FGM/C

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DEFINITION

• FGM/C – All procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reasons
• 100-140 million girls and women have experienced FGM/C
• 3 million girls undergo some form of this procedure every year
• Because of its devastating effects on female health, sexuality and the specific complications it causes during pregnancy, childbirth and the postpartum period, management of complications of FGM/C should be integrated into existing reproductive services.
### Structure and Function of Normal Female Genitalia

<table>
<thead>
<tr>
<th>Structure</th>
<th>Function</th>
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<tbody>
<tr>
<td>Vagina</td>
<td>Allows escape of the menstrual flow, sexual intercourse and delivery of the baby</td>
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<tr>
<td>External urethral orifice</td>
<td>Allows emptying of the bladder within a few minutes</td>
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<tr>
<td>Clitoris</td>
<td>Assists women to achieve sexual satisfaction</td>
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<tr>
<td>Perineum</td>
<td>Supports the pelvic organs and separates vagina from anus</td>
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<tr>
<td>Labia minus (minora)</td>
<td>Protects structures and orifices</td>
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<tr>
<td>Labia majus (majora)</td>
<td>Protects the inner structures and orifices</td>
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<tr>
<td>Fourchette</td>
<td>The base of the vaginal opening</td>
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TYPES
WHO FGM typology modified 2007

• Type I – Partial or total excision of the clitoris and the prepuce (Clitoridectomy)

• Type II - Partial or total excision of the clitoris and the Labia minora with or without excision of the labia majora (Excision)

• Type III – Narrowing of the vaginal orifice by creating a covering seal through the cutting and apposition of the labia minora and/or labia majora with or without excision of the clitoris (Infibulation)
   OR – Excision as in Type II, but with apposition of the cut ends, resulting in narrowing the vaginal introitus

• Type IV – Unclassified: All other procedures that fall under definition of FGM, e.g. pricking, piercing, incision, stretching, cauterisation or introduction of harmful substances into the vagina
TYPES

A. Normal

B. TYPE I

A. Prepuce removal only or
B. Prepuce removal and
partial or total removal
of the clitoris

C. TYPE II

Removal of the
clitoris plus part
or all of the labia
minora.

D. TYPE III

Removal of part
or all of the labia
minora, with the
labia majora
sewn together,
covering the
urethra and
vagina and
leaving a small
hole for urine and
menstrual fluid.
TYPE II
Type III
TYPE IV  PULLED LABIA MINORA
Where is FGM practised?

• Mostly in African countries, some in Asian countries

• Immigrant population groups in more developed countries

• India - widely practised by the Dawoodi Bohra community, a sect of the Shia-Muslims, who are led by the Syedna, locally termed as ‘Khatna’.
Most women infibulated
Circumcision and Excision widespread
Some cases reported
Circumcision practiced among groups
Practice of FGM and its distribution

- **Excision** – cutting of the clitoris together with all or parts of the labia minora (Type II), in West Africa

- **Infibulation** – removal of the external genitalia and sewing up or gluing together the sexual opening (Type III)

  1. **Pharaonic** – used to describe the practice of infibulation by some Islamic cultures (practice originated in Egypt at the time of Pharaohs)

  2. **Sudanic** – term used in Egypt, but the procedure not practised in Egypt now
Why it is done?

- Reasons to undergo FGM vary between cultures.

- Kenyan cultures that practice FGM/C are Patriarchal and largely patrilineal. Women are considered suitable for marriage, only if they have undergone FGM. There is a strong pressure on the girl, her family and their community to sustain the practice.
- enhances fertility
- gives the girl a cultural identity and is necessary for the girl to be initiated into adulthood
- external sign of sexual maturity and therefore readiness for sexual relations and childbearing.
- infibulation enhances sexual pleasure because of narrowing of vaginal opening
- uncut girls and women – have overactive and uncontrollable sex drive – promiscuous

**Uncircumcised women are considered unclean and promiscuous**. Communities believe that ext. genitalia are ugly and unhygienic. Removing the ext. genitalia makes a female spiritually clean.
Who cut the girls?

- Traditional birth attendants
- Growing evidence – medical practitioners and other health staff are engaged in FGM
- In Somali community, of 57 antenatal clients interviewed 35 reported being re-infibulated following previous pregnancy, 26 by nurse or midwife and 7 by a TBA
Devastating equipments used
FGM/C AND ITS COMPLICATIONS
Consequences vary by:

- Practitioner
- Type of FGM (I, II, III, IV)
- Place and conditions of operation
IMMEDIATE PHYSICAL COMPLICATIONS DUE TO THE PROCEDURE

• **Haemorrhage** (bleeding) - Commonest complication 22%
  • From clitoral artery
• **Infection**
  • wound infection
  • septicaemia
  • Tetanus and gangrene
• **Urine retention** from pain, swelling, or blockage of the urethra
• **Shock** from blood loss & intense pain

• **Damage to adjoining organs** from unskilled operation and/or use of blunt instruments – urethra, vagina, perineum, rectum
• **Fracture or dislocation** resulting from forceful holding down of girls
• **Spread of HIV and Hepatitis**
• **Death** - haemorrhage, neurogenic shock and septicaemia
Long-term Health Effects of FGM

**Keloid formation**

- Most frequent complications – keloid formation and vaginal narrowing due to stenosis

**Management**

Small – reassurance

Large keloid causing difficulty during intercourse or possible obstruction during delivery - removal
Cyst formation

- Development of implantation dermoids (Type III) – infected and painful due to internal haemorrhage

Management:
- Small, non-infected cyst – may be left alone after counseling or removed under local/regional anaesthesia
- Large or infected cyst – excision or marsupialisation
- Care to avoid further damage to sensitive tissue or injury to blood or nerve supply of area

Dissection tedious and difficult
Vulval abscess

- Abscess formation – deep infection due to incomplete healing of wound or an embedded stitch if labia have been sewn together.

Management
- incision with or without marsupialisation
- Antibiotics
Clitoral neuroma

- Clitoral nerve may be trapped in the fibrous tissue of the scar following clitoridectomy
- Extremely sharp pain over the fibrous swelling – sexual intercourse or even slight friction from underwear

Management
- Advice the women to wear loose underwear
- Lidocaine cream – local application
- Surgical excision of neuroma
Gynaecological complications

- **Pelvic inflammatory disease**
  - 3 times more likely in infibulated women
  - Due to ascending infection at the time of procedure or accumulation of discharge and menses

- Bacterial vaginosis and HSV 2

**Management** – identify likely cause of problem
- Type III – counsel on need to open up infibulation after providing antibiotic cover
- Vaginal swab – C/S
- Appropriate antibiotics
- Treat male partner
- If cause is obstruction due to stones or injury – refer for surgical intervention

Syndromic approach for reproductive tract infections
Infertility

- Infection
- trauma/psychosexual
- Rarely arise from failure of penetration because of very tight vaginal opening

**Management** – history and inspect the genitalia
- If infertility is due to failure to penetrate - counsel on need for surgical opening up.

- Refer to fertility specialist
Fistulae and incontinence

- Vesico-vaginal fistula or Recto-vaginal fistula - injury to external urethral opening or obstructed labour

Management:
- Identify the cause of incontinence and type of FGM
- SUI – exercises to strengthen pelvic floor muscles or refer to urologist
- Antibiotics – if infection is present
Vaginal obstruction

- May occur as a result of infibulation - vaginal stenosis, vaginal calculus formation or presence of vaginal hematoma
- May be accompanied by hematocolpos

Management:
- Identify the problem and type of FGM
- Counsel for opening up – infibulated
- Haematocolpos, stones or stenosis –

Surgical intervention
Menstrual disorders

- Severe dysmenorrhea with /without menstrual irregularity
- Tight infibulation or severe scarring leading to narrowing of the vaginal opening, pelvic congestion due to infection, anxiety over the state of the genitals, sexuality or fertility

Management
- Cause of dysmenorrhea - history and examination.
- Antispasmodic drugs - pain.
- If dysmenorrhea is due to the accumulation of menstrual blood as a result of infibulation - counsel on the need for opening up.
- Severe dysmenorrhea – look for other causes
Vulval ulcers

• May develop as a result of formation of urea crystals in urine trapped under the scar tissue

Management:

- Opening up her infibulation after counselling
- Antibiotics locally with or without 1% hydrocortisone cream.
- Chronic ulcer - surgical excision of the tough fibrous walls
Other gynaecological problems

- Difficult or impossible gynecological exams
- Limited contraceptive choices
Problems anticipated during pregnancy in women who have undergone FGM/C
• **Reproductive tract infections**
  - Initial treatment - empirical
  - If infection continues - de-infibulation
• **Spontaneous abortion and antenatal haemorrhage**
  - Opening up of an infibulation is important to establish the diagnosis and facilitate management
• **De-infibulation procedure**
  - Reversal of infibulation (type III FGM), or opening of the vaginal introitus.
  - Procedure is usually simple and the women are usually young and fit for anaesthesia and are therefore appropriate for either day care surgery

Deinfibulation is simple and can be done as day care procedure
OBSTETRICAL COMPLICATIONS
Antenatal and Early labour complications

• Difficult - antenatal assessment
  - intrapartum vaginal examinations
  - catheterisation

• >30% caesarean sections
Prolonged labour and/or obstruction

- Direct mechanical barrier to delivery – type III
- Vulval and Vaginal scarring and keloids act as obstruction- type I,II,IV (infection and inflammation – vaginal adhesions )

Soft tissue obstructions can be overcome by episiotomies
SECOND STAGE

- Normal genitalia
- Type III
• More perineal injuries –
  Lacerations
  - rectum, clitoris
  - avulsion of urethra from bladder
  - Fistulae
• Pain during and after de-infibulation (anterior episiotomy)
• Postpartum haemorrhage
• Postnatal genital wound infection
• Fetal hypoxia/damage/death
• Extended hospital stay
• Maternal death – unattended or inappropriately treated obstructed labour
FGM and Obstetric Outcomes
WHO Multicountry Study
The Lancet 2006 367:1835-41

- 28,509 women
- Higher rates of Caesarean Section
- Higher rates of post-partum haemorrhage
- Higher risks of episiotomy and perineal tears
- Increased perinatal deaths (1 to 2 per 100 deliveries)
Managing pregnancy for women with type I, II and IV

• severe vulval and vaginal scarring - cause obstruction during assessment and delivery.
• All women who have undergone type I and type II - examined at their first antenatal attendance to assess the degree of damage
• Type I, II, and IV with no particular complications – reassurance
• Extensive episiotomy (occasionally bilateral)

Pregnancy - good opportunity to give women education and information on:
- Basic health
- Normal and cut genitals
- Childbirth and postnatal care.
Managing pregnancy for women with Type III

- sensitive antenatal care.

- apprehensive about a pelvic examination, particularly if the opening is very tight and digital vaginal examination is likely to be uncomfortable.

- Examination - extent of the damage and the degree of physical barrier.
- If urinary opening 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.

Greater risk of major perineal damage during labour.
• Counsel the client and her husband on the importance of opening up her infibulation before delivery.
• Discuss the importance of not re-infibulating after delivery.
• Women who refuse to be opened up during pregnancy - informed about the dangers associated with infibulation during delivery.
• Follow-up support during the postpartum period is important to prevent re-infibulation at a later time.
• The physiological changes affecting menstruation and urination after de-infibulation – discuss

Advice strongly to deliver in hospital
Management of delivery

• To assess the degree of cervical dilatation - the scar can be opened in the mid-line anteriorly
• Performed under a local anaesthetic
• Second stage of labour may be complicated - uncontrolled tears, foetal asphyxia
• Extensive uncontrolled lacerations - Tears may involve the urethra and bladder anteriorly and the rectum posteriorly

No delay in performing a mid-line cut to minimize trauma, should not be extended beyond the urethra
Postpartum care of women with FGM/C

• In poor resource areas - training of TBAs in safe practice, such as safe techniques for incision of vulval scars performed at a sufficiently early stage in labour, may be desirable
• Sutured lacerations in the puerperium may become infected
• Simple, inexpensive remedies should be taught

Sugar and sugar paste dressings have proven efficacy and do not require sterile preparation
Psychological and Psychosexual Complications

• Fear, submission, inhibition and the suppression of feelings

• Posttraumatic Stress Disorder, memory problems

• Symptoms of psychological stress - sleeplessness, nightmares, loss of appetite, weight loss or excessive weight gain, as well as panic attacks, instability of mood, and difficulties in concentration and learning

• Older women - develop feelings of incompleteness, loss of self-esteem, depression, chronic anxiety, phobias, panic or even psychotic disorders
• **Sexual difficulties**
  – Painful intercourse and menstruation, vaginismus
  – Removal of sexually sensitive tissues, Reduced sexual pleasure
  – Experience sexual desires but physical mech. for sexual stimulation may be different
  – Inability to orgasm
PREVENTION OF FGM/C

- “Medicalization” of FGM/C
  Health professionals perform FGM/C – reduces pain and risks of girl’s health (performed hygienically)
- Increasing the proportion of healthcare facilities that provide care, counselling and support to girls and woman affected by FGM/C
- Reducing the proportion of women and girls who undergo FGM/C
- Increasing the proportion of communities that support the eradication of FGM/C
- Increasing the technical and advocacy capacity of institutions and communities to develop and manage FGM/C eradication programs
- Policy of banning FGM/C by all health workers and making it unlawful
Present scenario

• Some communities, although small, have already abandoned the practice. Reasons for abandoning:
  • Formal education
  • Harmful effects of FGM
  • Loss of significance
  • less severe form of circumcisions preferred (e.g. type I, IV)
• Younger and more educated females tend to disapprove of the practice more than their parents.
• Percentage of circumcised women seems to decrease with age.
• More agencies are becoming involved in eradication.
• FGM addressed in national, regional and international forum.
FGM/C violates human rights

• The Convention on the Rights of the Child protects the child’s right to equality irrespective of sex, to the highest attainable standard of health, to freedom from all forms of mental and physical violence; and freedom from torture, or cruel, inhuman or degrading treatment.

• FGM/C has recognized implications for the human rights of women and children. It is also considered to be a form of violence against girls and women.
Thank You