

# Australasian College for Emergency Medicine

## Statement on Female Genital Mutilation/Cutting

### Document review

---

<b>Timeframe for review:</b>	Every five years, or earlier if required
<b>Next review to be completed:</b>	April 2031
<b>Content owner:</b>	Emergency Medicine Standards and Advisory Committee
<b>Approval authority:</b>	Council of Advocacy, Practice and Partnerships
<b>Accessibility:</b>	Public (website)

### Revision history

---

Version	Date	Pages revised / Brief explanation of revision
V1	Mar-2004	Approved by Council of Advocacy, Practice and Partnerships

### Related Documents

This Policy should be read in conjunction with the following ACEM documents.

- [P35 Child at Risk](#)
- [P39 Identifying and Responding to Family and Domestic Violence and Abuse](#)
- [S633 Statement on Health of People Seeking Asylum](#)
- [S738 Statement on Gender Equity](#)
- [S881 Statement on Health and Human Rights](#)

### Copyright

2026. Australasian College for Emergency Medicine. All rights reserved.

April 2026

acem.org.au

# 1. Purpose and Scope

---

This position statement sets out the Australasian College for Emergency Medicine's (ACEM's) position on Female Genital Mutilation/Cutting (FGM/C) and provides information and resources for Emergency Departments (EDs).

This position statement applies to all EDs in Australia and Aotearoa New Zealand.

# 2. Terminology

---

## Female Genital Mutilation/Cutting (FGM/C)

FGM/C refers to the non-medical practice of wholly or partially injuring or removing the external female genitalia. See Appendix 1 for further information on the four types of FGM/C. FGM/C is mostly carried out on young girls aged between infancy and 15 years. <sup>1</sup>

## Infibulation

Infibulation refers to a procedure that narrows the vaginal opening by creating a seal. This usually involves cutting and repositioning the labia minora and/or labia majora, with or without removing the clitoris and/or prepuce.

## Deinfibulation

Deinfibulation refers to a surgical procedure to reopen the vagina in females who have been infibulated. <sup>2</sup>

## Re-infibulation

Re-infibulation refers to process of narrowing the vagina again after deinfibulation. <sup>1</sup>

# 3. ACEM Position

---

FGM/C constitutes a violation of human rights and represents a form of child abuse and gender-based violence. The practice causes immediate and long-term physical, psychological, sexual, and obstetric harm, and is rooted in gender inequality and the control of the bodies and sexuality of females.

ACEM unequivocally condemns FGM/C and supports the World Health Organization's position that the practice has no medical or ethical justification. <sup>1</sup>

FGM/C is illegal in all jurisdictions in Australia and Aotearoa New Zealand. ACEM expects all Fellows, Associates and trainees to be aware of and comply with relevant legislation, mandatory reporting requirements, and professional obligations. ACEM asserts that no medical practitioner should perform or facilitate FGM/C. Any clinician who engages in this practice is acting in breach of professional standards, may be subject to professional misconduct investigations and potential criminal prosecution.

ACEM acknowledges that women and girls\* living with FGM/C reside in Australia and Aotearoa New Zealand and affirms that they must access prompt, trauma-informed, culturally safe care when attending EDs across Australia and Aotearoa New Zealand.

The elimination of FGM/C by 2030 is a global priority under the United Nations Sustainable Development Goals, particularly Goal 5: Gender Equality. <sup>3</sup> ACEM affirms its commitment to advocacy, education, and clinical leadership in addressing the health impacts of FGM/C and supporting the eradication of this harmful practice.

\*ACEM recognises that there may be people who do not identify as women or girls who have undergone FGM/C. However, in this document, the terms 'women' and 'girls' are used to align with the language used in WHO and UNICEF documentation.

---

<sup>1</sup> World Health Organization. Female genital mutilation fact sheet. 2025. <https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation>

<sup>2</sup> Government of Western Australia North Metropolitan Health Service. Female genital cutting/mutilation (FGC/M). <https://www.kemh.health.wa.gov.au/~media/HSPs/NMHS/Hospitals/WNHS/Documents/Clinical-guidelines/Obs-Gyn-Guidelines/Female-Genital-Mutilation-FGM.pdf?thn=0>

<sup>3</sup> United Nations. Sustainable Development Goals. 1992. <https://sdgs.un.org/goals>

## 4. Background

### 4.1 The Australasian Context

More than 230 million women worldwide have undergone FGM/C.<sup>4</sup> In some communities, beliefs that the practice encourages modesty, hygiene, aesthetic standards, or is a religious obligation persist. However, neither medical evidence nor religious teachings support these claims. The WHO explicitly identifies FGM/C as a form of gender-based violence and a human rights violation.<sup>2</sup>

FGM/C is deeply rooted in the cultures of approximately thirty nations across Africa, the Middle East, and Asia. A list of countries where FGM/C is commonly practised and the percentage of people in those countries who have undergone FGM/C is available in Appendix 2. While FGM/C is not a traditional practice in Australia or Aotearoa New Zealand, a growing number of women and girls are migrating to Australasia from countries with a high prevalence of FGM/C including Somalia (99 per cent), Sudan (86.6 per cent) and Indonesia (51 per cent). Data from the AIHW indicates that over 53,000 women and girls residing in Australia have undergone FGM/C. However, this figure is likely an underestimate due to incomplete records, women and girls being unaware of whether they have been cut, and clinicians' failure to recognise it.<sup>5</sup> One small study suggests that Australian-born children have been subjected to FGM/C.<sup>6</sup>

In Aotearoa New Zealand, while there is no data regarding current FGM/C practices, the 2023 census data suggest that approximately 5000 people may be at risk based on their ethnicity.<sup>7</sup> Migrating to a country where FGM/C is not traditionally practised, has been shown to support its abandonment. This is likely due to reduced social and cultural pressures, and increased education in these areas.<sup>8</sup> ED physicians need to be alert to the practice of FGM/C and implications for patient care.

People who have undergone FGM/C may experience long-term health complications, depending on the type and extent of the injury, and are likely to seek emergency care.<sup>9</sup> In Australia and Aotearoa New Zealand, EDs play a crucial role in leading a coordinated response that safeguards women and girls, and ensures patients receive trauma-informed, culturally sensitive, and evidence-based care that adheres to the highest clinical and ethical standards.

In Australia and Aotearoa New Zealand, it is illegal for medical practitioners to perform FGM/C. All states and territories in Australia have passed laws against FGM/C. However, there is no federal law specifically addressing FGM/C. Re-infibulation and taking a child abroad to undergo FGM/C are also illegal across all states and territories. In Aotearoa New Zealand, FGM/C is illegal as per the Crimes Act 1961, which also prohibits travelling abroad to facilitate or undergo FGM/C, as well as assisting or encouraging individuals in Aotearoa New Zealand to perform FGM/C on a resident or citizen overseas. The ACEM policy *P35 Child at Risk* gives information regarding mandatory reporting of suspected child abuse or neglect, including of children who have had or are at risk of FGM/C.

### 4.2 Medicalisation of FGM/C

UNICEF estimate that approximately 66% of all recent FGM/C procedures are currently conducted by health care professionals.<sup>10</sup> Medicalised FGM/C is wrongly assumed to be a safe alternative. However, even when performed by a health professional, FGM/C still involves the excision of healthy tissue. It remains a human rights violation and is a breach of the medical ethics principle of 'do no harm'.<sup>4 11</sup>

4 UNICEF. Female genital mutilation. 2025. <https://data.unicef.org/topic/child-protection/female-genital-mutilation/>

5 Australian Institute of Health and Welfare. Discussion of female genital mutilation/cutting data in Australia, Summary. 2019. <https://www.aihw.gov.au/reports/women/discussion-of-female-genital-mutilation-cutting/summary>

6 Zurynski Y, Phu A, Sureshkumar P, Cherian S, Deverell M, Elliott EJ, et al. Female genital mutilation in children presenting to Australian paediatricians. *Arch Dis Child*. 2017;102(6):509–15.

7 Stats NZ. 2023 Census population counts (by ethnicity group, age and Māori descent) and dwelling counts. 2023. <https://www.stats.govt.nz/information-releases/2023-census-population-counts-by-ethnicity-group-age-and-maori-descent-and-dwelling-counts/>

8 Varol N, Hall JJ, Black K, Turkmani S, Dawson A. Evidence-based policy responses to strengthen health, community and legislative systems that care for women in Australia with female genital mutilation/cutting. *Reproductive Health*. 2017 Dec;14(1):63

9 Abdulcadir J, Catania L, Hindin MJ, Say L, Petignat P, Abdulcadir O. Female Genital Mutilation. A visual reference and learning tool for health care professionals. *Obstetrics & Gynecology*. Nov 2016;128(5):958–63

10 UNICEF. Female genital mutilation: a global concern. 2024. <https://data.unicef.org/resources/female-genital-mutilation-a-global-concern-2024/>

11 End FGM European Network. The time is now: end female genital mutilation/cutting (FGM/C). 2025. [https://www.endfgm.eu/editor/files/2025/02/The\\_Time\\_is\\_Now\\_End\\_Female\\_Genital\\_MutilationCutting\\_An\\_Urgent\\_Need\\_for\\_Global\\_Response\\_2025\\_ENGLISH\\_1.pdf](https://www.endfgm.eu/editor/files/2025/02/The_Time_is_Now_End_Female_Genital_MutilationCutting_An_Urgent_Need_for_Global_Response_2025_ENGLISH_1.pdf)

### 4.3 Health Impacts of FGM/C

FGM/C may result in significant biopsychosocial issues, depending on the extent of the injury. <sup>1</sup>These include:

#### Immediate and Short-term Effects

- Haemorrhage
- Infection
- Severe pain
- Urinary retention
- Psychological distress
- Death

#### Long-term Effects

- Menstrual problems; including dysmenorrhoea and impedance of menstrual flow
- Pelvic pain and infection
- Pelvic floor dysfunction
- Genital scarring; such as neuromas, epidermal cysts and keloids
- Obstetric complications; such as prolonged labour, perineal injury, obstetric fistula, postpartum haemorrhage and increased perinatal mortality (particularly with Type 3).
- Urinary problems; including urinary tract infections, poor urinary flow or retention, renal tract calculi or strictures
- Sexual issues; including dyspareunia, greater susceptibility to sexually transmitted infections and sexual dysfunction
- Psychological problems; including depression, anxiety and post-traumatic stress disorder <sup>1 12</sup>

## 5. Clinical Care Considerations

---

### 5.1 Clinical Practice

#### Screening

In Australia and Aotearoa New Zealand, consider screening women from high prevalence countries if they present to the ED with a complaint that may relate to FGM/C. <sup>10 13</sup> A list of countries where FGM/C is commonly practiced is available in Appendix 2.

#### Importance of Language

Staff should discuss FGM/C sensitively and use language that is comfortable for the patient. The term 'mutilation' is used by the WHO and UNICEF to highlight the seriousness of the issue, however many women find the word isolating and stigmatising. Some women prefer the term 'cutting' or 'circumcision', and there are various terms in local languages. The best practice is to ask and use the women's preferred term. <sup>14</sup>

#### Use of Interpreters

Interpreter services can support effective and respectful communication. Women should be asked whether they would like an interpreter and, if so, whether they prefer an in-person or telephone interpreter.

Not all women will welcome the use of an interpreter—particularly in cases involving rare languages or dialects, where knowing the interpreter personally may raise concerns about privacy and confidentiality.

---

<sup>12</sup> World Health Organisation. WHO guidelines on the management of health complications from female genital mutilation. 2016. <https://www.who.int/publications/i/item/9789241549646>

<sup>13</sup> Diaz MP, Bronw AE, Fleet J, Steen M. What women want: A reflexive thematic analysis of the healthcare experiences of women with female genital mutilation/cutting in South Australia. *Women and Birth*. Nov 2023;36(6):e652-660

<sup>14</sup> World Health Organization. Care of girls and women living with female genital mutilation. 2018. <https://www.who.int/publications/i/item/9789241513913>

Where an interpreter is requested, every effort should be made to provide a female interpreter. Additionally, clinicians should work with the woman to accurately identify her specific language and dialect; for instance, requesting an 'Arabic' interpreter without clarifying the country or region of origin is insufficient, as significant dialectal variations may affect comprehension.<sup>12</sup>

## Referrals

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists recommend early identification based on their presenting symptoms to manage ongoing symptoms. Women with Type 3 FGM/C should be referred to a gynaecologist. De-infibulation may be necessary before intercourse or childbirth.<sup>15</sup>

All women disclosing FGM/C should be offered psychological counselling via their GP after ED discharge, but this requires a sensitive approach, considering cultural differences in perceptions of psychology. Sexual health counselling is suggested for preventing or treating female sexual dysfunction among women living with FGM/C.<sup>9</sup>

Patients should be referred to local FGM/C support groups or clinics if available. A list of resources is provided in the Resources section.

## 5.2 Emergency Departments and FGM/C

### Staff Education and Training

Most ED staff have limited knowledge and understanding of FGM/C as it may not be part of existing curricula. Comprehensive training for ED staff by experts in FGM/C care is essential to ensure culturally safe and trauma-informed care for women. This is especially important for EDs that serve larger demographics of women from high-risk countries. With appropriate training and knowledge, healthcare providers can contribute to effective clinical management, support evidence-based prevention strategies, and facilitate respectful, culturally informed communication.<sup>16</sup> See the Resources section for a list of organisations that provide resources and training in the management of FGM/C.

### Develop and Implement Clear Clinical Policies for FGM/C care in ED

EDs should establish standardised, evidence-based protocols for identifying, documenting, and supporting women with FGM/C and managing symptoms. These protocols should include pathways for clinical care (e.g. pain management), referral processes, and culturally safe communication strategies. Clearly defined procedures reduce variability in care, empowering clinicians, and women.

### Ensure Robust Child Protection Protocols

All ED staff need to be aware of and follow local jurisdictional laws related to child safeguarding and mandatory reporting of suspected child abuse or neglect, including of children who are living with or are at risk of FGM/C. Hospitals must maintain strong child protection frameworks that explicitly address FGM/C as a form of gender-based violence and physical abuse. ED staff should be trained to identify children at risk, know how to make mandatory reports, and engage appropriately with families and child protection services.<sup>17</sup> Refer to the ACEM policy *P35 Child at risk* for more guidance on issues of awareness, detection and management in the ED of children at risk of abuse or neglect.

### FGM/C Diagnosis Code to Improve Data Collection and Evaluation

The routine use of specific diagnosis codes for FGM/C in clinical documentation will help capture the prevalence and characteristics of these presentations in the ED. This data is crucial for identifying service needs, informing resource allocation, and contributing to broader public health surveillance. Coding also bolsters advocacy for funding and policy change by quantifying the impact on the health system.

<sup>15</sup> RANZCOG. C-Gyn 1 Female genital mutilation/cutting (FGM/C) Clinical Guideline. <https://ranzocg.edu.au/wp-content/uploads/Female-Genital-Mutilation.pdf>

<sup>16</sup> Said A, Conn C, Nayar S. New Zealand should intensify efforts to eliminate female genital mutilation by 2023: the views of women from communities that practice FGM/C. *Pacific Health*. 2018;1

<sup>17</sup> The Royal College of Emergency Medicine. A universal FGM flowchart and reporting tool. June 2017. [https://rcem.ac.uk/wp-content/uploads/2021/10/FGM\\_BP-Guide\\_Jul2017.pdf](https://rcem.ac.uk/wp-content/uploads/2021/10/FGM_BP-Guide_Jul2017.pdf)

## Collection of Comprehensive Socio-demographic Data to Inform Service Delivery

The accurate collection of socio-demographic data allows health services to gain a better understanding of the populations affected by FGM/C. This information can help tailor care, guide interpreter services, support culturally appropriate outreach, and identify trends or inequities in access to emergency care.

## 6. Resources

---

### 6.1 Guidelines

#### Other Medical Colleges

- RANZCOG: [C-Gyn 1 Female Genital Mutilation/Cutting \(FGM/C\)](#)
- RCEM: [A universal FGM flowchart and reporting tool](#).
- AMA: [Female genital mutilation - 2017](#)

#### World Health Organization

- [Female genital mutilation fact sheet](#)
- [Guideline on the prevention of female genital mutilation and clinical management of complications](#)
- [Care of girls and women living with female genital mutilation](#).

#### UNICEF

- [Female genital mutilation](#).

### 6.2 Australian Resources and Education

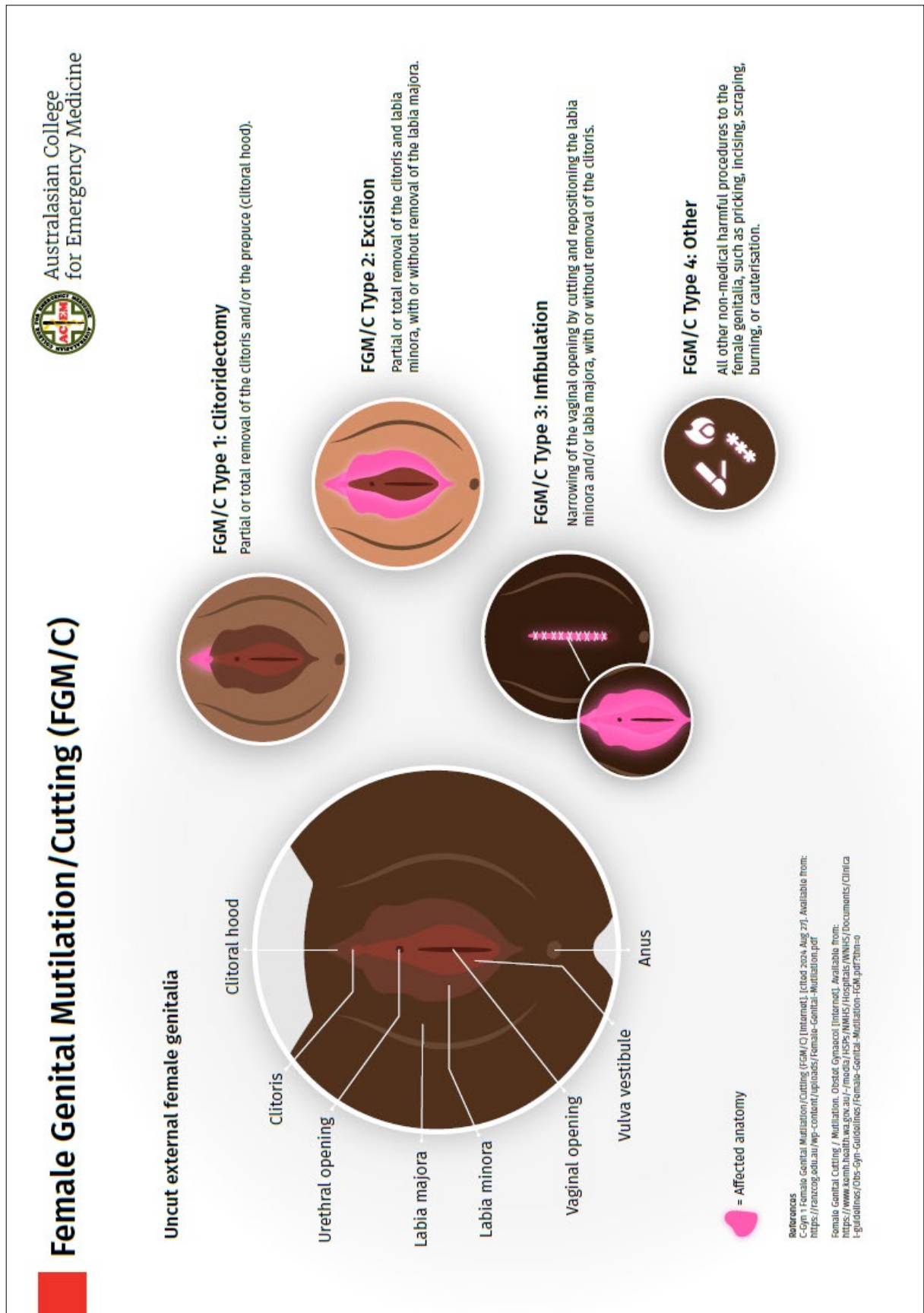
- **Western Sydney Local Health District:** [NSW Education Program on Female Genital Mutilation \(FGM\)](#) A state-funded program providing education, resources, and support to prevent FGM/C in NSW, with a focus on community engagement, professional training, and legal awareness.
- **Royal Women's Hospital (Victoria):** [Family & Reproductive Rights Education Program](#) A specialist clinic offering holistic care to women affected by FGM/C from any background, including reproductive health services, deinfibulation, counselling, and culturally sensitive support.
- **True:** [FGM/C Education for Multicultural Communities](#) A Queensland-based health organisation offering multilingual education sessions and resources to increase awareness and reduce FGM/C within multicultural communities. True provide training and resources to health professionals, interpreters and translators, and community workers on FGM/C.
- **Family Planning Victoria:** [Improving the health care of women and girls affected by female genital mutilation/cutting: A service coordination guide](#). A comprehensive national guide for health and community professionals to coordinate care, provide culturally safe services, and navigate legal and clinical responsibilities regarding FGM/C.
- **SAFE:** [South Australian FGM/C Education \(SAFE\) Program](#): The South Australian Female Genital Mutilation/Cutting Education (SAFE) Program supports midwives and nurses to provide culturally safe care to women affected by FGM/C.

### 6.3 Aotearoa New Zealand

- FGM in NZ: [Resources for Health Professionals](#) New Zealand This site offers comprehensive resources for health professionals working with women affected by FGM/C.
- Women's Health Action: [Genital Alteration and Mutilation](#) This page provides information on FGM/C and cosmetic genital alterations.
- Oranga Tamariki Practice Centre: [Female Genital Mutilation](#) This resource provides guidance for child protection professionals on responding to actual or suspected cases of FGM/C.

## 7. Appendices

### 7.1 Appendix 1: Classification of FGM/C



## 7.2 Appendix 2: List of Countries with a High Prevalence of FGM/C

FGM/C is traditionally practised in about 30 countries across Africa, the Middle East, and Asia. Some nations have laws criminalising FGM/C, but it still frequently occurs in these regions.<sup>10</sup>

Country	Percentage of females who have undergone FGM/C
Somalia *	99
Guinea	96
Djibouti	90
Mali	89
Egypt *	87
Sudan	87
Sierra Leone	83
Eritrea *	83
Gambia	73
Ethiopia *	65
Mauritania	64
Burkina Faso	56
Indonesia *	51
Guinea-Bissau	52
Cote d'Ivoire	37
Chad	34

\* In Aotearoa New Zealand, consider screening women from these four refugee communities, and one migrant community, living in New Zealand, who practice FGM/C.

National FGM Centre publish an interactive map containing information on the prevalence rates in countries across the world. <https://nationalfgmcentre.org.uk/world-fgm-prevalence-map/>