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CLINICAL ARTICLE

Health education and clinical care of immigrant women with female genital mutilation/cutting who request postpartum reinfibulation

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ABSTRACT

Objective: To evaluate the percentage of women with female genital mutilation/cutting who request postpartum reinfibulation, and to assess outcomes after specific care and counseling. *Methods:* A retrospective review was undertaken of consecutive medical files of immigrant women with FGM/C who attended a center in Geneva, Switzerland, between April 1, 2010, and January 8, 2014. The number of postpartum reinfibulation requests and outcomes were assessed. If a patient requests postpartum reinfibulation despite receiving detailed information and counseling, a longer follow-up is arranged for further counseling. *Results:* Among 196 women with FGM/C, 8 (4.1%) requested postpartum reinfibulation. All eight were of East African origin, had FGM/C type III, and received a longer and more targeted follow-up than did those who did not request reinfibulation. After at least 1 year of follow-up, none of the eight was willing to undergo reinfibulation. One woman who attended the clinic only once during her first pregnancy consulted the emergency ward of the study center 3 years later because of postcoital bleeding following infibulation performed in her home country a few months after her second delivery in Switzerland. *Conclusion:* Specific care and counseling for women with FGM/C type III can improve the acceptability of defibulation without reinfibulation.

1. Introduction

Female genital mutilation/cutting (FGM/C) involves the partial or total removal of the external female genitalia for non-therapeutic reasons, and is classified into four types by WHO [1]. FGM/C type III—infibulation—is the narrowing of the vaginal orifice by the apposition of the labia majora or minora, with or without the cutting of the clitoris. It accounts for about 15% of FGM/C cases and is mainly practiced in countries such as Somalia, Sudan, and Djibouti [1]. Complications of infibulation can be urogynecologic, obstetric, and psychosexual [2].

Defibulation is a surgical procedure that can be performed before or during pregnancy, or in labor, through which the infibulation scar is opened, exposing the urethra and vagina. It is done as part of treatment of urogynecologic complications and allows physiological delivery, sexual intercourse, micturition, menstrual flow, and gynecologic procedures [3]. Although defibulation is a simple surgery, it involves physical, physiological, and cultural changes that require specific counseling [4].

Reinfibulation is defined as the re-stitching of scar tissue created by infibulation or suturing of the labia after delivery or a gynecologic procedure, and includes infibulation performed in women with FGM/C other than type III [5,6]. It is estimated that 6.5–10.4 million women worldwide are likely to have undergone reinfibulation [6], especially in countries such as Somalia, Sudan, Djibouti, and Eritrea [1,6]. In some cultures, resuturing is considered to be honorable/purifying [7], improve male sexual pleasure, and beautify the genitals [8].

Reinfibulation raises legal, medical, and ethical issues [9]. Most recommendations—including those from the International Federation of Gynecology and Obstetrics, WHO, and other United Nations organizations—state that women's health should be promoted and reinfibulation should not be performed [1,5,7]. In the UK, reinfibulation is illegal [10]. In other countries, including the USA, gynecologists and obstetricians are free to choose whether to perform the procedure; it is considered that informed adult women can choose to have their genitalia re-stitched [11]. This practice is controversial, because reinfibulation performed by a healthcare provider is considered a form of medicalization of genital mutilation, which is defined by WHO as any FGM/C practiced by a healthcare provider in a clinic, at home, or elsewhere.

Despite most of the literature recommending that reinfibulation should not be performed, no studies have been published regarding the strategies that could be followed to avoid distress in women asking

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for the procedure but who are denied it. Healthcare providers are often unfamiliar with, or untrained in, FGM/C and its management. In high-income countries, beliefs, values, habits, norms, and aesthetic definitions can be very different from those of migrant patients with FGM/C. Healthcare providers can be confused or uncomfortable following a reinfibulation request because of contrasting beliefs, medico-legal recommendations, and their desire to be culturally sensitive and honor their patients' wishes.

The Swiss Society of Gynecologists and Obstetricians recommends that reinfibulation requests should be declined and that the possible complications of the practice should be explained to women [12]. In exceptional cases, a partial infibulation can be performed provided that menstruation, micturition, sexual intercourse, and gynecologic exams are possible [12]. The Swiss Penal Code (Article 124) does not specifically address the issue of reinfibulation [13].

The present study aims to assess the percentage of women with FGM/C who request postpartum reinfibulation at the Department of Obstetrics and Gynecology of the Geneva University Hospitals (HUG), Geneva, Switzerland, and to evaluate the care and counseling provided to such women.

2. Materials and methods

A retrospective review was undertaken of consecutive medical files of immigrant women who had undergone FGM/C in their home country and who attended the outpatient clinic for women with FGM/C of the Department of Obstetrics and Gynecology of HUG between April 1, 2010, and January 8, 2014. The study research protocol was approved by the HUG institutional review board. Informed consent was waived because contacting all women by phone would have been difficult as a result of language barriers and frequent changes in contact details in the study population.

All pregnant women with FGM/C attending HUG are referred to the specialized clinic for women living with FGM/C, which was established in 2010. They are seen during pregnancy and 6 weeks after delivery. Additional appointments are scheduled if necessary or when requested by women. Women are examined and counseled by a gynecologist with clinical, surgical, and cultural expertise in FGM/C. Specific needs or worries are explored and discussed, together with prevention and information on the Swiss penal code regarding FGM/C. The discussion and the recommendations to follow at the delivery are documented in the patient's obstetric files.

Women who have FGM/C type III receive detailed information and counseling on their genital anatomy and physiology, and on defibulation, with the help of illustrative drawings. Any myths and cultural beliefs associated with infibulation, FGM/C, slow micturition, and intact or defibulated external genitalia are discussed. Women can choose between partial defibulation (opening until the urethral meatus is uncovered) or total defibulation (opening until the clitoris) during the second trimester of pregnancy or in labor. If a patient asks for postpartum reinfibulation despite having being informed and counseled, a longer follow-up is arranged and the importance of postpartum pelvic floor training (nine sessions) is stressed, improving awareness and self-knowledge of the anatomy and physiology of the genitalia. With the woman's consent, her partner is involved in the discussion on defibulation, and the advantages of not re-stitching the labia (for micturition, menstruation, sexual intercourse, future deliveries, or eventual gynecologic procedures) are explained to the couple. In case of language barriers, a certified interpreter accepted by the woman or the couple ensures communication during the consultation. The counseling and care offered are summarized in Box 1.

For the present study, information on sociodemographic characteristics (age, home country, religion, marital status, time spent in Switzerland, and occupation), FGM/C (age at which it was performed, memories of the FGM/C procedure, and immediate and long-term complications), reasons for consulting and, in case of pregnancy, obstetric outcomes (type of delivery, blood loss, defibulation, episiotomy, tear, duration of the second stage of labor, postpartum complications, postpartum perineal physiotherapy, documented prevention of FGM for the neonate, sex and weight of the neonate, and Apgar score) was collected. Data were collected in an SPSS version 22 database (IBM, Armonk, NY, USA).

Box 1
Prepartum, peripartum, and postpartum counseling protocol for women who request reinfibulation.

Prepartum care

- Use a certified interpreter in case of language barriers
- Take time for the consultation
- Discuss the respective changes occurring after delivery and defibulation (e.g. in micturition, menstruation, genital appearance, and sex) using illustrations
- Clarify the advantages of performing defibulation
- Explore patient beliefs, fears, and myths regarding uncut and defibulated genitalia
- Provide correct information respectfully (e.g. defibulated genitalia are not "wide and open"; faster micturition is not "vulgar")
- If possible, let the woman decide between partial defibulation (opening up to the urethral meatus) or total defibulation (opening up to the clitoris)
- If possible, with the woman's agreement, include the partner in the discussion, and encourage an exchange of views by the couple
- Explain that reinfibulation is not in the patient's and her partner's best interests in terms of health (urogynecologic, obstetric, and sexual complications)
- Explain the medico-legal recommendations

Peripartum care

- During intrapartum defibulation, respect the woman's choice regarding the level of opening (partial or total defibulation)
- In case of a supra-clitoral or supra-urethral tear, reconstruct the vulvar anatomy in the most physiological way, leaving the urethral meatus and the vaginal orifice uncovered; avoid asymmetries of the labia
- Explain to the woman each of the different procedures she underwent (e.g. perineal tear, episiotomy, and defibulation)

Postpartum care

- Use a certified interpreter in case of language barriers
- Take time for the consultation
- During the postpartum check, explore the woman's feelings regarding the new appearance and physiology of her genitalia
- Repeat explanations on possible false beliefs and myths
- Do not focus only on reinfibulation, but also care for the woman's overall health, including breastfeeding, contraception, sexual health, and postpartum incontinence
- Propose pelvic floor training and explain the advantages, including a better perineal tonus and self-knowledge of her own genitalia
- If possible, with the woman's agreement, include the partner in the discussion, and encourage an exchange of views by the couple
- If the woman dislikes her genitalia or discloses a distress linked to her genitalia, schedule a new follow-up appointment; reassure her by explaining that adjusting to such a change can require time; and investigate the cause of the dislike and distress to allow it to be addressed