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Female Genital Mutilation

 DISCLAIMER

The content of this presentation is explicit and some may find it offensive or disturbing.

OBJECTIVES

At the end of the presentation, the learner should be able to:

• Explain the different types female genital mutilation and their consequences
• Increase your sensitivity to the impact female genital mutilation has on the affected women
• Improve quality of care to patients who present with mutilated genitals
  • Have an approach specifically to our pregnant patients who had FGM
• Understand the legislation and clinical guidelines regarding FGM in Canada

OUTLINE

• Classification
  • Types of FGM
  • Who is affected
• History of FGM
  • Origin of the practice
  • Why does the practice occur
• Health Consequences
  • Short term
  • Long term
  • Pregnancy and Childbirth
• Attitudes/Care for Patients with FGM
• Recommendations during Prenatal Care, Birth and Post-partum
• The Law, Human Rights in Canada

WORLD HEALTH ORGANIZATION

“Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons”

TYPES OF FEMALE GENITAL MUTILATION

• Type I: Clitoridectomy
  • Partial or total removal of the clitoris and/or the prepuce

Department of Gender and Women’s Health
World Health Organization, Feb 2012
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Type II: Excision
- Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora

Type III: Infibulation
- Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris

Type IV: Other harmful procedures to the female genitalia for non-medical purposes
- Pricking
- Piercing
- Incising
- Angarya cuts - scraping of the vaginal orifice
- Gishiri cuts - cutting of the vagina
- Stretching
- Cauterization

About 140 million girls and women worldwide
- In Africa, about 92 million girls 10 years old and above
- FGM is most often carried out on young girls between ages 4 and 14
- Practice is most common in the western, eastern, and north-eastern regions of Africa; Asia and the Middle East
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**Origins of the Practice**

- **Pharonic Circumcision**
  - Started in Egypt and spread to East Africa
- **Association between FGM and male dominance in society**
  - Muslim culture condones male gratification at the expense of female satisfaction
- **Western Society**
  - Cure for “female problems”

**When and How Is It Done?**

- Performed usually between ages 4-14
- Instruments and anesthesia
- Typically a traditional birth attendant or an older woman performs the circumcision
- Substances covering the wound
- After the procedure, girl’s legs are bound together from the waist to ankles for several weeks to encourage healing

**Socio-cultural reasons**

- Having a clitoris will prevent the girl to mature
- Pre-requisite for marriage

**Hygienic and aesthetic reason**

- Woman’s external genitalia is ugly and dirty

**Spiritual and religious reasons**

- Linked to spiritual purity and therefore required

**Psychosexual reasons**

- Help control her sex drive to prevent premarital sex
- Believed to cure infertility

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A circular flake used for circumcision, from Great Lake, south coast of Western Ethiopia. (Donor: R.A. Harrison, Inc.)

A stone knife, with awl, usually used for corresponding operation on girls, from Great Ethiopian Rift Valley. (1999,11,12,26)

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Female Genital Mutilation

Health Consequences: Short Term

- Serious complications (either immediate or delayed) ~50% in type II or III FGM compared to 18% with type I FGM
- Severe pain - 87.3%
- Severe bleeding - 81.3%
- Infection - 36.6%
- Retention of urine - 70.1%
- Injury or trauma to other organs
- Fracture or dislocation of the clavicle, humerus or the hip joint from heavy pressure/restraining the struggling girl

Chalmers, B., Omer-Hashi, Kowser. Female Genital Mutilation and Obstetric Care; Victoria 2003

Health Consequences: Long Term

- Obstructive Outflow
  - Chronic urinary tract infections and/or pyelonephritis
  - Dysmenorrhea or haematocolpos - 74.3%
  - Calculus formation in the vagina
- Severe scarring - 52.4%
  - Acute or chronic pelvic inflammatory disease, leading to infertility - 23.8%
  - Cysts or abscesses in the region of the scar - 24.1%
- Prolonged and obstructed labour

Surgical Complications

- Vesico-vaginal or recto-vaginal fistulae
- Obturator neuropathy
- Vaginismus
- Dyspareunia

Misc.

- HIV/AIDS
- Post-traumatic Stress Disorder, Sexual dysfunction, Flashbacks

Psychological Adjustment

- Although the procedure is very painful....
  - Most report being proud of their FGM experience - 72.9%
  - Feeling “pure” because of it - 52.6%
  - Consider themselves more beautiful - 30.1%
  - Feel more faithful to their husbands - 30%
  - Report feelings of regret and anger - 5.3%
  - Feelings of betrayal - 3%
- Almost all the women who had received type III FGM (96.1%), and lived in Canada for an average of 6.1 years
  - 48.8% of the women wished to have a daughter of their own circumcised
  - 35.7% of their husbands would wish for FGM for their daughters

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Regular prenatal visits are not the norm

Performing a pelvic exam on an infibulated woman can be very challenging

Infibulated scar can prolong 2nd stage, preventing the normal stretching of the perineum to allow passage of the baby

Lacerations during delivery due to rigidity of the perineum

Development of obstetric fistulae, from prolonged labour, during which the fetal head presses against the bladder or rectum

Need for a cesarean section

Mediolateral episiotomy is done; bilateral if the woman is a primagravid, no elasticity due to repeated stitching, large baby, or for forceps delivery

Following birth, the episiotomies are repaired and the mother is re-infibulated

Genital wound infection in the postpartum period occurs particularly in women with type III FGM

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Female Genital Mutilation

- Lead to fear, submission, and inhibition
- Suffer feelings of betrayal, bitterness and anger
- The experience of genital mutilation and its effect on them psychologically are comparable to the experience of rape
- May affect her ability to form intimate relationships in the future, or even with her children
- Sexual dysfunction – not only dyspareunia but also with emotionally

- Initial reactions of health care professionals were shock or disgust; 87.5% reported hurtful comments from their caregiver
- Women report being afraid of seeking prenatal care in Canada – 74.7%
  - Sought prenatal care from family or friends – 46.3%
  - Family physician – 63.7%
  - Walk-in clinic – 37.7%
  - Obstetrician – 31.9%

**During Pregnancy**

**Types of Female Genital Mutilation**

- **Type I: Clitoridectomy**
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**Types of Female Genital Mutilation**

- **Type IV:** Other harmful procedures to the female genitalia for non-medical purposes
  - Pricking
  - Piercing
  - Incising
  - Angulya cuts - scraping of the vaginal orifice
  - Gishiri cuts - cutting of the vagina
  - Stretching
  - Cauterization

**Management of Type I, II, III FGM**

- If no complications occurred, the woman will require no special management or treatment during pregnancy
- Vaginal infections or abscess
  - Vaginal swabs for diagnosis
  - Antibiotics
  - Surgical intervention if necessary

**Management of Type III FGM**

- Perform assessment to confirm type III FGM
- Record appearance of the vulva to avoid unnecessary examinations in the future
- Counsel pt and her husband on the importance of opening up her infibulation before delivery and **not re-suturing after delivery**
- Women with tight introitus (1cm or less) are at much higher risk of perineal damage during labour
  - General rule: If the urinary meatus is visible or 2 fingers can be introduced into the vagina without discomfort, the mutilation is unlikely to cause major physical problems at delivery
- Advantages of opening the infibulation
  - Allows for easier delivery
  - Clean samples of urine can be obtained
  - Vaginal infections, PPROM, or antepartum bleeding can be investigated properly

**Management during Labour & Delivery**

- Scar can be opened along the midline
  - Incision should be made during a contraction and when presenting part is pressing on the vulva
  - A posterior lateral episiotomy may be needed as well
- Women with FGM type I, most are able to deliver vaginally without an episiotomy
- Inform patient that after delivery, the sides of the wound will be sutured separately

**Department of Gender and Women's Health; World Health Organization, 2012**
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**Indications that FGM May Take Place**

- The family comes from a community that is known to practice FGM
- Parents state they will take the child out of the country for a prolonged period
- A child may talk about a long holiday to a country where the practice is prevalent
- A child may confide that she is to have a “special procedure” or celebration

**FGM in Canada**

- 70,000 immigrants and refugees from Somalia and 10,000 from Nigeria in Canada
  - 29,000 in Toronto
  - 4,500 in Ottawa
- Criminal Code of Canada
  - Control transportation of female children outside of the country to obtain genital mutilation
- In Ontario, a duty to report FGM exists under the policy of the CPSO and under the Child and Family Services Act

**Human Rights**

- “Female Genital Mutilation is a fundamental human rights issue with adverse health and social implications... (it) violates the rights of girls and women to bodily integrity and results in perpetuating gender inequality”

**CPSO**

- “Any physician who becomes aware of a procedure of this nature being performed by another physician should, in accordance with the Code of Ethics, bring this information to the attention of the College at the earliest opportunity. Since the performance of circumcision, excision and/or infibulation on any female child by any person may constitute child abuse, the Children’s Aid Society and appropriate police agencies must be notified”

**Management During Post-Partum Period**

- Same as any other woman
- Sitz baths twice a day along with lidocaine cream (2%)
- Inform her about changes in terms of urination, menstrual flow and sexual intercourse
- If delivered a baby girl, counsel patient and husband regarding consequences of allowing her daughter to be excised


**Ontario Human Rights Commission 2006 Canadian Census Population**

**College of Physicians and Surgeons of Ontario, College Notice No.25 published in March 1992.**
November 2013, Number 299

- Performing or assisting with the practice of FGM in Canada is a criminal offence
- Reporting to appropriate child welfare protection services is mandatory when it is suspected that a female child has been subjected or at risk of FGM
- Any requests for infibulation must be declined

In 2008, WHO passed a resolution (WHA 61.16) on the elimination of FGM
In 2010, WHO published a “Global strategy to stop health care providers from performing female genital mutilation”

To become aware of the types female genital mutilation and the consequences that occur
Become sensitive to the impact female genital mutilation has on the affected women
Improve quality of care to patients who present with mutilated genitals
  - Have an approach specifically to our pregnant patients who had FGM done
Become familiar with legislation and clinical guidelines regarding FGM in Canada

References

- Department of Gender and Women’s Health; World Health Organization, February 2012
- Chalmers, B., Omer-Hashi, Kowser. Female Genital Mutilation and Obstetric Care; Victoria 2003
- Female circumcision as a public health issue, NEJM, 1994
- Hamoudi, A., Shier, M. Late Complications of Childhood Female Genital Mutilation; JGOC 2010; 32 (6): 587-9
- SOGC Policy Statement, No 272, February 2012: Female Genital Cutting/Mutilation