Female genital mutilation

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Recommendations

Female genital mutilation (FGM) is prohibited by law in Norway. The law also prohibits the reconstruction of infibulation following birth.

When children are thought to be at risk for FGM, the act of prevention (avvergeplikten) enters into force.

Women from countries practicing FGM should be asked if they are circumcised, and if so, this should be documented on the antenatal chart (Recommendation).

We suggest that the woman`s own attitude to FGM is clarified if she comes from a country where FGM is traditionally performed.

We recommend that women who have been circumcised are examined or referred to a specialist to clarify if she needs reversal of infibulation (defibulation) during pregnancy or birth.

We recommend episiotomy on indication in addition to defibulation, but an episiotomy should not replace defibulation.

We recommend that all women who have undergone FGM should be informed about Norwegian legislation during pregnancy or post partum.

Information

Pub-med, Royal College of Obstetricians & Gynecologists, Cochrane database, Up to Date.

Background

With increasing migration medical personnel in Norway are more frequently encountering women who are circumcised in childhood.[1] (IV), [2] (IV). FGM is an old tradition considered necessary for a woman.[3] (IV). FGM is a harmful traditional practice. Infibulation, the most extensive form of FGM has the most severe obstetric consequences. However, studies from African countries have reported increased risk of obstetric complications for less severe forms of FGM.[4] (III),[5] (IV),[6] (III).

Legislation[7]

The description mutilation is used to emphasize that the procedure is destructive. All forms of mutilation are prohibited.
Prison sentence is up to four years, but can be extended to ten years if it results in death or severe injury. The female genital mutilation act includes anyone who performs or participates in FGM. The female genital mutilation act also prohibits reconstruction of previous genital mutilation, and can result in the same prison sentence as mentioned above.

Health care workers are urged to prevent FGM when a girl is suspected to be at risk, and confidentiality should not prevent contact with child protection units.

It is prohibited to avoid prevention of FGM.

An offence under the prevention act is a prison sentence up to one year. If FGM has already happened, medical personnel can report or give information only after consent from the parents.

Definitons

FGM includes different types and forms of procedures where external genital parts are removed partially or completely, and where the purpose is ritual or non-medical.

Type I: Partial removal of the clitoris

Type II: Partial removal of the clitoris and partial or complete removal of the labia minora

Type III: Partial or complete removal of the external genitals and appositioning, so that the urethral opening is covered by a seal and

the vagina orifice is narrowed (infibulation)

Type IV: All other harmful procedures including pricking, piercing, incising, scraping and cauterizing the vagina to narrow the lumen.

Prevalence

Global

It is estimated that 130 million women have undergone FGM. The tradition is practiced by Muslims, Christians and among other religious groups mainly in Africa, particularly on Africa`s horn, and to a lesser extent in certain countries in Asia and in the Middle East.

National

Approximately 10.000 circumcised women are currently living in Norway. 97 % of Somali women have undergone FGM, and approximately 80% have type III. FGM has not been reported to take place in Norway, but is reasonable to assume that Norwegian residents have been mutilated during holidays abroad.

Risk factors for FGM

- Sister(s) who are already mutilated
- Vacations to the parents country of origin

Indication /method/diagnosis

All women with type III should be defibulated antenatally. The opening procedure is best performed before pregnancy occurs. It can also be performed during the second trimester, later in gestation or during birth. In Norway it is prohibited to reconstruct the circumcision after delivery.
FGM is diagnosed by asking the woman if she is closed, and by inspection of the external genitals.

Treatment/follow-up[1] (IV),[8] (IV)

Antenatal care

Gynecological examination has to be performed in a careful manner. The woman should be informed during the exam. An interpreter should be used

when appropriate. A plan for the delivery with an opening procedure (defibulation) and adequate pain relief should be made in due time. It is recommended that women with type III be referred to special care for defibulation antenatally. Defibulation can be performed in local, spinal or general anesthesia. Local anesthesia is often sufficient, but insufficient pain relief can increase the risk of traumatic flashback, and spinal or general anesthesia can be necessary. The woman`s need for pain relief must be considered individually.

Type of FGM and the need of defibulation should be noted on the antenatal chart. The woman needs to be informed and it should be clarified if a defibulation should be performed in case of cesarean section.

Labour and Delivery

The gynecologist on duty should be informed when a circumcised woman is in labour. If defibulation is necessary, it should be clearified if midwife or gynecologist is going to do the procedure. It is important to remember that infibulation is not an indication for cesarean section. Sufficient pain relief is important.
Defibulation during labour is performed when bladder catheterisation or electronic fetal monitoring with a scalp electrode is necessary. It should be performed no later than when the fetal head has reached the pelvic floor, and before maternal pushing starts.

Defibulation (opening procedure)

One or two fingers are placed under the covering seal. Inject local anesthesia in the seal, the size of the injecting needle is determined by the thickness of the seal. The seal can occasionally be so thin that injection is difficult. Local anesthesia might be necessary in addition to epidural analgesia.

An incision is made anteriorly until the urethral orifice is exposed, keeping one or two fingers under the seal to protect the tissue underneath. If the woman is not in labour, it is recommended to try to open the area around clitoris if it is palpable under the scar tissue. Avoid stretching the tissue. After delivery the raw edges on each side are sutured continouslly or with single sutures using absorbable suture materia.l (Figure page 22-23 in[1] or figure 1-4 in[9]). If there is an anterior laceration it can be necessary to suture, but it is prohibited to reconstruct a previous infibulation. A low treshold for performing an episiotomy is recommended, but it should not replace an opening procedure (defibulation). Perineal lacerations and episiotomies are repaired as usual, and a rectal exploration is recommended to detect a possible fistula formation.

Offer pain relief

Suggestion: *Naproksen* in combination with *paracetamol* after delivery or in early gestation, but *paracetamol* or *codein* and *paracetamol* for 2-3 days when defibulation is performed later than 28 weeks of gestation. *Lidocaine* gel can be applied locally daily if needed.

For pain relief and hygienic reasons it is recommended to wash or rinse the external genitals with lukewarm water when urinating. To prevent infection, daily bath using a mild soap for one week is recommended. Sexual intercourse should be avoided for four to six weeks after defibulation. Routine follow-up is not necessary, but the woman should be offered a consultation if needed.
The local community health centre should be informed. All circumcised women should be informed about Norwegian legislation, and asked about their attitudes regarding circumcisison of their own daughters. This also applies to those circumcised women who did not need an opening procedure during pregnancy or childbirth. If the woman has given birth to a girl, a risk assessment for FGM should be done.

Complications

Women with type III circumcisison are reported to have increased risk of lacerations, vesico-vaginal and recto-vaginal fistulas, postpartum haemorrhage and prolonged labour[4] (III). There is an association between perinatal and maternal mortality and infibulation, but the mechanismns are not clear [6] (III),[10] (IV),[11] (II). General health conditions and suboptimal health care might be of importance. Infibulation makes fetal monitoring and bladder emptying difficult during labour, and can result in unnecessary cesarean sections. [6] (III),[12] (III). Good obstetric care reduces the risk for complications.

Patient information

Circumcised women should be told that the best time for defibulation is before pregnancy occurs, and during gestation it can be performed until 38 weeks. It should be explained that after defibulation she will more open, and that the passing of urine might occur faster than she is used to.
If she does not want defibulation during gestation, it can be performed during labour, and she should be informed about the procedure and the options regarding pain relief. It might be necessary to emphasize that faster urinating and a feeling of being more open is normal. Information about complications associated with FGM can be relevant in order to prevent FGM of daughter(s). Use interpreter when needed.

Key words

- Female genital mutilation
- Infibulation
- Defibulation
- Obstetric complications

Assessment of evidence

Due to the sensitive nature of this issue obstetric complications are diffucult to study. Most studies are descriptive case- studies or descriptions of selected groups. Knowledge about the incidence of different is lacking, and complications are not always registered. Selection bias and confounding due to socioeconomic and other factors might be a problem. Long time interval between FGM and the development of complications makes studies of causality difficult. However, there seems to be an association between the extent of the circumcision and the risk of obstetric complications [4] (III),[5] (IV),[6] (III).

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