Female genital mutilation and childbirth

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ABSTRACT

The practice of female genital mutilation sadly remains to this day, part of the life of many women worldwide. In the Middle East and Africa, it is hard to practice obstetrics and gynecology without some knowledge of the condition. This review is an attempt to discuss the salient points as regards to management of these women during pregnancy and labor.

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Female genital mutilation (circumcision) comprises all procedures that involve partial or total removal of the female external genitalia or injury to the female genital organs for cultural or any non-therapeutic reasons.[1] Specific law exist against the practice of female genital mutilation (FGM) in many countries.[2] It is estimated that there are approximately 120-140 million victims of FGM worldwide. Approximately 2 million females had undergone one form of the procedure or other every year. Most of these women live in Africa and some Asian countries.

An influx of young couples, refugees and students from countries where circumcision is still widely practiced has meant that health care providers worldwide have to deal with associated problems. Circumcised women are concerned with the health providers lack of knowledge and cultural implications of FGM. Many countries have developed a code of conduct and guidelines for health professionals.[3] In this review, we tried to examine the range of practice, complications associated with FGM and different management strategies.

World Health Organization (WHO) classification of female genital mutilation.[4] Female genital mutilation comprises a wide spectrum of excision. The WHO has developed a classification within which most of these women would fall. Type 1 - excision of the prepuce, with or without excision of part or all of the clitoris. Type 2 - excision of the clitoris with partial or total excision of the labia minora. Type 3 – excision and stitching or narrowing of part or all of the external genitalia. Type 4 - unclassified, which includes the following: 1. Pricking, piercing or incising of the clitoris or labia; 2. Stretching of the clitoris or labia; 3. Cauterization by burning of the clitoris and surrounding tissue; 4. Scraping of tissue surrounding the vaginal orifice (angurya cuts); 5. Cutting of the vagina (gishiri cuts); 6. Introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and 7. Any other procedure that falls under the definition of female genital mutilation given above.

The impact of FGM on the management of pregnancy, childbirth and postpartum period. *Antenatal assessment.* In areas where type 3 FGM does not involve the majority of the population, the health worker needs to inspect the vulval area at the first antenatal visit. In women having their first baby, this will establish the extent of damage and degree of physical barrier. As a general guideline, if the urinary meatus can be observed (digital examination is not mandatory) or if 2 fingers can be passed into the vagina without

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Figure 1 - 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. Original image generated from FORWARD International, United Kingdom.

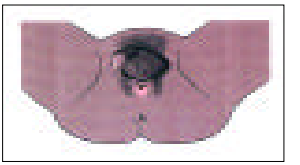

Figure 3 - An inclusion cyst (common complication of female genital mutilation). Original image generated from FORWARD International, United Kingdom.

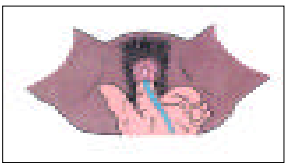

Figure 2 - A urinary catheter can be inserted to obtain a clear sample of urine using one finger as shown in this diagram. Original image generated from FORWARD International, United Kingdom.

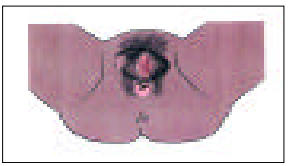

Figure 4 - Surgical removal of inclusion cyst involves a longitudinal incision. The cyst can then be evacuated and the dead space closed with either continuous or interrupted stitches. Original image generated from FORWARD International, United Kingdom.

discomfort, the mutilation is unlikely to cause major physical problems at delivery,[5] wherever this occurs. 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 those countries where type 3 is virtually universal, hospital delivery is often not an option. However, the traditional birth attendants (TBAs) are familiar with the practice of FGM and that reduces the complications directly arising from the procedure and gives the laboring women comfort and physiological support. In areas where FGM is not common, a tight interoitus (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 a hospital where skilled staff trained in this type of complication is available. Some centers prefer to perform a mid-trimester elective defibulation. It makes it easier for the patient and medical staff to approach the delivery.

Such a practice may inflict both physical and psychological trauma upon the patient. She would undergo a surgical procedure, at a time where she is most vulnerable, that would not have been carried out in her native country. She would have a cosmetically new appearance to her external genitalia that is foreign to her and her husband. We believe that the long term psychological effects of such practice need to be assessed before it becomes a standard practice.

Elective defibulation (decircumcision). The operation to open up type 3 FGM consists of the following steps: 1. Observe an aseptic technique (washing hands thoroughly, wearing gloves and others). 2. Locate the remaining opening and clean the surrounding area. 3. Lift the scar tissue from the underlying tissues using a finger, (**Figure 1**). 4. Incise in the mid-line to expose the urethral opening. Do not incise beyond the urethra. Extending the incision forward may cause hemorrhage, which is difficult to control. 5. Suture the raw edges to secure hemostasis and prevent adhesion formation. Healing should take place within one week.

Complications of pregnancy, which pose special problems in the management of FGM. 1. Antepartum hemorrhage. 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 labor. 2. Urinary tract infection. They may be more common ill women with type 3 FGM. There is, however, a clear 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. When 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 the hospital, important decisions may depend on the degree of proteinuria. In women with type 3 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. If this is not possible for any reason, the obstetrician can attempt to obtain clear sample of urine using a urinary catheter.(**Figure 2**)

Labor in the presence of type 3 FGM. Where the introitus is tight and defibulation was not performed antenatally using appropriate analgesia. 1. First stage of labor. Pelvic examination to diagnose and assess progress of labor can be very painful for the infibulated women. Before conducting the pelvic examination, the health care provider will need to have knowledge on the circumcision and be willing to talk and to bridge the cultural gap between him or her and the patient. To increase comfort during 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. 2. Second stage of labor. The second stage of labor should be conducted in the usual manner. However, a specific delivery protocol should be used. The main point in the second stage of labor 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 labor with crowning of the head and before episiotomy, allowing sufficient widening of the introitus for expulsion of the fetal head, or breech delivery.[6] The index finger of the left hand is inserted through the introitus and directed to the pubis. The flap of the skin anterior is raised. Using a pair of scissors, cut this in the mid longitudinal line **(Figure 1)**. The introitus is thus, widened and the urethral opening exposed. In women with more severe stenosis, insert a probe through the pin hole opening and make an incision along the probe and excise the scarring tissue.[7] This may also be performed, if there is an indication for episiotomy. There is no need to incise the circumcision scar before the second stage of labor, as this will cause unnecessarily bleeding.

Care after delivery. After delivery, the raw bleeding edges must be secured in some fashion. A circular stitching on the edges of the labia majora is performed, 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 select different degrees of repair after delivery, and this should be discussed beforehand. Caring for the ritually circumcised women in labor poses highly specialized problems with which, the contemporary obstetrician needs to be familiar.[9] Incision of the anterior circumcision in the second stage of labor and sensitivity to the psychological and cultural needs of the patient will bring best result. Late complications such as inclusion cysts may also need to be sensitively managed. (**Figures 3 & 4**).

Medicalization. The question 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 favor of it was that it could be a temporary measure or as a first step towards eradication of the practice. The argument against medicalization was that it legitimized the practice.[10] The United Kingdom has prohibited the practice since 1985. The prohibition of circumcision act was recently strengthened by the FGM act passed last October 2003, which explicitly makes it illegal to take girls abroad for circumcision.[11]

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