GenWest Gender Justice and Change.

Women's Health in the North
voice • choice • power

phn North Western Melbourne
An Australian Government Initiative

Social, cultural and clinical aspects of female genital cutting

Thursday 27 November 2025

Acknowledgement of Country

GenWest, Women's Health In the North and the NWMPHN recognise that the land on which we work and provide our services always was and always will be Aboriginal land. We pay our respects to Elders past and present.

We proudly acknowledge the Aboriginal and Torres Strait Islander communities across Melbourne's northwest, their rich cultures, diversity, histories and knowledges, and the deep contribution they make to the life of this region.

We acknowledge the ongoing impacts of colonisation, as well as the strength and resilience of Aboriginal and Torres Strait Islander communities, and express solidarity with the ongoing struggle for land rights, self-determination, sovereignty, and recognition of past injustices.

Who we are

GenWest and Women's Health In the North are both organisations working towards gender equity. A key aspect of this work is sexual and reproductive health.

Our work includes providing health education to communities in the north-west region and advocating for sexual and reproductive health and rights.

We work in partnership with women's health services across the state and partners from community health, local Government and health services.

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Housekeeping – Zoom Meeting

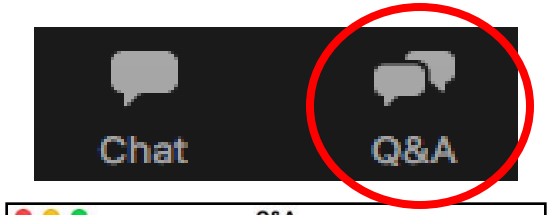
All attendees are muted

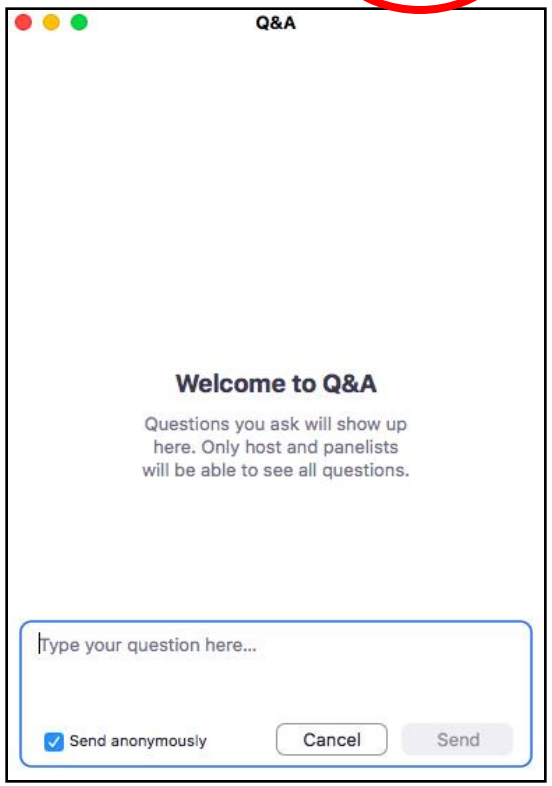
Please ask questions via the Q&A box only. Questions will be asked anonymously to protect your privacy

There will be a dedicated discussion component at the end of the session.

This session is being recorded, you will receive a link to this recording and copy of slides in post session correspondence.

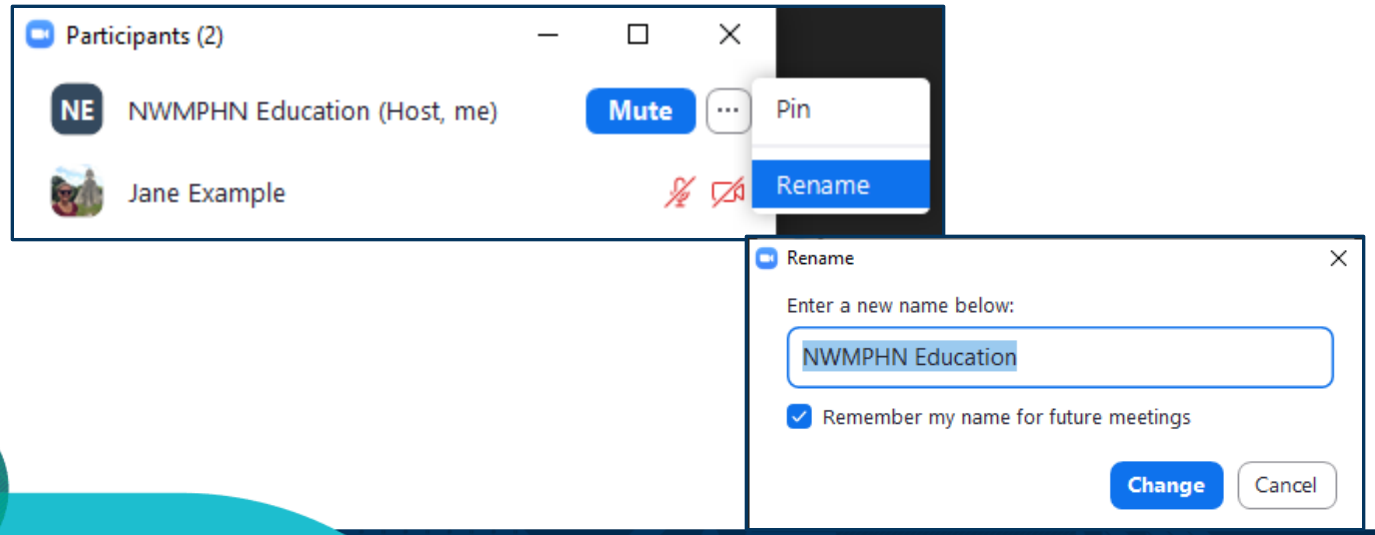
Please ensure you join the session using the name you registered with so the PHN can mark your attendance . Certificates and CPD will not be issued if we cannot confirm your attendance.

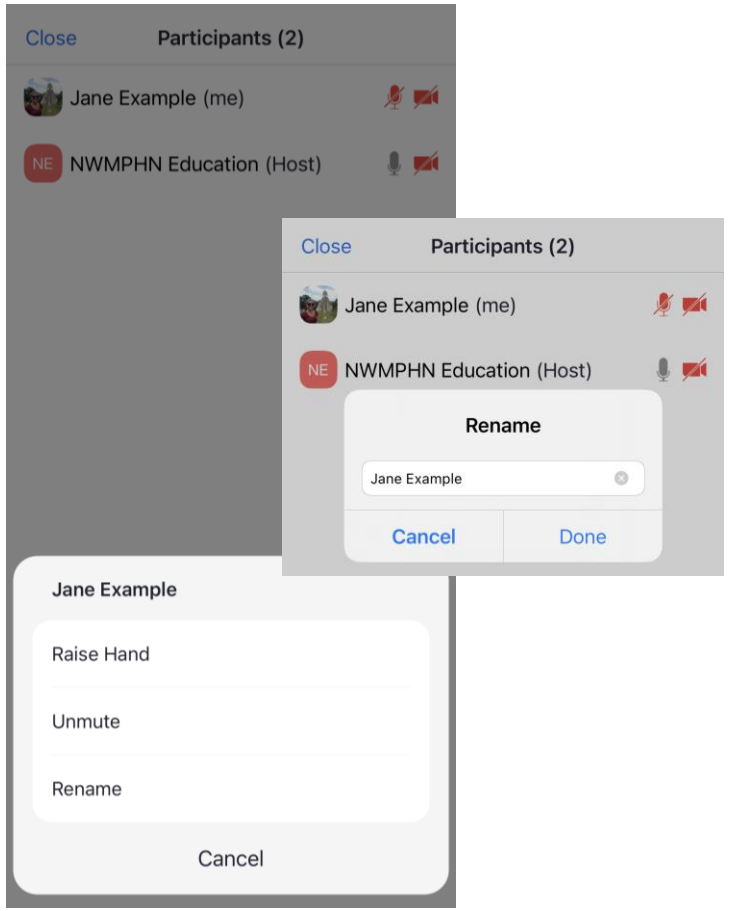




How to change your name in Zoom Meeting

1. Click on *Participants*
2. **App:** click on your name
   Desktop: hover over your name and click the 3 dots
   Mac: hover over your name and click ***More***
3. Click on ***Rename***
4. Enter the name you registered with and click
   Done / Change / Rename





Agenda

Session Outline

- Introduction to female genital cutting
- Family and Reproductive Rights Education Program (FARREP) and providing culturally sensitive support
- Clinical services at The Women’s
- Discussion and Q&A

Speakers

- Intesar Homed, Women’s Health In the North
- Shukria Alewi, GenWest
- Marie Jones and Sarah Chisholm, The Royal Women’s
- Joanne Gardiner, cohealth

Introduction to FGC, Family and Reproductive Rights Education Program (FARREP) and providing culturally sensitive support

Intesar Homed, Women's Health in the North
Shukria Alewi, GenWest

Overview

Part 1: Introduction to female genital cutting

- Definitions and terminology
- Prevalence rates
- History of FGC
- Cited reasons for practice
- Human rights frameworks

Overview

Part 2: Family and Reproductive Rights Education Program (FARREP) and Providing Culturally Sensitive Support

- Overview of FARREP
- FARREP at GenWest and Women's Health In the North
- Working with communities who have migrated from countries with prevalence of FGC
- Barriers to sexual and reproductive health services for women who have migrated from countries with prevalence of FGC
- Referral pathways
- Existing resources and clinical guidelines.

230 million

women and girls worldwide undergone some form of FGC

144 million

women and girls in Africa alone undergone FGC

30 countries

Practiced in parts of Africa, Asia and the Middle East

53,000

estimated people living in Australia from countries known to practice FGC in 2019

Definition

Female genital cutting can be defined as:

"All procedures that include partial or total removal of female genital organs or other injury to female genital organs for non-medical reasons."

For discussion

- **What do you know about FGC?**
- **What have you heard about the history of the practice?**

History of the practice

- Mummies of Egypt back to the 16th century
- In Roman times, forms of infibulation were used on female slaves as a form of contraception (French, 1992).
- United States (1890s), FGC was practiced by doctors to cure female weakness.
- Western countries including England have used FGC to “cure” women for psychological ailments and so called “female deviances” (Tubia 1995, p.21).

For discussion

- **Do you know at what age the procedure is carried out?**

When is the procedure carried out?

- The procedure may be carried out when the girls are:
    - newborn
    - during childhood
    - adolescence
    - just before marriage
    - during first pregnancy

- Most FGC cases are thought to take place between the ages of 5 and 8.

For discussion

From terminology listed below, which terms will you use when discussing FGC with community?

1. Female circumcision
2. Female genital mutilation
3. Traditional cutting

Terminology

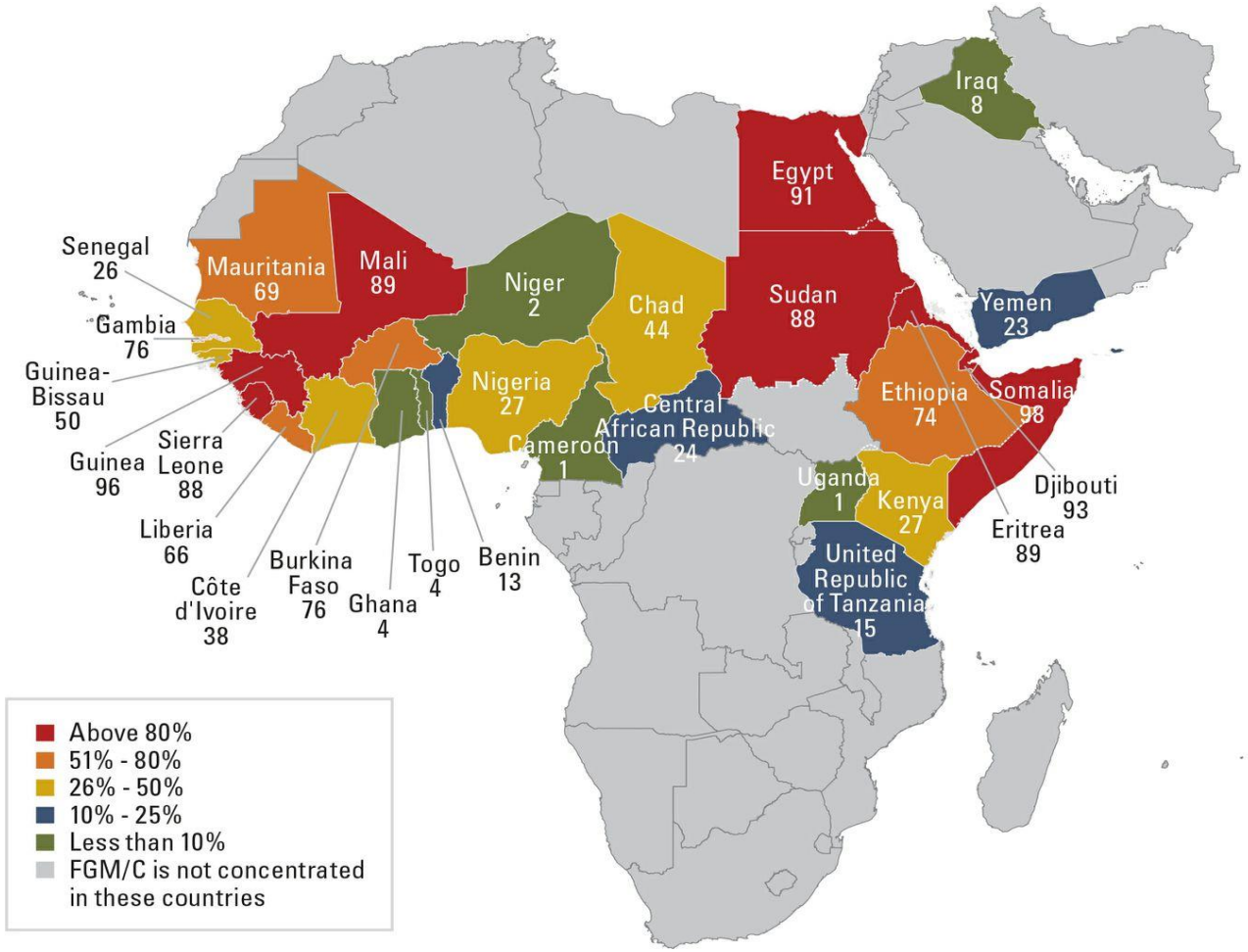
- Use of the word ‘mutilation’ reinforces the harm caused by the practice and reiterates that it is a gender-based, human rights violation.

- Terms such as ***‘Female circumcision’*** or ***‘Traditional cutting’*** are more effective in engaging families and communities.

- Terminology is very important as the term ‘mutilation’ can polarise communities where the practice is a cultural custom.

Map 4.1 FGM/C is concentrated in a swath of countries from the Atlantic Coast to the Horn of Africa

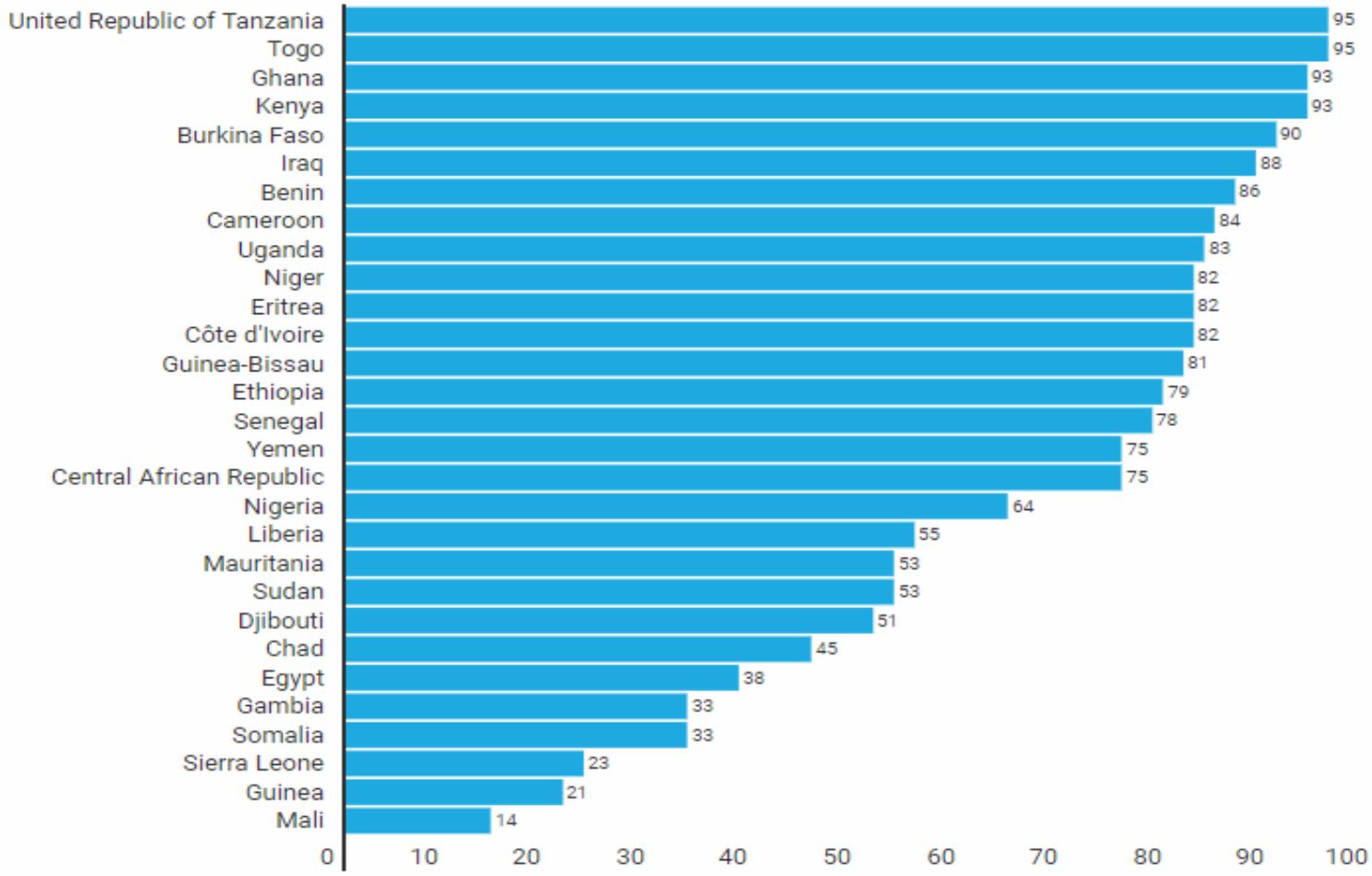
Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by country



Notes: This map is stylized and not to scale. It does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers. In Liberia, girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM/C since it is performed during initiation into the society, as explained in Box 4.2. Data for Yemen refer to ever-married girls and women. The final boundary between the Republic of the Sudan and the Republic of South Sudan has not yet been determined.

Sources: DHS, MICS and SHHS, 1997-2012.

Percentage of girls and women aged 15 to 49 who have heard about FGC and think the practice should end



UNICEF global databases, 2017

For discussion

Do you know what the prevalence rate of FGC is in Victoria?

Prevalence of FGC in Victoria

- Difficult to estimate because we have no data
- However, there is high settlement of women and girls from countries where FGC is prevalent

Estimate prevalence of FGM/C in Australia , by country of birth , 2017

Estimated prevalence of FGM/C in Australia, by country of birth, 2017

Country of birth	Estimated number of girls and women in Australia with FGM/C[a]
Côte d'Ivoire	102
Egypt	20,381
Eritrea	2,388
Ethiopia	5,206
Ghana	135
Guinea	525
Iraq	3,616
Kenya	2,996
Liberia	1,070
Nigeria	934
Sierra Leone	1,954
Somalia	4,831
Sudan (north)	8,364
Tanzania	273
Other[b]	312
Total[c][d]	**53,088**

Estimated prevalence of FGM/C in Australia, by age group 2017

Estimated prevalence of FGM/C in Australia, by age group[a], 2017

Age group (years)	Estimated number of girls and women in Australia with FGM/C	Estimated number of girls and women in Australia[b]	Age-specific prevalence per 1,000 girls and women in Australia[c]	Estimated proportion of all girls and women in Australia with FGM/C (%)[d]
0–4	410	764,887	0.5	0.8
5–9	988	773,385	1.3	1.9
10–14	1,737	715,467	2.4	3.3
15–19	2,604	724,218	3.6	4.9
20–24	3,511	842,755	4.2	6.6
25–29	4,820	921,491	5.2	9.1
30–34	5,634	924,243	6.1	10.6
35–39	5,029	830,943	6.1	9.5
40–44	4,602	805,939	5.7	8.7
45–49	4,162	840,186	5.0	7.8
50–54	3,555	782,812	4.5	6.7
55–59	3,152	767,759	4.1	5.9
60–64	3,068	682,895	4.5	5.8
65–69	2,955	607,738	4.9	5.6
70–74	2,479	487,400	5.1	4.7
75 and over	4,383	922,396	4.8	8.3
Total[e]	**53,088**	**12,394,514**	**4.3**	**100.0**

For discussion

Do you know what people's reasons are to get FGC done?

Main reasons cited for practice

- Preservation of traditional practice and cultural identity
- Hygiene and cleanliness
- Protection of virginity
- To ensure fidelity
- To promote marriageability and social and economic status
- To enhance the husband’s sexual pleasure
- Religious observance
- Social pressure from peers
- It is a rite of passage
- It upholds the family honour

Royal Women’s Hospital 2018

For discussion

Do you think religious scriptures advocate or justify the practice of FGC?

FGC and Religion

- FGC is practised by communities and often claimed to be carried out in accordance to religious beliefs
- However, FGC predates Christianity, Islam and Judaism
- The Bible, Quran, Torah and other religious text do not advocate or justify FGC

For discussion

- **Where do you think the procedure of FGC is carried out ?**
- **Who do you think carries out FGC?**

Who carries out FGC?

- Usually carried out by an older women for whom it’s a way of gaining prestige and can be a source of income
- It is also carried out in hospitals (in some practising countries)
- The procedure includes the girl being held on the floor usually by a lot of women, and the procedure carried out without medical expertise, attention to hygiene or anaesthesia

Human Rights Framework

- FGC constitutes a violation of the rights of women and girls.
- FGC violates a number of treaties
  - Covenant on Civil and Political Rights
  - Covenant on Economic, Social and Cultural Rights
  - Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)
  - Convention on the Rights of the Child
  - Convention relating to the Status of Refugees and its Protocol relating to the Status of Refugees

(WHO 2008, p.8; Rahman & Toubia 2000)

Efforts to Eradicate FGM/C

- International response
- Australian response

International status of FGC

- Illegal in Europe, North America, New Zealand and Australia.
- Illegal in parts of Africa

  Issues with enforcement of legislation
- Medicalised in some countries as part of a ‘harm reduction strategy’

International response

- UN General Assembly accepted in December 2012 resolution to eliminate FGC.
- WHO published global strategies to stop health care providers from performing FGC in 2010.
- Research shows decrease in prevalence of FGC as increased number of women and men support ending of the practice.
- Post-COVID has seen an increase in the practice, in part due to disruptions in schooling, and impacts on NGO advocacy work.

For discussion

- **Do you know what the legal status of FGC is in Victoria?**

Legal status of FGC in Victoria

Relevant Victorian legislation:

- Crimes (Female Genital Mutilation) Act 1996
  - Legal status of FGM/C
- Children, Youth and Families, Act 2005
  - Mandatory reporting

Part II

What is FARREP?

- Established in 1995
- A state-wide program funded by Department of Health (DoH)
- Aims to prevent FGC and redress the sexual and reproductive health issues in communities affected by FGC
- Based on UN initiatives to eradicate FGC

FARREP at GenWest

- Sits within Action for Equity which is a sexual and reproductive health strategy for Melbourne's west

- Work with a range of health professionals to their build capacity to ensure the provision of culturally appropriate services in Melbourne’s west

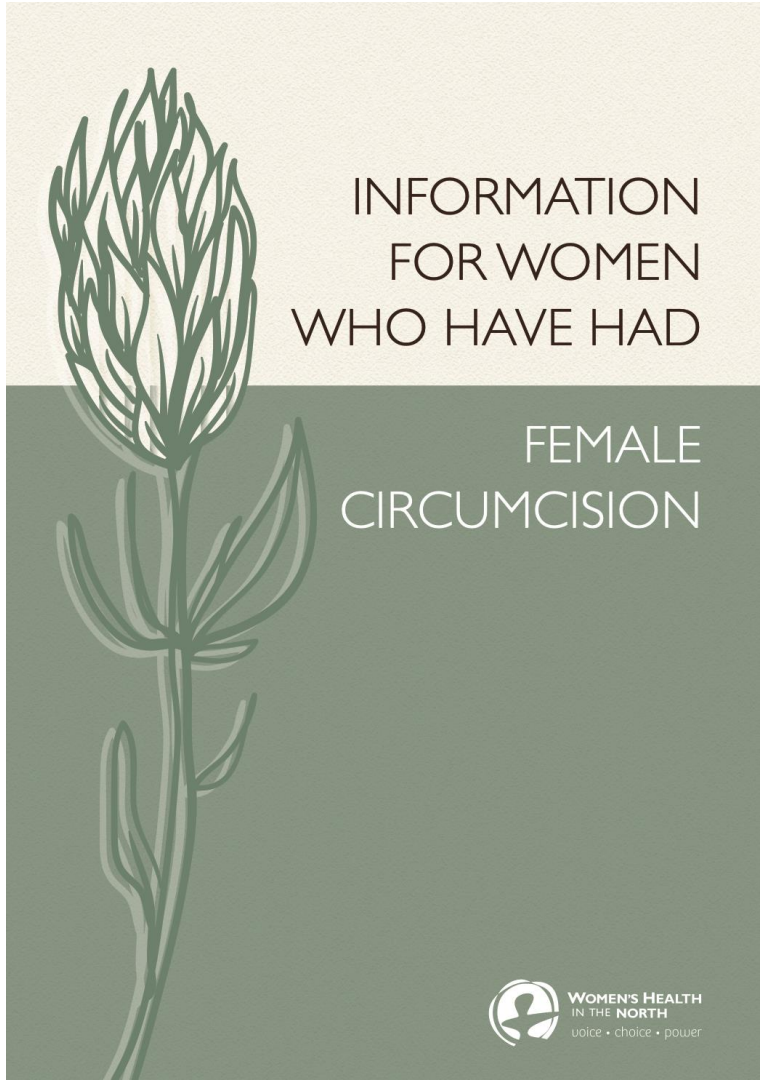
- Improving the sexual and reproductive health and wellbeing of women from communities who have migrated from countries with FGC prevalence and work to prevent the practice

FARREP at WHIN

- Sits within Freedom, Respect and Equity in Sexual Health which is a sexual and reproductive health strategy for Melbourne's north.

- Delivers FGC professional education sessions to clinicians and allied health staff focusing on culturally sensitive service provision.

- Works with women from communities that traditionally practise FGC, to support their sexual and reproductive health and to work to prevent the practice



Working with communities who have migrated from countries with prevalence of FGC

For discussion

Do you know the implications of settlement on communities?

Impact of migration and settlement for communities who have come from countries with high FGC prevalence rate

- Grief
- Settlement issues and language barriers
- Isolation and mental health issues
- Culture shock
- The legal status of FGC
- Intergenerational conflict
- Different gender roles/ expectations
- Health illiteracy
- Difficulty navigating bureaucratic systems
- Experience of racism

For discussion

What do you think are the health needs of women and girls from FGC prevalence communities ?

Health needs of the women and girls are:

- Education
- Counselling
- Regular gynaecological check ups
- Intensive ante-natal and post-natal care
- Restorative surgery (De-infibulations)
- Menopausal care

Why is it important to work with women and girls?

- Assist in meeting the sexual and reproductive health needs of women and girls who have migrated and settled from countries with prevalence of FGC and prevent its occurrence.
- Improve health outcomes.
- Improve access to services.

Traditional African communities

- Women's traditional role is to be a good mother and carer
- Pregnancy and birth is mostly women's business
- Women rely on female relatives and friends for support during this time
- Traditional practices (e.g. 40 days rest) are common in some communities
- Many African cultures are oral, so information is passed on verbally

Traditional African communities

- Health systems in many African countries are inadequate
- There is no context for preventative health (e.g. having cervical screening)
- Health education is limited
- Women experience barriers when accessing the health system
- Different gender roles and expectations
- Poor health literacy
- Experiences of racism and discrimination

Things to consider when working with women

- Be clear about your role, scope, authority and responsibility
- Make appropriate referrals by knowing what services are available in your area and what they can do
- Be clear with women about what is happening and ensure that they are informed at every stage
- Do not assume anything
- FGC comes in many forms

Things to consider when working with women

- Use skilled female interpreters where possible
- Consult with FARREP workers and the target community
- Use welcoming manner and friendly body language
- Maintain a non-judgemental and respectful approach

Have in the back of your mind

- Countries where FGC is more prevalent but don’t generalise
  - Somalia, Eritrea, Djibouti, North Sudan: Type III
  - Egypt, Ethiopia, Mali, Sierra Leone, Middle East , India etc: Type I & II
  - Indonesia: Type I
- There will always be women from areas of these countries who will not practice FGC… therefore you need to ask the question?

Starting the conversation

1. “Many women from XXXX practice traditional cutting, is this something you have experienced?” (some may not know)

2. Explain that when examining her it may be that if it is difficult to perform the test and she will need referral to another specialist clinic

How to support the woman

1. Always use female interpreters – onsite is preferable but not always possible
2. Reassure the woman that the consultation is confidential and private. It might take more than one appointment
3. Let the woman know that she can bring a friend or relative to the appointment for support
4. Use simple English to explain the test – use diagrams/ flip charts/ appropriate websites

Referral/Support Services

- The Royal Women's Hospital
- FARREP workers in Victoria:
  - GenWest
  - Women's Health In the North
  - Cohealth
  - Monash Health
  - Darebin Council Youth Services
  - Multicultural Centre for Women's Health
  - Banyule Community Health
  - Mercy Hospital for Women

Female Genital Mutilation:
Optimal Clinical Care for women who have experienced FGM

The African Women's Clinic
The Royal Women's Hospital

Marie Jones Nurse Practitioner Midwife AWC Coordinator
Sarah Chisholm Clinical Nurse Midwife Specialist

November 2025

the women's
the royal women's hospital

Family and Reproductive Rights Education Program (FARREP) The African Women's Clinic

RWH FARREP

- Medina Idriess
- Jebbeh Manduleh

AWC

- Marie Jones
- Sarah Chisholm
- Eboni Cameron

Responding to Women's Needs in Victoria

Family and Reproductive Rights Education Program (FARREP)

- **1990's** – Increasing numbers of migrant and refugee women affected by FGM/C presenting for pregnancy care in Melbourne
- **1997** – Statewide program established following introduction of legislation and UN initiatives to end FGM. Other states and territories have *bi-cultural* workers

FARREP at The Women's

- Provide advocacy, education and support for women affected by FGM
- Link between the woman and AWC, enabling women to achieve timely and accessible services through The Women's
- To promote the elimination of FGM through supporting a change in local and community attitudes to the practice
- At RWH, located in Social Work Department Monday-Friday 9-5pm
- Workers can come to ANC / inpatient wards to support affected women

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Responding to Women's Needs in Victoria

- **1997** – FARREP established Statewide
- **2010** – *Deinfibulation Clinic* established Nurse Midwife led response in collaboration with FARREP
- **2015** – Renamed *African Women's Clinic*

The African Women's Clinic - Overview

Nurse midwife led clinic in collaboration with FARREP

Referrals received from:

- Self (Online research, word of mouth through family, friends, community)
- General Practitioners or other Community HCP's
- RWH clinicians (ANC, WEC, Urogynaecology Clinics)

Consumers:

- Pregnant and non pregnant women of all ages
- Women planning to marry
- Women experiencing sexual difficulty

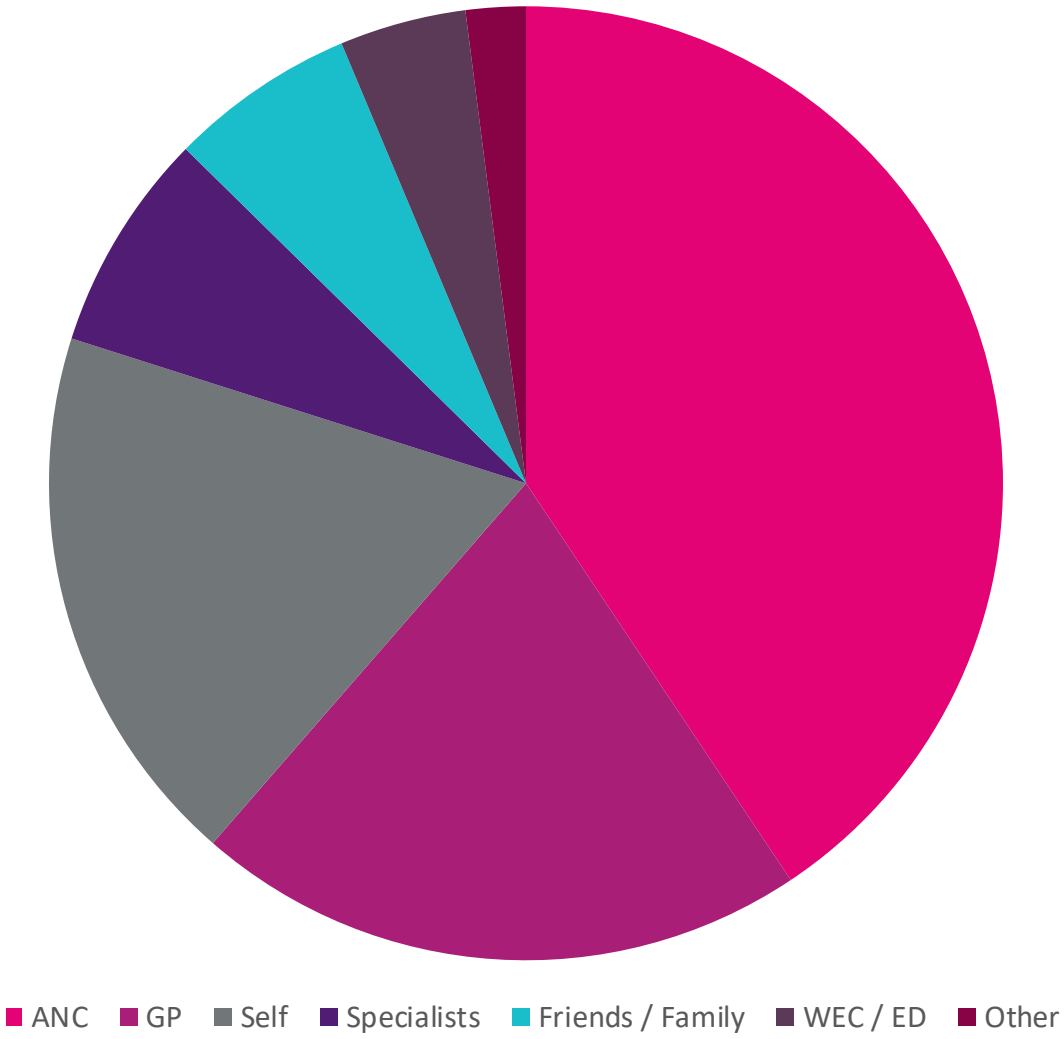
What we provide:

- Clinic 3 Fridays per month (Increased in 2025)
- Holistic health assessment, including FGM/C
- Support and education
- Deinfibulation procedure under local anaesthesia in clinic rooms
- Internal referrals

Referral Sources

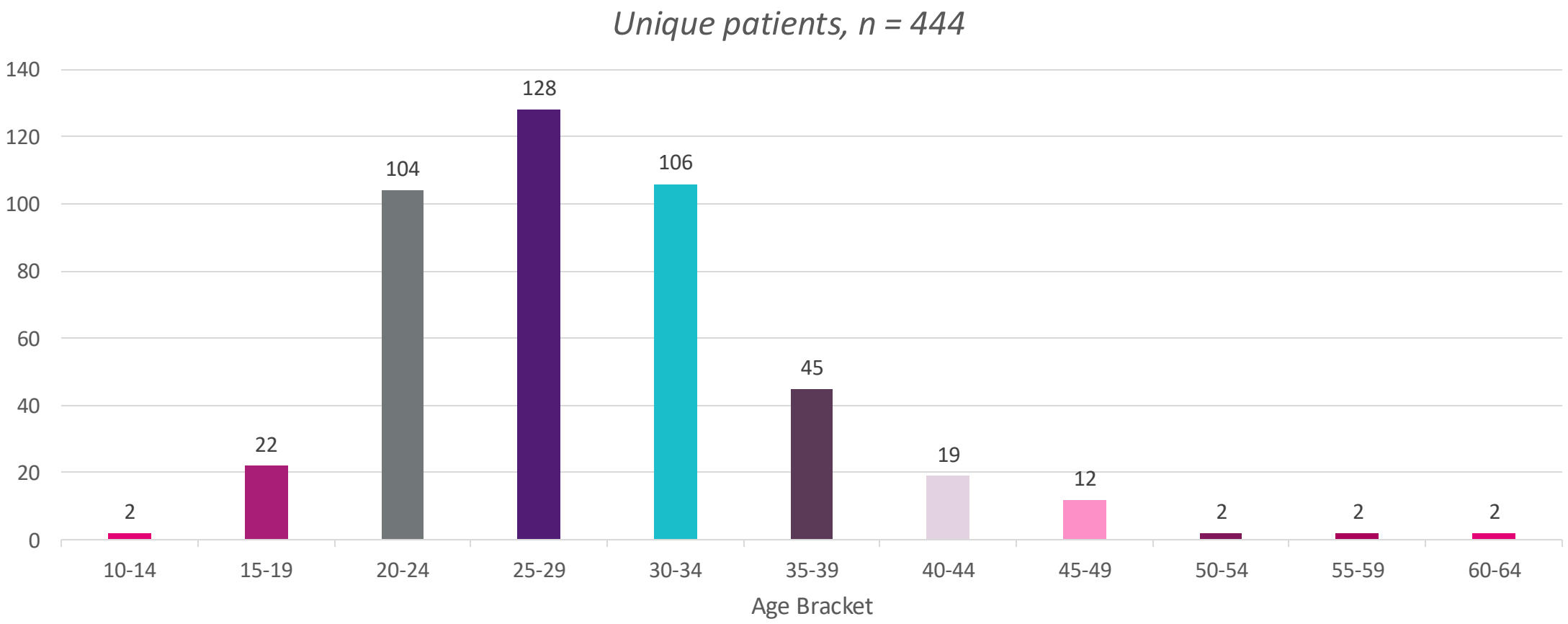
Antenatal Clinics	180
GP	92
Self Referred	82
Specialists	33
Friends / Family	28
WEC / Emergency	19
Other	9

Incoming Referrals to AWC, n = 443



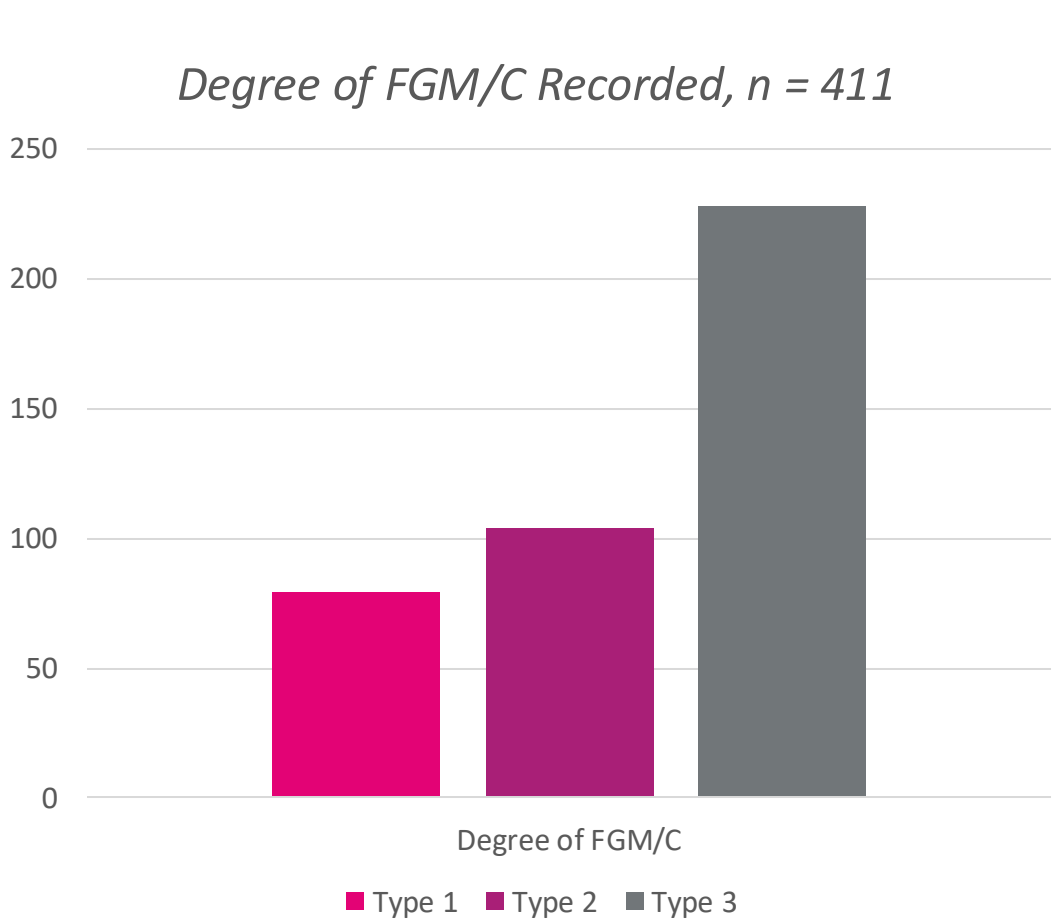
(Martin et al., 2021)

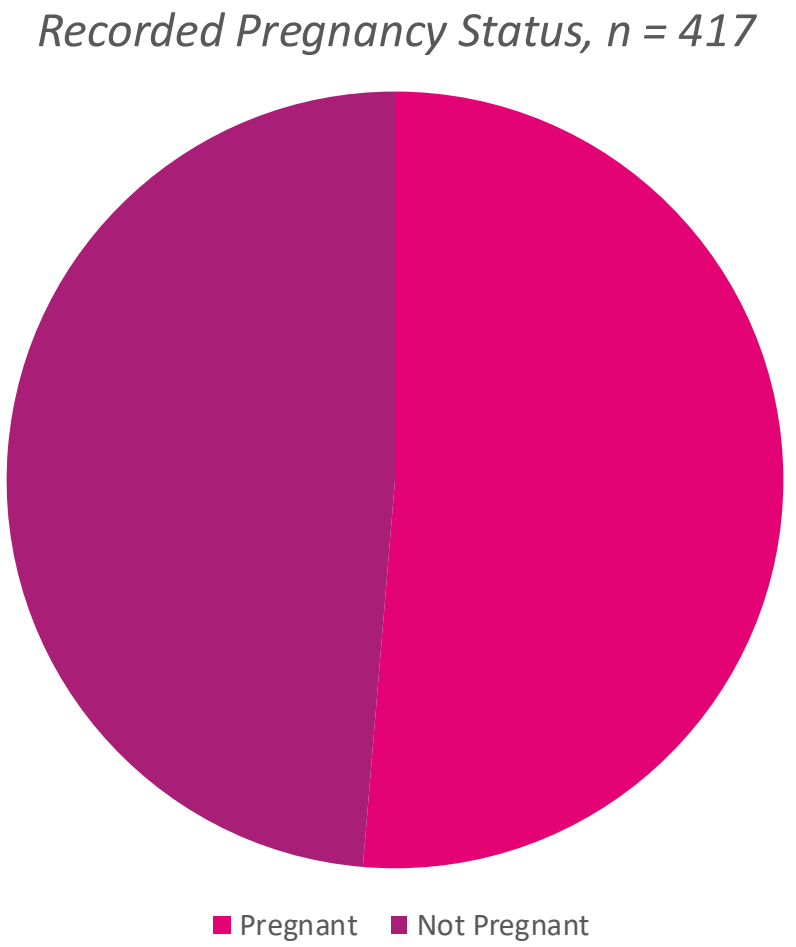
Age at First AWC Appointment



(Martin et al., 2021)

African Women's Clinic – Consumers





(Martin et al., 2021)

African Women's Clinic

Initial Appointment

- Interpreters!
- Consultations can take longer than typical appointments – we give women as long as they need.
- Comprehensive and Holistic Health Assessment
- Address concerns or symptoms related to FGM
  Chance for women to discuss experience of FGM with HCPs who otherwise wouldn't be familiar with the practice
- Physical Gynae Assessment
  With consent, using mirror
  Assess FGM Type, concerns, discuss what has likely happened
- Opportunistic CST/STI screening
  Under-screened population
- Opportunistic education regarding sexual and vulval health and function
  Use of 3D vulval model 'Cliterate'

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Issues affecting Health Service Access

Women learning they are different
- Shame and stigma

Discussing their health issues that may be too difficult to verbalise

- Women think they may be “judged”

Distinguishing symptoms that are actually caused by FGM

- not just part of being a woman

Psychological Issues
- Traumatic painful memories of extreme pain – flashbacks

Family conflict / Privacy
- Being able to access a health service without anyone knowing
- Always check re: mail to home address, phone calls, texting the most used communication

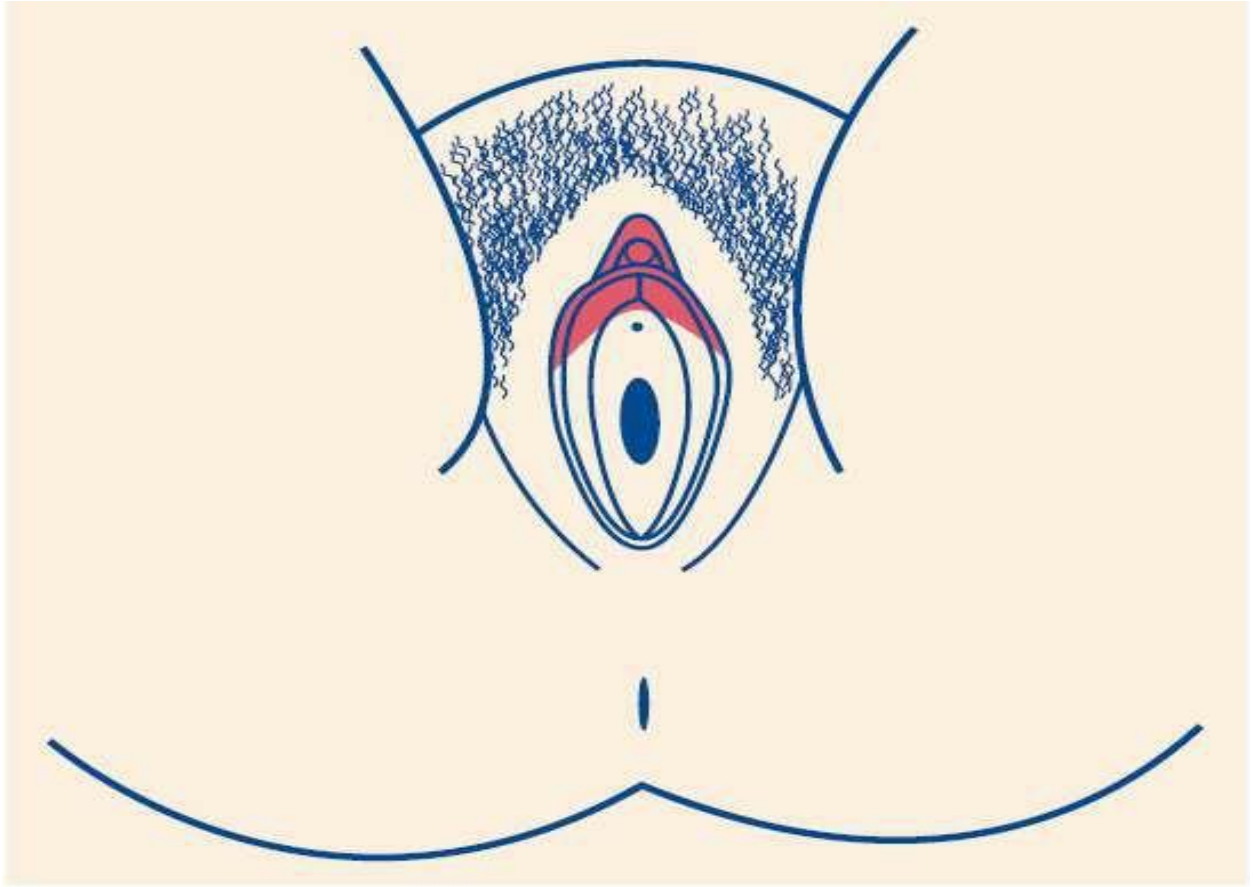
Trigger Warning
Diagrams and Photographs of FGM

Some women consent for photographs of their vulva to be taken in AWC for educational purposes.

We acknowledge these women and thank them.

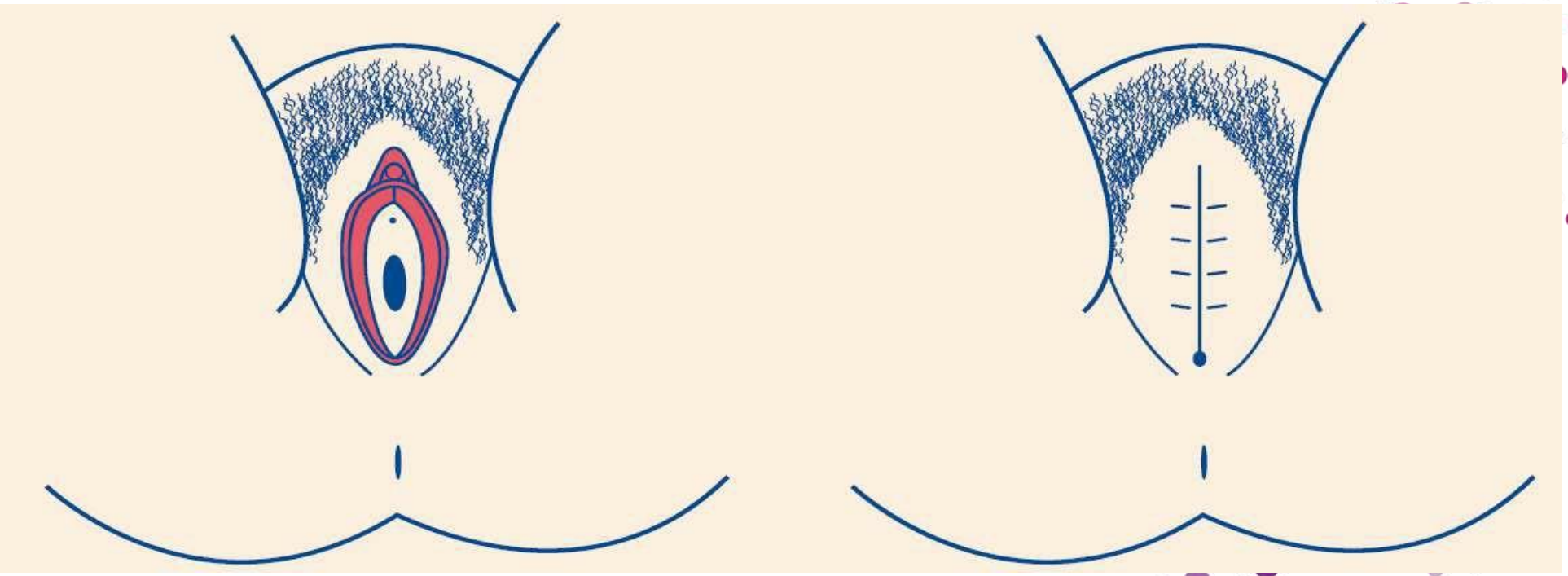
FGM Type 1

Clitoris has been cut which is often called ‘Sunna’



FGM Type 2, 3 and 4

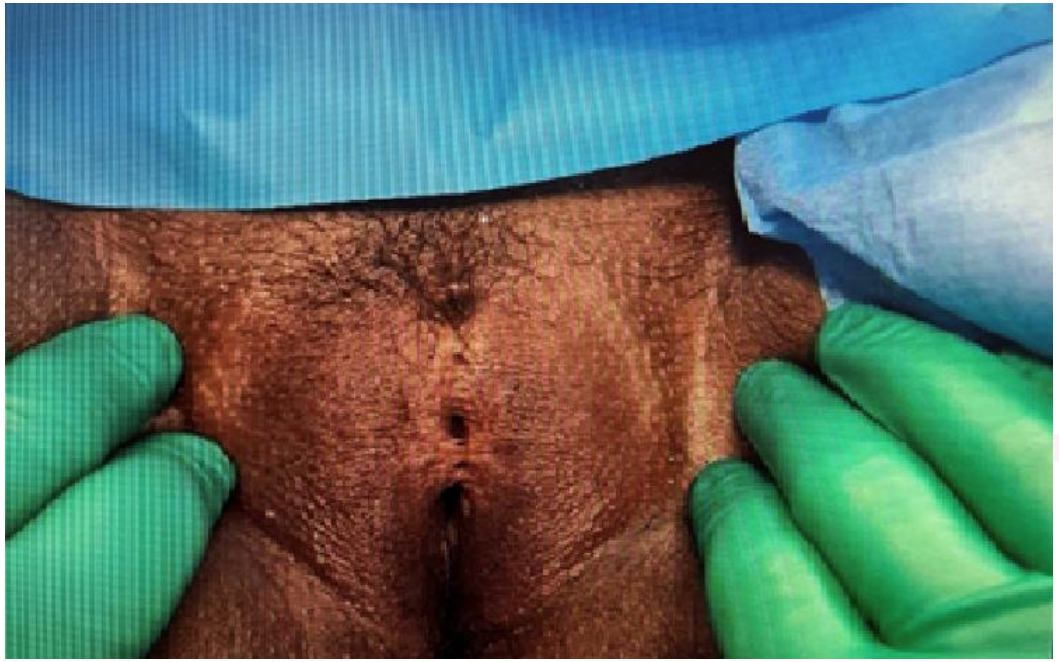
Type 2: Clitoris cut/removed and labia minora cut/removed.
Type 3: Clitoris cut/removed, labia minora cut/removed and vagina sutured to close with a small hole left for urine and menstruation.
Type 4: piercing/ other cutting/ cauterisation of the vagina.



FGM Type 3

Skin ‘Bridges’

- Relatively common in FGM Type 3
- Likely to occur as the girl may have tried to run away, not have sat still for days after her FGM (many have their legs bound for prolonged periods)



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Consequences of FGM

No Health Benefits

Short Term:

- Pain, distress, haemorrhage, infection or sepsis, urinary retention, death

Long Term:

- Extensive scarring, cysts, abscesses
- Urological – dysuria, recurrent urinary tract infections
- Gynaecological and sexual function – dyspareunia, dysmenorrhea, inability to perform cervical screening
- Reproductive Issues – infertility, pain, difficulty with digital and speculum vaginal examinations
- Childbirth complications – Caesarean Section, perineal trauma
- Sexuality – identity

Psychological Impacts:

- Often for the first time learning they are ‘different’
- Shame and stigma
- Traumatic memories / flashbacks – triggers
- Conflict – dealing with realisation harm initiated by family
- Marriage and sexuality – pleasure vs trauma, consent vs duty

African Women's Clinic
Interdisciplinary Care

Referrals to RWH Interdisciplinary Team for collaborative care:

- Pelvic Floor Unit Consultants
  - Urogynaecological problems (cysts, abscesses, dysuria)
  - Deinfibulations requiring general anaesthesia (extensive infibulation or genital scarring, significant psychological trauma)
- External Psychosexual Counselling Services
  - Traumatic memories
  - Dyspareunia
  - Affected women exploring how to achieve pleasure during intimacy
- Physiotherapy: Pelvic floor strengthening, incontinence, dyspareunia
- Social Work
  - Housing, financial assistance, family violence

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Deinfibulation Procedure

Planned Deinfibulation allows restoration of anatomy and function, to the extent possible

Avoid the term ‘reversal’

Prior to marriage / commencement of a sexual relationship

- To improve sexual function and experience
- Avoid pain of the men ‘breaking through’ infibulated tissue as is often the cultural expectation

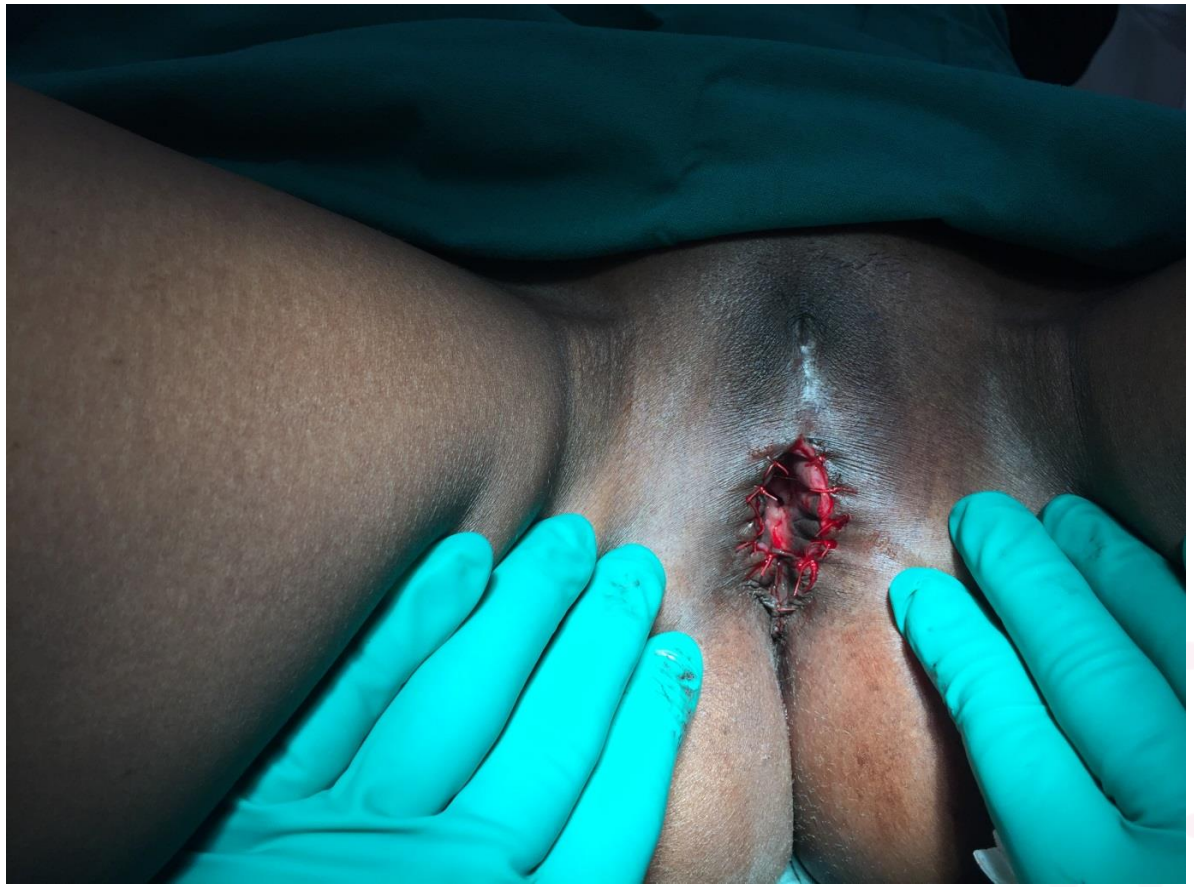
Antenatally

- To facilitate birth
- Minimise perineal trauma and haemorrhage
- Allay maternal anxiety regarding birth
- Reduce rate of CS due to FGM/C

Women’s Health Clinics – Procedure Room

- AWC is the only clinic in Australia to do this procedure as an outpatient under local anaesthetic, by nurse midwives
- Other hospitals do it under GA, added to long medical gynae waitlists.

Another completed procedure



Case Study: Undiagnosed FGM Type 3 in labour

Background:
- 28 y.o. G1P0 Somalian born Australian resident
- Asked about FGM status at initial ANC booking – documented response is 'No'
- Not seen antenatally with AWC/FARREP

Labour & Birth:
- Presented with SROM and abnormal CTG, admitted for IOL
- FGM Type 3 noted only when needing FBS – unable to complete
- Proceeded to Code Green emergency CS

Presentation:
- Seen on PNW by Sarah – woman thought only her clitoris cut 'a little bit'
- Had been experiencing dyspareunia, PCB, dysuria and dysmenorrhea

Interventions:
- Referral completed during postnatal stay for assessment by AWC
- Deinfibulation performed in AWC at 2 months postpartum

Outcome:
- **Significant** improvements in sexual function, voiding, periods, quality of life
- Currently pregnant again
- Planning TOLAC

Key takeaways:
- **Screening** – How and when we screen for, ask about, and document FGM is important
- **Opportunity** – pt reports wasn't asked in any healthcare setting, had not had CST or STI screening, and was not identified antenatally
- **Education** – Women can be unaware how their FGM can be the cause of multiple urogynae problems
- **Awareness** – Some HCW's and women still assume deinfibulation is only necessary to facilitate vaginal birth

Case Study:
Long term consequences of FGM

Presentation:
- 29 y.o. self-referral
- Called RWH FARREP as was nervous disclosing to GP
- Pt noted a vulval mass with continual growth over 7mths
- Sexually active once but traumatic, no longer active
- No other Sx in previous 28y

Background:
- Country of Birth – Kenya
- Occupation – Mental Health clinician in local health service
- Memory of FGM – nil clear, acknowledged likely suppression as trauma response

Examination:
- Large fluid filled cyst covering introitus, ~8x8cm
- Secondary to FGM Type 2, vulval cyst originating from clitoral scar tissue

Interventions:
- Referred to:
  - Pelvic Floor Unit
  - Psychosexual counselling service
- Excision & drainage of large vulval cyst in OT within 6 weeks of presentation

Outcome:
- Resumption of sexual activity, improved quality of life
- Psychological support accessed

Key takeaways:
- Complications – physical and psychological can affect any woman who has experienced FGM regardless of severity or memory
- Opportunity – most women want to be asked
- Referrals – effective pathways enable timely intervention

Legal Responsibilities - Mandatory Notification

- The performance of FGM and/or the removal of a child from Victoria to have such procedures performed are specifically prohibited in Victoria under the *Crimes (Female Genital Mutilation) Act 1996*
- Health practitioners are required to report possible FGM if they believe:
  - A child is in danger of having their genitals cut, including taking the child out of Australia for the purpose of FGM
  - A child has had their genitals cut since living in Australia
- It is mandatory to report suspected cases (under the *Children, Youth and Families Act 2005*) s162,s163,s182,s184

AWC Videos

Introduction to FGC | For health professionals | FARREP Video 1
https://youtu.be/Cpbwjd69ego

Asking about FGC | For health professionals | FARREP Video 2
https://youtu.be/VWH3xfPqpqY

Growth

Victoria

Joan Kirner Women's and Children's Hospital

- Upskilling MGP midwives

Dr Mansoor Mirkazemi

- Accepts AWC referrals for some women seeking vulval restoration

National - *Australian FGM/C Support Network for Health Practitioners*

New South Whales

Lynda Smith CMC - NSW Education program on FGM/C

South Australia

Monica Diaz Midwife Nurse Consultant – SA Health

Western Australia

Christine Waddell - Physiotherapist

Tasmania

Tigist Roba – Bicultural Community Health Program

the women's
the royal women's hospital

Thank You

For more information, contact:
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or visit
thewomens.org.au/health-professionals/sexual-reproductive-health/african-womens-clinic

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the women's
the royal women's hospital

HealthPathways Melbourne

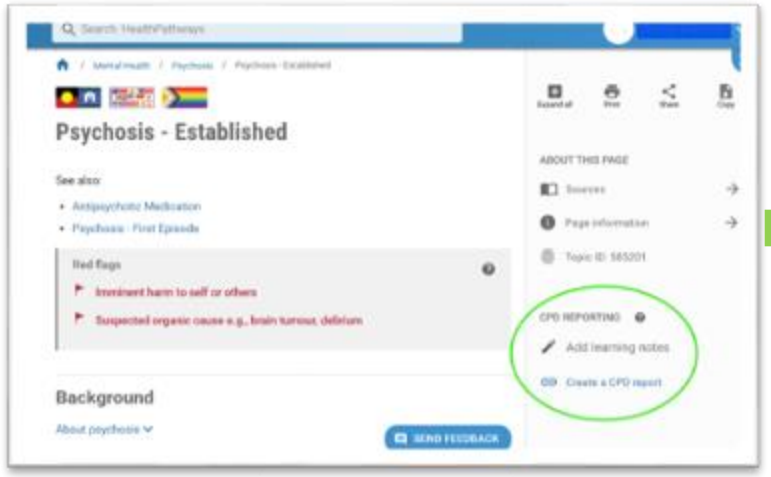
Social, cultural and clinical aspects of female genital cutting

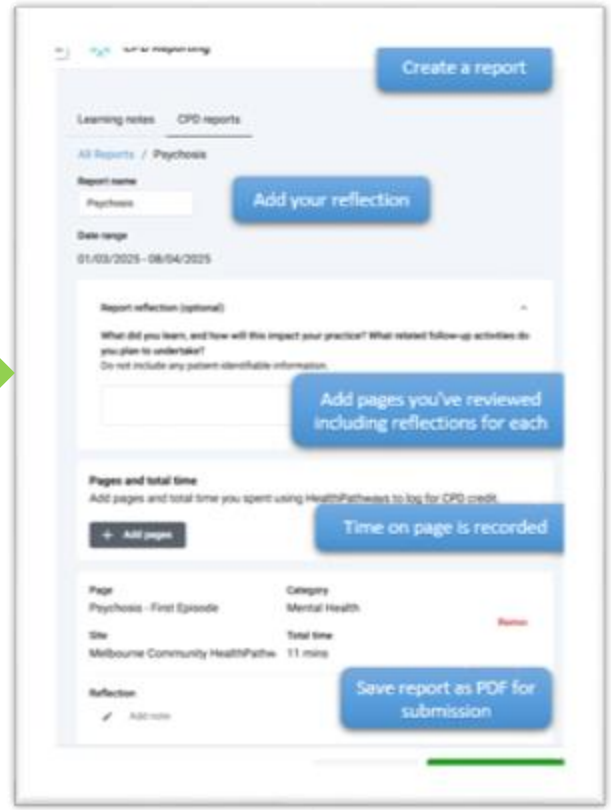
27 November 2025

Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts

- clear and concise, evidence-based medical advice
- Reduce variation in care
- how to refer to the most appropriate hospital, community health service or allied health provider.
- what services are available to my patients

HealthPathways CPD Reporting Tool





Step 1: Access a Pathway Page

- Navigate to a clinical pathway (e.g., *Psychosis – Established*).
- Click **"Add learning notes"** or **"Create a CPD report"** to begin tracking your CPD activity.

Step 2: Add Learning Notes

- Reflect on what you learned and how it will impact your practice.
- Include any planned follow-up activities.
- These notes are saved to your CPD record.

Step 3: Generate Your CPD Report

- Go to the **CPD Reporting** section.
- Add reflections, review pages, and confirm time spent.
- Export your report as a **PDF for submission**.

For further information on the CPD reporting tool, please see these videos:

- How to create a CPD report
- How to add learning notes

HealthPathways – Female Genital Cutting/Mutilation

Disclaimer: For presentation purposes only

HealthPathways – Female Genital Cutting/Mutilation

Female Genital Cutting/Mutilation (FGC/M)

See also:

- Refugee Health
- Vulvodynia

Background

About female genital cutting/mutilation (FGC/M)

Assessment

Use interpreter services if needed. Ideally, do not use family members to interpret.

1. Consider:
   - the clinical context in which discussion around FGC/M may be relevant.
   - the cultural challenges the patient may face.
   - the different types of FGC/M the patient may present with.
2. Discuss FGC/M with the patient. Consider questions to open discussion.
3. Record the patient's history.
4. If there are female children in the family, consider cultural beliefs towards FGC/M and children. Pay attention to possible indicators such as:
   - a female relative is visiting for a "special ceremony".
   - the child leaves the country and shows behavioural changes and urinary symptoms on return.
5. Perform a gynaecological examination. When indicated, perform cervical screening to avoid repeat examination. See Cancer Council Victoria – Female Genital Cutting (FGC) & Cervical Screening: A Guide for Practitioners.
6. Assess for long-term complications. [3]
7. If indicated, assess for pregnancy, noting that women affected by FGC/M often require specialised prenatal, antenatal, and postnatal care. Consider potential pregnancy-associated consequences of FGC/M: [3]
   - Difficulty with vaginal examinations in pregnancy or labour, intrapartum procedures, urethral catheterisation
   - Increased likelihood of severe perineal trauma or vaginal laceration, episiotomy, caesarean section
   - Fear of childbirth

Click on the dropdown to view supplementary information

Management

1. Aim to provide holistic care that is culturally-sensitive and non-judgemental.
2. Discuss any patient concerns relating to FGC/M and arrange specialist review in the African Women's Clinic if desired.
3. Consider referral for support via the Family and Reproductive Rights Education Program (FARREP).

> **Family and Reproductive Rights Education Program (FARREP)**
>
> Provides services for women from places where FGC/M is practised.
>
> Aims to assist women in getting appropriate health information and care, and can provide secondary consultations on any health matter concerning a woman from a place that practices FGC/M.
>
> See The Royal Women's Hospital – Family & Reproductive Rights Education Program (FARREP).

4. Manage specific situations:
   - Concerns about possible FGC/M of children
   - Deinfibulation
   - Antenatal care
   - If psychological or psychosexual concerns, consider referral to a psychologist or to a sex therapist.
5. Consider requesting refugee health referrals as required.

Referral

- If the patient requires support or review around matters relating to FGC/M, including consideration of deinfibulation, request review in the African Women's Clinic or via a FARREP worker.
- If there are concerns about FGC/M of a child, make a mandatory report.
- If the patient is pregnant or planning pregnancy, request review in the African Women's Clinic. If the patient is pregnant, refer also for non-acute obstetric referral and include documentation of FGC/M in the referral.
- If psychological or psychosexual concerns, consider referral to a psychologist or to a sex therapist.
- Consider requesting refugee health referrals as required.

Information

For health professionals

Female Genital Cutting/Mutilation

Relevant Pathways and Relevant Pathways

Female Genital Cutting/Mutilation (FGC/M)

Refugee Health

Vulvodynia

Interpreter and Translation Services

Reporting to Child Protection

Cervical Screening

Preconception Assessment

Women's Health

Gynaecology

Obstetrics

Referral Pathway

Adult Psychological Therapy and Counselling Referral

Adult Mental Health Service Referrals

Child and Youth Mental Health Referrals

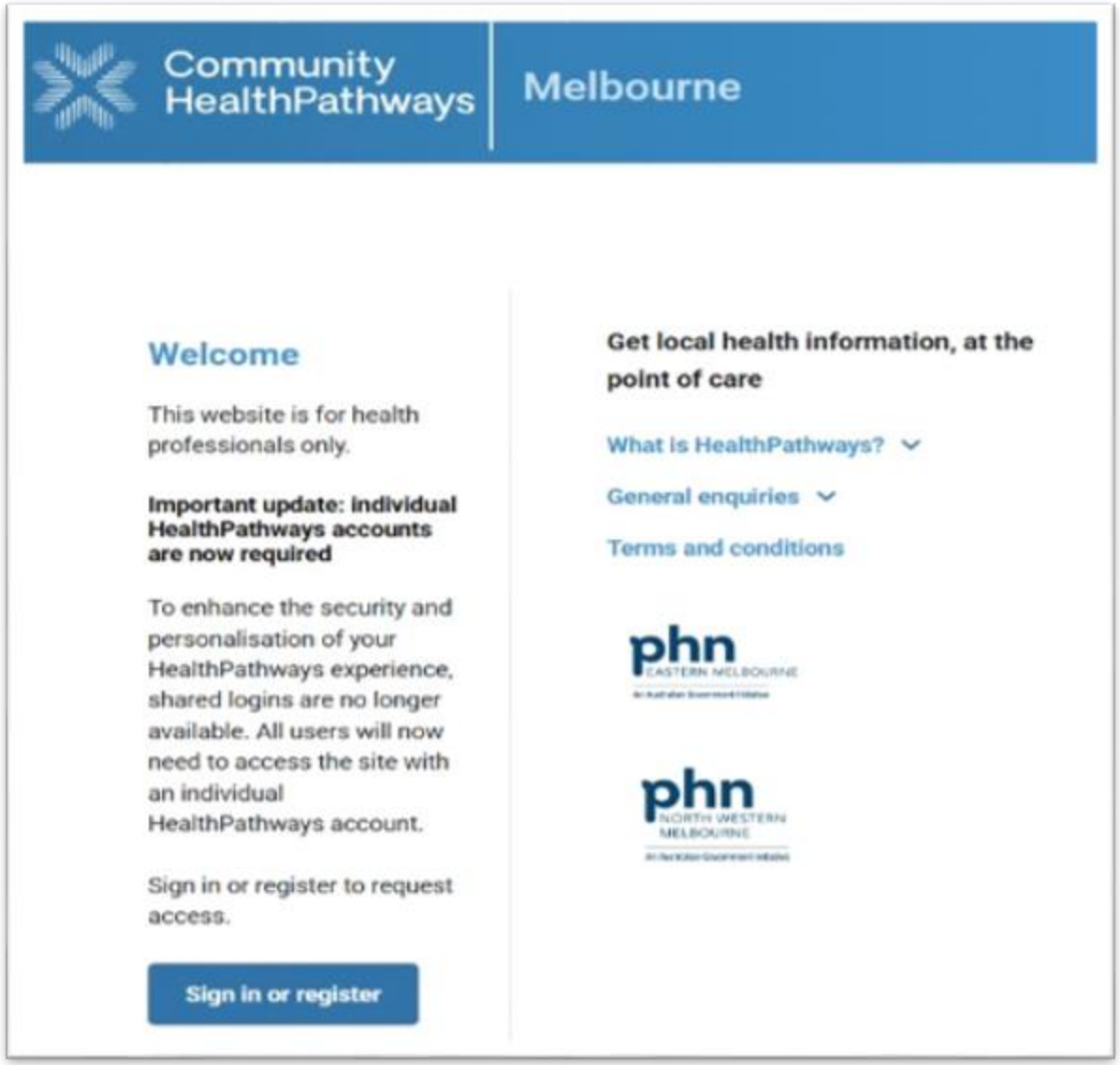
Non-acute Obstetric Referral (> 24 hours)

Refugee Health Referrals

Accessing HealthPathways

Please click on the **Sign in or register** button to create your individual account or scan the QR code below.

If you have any questions, please email the team info@healthpathwaysmelbourne.org.au



Q&A Discussion

Session Conclusion

We value your feedback, let us know your thoughts.

Scan this QR code

You will receive a post session email within a week which will include slides and resources discussed during this session.

Attendance certificate will be received within 4-6 weeks.

RACGP CPD hours will be uploaded within 30 days.

To attend further education sessions, visit,

https://nwmphn.org.au/resources-events/events/

This session was recorded, and you will be able to view the recording at this link within the next week.

https://nwmphn.org.au/resources-events/resources/

Thank you

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