

# Female genital mutilation

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## Abstract

*Female genital mutilation (Circumcision) comprises all procedures that involve partial or total removal of the female external genitalia and or injury to the female genital organs whether for ritual, cultural or other non-therapeutic reasons (W.H.O, Geneva, 1995).*

*Specific law do exist against the practice of Female genital mutilation (FMG) in many*

*countries. In a country like Sudan, where circumcision is widely practiced in spite of parliamentary act abounding the practice decades ago (Abu Shama, A. O., et al., 1949). It is illegal in many other part of the world like, United Kingdom, most European countries and in the United States.*

**Keywords:** genital, mutilation, circumcision

## Prevalence of female genital mutilation:

It is estimated that about 120 - 140 millions women and girls experienced FMG, and that about 2 million girls had undergone one form or other of the procedure every year. Most of these women live in Africa (Figure 1) and some Asian countries.

The type of procedure, the age when it is performed, the prevalence in the community and the socio-cultural and economic factors, which support its continuation, vary widely across the communities that practise FGM. In addition, formal health service provisions and the availability of trained health professionals also vary widely.

An influx of young couples, refugees, and students from countries where circumcision is still widely practised has meant that health care providers in USA and European countries are seeing these women in hospital outpatient clinics and GP practices making a global problem. These circumcised women are concerned with the health care provider's lack of knowledge about female circumcision. These women will require sensitive antenatal and intrapartum care. The physicians and the midwives should have some knowledge about the custom of female circumcision and infibulation, at least

what it looks like and not ask questions which are very embarrassing to the women at this very sensitive and highly emotional time. These women feared receiving poor care during pregnancy, particularly at the time of delivery. Many European countries have developed code of conduct for health professionals. At the national level many countries developed guidelines under different names, but these guidelines does not exist in every country where victim of FMG lives (Proceeding of the Female Genital mutilation expert meeting, November 1998).

## WHO CLASSIFICATION OF FEMALE GENITAL MUTILATION (WHO, 1997)

Type I - Excision of the prepuce, with or without excision of part or the entire clitoris

Type II - Excision of the clitoris with partial or total excision of the labia minora

Type III - Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).

Type IV - Unclassified include the following:

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); 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; and any other procedure that falls under the definition of female genital mutilation given above.

This classification system may not be always helpful, for example in cases that seems to comprise the most severe form of infibulation, the clitoral may actually still be present.

## Complications of female genital mutilation:

A: Immediate complications:

1. Severe pain
2. Infection and abscess formation
3. Severe haemorrhage, this probably is the most common cause for hospital admission following FGM. This some time may necessitate blood transfusion with all the possible complications of blood transfusion.
4. Acute retention of urine
5. Death is a very rare complication of FGM as the result of severe haemorrhage (clitoral artery is quite extensive and cutting it may result in severe blood loss) or septicemia.

B: Late complications of FGM:

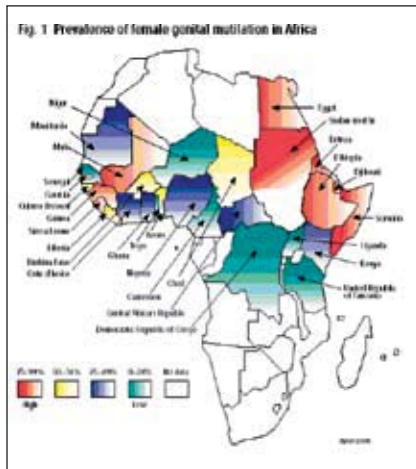


Figure 1

Sexual difficulty including pain and failure to consummate marriage. This is a common reason to seek medical advice and it may be the first time she presents to the care of the obstetrician.

Retention cyst occurs with all types of FGM and may reach a quite big size or become infected or may become infected necessitating immediate intervention, (Figure 2).

Variable degree of urinary obstruction, painful flow and recurrent urinary tract infection.

Keloid scar formation, this could be quite big and may cause embarrassment to the women and marital problems

Chronic pelvic infection is common and may lead to tubal blockage and primary infertility.

Fistula is extremely rare complication of FGM, and can be the result of injury at the initial procedure or following laceration in labour (Shandall).

Menstrual disturbance, dysmenorrhoea is a common problem.

Psychosexual problems and flashbacks (psychological reliving the experience many years later)

### Presentation and management of FMG outside pregnancy

The commonest presentation before pregnancy and in the adulthood are failure to consummate marriage, recurrent vaginal and urinary tract infection and inclusion cyst which can vary in size. Inclusion cysts may be so big that it interferes with walking and get

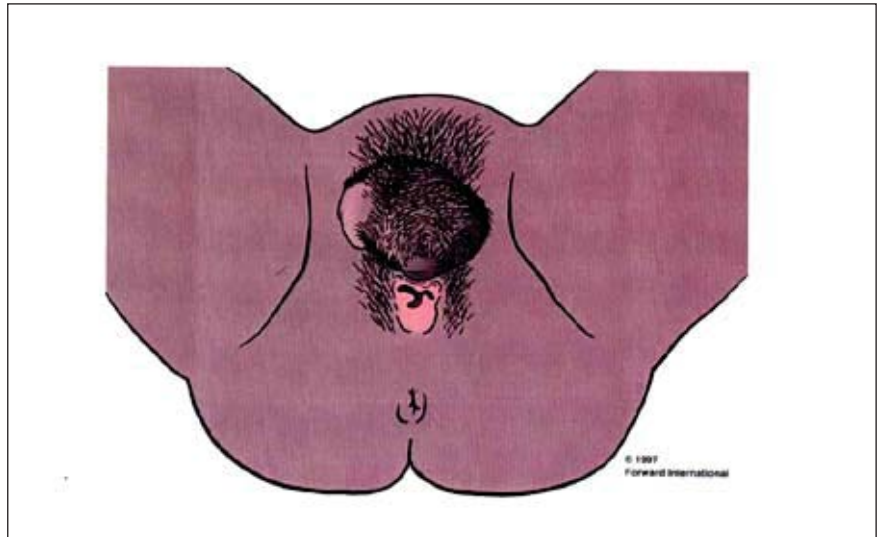


Figure 2: Inclusion cyst which can reach a large size causing pain, difficulty in walking and dyspareunia

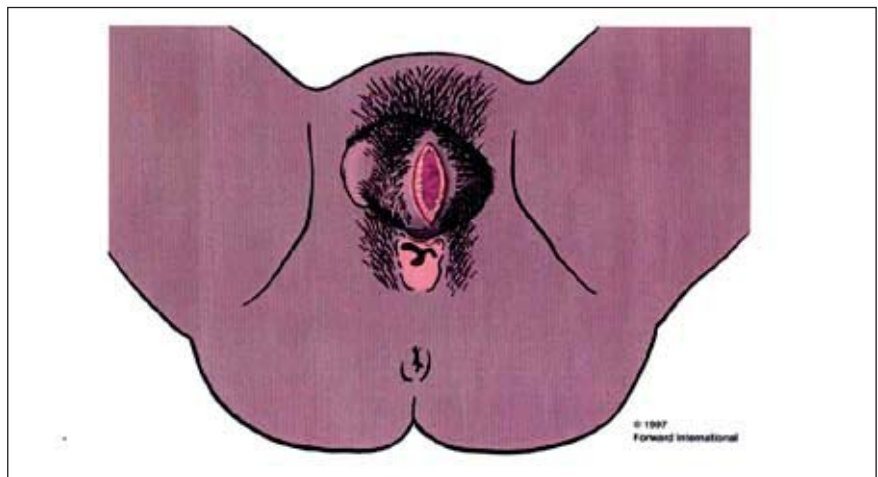


Figure 3: Surgical removal of inclusion cyst involve a longitudinal incision The cyst should then be evacuated and the dead space closed with either Continuous or interrupted stitches

infected and become very painful (Figure 2). The cyst can easily be removed under general anaesthesia or occasionally under local anaesthesia (Figure 3). The time of removal of this cyst is ideal time for defibulation after counselling the women and her husband in great details.

### Elective Defibulation

The operation to open up type III FGM consists of the following steps:

1. Observe an aseptic technique (washing hands thoroughly, wearing gloves etc.)
2. Locate the remaining opening and clean the surrounding area.
3. Rise up the scar tissue from the

underlying tissues using a finger, (Figure 4).

4. Incise in the mid-line to expose the urethral opening. Do not incise beyond the urethra. Extending the incision forward may cause haemorrhage which is difficult to control.

5. Suture the raw edges to secure haemostasis and prevent adhesion formation. Healing should take place within one week (Gordon H., 1998).

The impact of FGM on the management of pregnancy, childbirth and postpartum period.

### Antenatal assessment

In areas where type III FGM does not involve the majority of the population,

the health worker needs to establish whether or not the pregnant woman has undergone this type. Where type III FGM is common, the vulvar area must be inspected at the first antenatal visit. In women having their first baby, this will establish the extent of the damage, and the degree of physical barrier presented. Women with a tight introitus following FGM (opening 1 cm or less) are at greater risk of major perineal damage during labour than those who have not been sewn so tightly or whose mutilation has been partly reversed ("opened up") on marriage to allow the marriage to be consummated.

As a general guideline, if the urinary meatus can be observed or if two fingers can be passed into the vagina without discomfort, the mutilation is unlikely to cause major physical problems at delivery (Gabar I.A. 1985), wherever this occurs.

Digital assessment is not always needed, as the visual appearance may provide all the information required. Making a record of the appearance of the vulva may help to avoid unnecessary examinations in the future, or to highlight when specific procedures may be difficult to carry out.

If the woman has had previous pregnancies, the history of the deliveries will help to indicate whether she is likely to have persistent problems. It is important to find out whether resuturing has taken place following delivery. In this respect, there are major variations among communities, even in the same country. Repeated cutting and resuturing ("de-infibulation" and "re-infibulation") leave extensive scarring, which is often unstable. Though, if there is any doubt, the perineal area should be inspected to assess the extent of existing damage.

In areas where type III FGM is not common, a tight introitus (opening 1 cm or less) should be regarded as a major risk factor, especially if the scar is thick. Women with this condition should be required to deliver in hospital where skilled supervision of labour should reduce the incidence of major perineal trauma - although problems may still arise if the woman presents late in labour or if the baby is born on the way to the hospital.

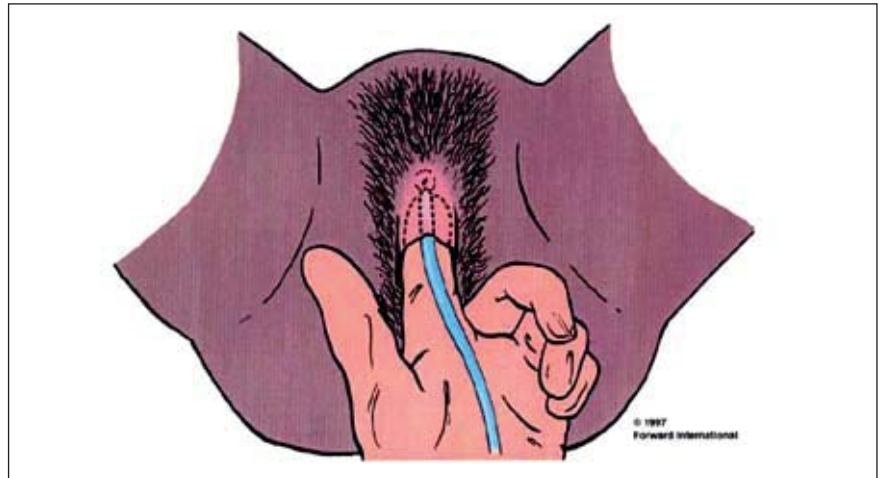


Figure 4: A urinary catheter can be inserted in presence of FGM even in the severest form, to obtain a clear sample of urine using One finger as shown in this diagram.

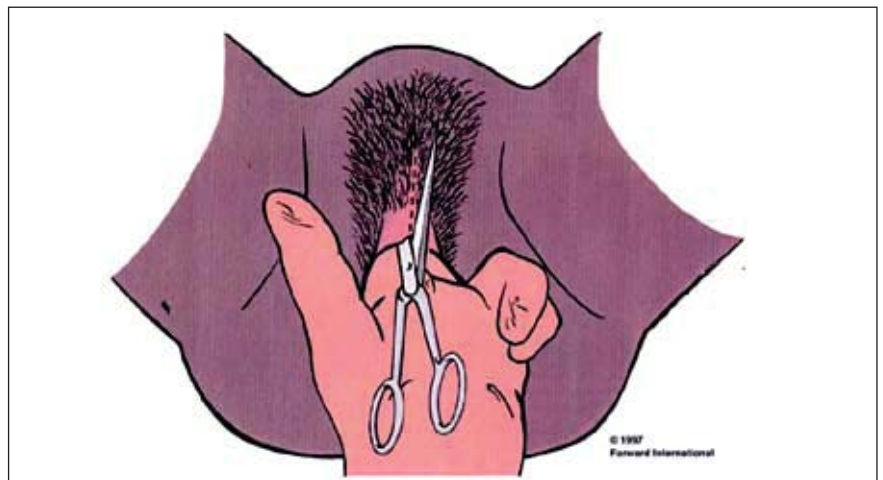


Figure 5: The index finger of the left hand is inserted through the introitus and directed to the pubis. The anterior skin flap is raised and anterior incision is made.

In those countries where type III is virtually universal, hospital delivery is often not an option. However, the traditional birth attendants (TBAs) are familiar with the practice of FGM and can reduce the complications directly arising from the procedure and give the labouring women comfort and physiological support.

Complications of pregnancy, which pose special problems in the management of FGM.

#### 1: Antepartum haemorrhage

Again the same principles apply - if the FGM interferes with appropriate assessment and management, it will be necessary to open up the closed vulva during pregnancy and before labour.

#### 2: Urinary tract infection

Urinary tract infections are common in pregnancy. They may be more

common in women with type III FGM. There is, however, clearly a difficulty in obtaining a clean sample of urine for investigation. A catheter sample cannot be obtained and other urine samples are contaminated by vaginal secretions. Where the diagnosis cannot be established with certainty, where urinary infections are recurrent, or where there has been an attack of severe pyelonephritis, the introitus should be opened up.

#### 3: Pre-eclampsia

When hypertension develops in pregnancy, and the patient is referred to hospital, important decisions may depend on the degree of proteinuria. In women with type III FGM, the urine is always contaminated with vaginal secretion and may therefore show false proteinuria. Where this is a serious



problem, the scarring should be opened up. If this is not possible for any reason the obstetrician can attempt to obtain clear sample of urine using a urinary catheter in presence of type III FGM. (See figure 4)

## LABOUR IN THE PRESENCE OF TYPE III FGM

Where the introitus is tight, and defibulation was not performed antenatally, it is difficult to assess the degree of cervical dilatation. If there is a problem of assessment, the scar can be opened in the mid-line as described previously. Ideally, this should be performed under local anaesthesia. Topical analgesic ointments have so far proven ineffective in providing any significant pain relief, although recent research by the pharmaceutical industry suggests that effective anaesthetic creams may soon be available, providing a useful alternative to local anaesthesia. Usually there is little bleeding from the relatively avascular scar tissue. In these circumstances, suturing should be delayed until after delivery.

With a wider opening, normal assessment is possible, and a decision about anterior division of the scar, often combined with episiotomy, can be delayed until the second stage of labour. The second stage of labour may be complicated if the foetal head is held up on the scar tissue. This is dangerous to both the mother and baby and this is the time when uncontrolled tears can occur, as well as foetal asphyxia. There should be no delay in performing a mid-line cut in the anterior scar to minimize trauma. To avoid unnecessary bleeding, the incision should not be extended beyond the urethra – no extra space is created by doing so. On

average, this will leave 4-5 cm of the old scar unopened as the mutilation always extends to the clitoral area.

## Assessment of labour progress (pelvic examination)

### First stage of labour

Pelvic examination to diagnose and assess progress of labour can be very painful for the infibulated women. Before conducting the pelvic examination, the health-care provider will need to have the knowledge about the circumcision and be willing to talk and to bridge the cultural gap between him or her and the patient. To increase comfort during the pelvic examination, the attending health-care provider can conduct bimanual examination using a single finger. The use of the epidural analgesia is always encouraged if available.

### Second stage of labour

The second stage of labour should be conducted in the usual manner. However, a specific delivery protocol should be used. The main point in the second stage of labour is that, the circumcision scar which consists of a flap of skin enclosing the upper part of the vestibule, to be incised during second stage of labour with crowning of the head, before episiotomy allowing sufficient widening of the introitus for expulsion of the foetal head, or breech delivery. The index finger of the left hand is inserted through the introitus and directed to the pubis. The flap of the skin anterior to it is raised. Using a pair of scissors this cut in the mid - longitudinal line (Figure 5). The introitus is thus widened and the urethral opening exposed<sup>3</sup>. In women with more severe stenosis insert a probe through the pin - hole opening and

made an incision along the probe and excise the scarring tissue [7]. If there is an indication for episiotomy, this may also be performed. There is no need to incise the circumcision scar before the second stage of labour, as this will cause unnecessarily bleeding.

### Care after delivery

After delivery, the raw bleeding edges must be secured in some fashion. A circular stitching around the edges of the labia majora leaving the vulval area open [8]. This will allow free flow of urine and menstrual blood. This also facilitates intercourse and may relieve dyspareunia. Individual patients may elect different degrees of repair after delivery, and this should be discussed beforehand. Caring for the ritually circumcised women in labour poses highly specialised problems with which the contemporary obstetrician needs to be familiar [9]. Incision of the anterior circumcision in the second stage of labour and sensitivity to the psychological and cultural needs of the patient will bring the best results.

### Medicalisation

The question of medicalisation of FGM (to carry out the procedure under hygienic circumstances) is a common question, in my view this should not be encouraged. The most common argument in favour of medicalisation was that it could be a temporary measure, as a first step towards eradication of the practice. The argument against medicalisation was that by medicalisation of the practice is legitimised [10].

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