Female genital mutilation de-infibulation: antenatal or intrapartum?

Sushama Gupta
Pallavi Latthe

Abstract

Women who have had female genital mutilation (FGM) often experience adverse short and long term health effects. Owing to increasing international migration FGM has become a global concern. Health professionals involved in the care of these women need to be aware of the complications that may present during labour as well as the sensitivity of the matter. This review summarises the studies available looking into the ideal time for deinfibulation.

Keywords deinfibulation; female genital mutilation; FGM

Introduction

FGM is defined as all procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. More than 200 million girls and women alive today have had this procedure with an estimated 137,000 of them who are living in UK. It is practised in 30 countries, mainly in East Africa but also in some countries from Middle East and Asia. FGM is carried out in girls between infancy and age of 15 years. It can form an important part of female cultural/community identity and is perceived by many as an integral part of social conformity. Because of migration and movements of refugees, the issue of FGM has become a global concern. More than 3 million girls are estimated to be at risk of FGM annually.

There are four major types of FGM that are described:

Type 1: This is the partial or total removal of the clitoris often called clitidectomy.

Type 2: Partial or total removal of clitoris and labia minora, with or without excision of labia majora (also called Excision).

Type 3: This is also called Infibulation. It involves narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora or majora in the midline with or without removal of clitoris (see Figure 1) Type 3 FGM is the most extensive type and is associated with the most significant morbidity and mortality. Type 3 FGM is experienced by about 10% of all affected women.

Type 4: This includes all other harmful procedures to the female genitalia for non-medical purposes. E.g. Pricking, piercing, scratching etc.

There are no health benefits with FGM. There are immediate and lifelong health effects including, obstetric, sexual, psychological, and economic impacts associated with FGM. Obstetric complications are:

- Difficulty in vaginal examination and catheterisation
- Prolonged and Obstructed labour
- Perineal tears
- A high caesarean section rate due to difficulty in fetal monitoring and lack of adequately trained obstetric staff
- Increased incidence of PPH
- Increased still birth and early neonatal death rates
- Increased neonatal morbidity from hypoxia and brain damage

Deinfibulation

Deinfibulation refers to the practice of surgically opening the sealed vaginal opening in a woman who has been infibulated. It has been shown to improve health and well-being as well as obstetric outcomes. Studies have shown deinfibulation is associated with improved gynaecological and obstetric outcomes. Deinfibulated women were at significantly less risk of having a caesarean section (odds ratio (OR) 0.19; 95% confidence interval (CI) 0.09, 0.39; 2 studies) and postpartum haemorrhage (OR 0.31, 95% CI 0.12, 0.83; 1 study) compared to type 3 FGM women without defibulation. However there is only limited direct evidence to support above statement. Deinfibulation can also facilitate bladder emptying thereby lessening the risk of urinary retention and chronic recurrent urinary tract infections associated with type III FGM. Reinfection is against the law and must never be performed.

Procedure

The procedure can be performed under local, spinal or general anaesthesia, as good pain relief is important, to avoid triggering flash back and post-traumatic stress. If a woman presents in labour and the plan is for deinfibulation in first or second stage of labour then epidural should be offered. An informed consent is essential. Using a probe or finger, the undersurface of the infibulation scar should be examined. Assess the length of the incision by inserting a finger under the skin flap when possible. If not possible use a pair of forceps to guide the posterior blade of the Mayo scissors carefully avoiding the urethral meatus. Perform an anterior incision along the midline of the skin flap until the urethral meatus can be visualised and the anterior flap is opened completely. Apply gentle pressure to control any bleeding. The raw edges on both sides are then over-sewn with fine rapidly absorbable suture. If performed in the second stage of labour during crowning the stretching of the fused labia allows good view of the fusion line and also minimizes blood loss. . There is no role for clitoral reconstruction following FGM because current evidence suggests unacceptable complication rates without conclusive evidence of benefit.
Uncertainty regarding timing of deinfibulation

The big question is what is the ideal time for deinfibulation? Currently there is no clear consensus on the optimal time of deinfibulation and there has been very slow progress in the development of evidence-based care around the timing of deinfibulation. RCOG (Royal college of Obstetricians & Gynaecologists) recommends that deinfibulation should be offered prior to pregnancy and preferably before first intercourse.

As per RCOG guidelines pregnant women with infibulation can be offered deinfibulation at one of the following stages:

- Early in pregnancy around 20 weeks
- During labour in first stage
- During crowning in second stage of labour.
- Perioperative after a caesarean section.

The advantage of deinfibulation early in gestation is that it allows the scar to heal well before delivery and also ensures that an appropriately trained midwife or obstetrician performs the procedure. Antenatal deinfibulation may be desirable to assist in the diagnosis and management of complications such as UTI, vaginal infection and incomplete miscarriage. It has also the advantage that the introitus is then adequate for vaginal examination. The Royal college of Midwives does not give clear guidance on the optimal timing of deinfibulation.

Overall, there appears to be relatively little direct evidence on preferences around timing for deinfibulation. WHO guidelines on the management of FGM recommend either antepartum or intrapartum deinfibulation with a suggestion that timing should be based on wider contextual factors including: patient preference, access to health-care facilities, place of delivery and the health care professionals (HCPs) skill level. In addition to a lack of consensus about when deinfibulation should be performed, there is also debate about whether timing affects outcomes with some individual studies suggesting that obstetric risks increase, the later the deinfibulation is undertaken, although these findings were not substantiated in a recent systematic review comparing childbirth outcomes between antepartum and intrapartum deinfibulation. There have been no qualitative studies that have directly explored men’s preferences for the timing of deinfibulation.

The current evidence base explores more general experiences of deinfibulation for women, and broader experiences of FGM for men and HCPs. A recent qualitative evidence synthesis reported that immigrant women from high income countries may not be willing to undergo deinfibulation as they were concerned about their physical appearance and social acceptability following the procedure, as well as highlighting fears about the skills and experiences of HCPs providing deinfibulation care. A small qualitative study of Somali women’s experiences of antenatal and intrapartum care in England has highlighted that women consciously delayed deinfibulation until labour to avoid undergoing multiple operations. However, women may also prefer deinfibulation during labour, as this is the usual practice in some countries where FGM is prevalent.

Studies of HCPs views on the timing of deinfibulation are also scarce. What influences patient decisions regarding timing of deinfibulation is yet to be understood. The health technology Assessment Programme has advertised for proposal to explore views of individuals involved in the care and support of these women like family, friends, partner, midwife or HCP to understand their views and preferences for the timing of deinfibulation and their views on how NHS services can best be delivered to meet the needs of FGM survivors and their families.

Conclusion

FGM is a global problem and should be managed sensitively. All women with type 3 FGM should be offered deinfibulation to avoid complications and to reduce morbidity. All women with type 3 FGM should have an individualized plan regarding the timing of deinfibulation after discussion regarding risks and benefits of deinfibulation. There are limited studies to support the ideal time for deinfibulation. Discussions must take into account language difficulties, psychological vulnerability and cultural differences.

Boyfriends, partners and husbands should also be offered counselling.

Most important is women whose preference and request for deinfibulation must be respected and granted.

Currently enough evidence is not available and research is needed to understand the factors that promote uptake of or act as barriers to deinfibulation:

- women’s knowledge and acceptance of the deinfibulation procedure and
- male partners views and knowledge on the surgical procedure.
All professionals involved in the care of women with FGM must complete e-module developed by Health Education England.

FURTHER READING
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