South Australian Perinatal Practice Guideline

Female Genital Mutilation

Note:

This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

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Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.

If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient's medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

Explanation of the aboriginal artwork:
The aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the aboriginal culture. The horse shoe shape design shown in front of the generic statement symbolises a woman and those enclosing a smaller horse shoe shape depicts a pregnant women. The smaller horse shoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in unison.

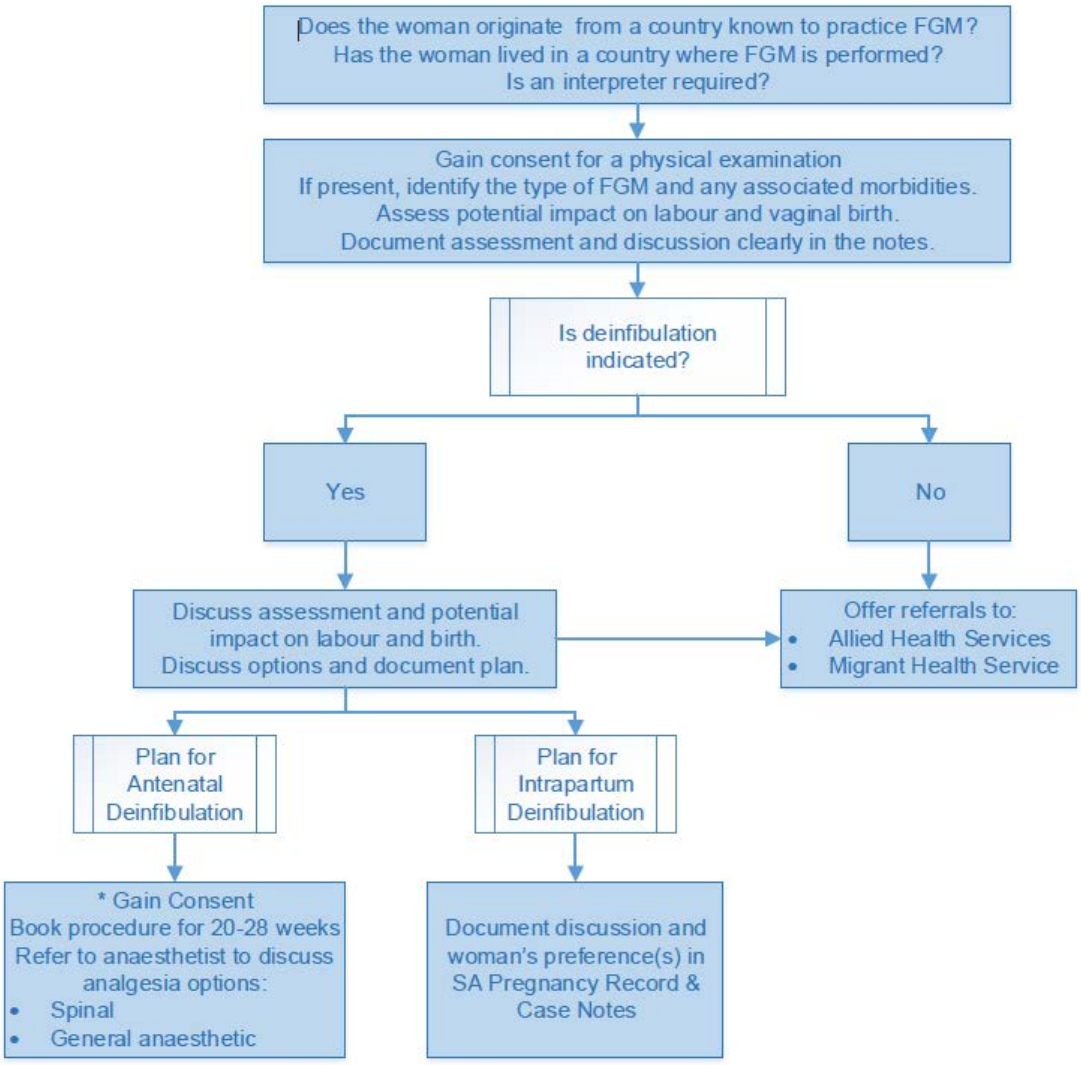
Australian Aboriginal Culture is the oldest living culture in the world yet Aboriginal people continue to experience the poorest health outcomes when compared to non-Aboriginal Australians. In South Australia, Aboriginal women are 2-5 times more likely to die in childbirth and their babies are 2-3 times more likely to be of low birth weight. The accumulative effects of stress, low socio economic status, exposure to violence, historical trauma, culturally unsafe and discriminatory health services and health systems are all major contributors to the disparities in Aboriginal maternal and birthing outcomes. Despite these unacceptable statistics the birth of an Aboriginal baby is a celebration of life and an important cultural event bringing family together in celebration, obligation and responsibility. The diversity between Aboriginal cultures, language and practices differ greatly and so it is imperative that perinatal services prepare to respectively manage Aboriginal protocol and provide a culturally positive health care experience for Aboriginal people to ensure the best maternal, neonatal and child health outcomes.

Purpose and Scope of PPG

The purpose of this guideline is to give information about the care considerations for pregnant and postnatal women who have experienced FGM.

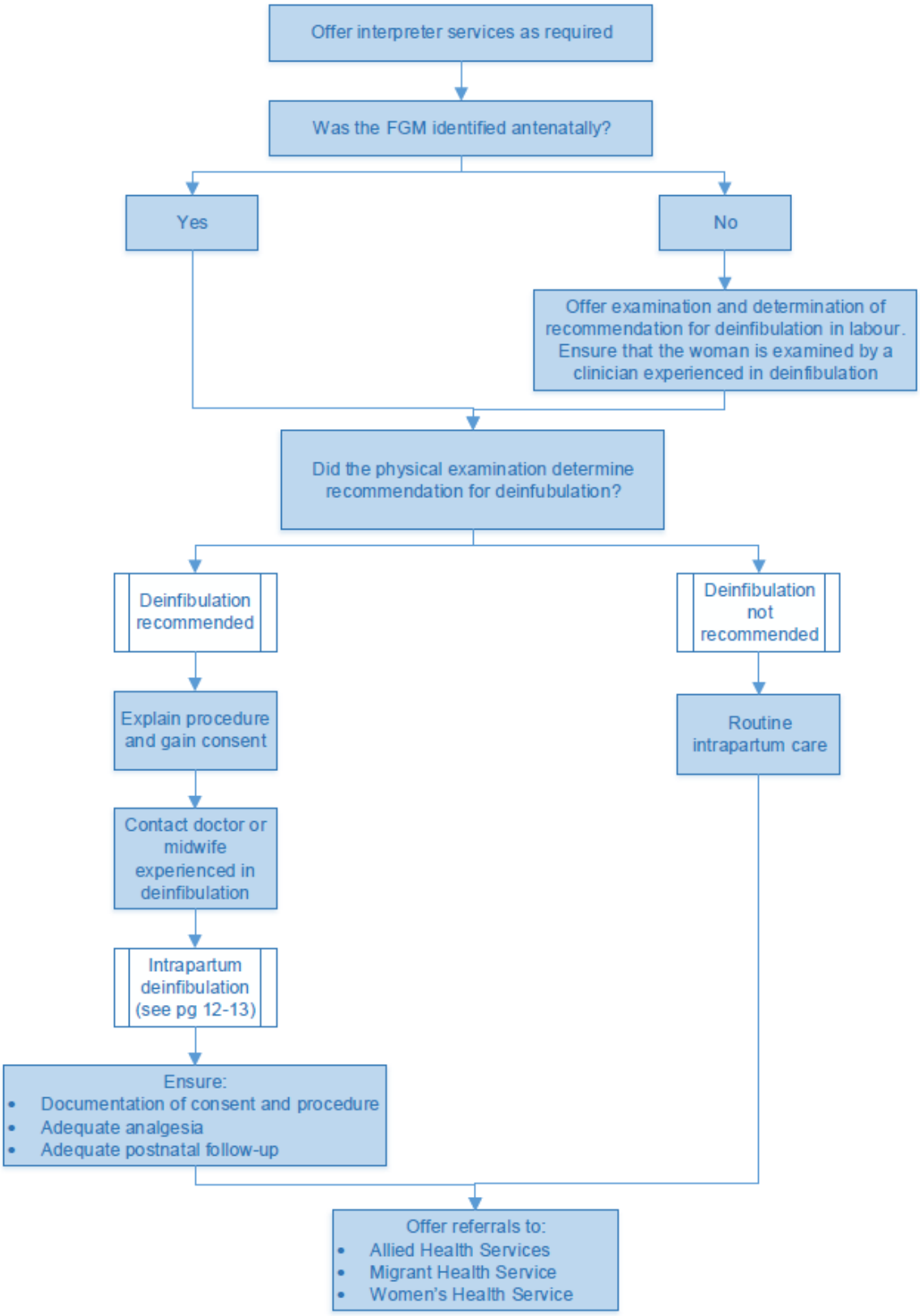
Government of South Australia
SA Health

Flowchart 1: Antenatal Identification of FGM



* Second trimester deinfibulation is recommended due to the possibility of first trimester miscarriage and that the woman may associate her deinfibulation with miscarriage

Flowchart 2: Intrapartum care of a woman with FGM



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Summary of Practice Recommendations

1. Female Genital Mutilation (FGM) refers to the deliberate partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.[1-3]

2. Women who have experienced FGM are significantly more likely to suffer adverse obstetric outcomes.

3. A woman's country of origin is the greatest risk factor for FGM. Women from affected countries should be screened antenatally and option of de-infibulation discussed.

4. **It is against the law to re-infibulate a girl/woman after birth of a baby or after any other type of gynaecological operation.[4,5]**

5. Women who have experienced FGM may experience significant psychological sequelae. Health practitioners must use sensitive language and refer to appropriate support services.

6. Antenatal discussion and education surrounding the birth and what to expect alongside clear documentation of intrapartum plan is essential.

Abbreviations

FGM	Female Genital Mutilation
FGC	Female Genital Cutting
PTSD	Post-Traumatic Stress Disorder
WHO	World Health Organisation
e.g.	For example

Definitions

Infibulation	Type III FGM includes removing part or all of the external genitalia and re-approximation of the remnant labia majora, leaving a small neointroitus[6]
Deinfibulation	The separation of the fused midline structures and restoration of the vaginal opening for women who have experienced infibulation
Sunna	Type I or II FGM are sometimes referred to as Sunna in some communities to imply that the practise is prescribed by religion
Somatization	The physical manifestation of psychological distress
Dyspareunia	Painful or difficult sexual intercourse
Apareunia	The inability to perform sexual intercourse as a result of physical or psychological sexual dysfunction
Clitoridectomy	The removal, or partial removal of the clitoris
Angurya cuts	Scraping of the vagina or surrounding tissue
Gishiri cuts	Cutting of the vagina or surrounding tissue
Pharaonic circumcision	Type III FGM is often called ‘pharaonic’, implying its deep cultural roots
Somalian circumcision	Type III FGM is sometimes referred to as ‘Somalian circumcision’
Re-infibulation	The re-suturing of an infibulation following birth or obstetric/gynaecological procedures
Dysmenorrhoea	Painful menstruation
Post-traumatic stress disorder	An anxiety disorder that can occur when a person who has lived through a terrifying or painful experience and finds themselves reliving the event repeatedly[7]

Introduction

Female Genital Mutilation (FGM) refers to the deliberate partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.[1-3] FGM is a global human rights issue and it is thought that worldwide up to 200 million women and girls have been subjected to the procedure and as many as 3 million girls are still undergoing the practice annually.[1,8,9,10]

The origins of this centuries old practice are unclear and pre-date most contemporary religions. **FGM is not a religious practice and no religion condones it.**[6,11,12] FGM is performed primarily because of its grounding in historical and cultural traditional practices.[1] It continues to be practiced for different reasons, for example:[1,7]

- some communities believe it to be a religious requirement,
- it is seen as a rite of passage in some communities,
- provides identity/status in the woman's community,
- it is seen to safeguard virginity and chastity,
- it is seen as a method of ensuring fidelity after marriage,
- it is considered to enhance fertility,
- it is viewed as respect for traditional practices,
- it is viewed as a sign of femininity (the clitoris is considered masculine),
- a method of preventing rape,
- it is viewed as 'cleaner', and;
- for aesthetic reasons.

The age at which girls may experience FGM differs across countries and cultural groups.[7] This means some girls will be subjected to it before they turn five and others may experience the procedure from 5-14 years or before marriage.[7]

The practice of FGM and its significant consequences continues to affect a growing number of women and girls in Australia because of global migration.[13]

Women who have experienced FGM are significantly more likely to experience adverse obstetric outcomes than women without FGM.[14]

Countries where FGM is performed

Health care professionals should be aware of where FGM is performed. A woman's country of origin or where she spent her childhood years is the strongest risk factor for FGM.[3] FGM is most commonly performed in parts of Africa.[3,15] Migrants who have experienced FGM from Somalia, Sudan, Ethiopia, and Egypt are more commonly seen in the Australian health care system.[3] In Sudan and Somalia more than 80% of women have undergone FGM (mostly type III). FGM is also practised in a few populations in the Middle East and Asia.[1,3]

Percentage of girls and women aged 15-49, who have undergone FGM during 2004-2015:[10]

- 90% prevalence of FGM: Somalia, Guinea, Djibouti, Sierra Leone
- 80 – 89% prevalence of FGM: Mali, Egypt, Sudan, Eritrea
- 50 – 79% prevalence of FGM: Liberia, Mauritania, Ethiopia, Gambia, Burkina Faso.
- 20 – 49% prevalence of FGM: Kenya, Central African Republic, Senegal, Nigeria, Côte d'Ivoire, Chad, Guinea-Bissau.
- < 20% prevalence of FGM: Yemen, United Republic of Tanzania, Benin, Iraq, Togo, Ghana, Niger, Uganda, Cameroon.

Types of FGM

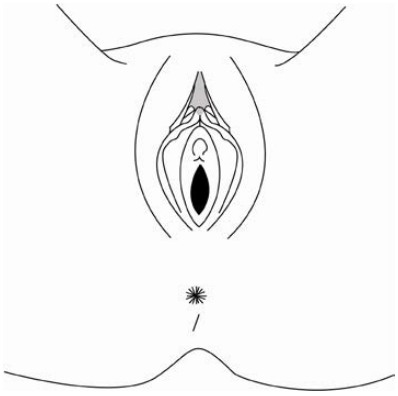
There are four types of FGM identified by the World Health Organisation.[1] Types I and II are the most widely practiced – and most commonly seen within the context of the South Australian Health System. Type III, which is often referred to as infibulation, is the most extreme form of FGM and is associated with both short and long-term health consequences. Type IV includes all other harmful procedures to the female genitalia for non-medical reasons.[7]

Type I*

Partial or total removal of the clitoral glans (clitoridectomy) and/or the prepuce.
Other terms used to describe Type I FGM include:

- circumcision,
- ritualistic circumcision,
- sunna, and;
- clitoridectomy.

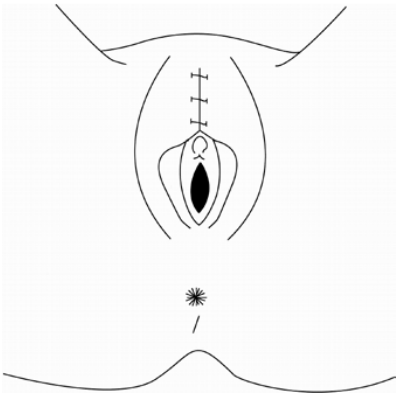
*The shaded area denotes the excised tissue



Type II

Partial or total removal of the clitoral glans and the labia minora, with or without excision of the labia majora (excision).
Other terms used to describe Type II FGM include:

- clitoridectomy,
- sunna,
- excision,
- circumcision, and;
- infibulation.



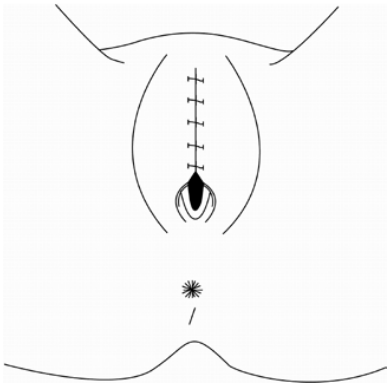
Type III

Narrowing of the vaginal opening with the creation of a covering seal by cutting and appositioning the labia minora (type IIIa) or labia majora (IIIb) with or without excision of the clitoral prepuce and glans (infibulation).[7]

Other terms used to describe type III FGM include:

- pharaonic circumcision, and:
- Somalian circumcision.

Type III can result in a very small opening that may cause difficulties with urination, menstruation and sexual intercourse, as well as serious problems in childbirth.



Type IV

All other harmful procedures to the female genital organs for non-medical reasons, including:

- 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

Legal Considerations

Australian health care professionals must be aware of women and girls who are at risk of FGM.[3] It is important that health care professionals explain to women and their families that **FGM is illegal in Australia.**[3] FGM is prohibited by way of legislation in all states and territories in Australia.[3]

FGM must not be performed in Australia.[3] Legislation also extends to prohibit the provision of assistance, procurement and facilitation of the performance of FGM within Australia or overseas. [3] In South Australia FGM is covered under section 26 of the *Children's Protection Act 1993 (SA)*, and section 33 of the *Criminal Law Consolidation Act, 1935 (SA)*. [4,5]

It is **illegal** to perform the following types of FGM with the only exception to this being under exceptional circumstances as a result of a medical condition:[4,5]

- Remove or cut out any part of the female genital area (excision)
- Stitch up the female genital area (infibulation)
- Cut the clitoris or part of the clitoris (clitoridectomy)
- Damage the female genital area in other ways. The female genital area refers to the clitoris, the vagina and labia (minora and majora)

South Australian Legislation specifically indicates that **it is illegal to**:

- aid, abet, counsel or procure a person to perform FGM on a woman, girl or female baby.[4,5]
- perform FGM even if the woman or girl wants it to be performed.[4,5]
- leave South Australia for the purpose of having FGM performed.[4,5]

In South Australia, the jail term for performing, aiding or employing another to perform FGM is 7 years.[4,5]

It is against the law to re-infibulate a girl /woman after birth of a baby or after any other type of gynaecological operation.[4,5]

Health care professionals are required to report incidents of FGM including situations where they believe a girl to be at risk of FGM. This does not include situations where women or girls have experienced FGM prior to migration. Health care professionals are mandated notifiers and should report via phone or the online reporting system:

- 131478
- www.reportchildabuse.families.sa.gov.au.

Health Complications for women who have experienced FGM

Short-term complications

Immediate and short-term complications from FGM include haemorrhage, pain, shock, genital swelling, infection, dysuria, acute urinary retention, fracture(s) and/or dislocation of bones (including clavicle, femur or pelvis) from the application of restraint during the procedure, wound healing delays and death.[1,7,12,16]

Long-term complications

Women can experience long term or lifelong complications from the FGM procedure.[2,6,17-19]

These include:

- pain
- chronic genital and urinary tract infections
- painful micturition
- menstrual problems including dysmenorrhoea
- pelvic inflammatory disease
- keloid scaring
- bleeding due to recurrent trauma
- epidermal genital cysts
- abscesses
- fistulae
- dyspareunia/sexual dysfunction
- apareunia and vulvovaginal lacerations during sexual intercourse
- obstetric complications
- infertility
- clitoral neuroma

Psychological Complications

Women who have been subjected to FGM have an increased likelihood of post-traumatic stress disorder (PTSD), anxiety and depression and psychosexual problems.[1] They are also more likely to experience a psychiatric diagnosis, suffer from somatization, phobias and low self-esteem.[20] Psychological consequences are more likely to be experienced by women who have experienced Type II or Type III FGM, particularly women who have experienced ongoing physical sequelae.[7] Psychological complications can also be associated with women's experiences of pre-migration trauma. Practitioners should complete a comprehensive assessment of the individual woman's circumstances and assessment of her emotional well-being.

Obstetric Complications

FGM is associated with an increased risk of caesarean section, postpartum haemorrhage, episiotomy, difficult labour, obstetric tears and lacerations, instrumental birth and extended hospital stays.[1,16-18,21] The obstetric complications increase with the severity and the type of FGM performed.[1]

Care Considerations

FGM is a sensitive and complex subject that requires health professionals to engage with women in a culturally safe and appropriate manner.[22] Practitioners should ensure that the environment is private and creates a sense of safety, a non-judgemental approach should be employed and a professional interpreter offered where indicated.[2] Clinicians should be aware of their body language, maintain eye contact and ensure that they do not display inappropriate facial expressions, such as shock or disgust.[7] Avoid whispering (as if the subject was shameful).[7] Clinicians should listen to the woman and allow her opportunity to speak.[7] A female professional interpreter should be used at all times, if possible, when discussing sensitive issues such as FGM. Family members should not be used for interpreting[2] and clinicians should ensure the interpreter is acceptable to the woman.[7]

Sensitive language and history taking

Health care providers must be sensitive when interacting with women about FGM. Using the term 'mutilation' can make women who have experienced FGM feel stigmatised and many women prefer the term 'cutting'.[15] Other terms women may use include: sunna ('soo-na') and female circumcision.

Through careful, empathetic and sensitive history taking practitioners should document an accurate obstetric and gynaecological history including the woman's experiences of FGM – with attention to the age when FGM was performed, country where FGM was performed, health consequences, birth complications (if indicated) and whether deinfibulation has been carried out. If the woman has female children, it is important to document whether FGM has already been performed and the country where it was performed.

Health care professionals should use value neutral and clear non-judgemental language when talking about FGM and be aware of their own judgements and reactions. They should ask women about FGM in a sensitive but direct way. It is important to note that some women may not be aware that they are different to other women or even what 'normal' genitalia look like.

Ask direct questions such as:

> "Have you been cut down there?" *or*
>
> "Have you had traditional cutting or been circumcised?" *or*
>
> "I believe female genital cutting or circumcision is practised where you come from. Did this happen to you?"

Some women may feel more comfortable with a less direct approach with questions such as:

> "Where you grew up is it customary for women to have genital cutting?"
>
> "What about you – is this something you have experienced?" *or*
>
> "Do they do traditional cutting where you come from? Did this happen to you?" *or*
>
> "Is there anything special I need to be aware of? For example, any cultural or ritual practice or procedure that may have been performed on your genital area?".

If the woman experienced FGM at an early age she may not recall the event or know that her genitals have been altered.[7]

Counselling

The health consequences of FGM should be stressed when discussing FGM. Explain that depending on the type of FGM, deinfibulation may be necessary during labour to allow for birth. A detailed genital examination should be performed following the woman's consent. This will determine if deinfibulation is recommended (more common with type III). Deinfibulation involves an anterior episiotomy that should be performed by an experienced practitioner.

Clarify the woman's expectations around re-suturing and explain that once deinfibulation is performed, re-suturing to re-join the labia is illegal. Explain that the edges of the cut may be sutured to prevent bleeding, discomfort or accidental re-joining of the labia. Health professionals should consider involving the woman's partner in this conversation.

Depending on the type of FGM a woman has experienced and her individual circumstances, referral to psychological support and social work services should be considered/discussed. Consider referral to the Migrant Health Service if indicated.

Midwives caring for women either antenatally or intrapartum should consult with an obstetrician around care for women who have experienced FGM.[23]

Pre-pregnancy Counselling

If the woman presents prior to pregnancy, counselling can be arranged for the woman through the woman's general practitioner, gynaecologist, the Migrant Health Service or through the major tertiary hospitals.

Pre-pregnancy counselling gives health care providers the opportunity to identify if the woman has been experiencing any complications associated with FGM and develop an appropriate management plan.

Women planning a pregnancy can be counselled about the potential risks of a vaginal birth depending on the type of FGM and, if indicated, they can be offered deinfibulation prior to pregnancy.[6]

A discussion regarding the South Australian legal and Child Protection framework concerning FGM is an appropriate part of pre-pregnancy counselling. See legal considerations.

Antenatal Care Considerations

Health care professionals should be aware that some women with a refugee and migrant background may have had limited contact with the Australian health care system prior to pregnancy. Sexual and reproductive health issues are very sensitive and women who have experienced FGM may feel very uncomfortable discussing them with health practitioners.

It is preferable that health care professionals initiate discussion around deinfibulation and the law antenatally.

Written information should be offered to women in the relevant language. Resources in multiples languages can be found at the following link.

If a woman chooses to have antenatal deinfibulation then spinal, epidural or general anaesthesia should be considered in consultation with the woman, obstetrician and anaesthetist. Antenatal deinfibulation is recommended between 20-28 weeks.[7]

Genital examination

Practitioners should be aware that narrowing of the vagina due to Type III FGM can impede vaginal examination.[24] The genital examination should be carried out by a senior doctor or midwife experienced in FGM. If the health care professional gains consent to perform a genital examination, they should record the type of FGM in the woman's records.[2] They should also record whether or not deinfibulation is indicated and if any other FGM related morbidities are noted such as cysts and scarring.[2]

Some women who have experienced FGM may experience flashbacks to the original FGM procedure during obstetric examinations.

If the introitus is sufficiently open so that vaginal examination is possible and the urethral meatus is visible, then deinfibulation is not likely to be required.[2]

Women presenting with Type III FGM should be offered either antenatal or intrapartum deinfibulation.[1] The timing should be based on the following factors:[1]

- The woman's preference
- Obstetric history
- Access to healthcare
- Place of birth, and;
- The skill of the healthcare provider.

Detailed records (including diagrams) of the genital examination should be kept and shared with other health care professionals as required. This should be coupled with a detailed history identifying any complications the woman may have experienced because of her FGM including psychological distress. A care plan for labour should be developed with the woman. The woman's wishes regarding perioperative deinfibulation should be clearly documented in case of the need for a caesarean section during labour, particularly in the event of an obstetric emergency (deinfibulation may also be required to perform urinary catheterisation).

Intrapartum Care Considerations

Women with FGM should be informed of the risks of difficulty with vaginal examinations, catheterisation and application of fetal scalp electrodes.[25] They should also be advised (preferably antenatally) of the risks of delay in the second stage and spontaneous lacerations together with the need for deinfibulation with an anterior episiotomy in labour.[25] Women who have experienced FGM are also at increased risk of a mediolateral episiotomy, severe perineal trauma and have an increased risk of caesarean section.[3]

Parity may affect how the woman copes with labour. Anxiety, pain and fear may be experienced in all births subsequent to FGM but may be heightened during the first birth.

Women who have had a genital examination in pregnancy should have a documented care plan for labour.

Be aware that vaginal examinations may be difficult, painful or impossible. Ensure consent for all examinations. Stop the examination if the woman is unduly uncomfortable or if she asks you to stop. Some intrapartum procedures may be difficult or impossible such as amniotomy or the placement of a fetal scalp electrode.[3]

Urinary catheterisation may be difficult and painful due to the scar tissue.

Women with Type III FGM will require deinfibulation to give birth vaginally. This should always be performed as the primary procedure and alone may be sufficient to allow birth. However, if there is significant perineal scarring or other obstetric indications, then mediolateral episiotomy may be recommended.

Women with Type II FGM may also require deinfibulation to allow a vaginal birth and prevent the formation of vesico-vaginal and recto-vaginal fistula.

Intrapartum deinfibulation

Intrapartum deinfibulation is usually performed in the second stage of labour as the head descends. In some women it may be recommended in the first stage of labour if vaginal examinations or urinary catheterisation are not able to be performed.[6] Intrapartum deinfibulation is performed by a senior doctor or midwife skilled in deinfibulation or under the *direct supervision* of a skilled doctor or midwife and following the woman's consent.

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

Ensure consent is obtained with interpreting services if required.

Depending on the clinical context, regional or local anaesthetic may be used. If appropriate a topical local anaesthetic cream can be applied up to an hour before local anaesthetic infiltration. Ensure tested, effective analgesia before commencing the procedure.

A recommended procedural training resource can be found via the following link: http://www.fgmresource.com/

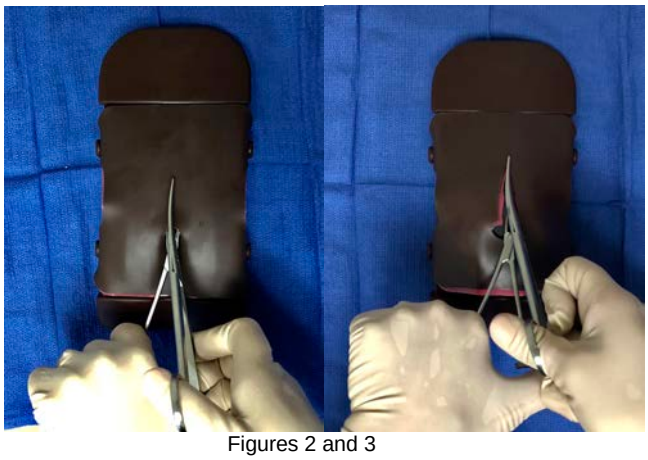
1. Position the woman in lithotomy and wash the vulva with an antiseptic solution. Ensure adequate lighting.

2. Using one finger feel inside the vaginal opening, behind the closed scar tissue for any dense adhesions. Usually the finger slides under a free flap of skin.

3. After checking for allergies, infiltrate the area with local anaesthetic if applicable and following local guidelines. Use artery forceps under the skin to protect the underlying tissues, see figure 1.

Figure 1

4. Make a straight incision anteriorly with either scalpel or scissors with care near the upper limit as scarring may extend to the urethral meatus. A scalpel is usually used when the scarring is significant making the entry of scissors too difficult. Artery forceps placed under the skin can protect the underlying tissues, see figures 2 and 3. Care should be taken not to extend too far anteriorly so as to damage the hidden clitoris or clitoral stump as this can lead to heavy bleeding.[3]



Figures 2 and 3

5. The cut ends now retract upwards and outwards to reveal the tissues beneath.

6. Health care professionals may also recommend a mediolateral episiotomy due to the formation of scar tissue around the introitus.

Suturing post deinfibulation

If the woman has not presented previously before labour, ensure that she understands the legal obligations of health care professionals in Australia. See Legal Considerations. Explain that it is illegal for health care professionals to reinfibulate the woman after the birth.

1. After deinfibulation, oversewing of the cut margins of the anterior incision is required to reduce the chance of the edges re-joining across the midline.

2. Use continuous sutures **or** interrupted sutures in absorbable suture material (i.e.. 3-0 vicryl rapide) to approximate the cut edges (see figure 4).

Figure 4

3. Any extension of the anterior incision above the urethra may be repaired at this time.

4. Any labial tears experienced during birth should be managed in the same way as women unaffected by FGM.[2]

5. Ensure the provision of routine advice on perineal care post the procedure. See *Perineal Care* PPG available at www.sahealth.sa.gov.au/perinatal

Postnatal/Post Deinfibulation Care Considerations

Women who have experienced deinfibulation will require additional postnatal support.

Postnatal urination, healing and the woman's psychological status should be monitored.

Pain relief

Ensure women are offered adequate analgesia for any perineal trauma post birth and deinfibulation.

Offer the woman ice packs.

Education

Advise the woman that intercourse should be avoided until the healing is complete and when she is comfortable.

Advise the woman of the physiological changes she can expect after deinfibulation:

- Urine will flow more quickly and in a larger, noisier stream
- Intercourse may feel different, for both herself and her partner, due to a wider opening of the vagina
- There may be a change in sensitivity of the vulva, either increased or decreased
- Menstrual bleeding may appear heavier
- Mucousy vaginal discharge may appear to be increased
- Appearance of her vulva will be altered

Advise the woman about the potential for the development of infection post deinfibulation. Ensure she understands the signs and symptoms and when and where to seek medical assistance.

This is also a time where health care professionals can educate the woman on her sexual health including the routine cervical screening test.

If the woman gives birth to a female baby discuss the appearance of the unaltered female genitalia.

Discharge planning

Ensure the woman and her partner understand the Australian law in relation to FGM.

Information is available in multiple languages for women from:

http://www.fgminaustralia.com.au/

Booklets are available in multiple languages for download from:

http://www.netfa.com.au/fgm-c-factsheets-pamphlets-booklets.php

Offer women printed information as indicated in her language.

Ensure follow-up services and treatment and referral for any complications related to the initial FGM.

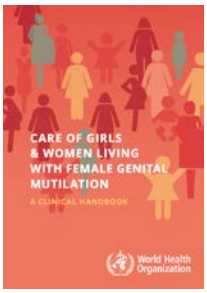
Support Services

The Women's Health Service Monday to Friday 9am-5pm. Phone: 8444 0700 (for appointments) Three sites: Port Adelaide, Elizabeth and Hillcrest.	Free, confidential women's health service for women living in metropolitan areas – no referral necessary.
Migrant Health Service 21 Market St Adelaide, SA 5000 Phone: 08 8237 3900 or 1800 635 566	• State funded health service for people from refugee and asylum seeking background. • Comprehensive refugee health assessments, multi-disciplinary primary care support and management. • Women's sexual and reproductive health clinics. Obstetric shared care. • Psychology and social work support • Health literacy education and health promotion.

Additional Resources

A resource for health professionals developed by FGM National Clinical Group's bi-annual conference in London, UK. Includes a procedural video.

http://www.fgmresource.com/



Care of Girls & Women living with Female Genital Mutilation; A Clinical Handbook (World Health Organization).

http://apps.who.int/iris/bitstream/handle/10665/272429/9789241513913-eng.pdf?ua=1

Improving the health care of women and girls affected by female genital mutilation/cutting; A national approach to service coordination (Family Planning Victoria).

https://www.fpv.org.au/assets/resources/FGM-ServeCoOrdinationGuideNationalWeb.pdf

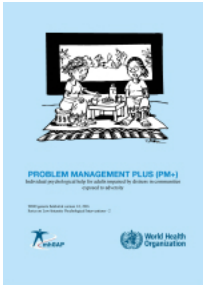
Female Genital Mutilation and its Management, Green-top Guideline No. 53

https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf

NETFA Best Practice guide for working with communities affected by FGM/C; The National Education Toolkit for Female Genital Mutilation/Cutting Awareness

Multicultural Centre for Women's Health: Melbourne

http://www.netfa.com.au/national-education-toolkit-for-fgm-c-awareness-best-practice-guide.php



Problem Management Plus (PM+)

Individual psychological help for adults impaired by distress in communities exposed to adversity

http://www.who.int/mental_health/emergencies/problem_management_plus/en/

E-Learning

FGM Learning

(Australian College of Midwives/Australian College of Nursing)

URL: http://www.fgmlearning.org.au/resources/1

The National Education Toolkit for Female Genital Mutilation/Cutting Awareness

(Multicultural Centre for Women's Health)

URL: http://www.netfa.com.au/

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Login as: guest

Password: RANZCOG@2015

URL: https://www.climate.edu.au/course/view.php?id=169

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