
Female genital cutting in women living in Norway – consequences and treatment

ORIGINAL ARTICLE

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BACKGROUND

Seven Norwegian hospitals offer an outpatient service for women who have undergone female genital cutting (FGC). This study presents symptoms, findings and treatment in women who were examined at the outpatient clinics in the period 2004–2015.

MATERIAL AND METHOD

Each hospital identified patients by searching for relevant diagnostic and procedure codes. All those who had been examined at the outpatient clinics were included. Data were retrieved from patient records.

RESULTS

A total of 913 women were included. The median age at the time of undergoing FGC was seven years, and at the time of consultation, 26 years. Almost half of the women were pregnant. The majority (81 %) had FGC type III (infibulation). Of these, 87 % had gynaecological problems. Of women with types I and II FGC, 55 % and 70 %, respectively, reported gynaecological problems. Altogether 64 % received surgical treatment, primarily deinfibulation (98 %). Few complications were recorded.

INTERPRETATION

In many young, non-pregnant infibulated women, FGC-related problems that can be treated with deinfibulation may have been present since childhood and adolescence. There is probably an unmet need for treatment, irrespective of the type of FGM.

Main findings

Nearly one-half of the women were pregnant, and their median age was 26 years.

Four out of five had female genital cutting (FGC) Type III.

Urogenital symptoms were frequently reported (55–87 %) for all types of FGC. Most often the treatment involved deinfibulation, which caused few complications.

Globally, more than 200 million girls and women have undergone FGC (1). This practice follows ethnic lines and is primarily embedded in culture, not religion (2). It involves interventions of varying extent and is classified into three main types (Figure 1) (3).

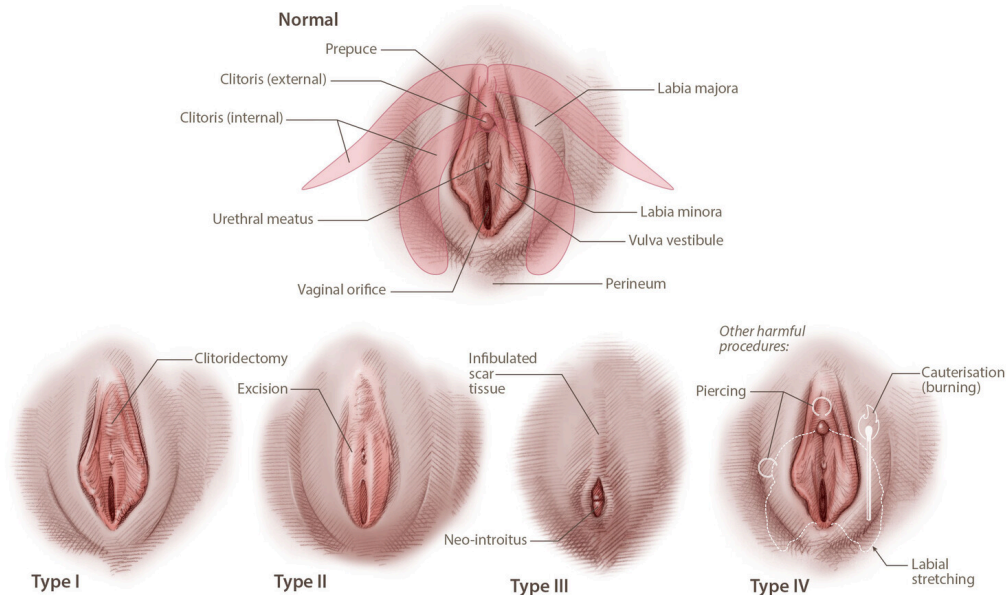


Figure 1 Types of FGC, based on WHO definitions. (2). a) Type I: Full or partial removal of the external part of the clitoris. b) Type II: Full or partial removal of the external part of the clitoris and the labia minora, with or without the labia majora. c) Type III: Narrowing of the vaginal opening with formation of a closing seal, formed by excision and fusion of the labia minora or

majora, with or without removal of the external part of the clitoris (infibulation). d) Type IV: All other harmful procedures to the genitalia.

FGC types I and II are the most widespread, but in some countries type III (infibulation) is widely prevalent (2). Approximately 17 300 women and girls who have undergone FGC were resident in Norway in 2013 (4). Of these, approximately one-half had immigrated from Somalia, where type III predominates (2, 4).

FGC is associated with urogenital problems and can have consequences for sexual and mental health, as well as for childbirth (5–7). However, there is a dearth of research-based knowledge about both health consequences and treatment (8),(9). Women who have undergone FGC are more exposed to urinary tract infections, bacterial vaginosis and painful sexual intercourse when compared to women who have not undergone the procedure (7). There is no evidence base for complications such as menstrual pain, discharge and pruritus, sexually transmitted diseases, infertility, vaginal obstruction and formation of cysts (7). Women who have undergone the procedure report reduced sexual pleasure and satisfaction more often than those who have not, but the evidence base for psychological consequences is uncertain (6). Meta-analyses have concluded that in general there is a heightened risk of adverse birth outcomes in these women (5). Some studies have reported that the risk increases proportionally from FGC type I to FGC type III (5, 10). The extent to which findings from studies in African countries can be transferred to high-income countries is unclear (11).

A systematic review of outcomes from surgical treatment of FGC-related problems identified studies of deinfibulation, cyst surgery and clitoral reconstruction, and found little evidence for the efficacy of the treatment (12). In 2004, in cooperation with the Directorate of Health, seven departments of obstetrics and gynaecology established outpatient clinics for the treatment of FGC. The objective was to improve the medical assistance in all health regions by building competence and collecting experiences, facilitating referrals and enquiries from other health services, and providing services to women who contacted the hospitals. A joint competence-building programme was implemented and a professional network established, which developed clinical guidelines and decided common rules for the use of diagnostic and procedure codes (13). Seven hospitals now offer these services. This study reports health problems, findings and treatment for women who came to the outpatient clinics for an examination in the period 2004–15.

Material and method

All hospitals offering outpatient services to women who have undergone FGC participated in the study: Drammen Hospital Trust, Haukeland University Hospital, Oslo University Hospital, Stavanger University Hospital, St Olavs Hospital, Trondheim University Hospital, Sørlandet Hospital, Kristiansand, and the University Hospital of North Norway, Tromsø. Each hospital identified all women who were registered with a relevant treatment code that was in use in the outpatient clinics in the period 2004–15. Patients with both a Norwegian last name and first name were excluded, while other patient records were assessed. We included all women who had been examined for an FGC-related issue at the outpatient clinic. A doctor, midwife or medical student collected the data from the patient records, including obstetric records systems. We

registered sociodemographic information about the FGC, gynaecological case history, findings, referrals and treatments. The FGC was categorised as type I, II, III or unknown. The data were collected in an online form and stored at the Service for Sensitive Data (TSD), University of Oslo.

Descriptive statistics were used, and the results explored by cross-tabulation. The data were analysed in SPSS Version 26 (IBM Corp., Armonk, NY).

A service user representative from the Norwegian Somali community participated in the project group.

The study was approved by the Regional Committee for Medical and Health Research Ethics and granted exemption from the requirement for informed consent (2015/433 REK South-East D).

Results

A total of 913 women were included, of whom 676 (74 %) were born in Somalia, 91 (10 %) in Eritrea and 41 (5 %) in Ethiopia (Table 1). Their median age at the first consultation was 26 years (inter-quartile range (IQR) 8). Altogether 419 (46 %) were pregnant, but the proportion varied from 31 % to 47 % between the hospitals. Further demographic information, including time of residence in Norway, is presented in Table 1.

Table 1

Types of FGC and background information for women who were examined in the outpatient clinics (N= 913)

	Number	Per cent
Type of FGC		
Type I	67	7.3
Type II	69	7.6
Type III	743	81.4
No FGC	22	2.4
Uncertain type/not stated	12	1.3
Median age at the first consultation (IQR)		
	26 (8)	
Country of birth		
Somalia	676	74.0
Eritrea	91	10.0
Ethiopia	41	4.5
Other ¹ /not stated	105	11.5
Marital status ²		
Married/co-habiting	475	62.2

	Number	Per cent
Other	289	37.8
Pregnant	419	45.9
Previous deliveries	180	19.7
No previous deliveries	733	80.3
Time of residence in Norway ³		
< 2 years	196	21.5
2–10 years	328	35.9
> 10 years	125	13.7
Language proficiency ⁴		
Spoke Norwegian	498	58.6
Communicated in another language	68	8.0
Spoke no Norwegian	284	33.4
Interpreter during the consultation		
Family member/friend served as interpreter	53	
No information on interpreter	33	

¹Nigeria, Gambia, Sierra Leone

²Missing information 16.3 %

³Missing information 28.9 %

⁴Missing information 6.9 %

Altogether 559 (61 %) had been referred from the primary health service, while 164 (19 %) contacted the hospital without referral. 426 (47 %) women had been examined at Oslo University Hospital.

FGC type III was found in 743 women (81 %), while 67 (7 %) had type I and 69 (8 %) had type II. In eighteen women (2 %) no signs of FGC were found. The median age at FGC was seven years (IQR 3). Six women had undergone FGC in their country of origin after having immigrated to Norway. Among the infibulated women, 126 (17 %) had undergone a deinfibulation or another corrective procedure, whereof 26 (21 %) in Norway. Among these 126 women, 45 (36 %) had undergone a reinfibulation. None had undergone this procedure in Norway.

Figure 2 shows the reasons for referral and contact by type of FGC. Among infibulated women, gynaecological problems were the main reason in 372 (36 %), while the reason for referral or contact was assessment of the FGC in 31 (46 %) of those with type I and 32 (45 %) among those with type II.

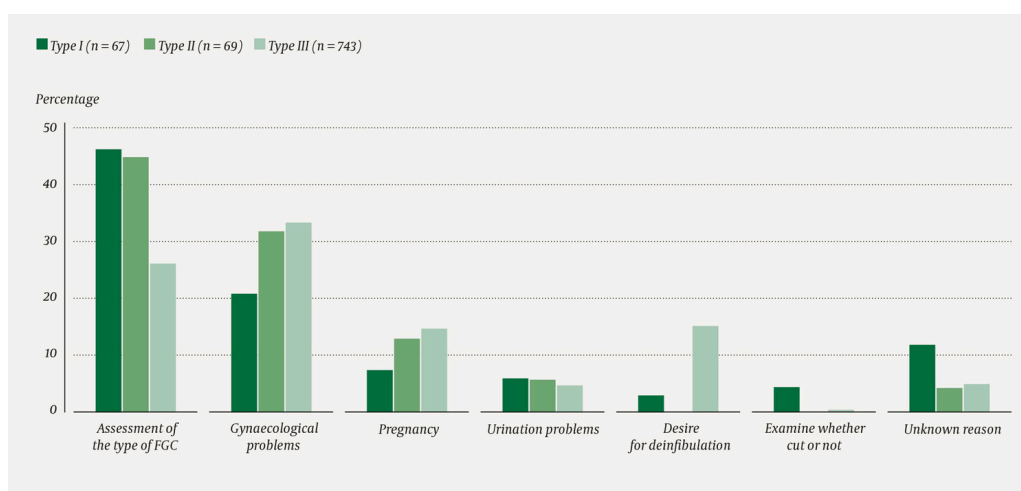


Figure 2 Cause of referral or contact in examined women by type of FGC (N = 879).

Figure 3 shows gynaecological problems by type of FGC. Pain was reported in all groups. Among women with FGC type III, 210 (28 %) reported difficult or painful sexual intercourse, and 161 (22 %) reported protracted or painful urination. Among women with type II, a total of 16 (23 %) and 8 (12 %) respectively reported these problems. Six women with type III had menstrual fluid retention.

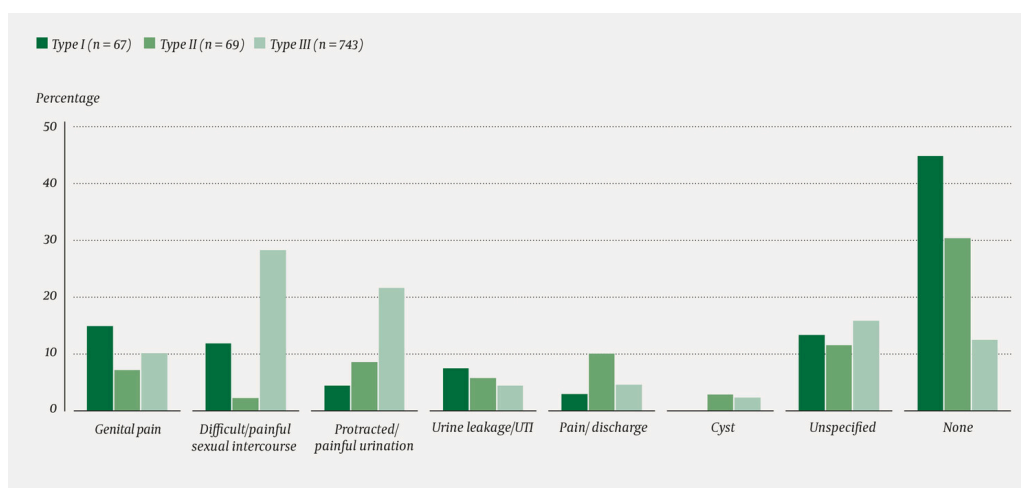


Figure 3 Number of registered urogenital problems in women examined, by type of FGC (N = 879). UTI = recurrent urinary tract infection.

The size of the vaginal opening was reported to be less than 1 cm in 124 (17 %) women with FGC type III and 1–4 cm in 382 (51 %), while the clitoris was described as unaffected in 172 (31 %). Among those with FGC type I or II, the clitoris was unaffected in 9 (14 %) and 8 (14 %) women respectively (Figure 4). Vulvar cysts were found in 44 women. The gynaecological examination was terminated in eleven women, because it was too painful or stressful.

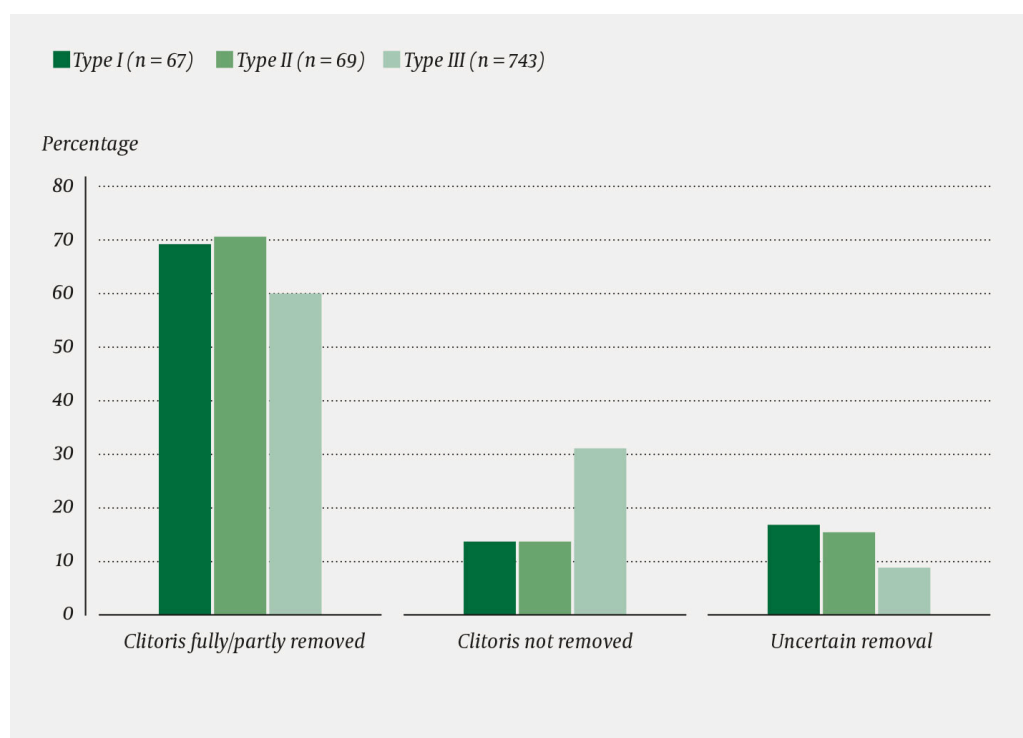


Figure 4 Condition of the clitoris by type of FGC (N = 879).

Of the women with a known type of FGC, 564 (64 %) were treated surgically. Deinfibulation was performed in 530 (94 %) of these, either in isolation or in combination with another procedure. In 348 (66 %) women, the infibulation was opened as far as the clitoris, and in 150 (28 %) as far as the urethral meatus. An opening during childbirth was planned for 49 (25 %) of the pregnant women who had been infibulated. A total of 32 (6 %) women had cysts removed.

While 404 (76 %) women were treated at the outpatient clinic under local anaesthesia, the remainder were treated in day surgery. The proportion treated in the outpatient clinic for deinfibulation or another correction of their FGC varied from 4 (7 %) to 303 (94 %) between the hospitals. In total, 77 women (15 %) underwent deinfibulation under general anaesthesia, but the figures varied from 1 (5 %) to 26 (46 %).

A postoperative consultation was documented for a total of 118 (21 %) women, and among these, 20 (17 %) had post-operative pain, five (4 %) reported an infection, while one woman had bleeding due to wound rupture.

Discussion

Many women had health problems that are relatively easily treatable and may have been present from childhood or adolescence. In view of this, the median age of 26 years was high. In combination with the large proportion of pregnant women who had been referred in connection with pregnancy check-ups, this may indicate an unmet need for treatment among young and non-pregnant women. This is consistent with qualitative studies that have reported a lack of awareness of the outpatient services among women in the user groups, and low social acceptance of deinfibulation outside the context of pregnancy and childbirth (14–16).

The proportion that contacted the outpatient clinic was higher among non-pregnant than pregnant women. This may reflect a lower awareness of health problems than of issues associated with birth among the referring agencies, and that women seek them out less frequently for urogenital problems. Norwegian guidelines recommend that both pregnant and non-pregnant women who have undergone FGC be examined and/or referred in order to determine their FGC status and need for surgical treatment (17).

The anatomical extent of FGC type III varied considerably. Such variations are described in the World Health Organization's (WHO) revised classification, which no longer assumes that the amount of genital tissue removed increases from type I to types II and III (3, 18). While 17 % of the infibulated women had a vaginal opening measuring less than 1 cm, the clitoris was described as unaffected in 31 %. One study reports that nearly one-half of the women had an intact clitoris below the infibulation seal (19). In comparison, the clitoris was unaffected in 14 % of the women with type I or type II in our material.

Consistent with previous studies, women with FGC type III had more gynaecological health problems than those with type I or type II (7). Up to one-half of the women with type I or type II FGC nevertheless reported pain, dyspareunia, problems with urination and other gynaecological problems. The outpatient clinics have no specific treatment options for these women. Psychosexual counselling services for women who have undergone FGC, as recommended by the WHO guidelines, are not provided in Norway (9).

As expected, deinfibulation was the predominant form of treatment. Opening the infibulation is necessary to re-establish vaginal functioning, but there is little evidence available on the effect of deinfibulation on health outcomes (12). The risk of caesarean section and perineal ruptures has been found to be lower in women who have been deinfibulated when compared to those who have not. It is unclear if it makes any difference whether the deinfibulation procedure is performed before pregnancy, during pregnancy or during childbirth (9, 12). One recent study found that deinfibulation prior to or during pregnancy did not protect against emergency C-section in primiparous Somali women in Norway (20). One explanation could be that women who were opened prepartum had a more extensive infibulation that implied a more persistent risk of C-section. Alternatively, in line with the hypothesis that scar tissue from the FGC negatively affects both the progression of the birth and the perineum (10), new scar tissue from the deinfibulation could be deemed to increase this effect. In this study, primiparous Somali women had a greater risk of C-section than primiparous women in general, irrespective of FGC status. Many women prefer to be deinfibulated during childbirth rather than during pregnancy (14, 21). Norwegian guidelines recommend that the woman's preferences be given weight. In our material, however, nearly three out of four pregnant women were deinfibulated during pregnancy. In the majority, the infibulation was opened up as far as the clitoris, in line with the recommendation when the woman is not in labour (17). We believe that the different practices between the hospitals in terms of whether the deinfibulation was performed under local anaesthetic, regional analgesia or general anaesthesia are due to custom. The fact that gynaecological examination and treatment can be especially painful and stressful for women who have undergone FGC has often been referred to, since this may cause them to have flashbacks to the procedure. In our material, one 1 % had their examination halted because it was too painful or mentally stressful.

FGC-related cysts are mainly epidermal inclusion cysts (12, 22). We found that nearly one-half of the women with such cysts did not report any symptoms. Most articles on cystectomy are case reports, and no complications have been reported (12). However, a study on clitoris reconstruction included a group of women who had clitoral cysts and underwent a parallel cyst excision. Post-operatively these women reported reduced sexual functioning scores, while the women without cysts reported an improvement (22). Caution could hence be advised with regard to removing small, asymptomatic periclitoral cysts.

As far as we are aware, no clitoral reconstructions have been performed in Norway, but are offered in some other European countries, including Sweden (23). They have been performed especially in women with FGC type II, and the motivation has been to restore identity, improve sexual functioning and reduce pain (14). Most patients are satisfied, but up to 20 % have reported a deterioration in sexual functioning (12, 14). The intervention is controversial, and is advised against in the UK and by the World Health Organization until better documentation becomes available (9, 24).

A number of qualitative studies have reported weaknesses in the Norwegian treatment services for women living with FCC. For example, women report insufficient knowledge among healthcare personnel, and there is no psychosexual counselling service (25, 26). The regional outpatient clinics appear to fulfil a need for treatment. A psychosexual counselling service can be linked with the outpatient clinics, and they will be an easily accessible resource for healthcare personnel. If clitoris reconstruction is to be provided, we recommend that it be undertaken as an interdisciplinary research project in collaboration with one or more of the outpatient clinics.

The strength of our study lies in its descriptive data from all the specialised outpatient services. The weaknesses inherent in the use of retrospective patient records data include data quality and missing information. The sample means that findings cannot be generalised to all those who have undergone FGC, and systematic data on complications are missing.

Conclusion

Many women had symptoms that may have been present since childhood and adolescence and that are easily treatable by deinfibulation. There should be a low threshold for referral. Doctors should pay attention to pain and other urogenital problems in girls and women who have undergone FGC, irrespective of type.

The authors wish to thank Ayyan Yasiin, Workshop for Primary Care, Church City Mission, for participating in the project group as a representative of the service user group. We also wish to thank the project participants who helped with the registration of data: Ellen Røkkum and Ingrid Langen at Oslo University Hospital, Signe Egenberg at Stavanger University Hospital, and Risa Lonnee-Hoffmann, Silje Tvenge and Tone Aalberg Andersen at St Olavs Hospital, Trondheim University Hospital. We also wish to thank R. Elise B. Johansen and Mai Mahgoub Ziyada at the Norwegian Centre for Violence and Traumatic Stress Studies for their contribution during the introductory phase of the project. The article has been peer reviewed.

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Publisert: 2 November 2021. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.21.0509
Received 29.6.2021, first revision submitted 28.9.2021, accepted 28.9.2021.
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