Contents

- **Type III** – Narrowing of the vaginal orifice with the creation of a covering seal by cutting and

List of recommendations

5.

FGM/C during their lifetime—a rate of 4.3 per 1,000 girls and women in Australia, or 0.4% of Australia's overall female population.[4]

6. Methods

The statement was developed according to approved RANZCOG processes, available in the Manual for Developing and Updating Clinical Guidance Statements.

Following these processes, the Research and Policy Team conducted an initial search for relevant guidelines published within three years. The WHO Guideline on the Management of Health Complications from Female Genital Mutilation (2016) and the systematic review commissioned to inform the guideline were identified as most recent.

The search terms used to retrieve publications in the WHO commissioned systematic review were then applied to undertake an updated electronic search of MEDLINE and CENTRAL on 11th October 2022 for literature published since 2015.

Reference lists of identified studies were screened for additional studies to include. The evidence retrieved in the database search, reference lists and searches of evidence included in Australian and Aotearoa New Zealand FGM/C Guidelines were used to inform the Evidence to Decision (EtD) domains where possible.

Assessment of the rigour, certainty and quality of the evidence was performed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach.

Phrasing for recommendations differs according to the strength of evidence- further explanation of recommendation types and classifications can be found in the Manual for Developing and Updating Clinical

7. Clinical Questions and Recommendations

Detailed Evidence to Decision summaries for each clinical question, including the study results, absolute effect estimates and certainity of the evidence for the reported outcomes, can be found in Appendix E- Evidence profiles.

Clinical Question 1

For women who have FGM/C identified during pregnancy, what are the obstetric outcomes if deinfibulation is offered, compared to no surgical interventions or management of sequelae only?

P[iv] Women who have FGM/C identified during pregnancy
I- Deinfibulation
C- Other non-surgical interventions (i.e., use of dilators) or symptomatic management (i.e., treatment of infections)
O- Intrapartum outcomes, perineal trauma, delivery type, birthing experience as reported by patient

Summary of evidence:

A systematic review of four observational studies[7] was used to inform this recommendation. A greater proportion of women with Type III FGM/C who did not undergo deinfibulation had a caesarean section delivery or PPH than those who had deinfibulation (uncertain at what point during their pregnancy). Little to no difference was found in episiotomy, prolonged second stage labour (>120mins) and Apgar score >5 at 1 minute.

A cohort study of nulliparous Somali born women who were migrants to Norway was published since the above systematic review.[9] This cohort study reports a higher rate of Obstetric Anal Sphincter Injury (OASIS) in women who had not had deinfibulation compared to those who had had deinfibulation during the antenatal period or prior to the pregnancy.

Clinical Question 2

For women who have FGM/C identified during pregnancy, what are the obstetric outcomes if deinfibulation is offered during the second trimester, compared to the intrapartum period if indicated?

P Pregnant women who have FGM/C identified during pregnancy
I Offer deinfibulation in antenatal period (second trimester)
C Defer to labour and deinfibulation only if indicated

[iv] **Please note, PICO**

Summary of evidence

Only observational studies were identified.

Studies compare operative procedures (deinfibulation, excision of cysts, or clitoral reconstruction) to no surgery. No studies comparing these procedures to other non-surgical interventions were identified. Differences in study methodology, procedure, and outcome measure preclude any meta synthesis of results.

The WHO did not make a recommendation regarding clitoral reconstruction in their 2016 guideline citing a lack of evidence, methodological concerns in the available evidence, and unacceptably high complication rates.

A 2021 systematic review by Nzinga et al included five observational studies reporting on sexual functioning after FGM/C.[15] The sexual function scores assessed using the Female Sexual Function Index (FSFI) of women with any type of FGM/C, were

Clitoral reconstruction: Auricchio et al (2021) conducted the most recent systematic review of clitoral reconstruction for FGM/C.[22] Eight studies were included in this review (n = 3063). Studies differed in their reconstruction technique. On average, studies reported 5% of patient had moderate postoperative complications (partial graft necrosis, haematoma, suture failure, moderate fever). Vulvar pain and dyspareunia before and after surgery were reported in two studies, the largest of which had a 71% loss to follow up rate at one year, half of patients reported an improvement of pain. Sexual function was reported in all the included studies and represented the primary indication for reconstructive surgery in most patients who suffered FGM/C. Only two of the included studies assessed sexual function using a v

		neglect of a child in such a manner as to subject or be likely to **subject a child to unnecessary injury**, suffering or dangers'
SA	Children's Protection Act 1993	All health professionals to report to the Child Abuse Report Line (Department for Education and Child Development- Families SA) if 'they have **a reasonable concern that a child is at risk of significant harm'**. It is up to the department to determine whether there are reasonable grounds for investigation/intervention.
WA	Children and Community Services Act 2004	FGM/C is not specifically mentioned, however the Department of Child Protection and Family Support have stated mandatory reporting of FGM would fall under this Act, however it **is noted as physical, not sexual abuse**. In any case, when FGM/C is identified, a healthcare professional must make a child protection notification to the local CPFS District Office.
TAS	Children, Young Persons and Their Families Act 1997	Broad range of mandatory reporting duties for four classical forms of child abuse and neglect. FGM/C is covered by Section 3(1)(2)- reporting is mandated if 'the injured person has suffered, or is likely to suffer, **physical or psyc**

NB: This information was captured from jurisdictional information obtained from Australian and Aotearoa New Zealand data sources, accessed online. The following publications were additionally used as reference documents:
- *Child Abuse and Neglect: A Socio-legal Study of Mandatory Reporting in Australia- Report for the Tasmanian Government* **(Mathews, B et al 2015)** was additionally used as a reference document.
- **Improving the health care of women and girls affected by female genital mutilation/cutting: A national approach to service coordination**, *Family Planning Victoria 2014*
- **New Zealand Nurses Organisation- Reporting Abuse- Actual or suspected: Frequently Asked Questions**
- FGM & the NZ Law, Webpage- accessed online on 23rd January 2023. **https://fgm.co.nz/fgm-nz-law/**

9. Recommendations for future research

This Clinical Guidance Statement identified a gap in available, current, and accessible research on the following topics:

- Obstetric and gynaecological care for women who have been impacted by FGM/C.
- Accurate prevalence data of FGM/C in Australia and Aotearoa New Zealand.
- Acceptability studies for deinfibulation.
- Access to continuity

10. References

1. (WHO) WHO. WHO guidelines on the management of health complications from female genital mutilation. Geneva, Switzerland: Research DoRHa; 2016.
2. Moeed SM, Grover SR. Female genital mutilation/cutting (FGM/C): Survey of RANZCOG Fellows, Diplomates & Trainees and FGM/C prevention and education program workers in Australia and New Zealand. Australian and New Zealand Journal of Obstetrics and Gynaecology. 2012;52(6):523-7.
3. Farouki L, El-

24. (NETFA). Multicultural Centre for Women's Health (MCWH); 2023 [cited 2023 10/02]. A

Research & Policy Team[vi]	Po

[vi] RANZCOG wish to acknowledge the contribution of the technical support provided by the University of Auckland (Dr Karyn Anderson, Ms Marian Showell) who have supported the identification and appraisal of evidence.

	The raw edges will retract as the head begins to crown. RANZCOG addition: If a medio-lateral episiotomy is required, the incision position should be directed at 60 degrees to the midline.
	Control the birth of the emerging head with light downward pressure as usual, carefully monitoring