

# Female Genital Mutilation/Cutting (FGM/C)

A Visual Reference and Learning Tool  
for Health Care Professionals



## FGM/C Global Prevalence



- High prevalence countries (more than 60%)
- Medium prevalence countries (20% to 60%)
- Low prevalence countries (less than 20%)
- FGM/C is not prevalent in these countries

United Nations Population Fund, 2015

This is a visual reference learning tool on female genital mutilation/ cutting (FGM/C). We envision that the visual reference can be used as a standalone guide for patient management and can be consulted by caregivers when unsure on the type of FGM/C diagnosed. The guide and accompanying text can facilitate training of health care providers globally in accurate diagnosis for both clinical management, patient-provider communication, and accurate recording and reporting to governments where required. This reference tool also could be integrated into surveys for monitoring the prevalence of FGM/C types and subtypes.

**Table of Contents**

<b>2</b>	<b>FGM/C Classifications</b>
<b>7</b>	<b>FGM/C Diagnosis in Pre-Pubertal Girls</b>
<b>13</b>	<b>Defibulation Procedure, Counseling Guidelines, Pre &amp; Post-Operative Care</b>
<b>20</b>	<b>Community Engagement, Cultural Considerations &amp; Ethical Analysis with FGM/C-Affected Communities</b>
<b>22</b>	<b>Documentation Do's and Don'ts</b>
<b>25</b>	<b>References</b>

# FGM/C Classifications

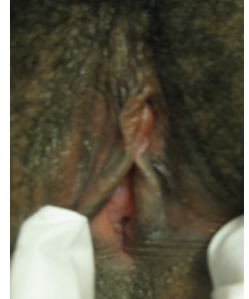
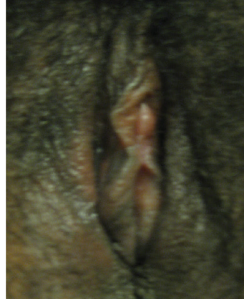
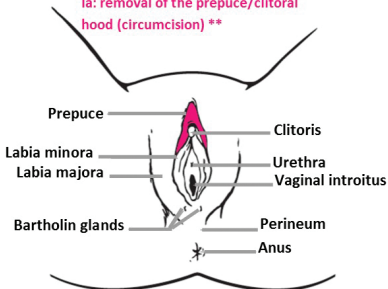
## Partial or total removal of the clitoris\* and /or prepuce

\*refer to page 6

### FGM/C Type Ia

Partial or total removal of the clitoris\*  
and/or the prepuce (clitoral hood)

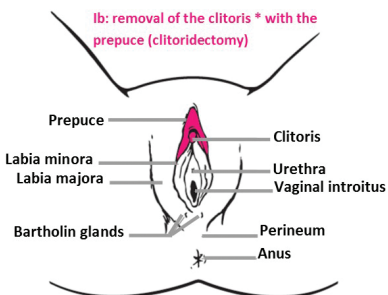
Ia: removal of the prepuce/clitoral  
hood (circumcision) \*\*



### FGM/C Type Ib

Partial or total removal of the clitoris\*  
and/or the prepuce (clitoral hood)

Ib: removal of the clitoris \* with the  
prepuce (clitoridectomy)





# FGM/C Classifications

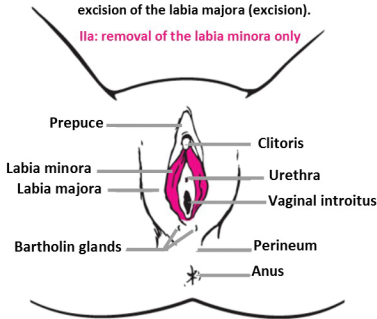
Partial or total removal of the clitoris\* and labia minora, with or without excision of the labia majora

\*refer to page 6

## FGM/C Type IIa

Partial or total removal of the clitoris\* and the labia minora, with or without excision of the labia majora (excision).

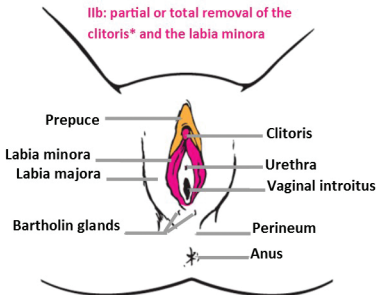
IIa: removal of the labia minora only



## FGM/C Type IIb

Partial or total removal of the clitoris\* and the labia minora, with or without excision of the labia majora (excision).

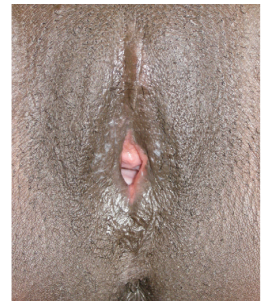
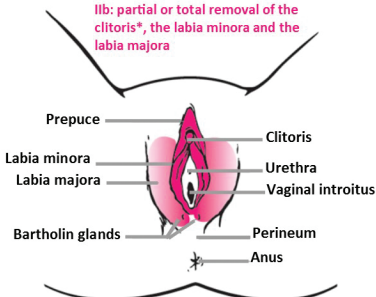
IIb: partial or total removal of the clitoris\* and the labia minora



## FGM/C Type IIc

Partial or total removal of the clitoris\* and the labia minora, with or without excision of the labia majora (excision).

IIc: partial or total removal of the clitoris\*, the labia minora and the labia majora

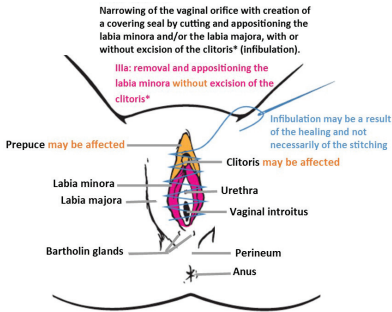


Obstet Gynecol 2016 Abdulcadir et al

# FGM/C Classifications

Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)

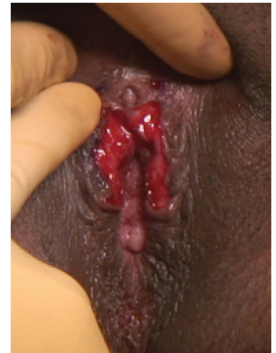
## FGM/C Type IIIa



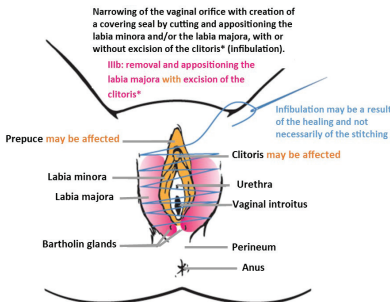
Before Defibulation



After Defibulation



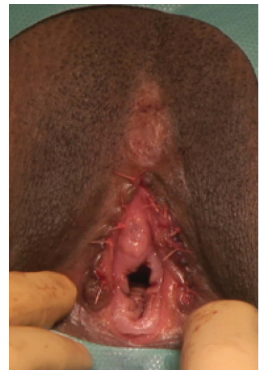
## FGM/C Type IIIb



Before Defibulation



After Defibulation



Obstet Gynecol 2016 Abdulcadir et al

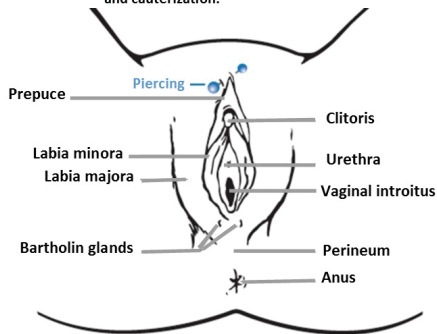
Reinfibulation is the practice of sewing the external labia back together after defibulation. Reinfibulation is illegal in some countries. It is not recommended by FIGO and WHO.

# FGM/C Classifications

All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, pulling, piercing, incising, scraping and cauterization

## FGM/C Type IV

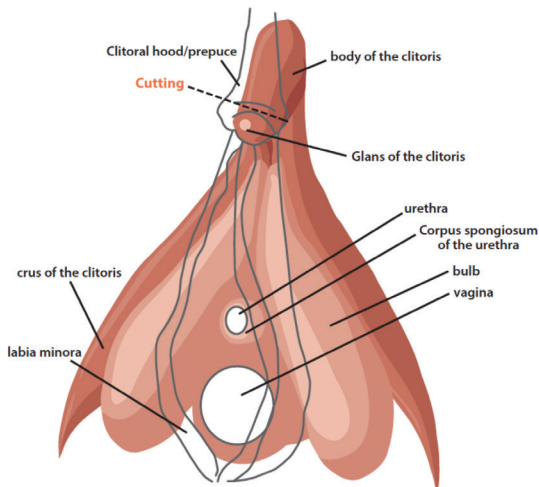
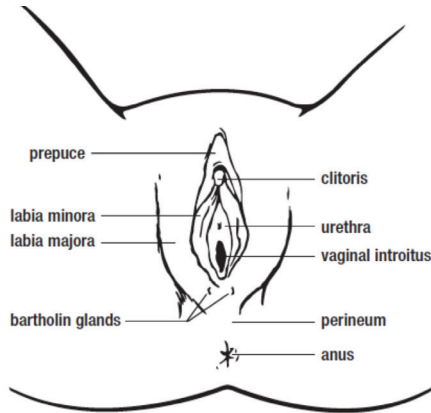
Unclassified. All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization.



Obstet Gynecol 2016 Abdulcadir et al

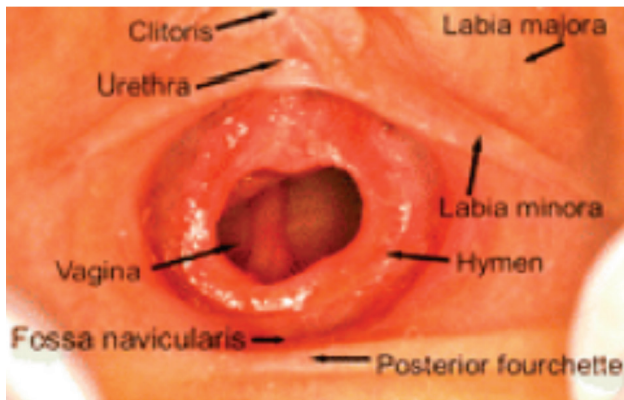
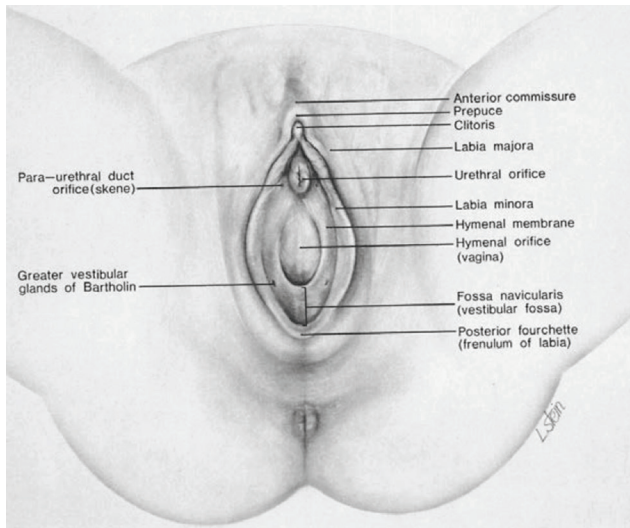
## FGM/C Classifications

\*In the World Health Organization classification, when there is reference to removal of the clitoris, only the glans or the glans with part of the body of the clitoris is removed. The body or part of the body and the crura of the clitoris remain intact as well as the bulbs, two other sexual erectile structures.



Obstet Gynecol 2016 Abdulcadir et al

# FGM/C Diagnosis in Pre-Pubertal Girls

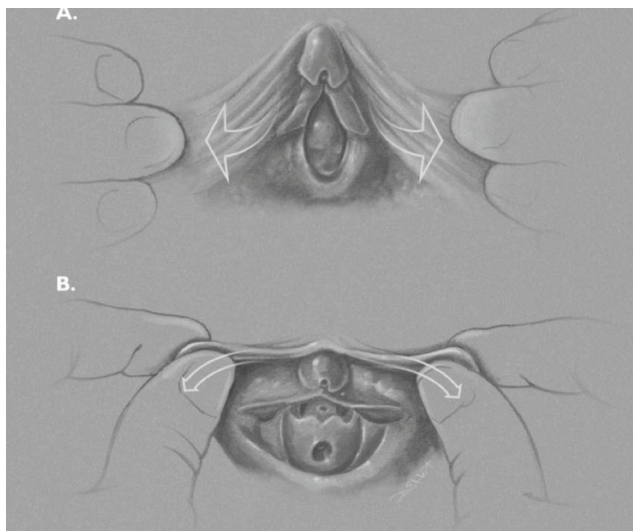


Peds in Review 2014 Jacobs A et al

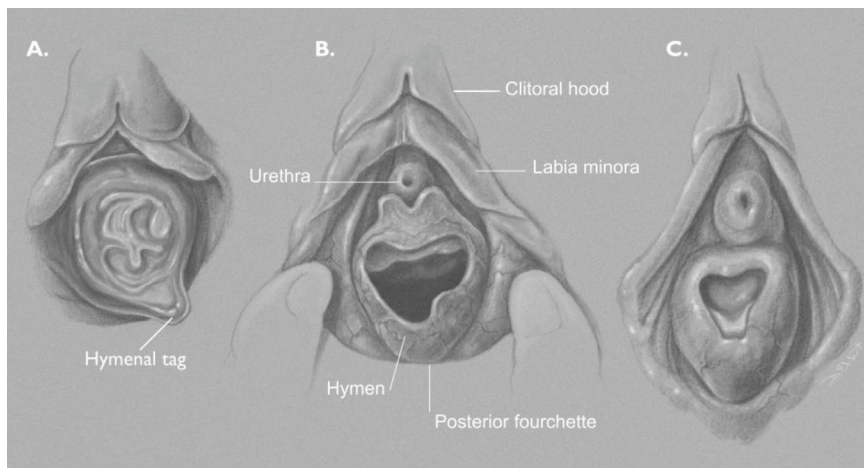
Peds in Review 2006 Graham E et al



## FGM/C Diagnosis in Pre-Pubertal Girls



Peds In Review, Graham, E et al 2006

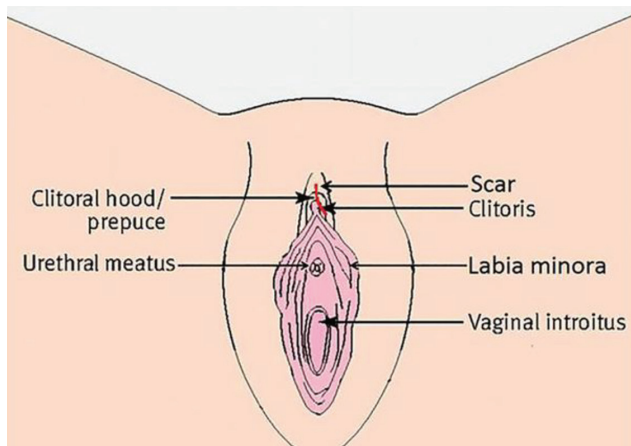


Peds in Review 2006 Graham E et al



## FGM/C Diagnosis in Pre-Pubertal Girls

**Type Ib or Type IV FGM/C, scarring with excised clitoris\* and prepuce OR linear scar from superficial cutting with adhesions in a Tanner 5 female**



BMJ open, Creighton S et al 2016

**Type IIc FGM/C** in a pre-pubertal girl (excised prepuce/clitoris\*, and labia minora, OR excised prepuce/clitoris, partially excised right labia minora, absent left labia minora and partial anterior fusion of labia minora covering urethral meatus and proximal vaginal introitus).



Photo courtesy of UW Medicine/Harborview Medical Center for Sexual Assault & Traumatic Stress

### Pre-pubertal female with Labial Adhesions, No FGM/C

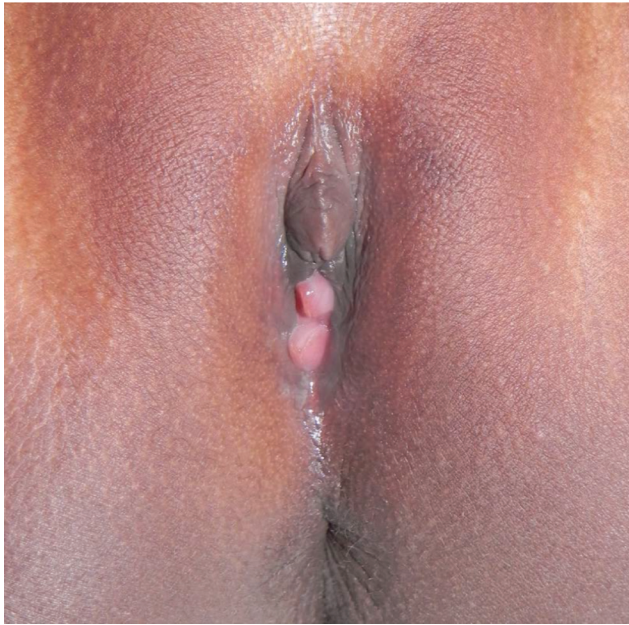
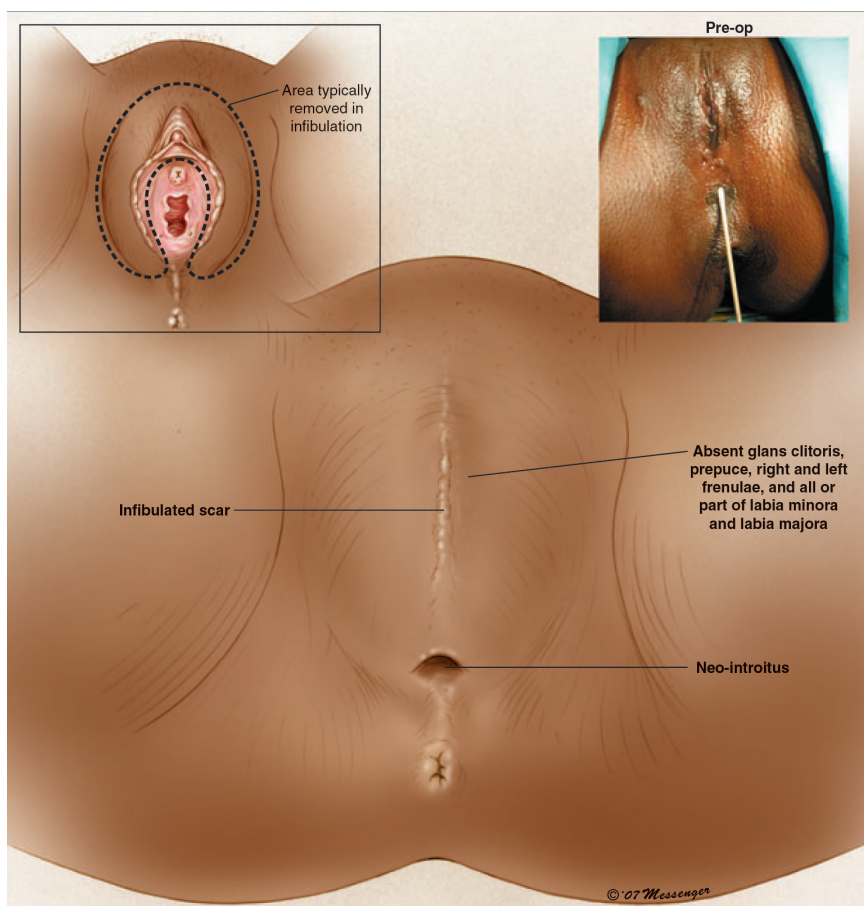


Photo courtesy of UW Medicine/Harborview Medical Center for  
Sexual Assault & Traumatic Stress

**Peri-clitoral adhesions in 18 month old female,  
No FGM/C**



Photo credit: J Young



Johnson and Nour, 2007

**Defibulation** is a procedure that opens the vulvar scar tissue, exposes the introitus, and creates new labia. Defibulation is recommended for infibulated women who suffer from genito-urinary complications, and/or dyspareunia and allows physiological delivery and gynecological procedures. Surgery can be performed under general, local or regional anesthesia. Pregnant women should be defibulated during their second trimester or during labor, under local or regional anesthesia. During labor, defibulation can be performed during the first stage (preferably).

**Note:** Type I and Type II **do not** need defibulation procedure.

### Contraindications

- Refusal of the woman
- Tissue cannot be lifted and incised

### Equipment Needed

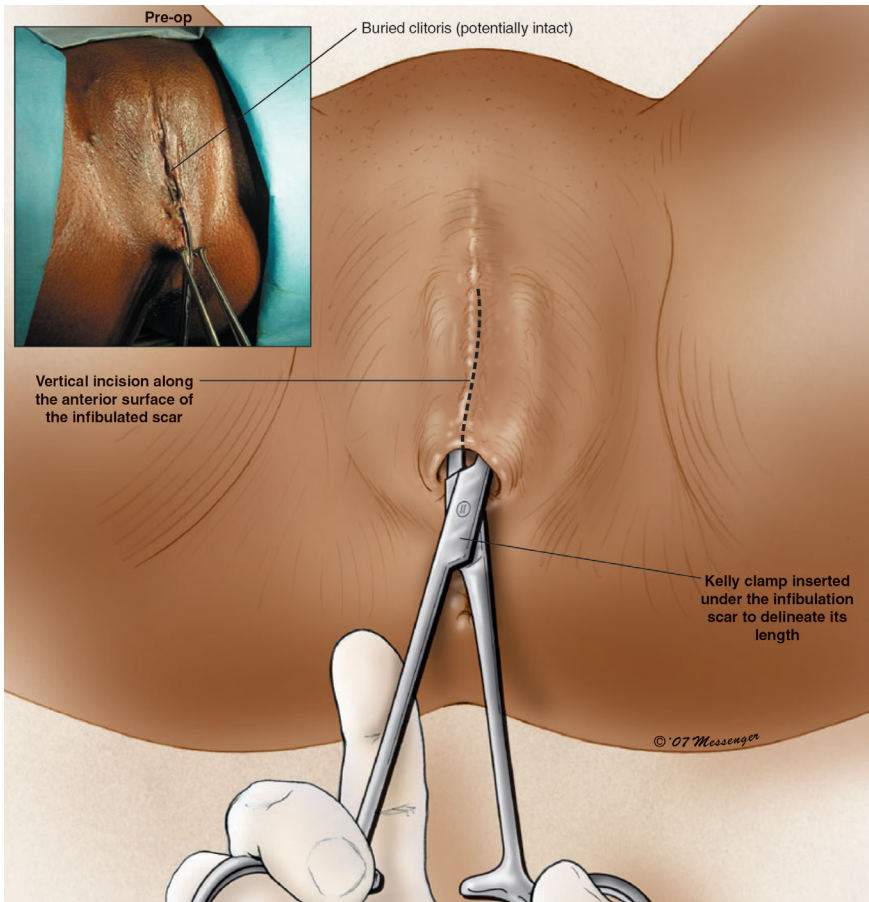
- Sterile gloves
- Disinfection prep
- 10 cc syringe
- 22 or 25 g needle for injection
- EMLA cream (before applying local anesthetic injection)\*
- Local anesthetic injection (1% Xylocaine, 0.25% Bupivacaine HCL and Epinephrine 1:200,000)
- Scalpel or straight Metzenbaum scissors or curved Mayo scissors (depending on the thickness of the scar tissue)
- Adson plain or rat-toothed tissue forceps
- Needle driver
- 4-0 monocril or vicryl suture on SH needle
- Suture scissors
- Mosquito clamp

\* if defibulation is performed under local anesthesia

### Pre-operative Counseling

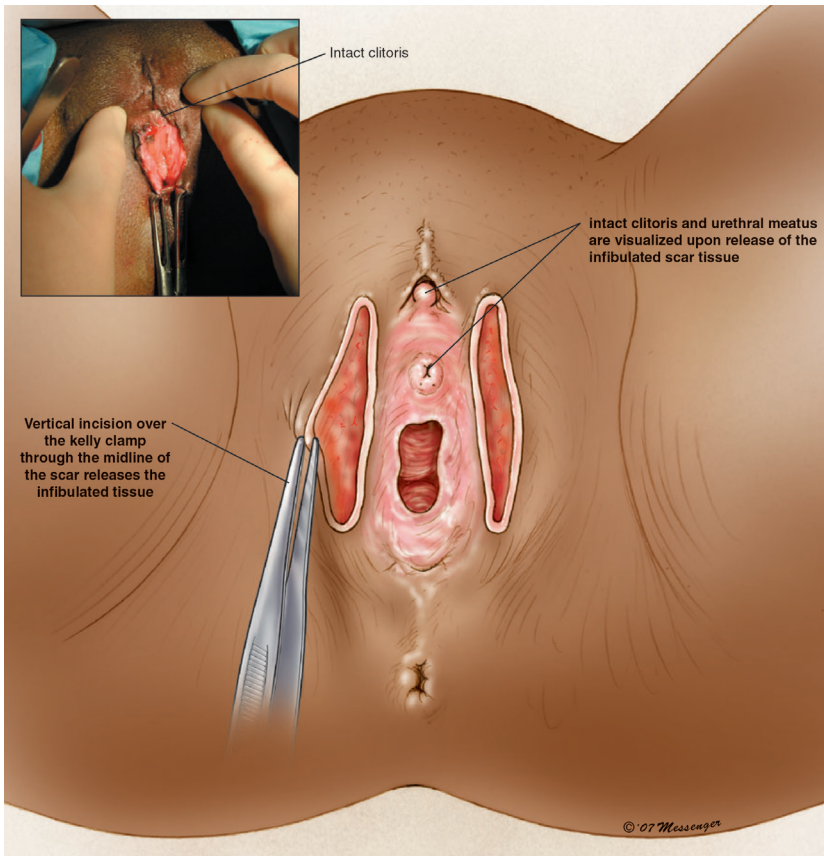
- Education on anatomy and physiology before and after defibulation (e.g. false beliefs on infibulated and defibulated external genitals, virginity, sexuality, and genital self-image)
- Information on anesthesia (local, locoregional or general), surgery, advantages and follow-up
- Agreement on the opening (up to 1 cm above the urethra or up to the clitoris)
- Reassurance on intraoperative and postoperative pain (not the same as for original FGM/C)
- If during pregnancy give the woman/girl the choice of undergoing defibulation during pregnancy (2nd trimester) or labor (first phase)





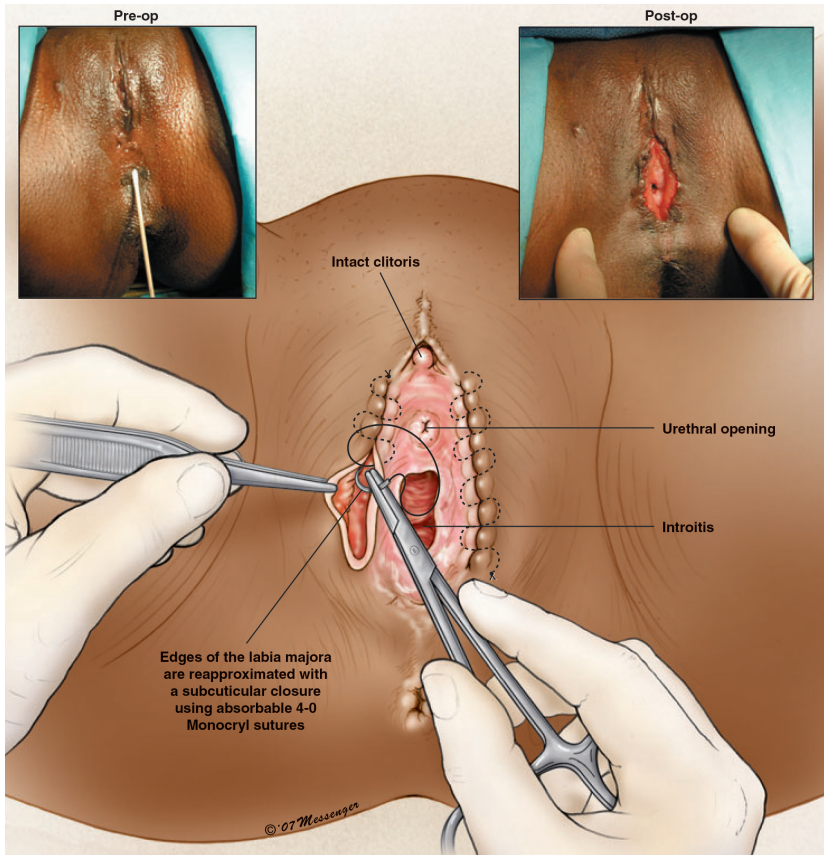
Johnson and Nour, 2007

- Palpate the clitoris and assess where the urethral meatus might be
- Place a finger or a Mosquito clamp under the cutaneous bridge of the defibulation and tent it outward. Additional orifices can be present along the infibulation scar
- To avoid labial asymmetry, make sure you decide on the central line of incision before tenting up on the skin of the infibulation. You can then draw this line



Johnson and Nour, 2007

- Incise with scissors (or a scalpel) along the midline and proceed from inferiorly to superiorly, up to the level agreed upon with the patient, uncovering the urethral meatus (partial) or the clitoral region (total defibulation)
- Be careful not to injure the urethral meatus and the clitoris or clitoral stump. In case of adhesions, a urinary catheter can be introduced for the duration of the surgery as soon as the urethra is accessed
- When performing defibulation during labor (in the absence of an epidural), incise the scar during the pain peak of a uterine contraction



Johnson and Nour, 2007

- Reconstruct the labia majora and/or labia minora by suturing the edges of the defibulated infibulation with continuous interrupted sutures
- Long-acting local analgesia may be injected to relieve post-operative pain
- Patients should be made aware that their voiding stream will change and they should avoid immediate sexual activity until fully healed
- For further guidance on defibulation, please refer to: Abdulcadir J, Marras S, Catania L, et al. Defibulation: a visual reference and learning tool. J Sex Med 2018;15:601-611

Postoperative Care

- Follow-up care within the first 1-2 weeks, and then again at 4-6 weeks. Explain the changes experienced (e.g. faster micturition) and that sexual intercourse can be resumed after 4-6 weeks and/or when it is suitable for both the patient and partner
- Prescribe local estrogen cream to apply to the vulva in the first few weeks to help promote tissue healing and reduce labial adhesion/agglutination. Advise the client on local vulvar hygiene and daily manual detachment of the labia to avoid spontaneous adhesion
- Provide analgesia (acetaminophen and ibuprofen)
- Good hydration and micturition under a water jet can help reduce burning caused by the urine passing on the defibulated area. Sitz baths are advised

CPT Codes:

- 13131** Defibulation (general procedure code)  
Repair of complex procedures on integumentary system
- 56441** Lysis of labial adhesions
- 56800** Plastic repair of introitus

FGC Diagnosis	ICD-10
FGM/C Unspecified	N90.810
Type I	N90.811
Type II	N90.812
Type III	N90.813
Other FGM/C	N90.818

\*for complicated procedures add -22 modifier and document additional work

### Antepartum Care

- Use a certified interpreter in case of language barriers
- Take time for the consultation
- Discuss the respective changes occurring after delivery and defibulation (e.g. in micturition, menstruation, genital appearance, and sex) using illustrations
- Clarify the advantages of performing defibulation
- Explore patient beliefs, fears, and myths regarding uncut and defibulated genitalia
- Provide correct information respectfully (e.g. defibulated genitalia are not “wide and open”; faster micturition is not “vulgar”)
- If possible, with the woman's agreement, include the partner in the discussion, and encourage an exchange of views by the couple
- Explain that reinfibulation is not in the patient's and her partner's best interests in terms of health (urogynecologic, obstetric, and sexual complications)
- Explain the medico-legal recommendations

### Intrapartum Care

- During intrapartum defibulation, respect the woman's choice regarding the level of opening (partial or total defibulation)
- In case of a supra-clitoral or supra-urethral tear, reconstruct the vulvar anatomy in the most physiological way, leaving the urethral meatus and the vaginal orifice uncovered; avoid asymmetries of the labia
- Explain to the woman each of the different procedures she underwent (e.g. perineal tear, episiotomy, and defibulation)

### Postpartum Care

- Use a certified interpreter in case of language barriers
- Take time for the consultation
- During the postpartum check, explore the woman's feelings regarding the new appearance and physiology of her genitalia
- Repeat explanations on possible false beliefs and myths
- Do not focus only on reinfibulation, but also care for the woman's overall health, including breastfeeding, contraception, sexual health, and postpartum incontinence
- Propose pelvic floor training and explain the advantages, including a better perineal tone and self-knowledge of her own genitalia
- If possible, with the woman's agreement, include the partner in the discussion, and encourage an exchange of views by the couple
- If the woman dislikes her genitalia or discloses a distress linked to her genitalia, schedule a new follow-up appointment; reassure her by explaining that adjusting to such a change can require time; and investigate the cause of the dislike and distress to allow it to be addressed

Nurturing meaningful partnerships with FGM/C-affected communities to build trust, open dialogue, counseling, and community outreach is one of the best approaches to combat the extreme fear and distrust that currently exists within immigrant and refugee communities who already face stigmatization. In doing so, we allow room for culturally-sensitive care for affected populations and an opportunity to prevent FGM/C among female minors.

## **Approaches to Consider**

- Connect with local organizations with expertise in working with FGM/C-affected communities
- Develop new community-based partnerships if there are no pre-existing relationships
- Seek assistance outside of your profession and develop a multi-specialty provider team, comprising: nurses, social workers, psychologists, counselors, case managers, certified medical interpreters, patient navigators, community health workers, child abuse specialists, gynecologists, urologists, general surgeons, and pediatricians
- Ensure the next generation of clinicians and scholars (students and residents of various disciplines) are exposed to culturally competent approaches to care for this population during their training
- Develop a Community Advisory Board/Coalition (CAB/CAC) to ensure long-term community partnerships, engagement and shared community leadership with FGM/C-affected communities. Consider engaging community stakeholders in CABs/CACs, such as local ethnic community-based organizations (ECBOs), refugee resettlement and voluntary agencies, public health, mental health and social service agencies, and academic partners.



**“FGM/C is physically and emotionally damaging, seriously impacting a girl’s reproductive, sexual, and mental health.”**

(Young J et al, AAP Clinical Report, 2018)

HOWEVER, we need to be mindful that:

- Parents may not have felt they had a choice, bound by prevailing cultural expectations
- FGM/C is viewed as setting daughters up for “success” as the practice is sometimes viewed as a prerequisite for marriage and acceptance
- Parents might not have been fully aware of what was going to happen to their children, or believed it has some medical benefit
- Parents that have their child undergo this practice is not a sign that they do not care about her, or are more likely to engage in other forms of abuse.

THEREFORE,

**We need to treat immigrant families whose children underwent FGM/C with compassion rather than judgment.**

This approach could help encourage remedial interventions, dissuade the family from having their other children undergo circumcision, and enable advocacy efforts with their communities.

## Documentation Do's & Don'ts

### Do:

- ✓ Ensure that informed consent, when appropriate, is documented in the medical record, e.g. to examine external genitalia.
- ✓ For children able to assent, obtain their assent before proceeding with examination of external genitalia.
- ✓ Carefully and objectively document any examination limitations, mishaps, or unusual occurrences in the record.
- ✓ Describe physical findings in detail and with language customarily used in similar situations. When possible, photo-document abnormal genital findings and maintain them in a secure, HIPAA-compliant fashion.
- ✓ Report impressions objectively, comprehensively, and in as simple language as possible. Seek expert opinion from well-versed medical providers in diagnosing FMG/C in pre-pubertal or pubertal girls if diagnosis is unclear.
- ✓ If new FGM/C performed within the host country -or abroad and after initial immigration—create the report in a timely fashion, and as soon after evaluation as possible.
- ✓ Document (in reasonable detail), where appropriate, all consultations with colleagues, patients/parents, and multidisciplinary partners.

(Young J et al, AAP Clinical Report, 2018)

### Don't:

- ❌ Insert language into the record or a report that is inflammatory, superfluous, or highly subjective (i.e., “profoundly”, “faulty”, “sloppy”, “terrible”, “negligent”, “careless”, “horrible”, “uncaring”, “pathetic”, “horrific”, “barbaric”, etc.).
- ❌ State conclusions that are not supported by specific facts or the medical literature, including FGM/C findings if you are unsure of diagnosis. Expert opinion suggests that FGM/C type I and II diagnoses are easily missed and normal variants in female genital anatomy may mimic type I and II (see photos, above).
- ❌ Record information in the record or a report that has primarily legal implications and patient care value (i.e., “Patient expresses concerns that the father intends to ensure that FGM/C is performed on his female children”).

(Young J et al, AAP Clinical Report, 2018)

# References

Funding provided by the U.S. Department of Health and Human Service Office on Women's Health under grant no. WH-AST-16-002, [Female Genital Cutting (FGC) Community-Centered Health Care and Prevention Project].

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View our resources at:

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