detected as the cause since physical examination may not necessarily form part of the clinical assessment prior to treatment. Antibiotics prescribed are likely to be ineffective, as recurrence will be highly likely unless the issue of urinary retention is addressed.

Other gynaecological symptoms

The management of other gynaecological symptoms will not usually deviate from usual practice, unless obstruction is contributing. Surgical intervention should be considered with caution where the area is already damaged and scarred (1). For women who come to surgery for any reason, deinfibulation (if relevant) should be discussed in case the woman wants this done at the same time (see Chapter 6).

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6. Deinfibulation

Summary

Deinfibulation is a surgical procedure to reverse infibulation, that is to open the vaginal introitus

Deinfibulation is a routine sequel to infibulation for most.

Deinfibulation may be expected prior to marriage, before or during pregnancy or at childbirth.

If requested prior to marriage, the procedure should be done urgently.

Surgery is usually straightforward but expectations should be clear and adequate anaesthesia (GA or spinal) is recommended.

Prevention of post-operative re-adhesion is necessary.

If infibulation is identified during pregnancy aim to perform deinfibulation antenatally.

If in labour, divide infibulation prior to making a decision about episiotomy.

Aim to obtain sanction of parents in the case of an adolescent, in the interests of minimising family conflict and trauma.

Consideration of deinfibulation

Deinfibulation is the term for reversal of infibulation (Type III FGM), or opening of the vaginal introitus. Of all women who have undergone some form of FGM, it has been estimated that only about 15% have been infibulated. In some areas this is the predominant form of FGM, and so it will be encountered more commonly in certain immigrant groups.

Deinfibulation is a relatively routine sequel to infibulation. In some communities it is required prior to marriage to allow for intercourse. Deinfibulation before marriage may prevent pain that would be expected if the task were left to the husband. Traditionally, in some societies the husband is expected to open the vulva either by cutting or by repeated penile penetration. Alternatively, a traditional birth attendant or other female practitioner will be employed to perform the deinfibulation.

Deinfibulation may also be requested in preparation for childbirth, either before or during pregnancy. For most infibulated women this will be a normal and expected part of pregnancy and the woman's expectations should be discussed.

Timely deinfibulation

As new arrivals to this country do not have access to their traditional networks, women may present to our health services within days or weeks of marriage requesting immediate help. Unfortunately, this approach does not fit well with our current system of public outpatient appointments being followed by a variable amount of time on a waiting list as a 'non-urgent' case. Many women requesting to see only a female doctor may compound delays.

It is important that a timely and safe service for deinfibulation be available to women in Australia. There is a need for a sympathetic approach, with help to bypass prolonged waiting times for outpatient appointments and provision of an urgent theatre date.

If required by a pregnant woman, deinfibulation is best done antenatally (after 20 weeks for anaesthetic reasons) to avoid difficulties during late pregnancy and labour. However some women prefer to have all their discomfort in the puerperium. The options should be discussed with the patient.

Women seeking deinfibulation

The surgical procedure required is usually not complex (see below) and the women are usually young and fit for anaesthesia and are therefore appropriate for either 'day case' surgery or inclusion on a list reserved for urgent conditions such as miscarriages or Bartholin's abscesses.

While deinfibulation may not be considered a physically urgent condition, for cultural and psychological reasons it should be considered as urgent as, for example, post-menopausal bleeding, and dealt with as speedily.

It is important to remember that surgery is not always required and may not be the answer

to discomfort with intercourse. Tenderness, lack of sensation and vaginismus may require sexual counselling, which in some cultures may not be appropriate.

Part of the process to eradicate the practice of FGM involves gaining the confidence of local communities and breaking down barriers of access to health care. Benefits from performing reversal procedures prior to pregnancy will flow through to the antenatal clinics, so that many of the problems of managing pregnancy and delivery will be avoided.

Suggested ways of facilitating care of women requesting deinfibulation include:

- educate local general practitioners and health workers that this is a problem that needs to be highlighted and dealt with quickly
- alert booking clerks in clinics and for theatre lists to watch for these referrals and expedite appointments
- identify one or two doctors or midwives with an interest in this area who can see these women urgently
- if possible do the procedure immediately or give a date at the time of initial consultation rather than placing names on a waiting list.

Adolescents seeking deinfibulation

Young women in Australia who have undergone some form of FGM and grown up in Australia may wish to have the procedure reversed at a time other than that which is culturally acceptable. This desire may strongly conflict with their parents' wishes. Like all operative procedures, it is obviously most desirable that such a procedure is sanctioned by the young woman's parents. However, it needs to be remembered that young women are legally able to consent to surgical procedures against their parents' wishes if they are at the age of consent (usually 18 years, but this varies from State to State). The situation is more complex for those who have not yet reached the age of consent. Although each case should be judged individually, girls aged 16 years or older are generally deemed mature and their wishes not to involve parents should be respected. In most cases the young woman should be encouraged to involve her parents and there should be detailed consideration of the most extreme possible consequences of not including them. Justification of reversal of FGM on medical grounds may potentially be less threatening to parents and community members and may provide a means for the young woman to carry out her wishes with minimal damage to her family relationships: provision of a medical certificate to this effect may be helpful. If there are no obstructive or other symptoms referable to FGM it may be in the best interests of the young woman to defer surgery until adulthood, particularly if parents are not supportive such that there is a substantial risk of ostracism by the family if she proceeds.

Women's expectations

It is important to be clear about the woman's expectations of an opening procedure. Education and counselling at this time are important to cover such issues as partial versus

complete opening. Some women may want the vulva opened to a degree just sufficient to allow intercourse, while others may wish to have a permanent, complete opening so that further division will not be necessary for childbirth. This may also be the time to dispel myths around the need for 'tightness' to enhance a husband's sexual pleasure and to explain the risks of repeated surgery to close and open the vulva for each birth.

It is important to talk about the change in voiding pattern that will follow deinfibulation, as bladder emptying will be much quicker and noisier than before. Some women have mistakenly thought themselves incontinent after deinfibulation due to the dramatic changes noted while urinating.

There may be variable degrees of vulval scarring as a result of the original procedure that was performed and there may be different amounts of tissue removed from beneath the adhesions. Sometimes, after dividing adhesions formed from the labia majora being sutured closed, intact labia minora and clitoris are found underneath but more often these tissues have been excised before initial closure.

Sometimes breakdown of tissue has already occurred and all that is necessary is division of narrow bands of skin across the introitus, while other times thick scar tissue has to be incised. The principles of surgery are the same in all cases.

In accordance with these issues, practitioners must be sure to use terminology which detracts from the sense of mutilation eg. 'cutting' or 'closing up' may be used as more neutral terms.

Performing deinfibulation

Anaesthesia

Although local anaesthesia is physically quite suitable for most deinfibulation procedures, and would be used in the second stage of labour as a routine, it may not be appropriate for elective reversal. Due to the cultural modesty of many women who have undergone FGM, exposure to several people in a theatre setting may be shameful, and although she may ask for it to be done quickly under local anaesthesia, an individual may not predict how she will feel during the procedure. It may bring back memories of the original infibulation and be psychologically traumatic.

For these reasons a short general anaesthetic (or spinal anaesthesia) may be more appropriate. If the reversal is done antenatally, anaesthetists usually prefer to wait until the second trimester to avoid exposure to anaesthetic agents in the early part of pregnancy.

Technique

In lithotomy the vulva is washed with antiseptic solution. Often it is not possible to clean inside the vagina due to the narrowness of the opening.

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. If the opening is too

small to allow passage of one finger the closed points of an artery forcep can be inserted and opened to allow initial division from the posterior part of the closed flap for a centimetre or so which will then allow entry of a finger.

Even under general anaesthesia infiltration with a local anaesthetic agent will decrease post operative discomfort. It is usually not necessary to use infiltration with a vasoconstrictor such as adrenaline as the tissues are not vascular.

A straight incision is then made anteriorly with either scalpel or scissors to the extent planned (see Figure 6.1), being careful near the upper limit as scarring may (but usually does not) extend to the urethral meatus. The cut ends of the incised skin now retract upwards and outwards to reveal the tissues beneath. Haemostatic suturing can be performed on each side to rejoin skin edges to themselves, so as to decrease the chance of raw edges healing again across the midline (see Figure 6.2). This can be a continuous running suture but may only need to be two or three interrupted sutures of a fine absorbable material.

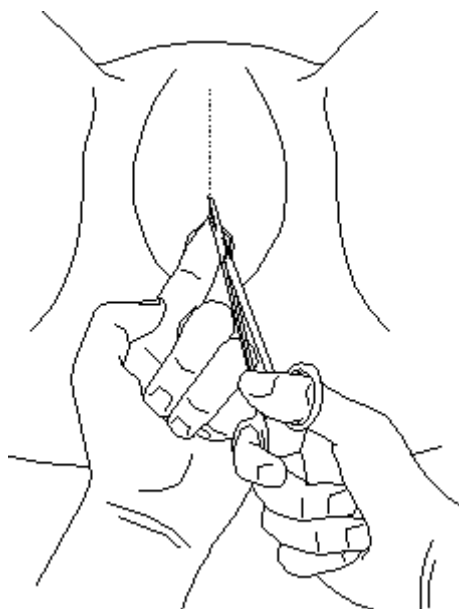


Figure 6.1: Dividing infibulation

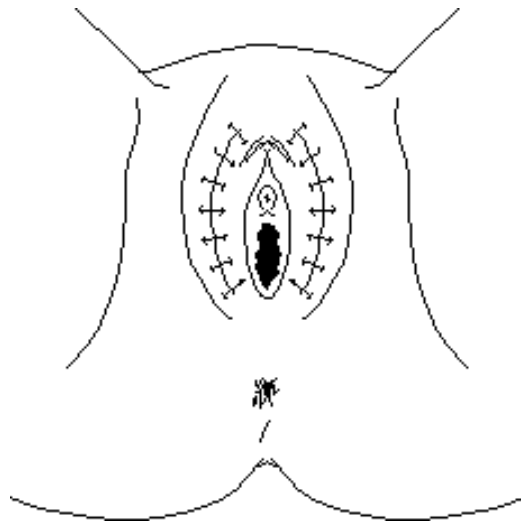


Figure 6.2: After divisions and suture

No dressing is required and the woman is usually well enough to go home after the usual anaesthetic recovery time. Rarely, reflex inability to void may need to be treated with overnight catheterisation and analgesia.

There are some reports of laser surgery for this purpose, but conventional techniques are generally quite satisfactory.

Post-operative care

Advice should be given about bathing twice a day during the early healing phase and gently checking that the suture lines are not healing together across the midline by passing a finger or soft cloth upwards across the vulva. If extensive raw areas remain after suturing, Vaseline gauze can be applied over those areas. Coitus should be avoided until healing is complete and the woman feels comfortable and confident. Husbands may need to be educated about the need to allow healing before the resumption of intercourse.

Further, while deinfibulation reverses the surgical procedure of FGM (to some degree) many of the psychological issues are likely to remain. Some women may not want to discuss their concerns around the time of the procedure, but may need support later. Information about local support services or further opportunities to raise post-operative concerns should be provided.

In labour

For special considerations during labour and delivery see Chapter 7: Pregnancy and childbirth.



7. Pregnancy and childbirth

Summary

The care of pregnant women should include approaches outlined in Practice guidelines.

Time should be taken to establish a clear understanding of the woman's expectations about childbirth.

Women may need to be advised and informed about the nature of care and any likely complications.

If infibulation has been performed, develop a plan for deinfibulation and discuss re-suture.

Routine examinations and assessment may need to be modified.

Be aware that midline episiotomies and tears may be taboo.

Consider and respect different expectations and understandings about caesarean section.

Ensure appropriate postnatal care and follow-up including maternal and child health care.

Antenatal care

The antenatal period is an important time for expectations and assumptions about childbirth to be discussed. There may be a need for time to be spent developing rapport and establishing a good relationship, so that the couple feel prepared for the birth of their child. In many ways this will be no different than for other couples, however where FGM may cause complications with birth it is important to have planned in advance and be aware of a couple's desired course of action. There may also be the issue of re-suture after birth, which is discussed below.

Expectations of antenatal care

The care of pregnant women should incorporate the approaches described in Practice guidelines. The antenatal period may be the first contact that the couple has with the health care system. Couples will probably be aware that in this country childbirth usually takes place in a hospital and that some antenatal care is required, however this may be very different from their past experiences. Some will not understand the reasons for frequent antenatal visits and may not be used to a medicalised approach to childbirth which may contradict their understanding of childbirth as a purely natural event (1). On the other hand, many women will appreciate the level of attention being paid and value this as an opportunity to find out more about childbirth including caesarean section and issues around sexual and reproductive health, child health and child development.

The care provider should ensure the woman and her partner gain an understanding of how child birth is managed in the support unit or centre in which she is to give birth. This should include discussion of who may be the support person at the birth and their role, plus what can be expected postnatally.

A visit to the delivery room and a general orientation to the unit or centre should be offered. Opportunities to be involved in childbirth and parenting classes should be explored.

It has been the experience of one Australian obstetric team that the confidence of women in the birth attendant is vastly enhanced when that carer has been involved in antenatal discussions and care. This has been of great assistance when decisions are required in labour and when deinfibulation and/or episiotomy are performed.

Expectations around childbirth

Affected women in Australia have indicated that pregnant women need information during pregnancy about how having undergone FGM will affect the birth process. If the woman is likely to have complications doctors need to explain them sensitively in advance.

Women who have experienced any form of FGM will, in most cases, not expect that this will make childbirth more difficult for them. Their desires for childbirth are likely to be similar to those of other women. Each can be assumed to want the best for her baby, herself and her family.

Once it is understood that the woman has undergone FGM it will be important to establish the way in which she and her husband would like her pregnancy to be handled. She may be reluctant to discuss this at first; there is a need to establish rapport and to understand the difficulty she may experience discussing this.

Women with more major forms of FGM (Type III, infibulation) are likely to have a view as to when there should be a reversal or easement of the closure (see Chapter 6). Some will be willing to have this done in the second trimester; some will expect it to occur during childbirth. It has been the experience of some that encouraging women to have deinfibulation performed during the antenatal period is advantageous because it alleviates many of the complications associated with a restricted introitus at the onset of labour (2).

Re-suture after delivery

The woman's expectations about re-suturing should be discussed in detail in the ante-natal period.

There may be an expectation that after child-birth the vulva will be closed to the same degree as it was previously. Re-suture to this degree is a health risk, may be considered illegal and should be discouraged. It is thought that re-suture has only become an issue in the last 50 years (3) since the development of modern suturing methods and it has been shown in the past that counselling prior to childbirth has substantially reduced the number of couples wanting the woman to have re-suture to the same degree.

The appearance of the genitalia may be very important to the woman and stitching of the vulval area should be very neat. This should also be discussed prior to delivery.

The possibility of marital desertion if the husband's wishes are not followed may need to be considered.

Some further issues to consider antenatally

Lesser degrees of mutilation may not be obvious on inspection and women may deny having ever undergone a procedure yet may still suffer pain on vaginal examination.

It may not be possible to do more than inspect the vulva of some women; performance of Pap smears and vaginal examinations may not be possible (see Practice guidelines).

A record of the husband's presence and his concurrence with whatever has been agreed or not resolved may be helpful.

There have been reports of infibulated women restricting dietary intake in fear that a large child will increase the pain associated with childbirth. The importance of a nutritionally balanced diet may need to be explained (1,4).

This may be the time to raise issues about FGM if the child is a girl.

Childbirth

The healthcare provider needs to appreciate that most women will be expecting a normal birth including those with the most extensive forms of FGM. A lack of extensive external evidence of FGM does not preclude internal scarring which may cause problems during delivery.

The degree of vulval opening or easement required to achieve a vaginal birth should be assessed early and continually as the labour progresses. An experienced practitioner familiar with the complications of FGM should be involved in assessment and delivery and it should be noted that for some there are taboos about midline episiotomies and tears. Particular skill and care may be needed in performing catheterisation, if indicated.

Childbirth and infibulation (Type III FGM)

The most extreme deviations from normal management of pregnancy and childbirth are likely to be for those who have undergone infibulation, which may restrict the following obstetric interventions both antenatally and in labour:

- speculum and vaginal examination
- induction of labour if necessary: preliminary deinfibulation may be required (see [Deinfibulation](#))
- assessment of progress in labour: rectal examination may be necessary
- catheterisation and bladder management; frequent voiding may avoid bladder overdistension and the need for catheterisation.

Planning for second stage management includes:

- consideration of opening or easing procedures to allow delivery
- discussion of the degree of re-suturing after delivery, if not planned antenatally.

Deinfibulation in labour

When this procedure is done during labour, it is usually in second stage as the head is descending, and suturing is performed after delivery is complete. Any anterior adhesions should be divided first and then a decision made about the need for the more usual medio-lateral episiotomy. It should be noted that a variable amount of scarring around the introitus may be present and distensibility of the lower vagina and perineum may not be as good as in women without prior genital trauma. If this tissue tears during delivery, vaginal and even urethral tears may be extensive, and so early recourse to a medio-lateral episiotomy may be worth considering. Sometimes bilateral episiotomies are required, but it is important that midline cuts and tears be avoided as damage to this area is often taboo. This may be a result of the difficulty dealing with the long term incontinence or fistulae that may have

resulted from ano-rectal trauma in traditional settings.

Occasionally deinfibulation may be required earlier in labour, or even to allow induction of labour, in which case it could be performed under epidural anaesthesia and suturing performed at the time as described for the elective procedure in [Deinfibulation](#).

Following delivery some degree of resuture may be required to achieve haemostasis and healing. Previous discussion should have addressed this so that introital narrowing may be kept to an absolute minimum.

Caesarean section

Caesarean section is often not welcomed nor readily agreed to by women who have had FGM or their husbands for a number of reasons.

There is a perception among some of the communities that Australian midwives and doctors lack the skills to do vaginal deliveries in women with FGM and resort to caesarean section for this reason. There is a perception also that caesarean sections are more commonly performed with women who have undergone FGM, although current data (5) do not support this. Some women have a fear of being 'practised on' by junior staff and it may be necessary to explain the roles and supervision of junior medical staff.

In many of the communities where FGM is performed caesarean sections will be rare. In many countries caesarean section will be performed only as a last resort when the mother's life is in danger. It is not generally performed to save the child, as expectations of foetal mortality are different from our own. Suggestion of this procedure may therefore create a fear that a woman's own death is imminent. The mother may also be concerned about risks to future pregnancies, as the inability to have another child may seem worse than losing the current one. If she plans to return to her country of origin, repeat caesarean section may not be readily available and there may be a significant risk of uterine rupture after caesarean section, particularly if several more pregnancies follow.

If reasons for caesarean section are understood and accepted, an elective procedure may still not be acceptable, with some women insisting on waiting for the onset of labour. The cultural and/or social significance of such decisions should be acknowledged, respected and accommodated if reasonably and safely possible. Outright refusal of caesarean section in the face of risk of fetal death may be incomprehensible to the health practitioner, but may be the chosen path of action for a woman and her family, even if the outcome seems unacceptable to care providers. Practitioners must conscientiously endeavour to explain any risks and the reasons for any recommended intervention, using interpreters as appropriate, and accept the informed decision of a woman and her family. Some have found a male practitioner to be accepted as more authoritative in such situations, even though a female practitioner may have been previously sought.

If every effort has been made to establish continuity of care giver and trust has developed between the woman, her partner and the care giver, much can be resolved.

Post-partum care

Women may need support and advice on the care of any perineal, vulval or vaginal wounds, or raw surfaces.

Urinary continence may be a post partum issue dependent on what occurred during the birth.

If the woman has had a caesarean section it is important that the issues surrounding the possibility of a vaginal birth in the future are explored, or conversely those associated with a recommendation that subsequent births be by caesarean section.

Every effort should be made to ensure the woman has access to appropriate support and professional care after she is discharged. A postnatal check should be offered. Again this may not be the previous experience of the woman and may not be taken up as a health care opportunity.

Maternal and child health visit

Maternal and child health nurses are in an ideal and influential position to provide further education regarding FGM.

In the States and Territories where there is an established maternal and/or child health service, the universality and availability of the maternal and child health service counters perceptions of discrimination and women may feel encouraged to raise issues in a non-threatening environment with a trusted professional.

The first visit

Being familiar with the incidence of the practices may alert the care giver to a possibility that a woman may have more than the usual postnatal recovery needs.

In a municipality where relevant communities are living there may be a need for a system of notification with maternity hospitals to identify affected women. The birth notification and the birth details in the Child Health Record may give no indication of maternal health, but the Peri-natal Data Collection sheet may indicate problems such as episiotomy repairs.

The home visit is the first opportunity to develop a relationship with the mother and inquiry into her physical state may elicit an indication that she may be experiencing difficulties. The mother may need support and information relevant to the care of perineal, vulval or vaginal wounds. For women who have not had reinfibulation to the same degree as before the birth some support may be needed relevant to changes in appearance, the experience of sex and with respect to changes in urinary voiding patterns.

If the new baby is a girl, the examination of the baby is the ideal time to begin education and discussion of unaltered female genitalia, as some women may not be aware of their appearance. The nurse should be sensitive to opportunities to discuss the health effects of FGM, if raised by the mother and if it seems possible to respond without alienating the

family and discouraging confidence in health care services.

Normal female hygiene should be discussed if necessary and the appearance of normal mucous membrane should be casually explained. There should not be an over-emphasis on cleanliness.

Communication

Asking a woman if she had any particular difficulties during her pregnancy or delivery may identify those requiring follow-up. Knowledge of a referral to a gynaecologist or attendance at the obstetrician's for ongoing supervision may provide the opportunity to inquire about the nature of the problem.

Women identified as having undergone FGM should be cared for with a focus on ongoing health and it may therefore be necessary to ascertain (without pressure) the nature and extent of the procedure she has undergone.

The development of rapport is a vital component of this process and once a trusting relationship is developed it is reasonable to discuss her expectations of further pregnancies.

Legislation

Families may well be aware of the law through community discussion and may seek the interpretation of the Maternal and Child Health Nurse. It is therefore important to be familiar with the relevant law (see Chapter 2). The relationship established between the family and the nurse may provide an opportunity for the family to raise issues later, especially as their daughter grows.

The foundation laid by education and information at this early stage may be crucial in assisting the family in their decision not to seek or to permit any mutilation of their daughter.

Resources

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Conclusion

This booklet provides information to assist practitioners in the delivery of health care to women and girls who have experienced or may be at risk of female genital mutilation. We have attempted to provide enough background to give an idea of the extraordinary complexity of the related issues in the lives of these women and girls within their own communities and in broader society, especially in a new country. It has not been possible to do justice to all the reproductive health, quality of life, human rights and gender issues involved, but we hope that it will succeed in contributing to a better recognition and exploration of women's needs, resulting ultimately in improvements in the care we are able to offer. We hope that this care will also support women and their communities in their efforts to achieve change, contributing to the eradication of female genital mutilation.

Appendices

Appendix A: Steering Committee Membership

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Dr Anne Beck

Retired General Practitioner

Kensington, Victoria

Ms Umalkher Dalmar

African Women's Working Group

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Ms Helen Rankin
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Canberra, ACT

Dr Margaret Ryan
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Dr Susan Sawyer
Deputy Director
Centre for Adolescent Health
Parkville, Victoria

Ms Di Surgey
Coordinator
Women's Health in the North
Reservoir, Victoria

Appendix B: State and Territory contacts for the National Education Program on Female Genital Mutilation

State/Territory	Contact	Phone number
ACT	Project coordinator ACT Community Education Program on Female Genital Mutilation PO Box 825 CANBERRA, ACT 2601	(02) 6207 5416
New South Wales	Project manager NSW Education Program on Female Genital Mutilation Transcultural Mental Health Centre 5 Fleet Street NORTH PARRAMATTA NSW 2151	(02) 9840 3800
Northern Territory	Coordinator NT Education Program on Female Genital Mutilation Northern Territory Department of Health Services PO Box 40596 CASUARINA NT 0811	(08) 8999 2932
Queensland	Project Officer State-Wide and Non Government Health Unit 202 Adelaide Street BRISBANE QLD 4000	(07) 3234 1357
South Australia	Female Genital Mutilation Program Coordinator Migrant Health Services South Australian Health Commission 21 Market Street ADELAIDE SA 5000	(08) 8200 3937
Tasmania	Project Officer Tasmanian Education Program on Female Genital Mutilation Women's Health Unit Department of Community and Health Services GPO Box 125C HOBART TAS 7001	(03) 6233 2629
Victoria	Coordinator Victorian Education Program on Female Genital Mutilation Women's Health Unit Department of Human Services 5/555 Collins Street MELBOURNE VIC 3000	(03) 9616 7292
Western Australia	Coordinator WA Education Program on Female Genital Mutilation Multi-cultural Access Unit Health Department of Western Australia 83 Fairfield Street MOUNT HAWTHORNE WA 6016	(08) 9242 9218

Appendix C: Summary of mandatory reporting in Australia

State/Territory	Legislation	Person required to notify	Recipient of notification
COMMONWEALTH	Family Law Act 1975	Personnel of the Family Court	A prescribed child welfare authority
ACT	Children's Services Act 1989 (Section 103(21))	Medical practitioners, dentists, nurses, police, teachers, persons employed to counsel children in school or persons employed in the Department of Health Authority whose duties include matters relating to children's welfare or persons providing child care in a premise licensed for that purpose.	The Director
NEW SOUTH WALES	Children (Care and Protection) Act 1987 Regulation 10	Medical practitioners, school principals, deputy principals, teachers (in a school), school social workers, early childhood teachers in schools, school counsellors.	Department of Community Services
NORTHERN TERRITORY	Community Welfare Act 1983	Any person. Police may report and/or intervene directly - if they intervene they must report to the Dept. within a limited time frame.	Department of Health and Community Services
QUEENSLAND	Health Act 1937	Suspected maltreatment or neglect - medical practitioners.	A person authorised by the Director-General, Medical Health Services (Chief Health Officer) Department of Health.
SOUTH AUSTRALIA	Children's Protection Act 1983 (section 11(1&2))	Medical practitioners, dentists, registered or enrolled nurses, psychologists, teachers in any institution including kindergartens, police, employees or volunteers in Government or non-Government agencies providing health and welfare services wholly or partly to children (as defined), social workers, family day care providers.	Department for Family and Community Services

TASMANIA	Child Protection Act 1974. Child Protection Order 1977 being Statutory Rules 1977, No 3205	Probation officers, child welfare officers, welfare officers, persons holding children's boarding home or day nursery licences, school principals including infant schools, kindergarten teachers, officers engaged primarily in welfare work, Education Department guidance officers, psychologists, social workers, medical practitioners, registered nurses.	Child Protection Board Child Protection Unit (Department of Community Health Services)
VICTORIA	Child & Young Persons Act 1989 section 64	Medical practitioners, nurses, teachers and school principals, police, (youth and care workers, social workers in the health, education, community and welfare services fields, probation and parole officers, psychologists – not gazetted at this time).	Director General
WESTERN AUSTRALIA	No provision for mandatory reporting	N/A	N/A