

# Obstetric Care for Women Affected by Female Genital Cutting

Female Genital Cutting (FGC) is the practice of total or partial removal of the external female genitals or other injuries associated with the genital organs for cultural, religious, or other non-medical or therapeutic reasons. It is considered a serious violation of human rights that carries physical and psychological health consequences. While it is internationally recognized and almost globally condemned, approximately 200 million women have been affected by the practice and 3 million are at-risk of the practice annually. In the U.S., it is estimated that 513,000 girls under the age of 18 have experienced or are at risk of FGC in the U.S. Take time to learn more about the historical and cultural aspects of the practice and gain insight into the complexity of the issue with [BRYCS Community Conversations](#).

## Culturally Competent Care

Culturally competent care involves treating all patients with sensitivity, dignity, and respect and includes incorporating, understanding, and valuing diverse cultural differences. It also includes reflecting on your own health-related values to facilitate care that is ethical and patient-centered.



- Have trained female interpreters. It is critical to ensure the patient feels comfortable to communicate fully.
- Use visuals and pictures when explaining the female anatomy for FGC. This can help with the language barriers and provide helpful education about the female anatomy and FGC.
- Terminology of FGC can be challenging in the medical setting. Female circumcision or cutting is usually the most understood and least offensive term with patients and interpreters
- Provide patient centered care: take time to explain practices that will protect her health, but ultimately respect her wishes.
- Take time during the prenatal care visits to explain what happens during childbirth. Possible scenarios should be discussed with the patient allowing time for her to ask questions or state her views.

## Prenatal Care

Prenatal care visits may not be the cultural norm among women affected by FGC. A whatever point during the pregnancy a woman presents seeking obstetric care, extra time should be taken to build trust and provide information about antenatal care in the U.S.

- Take time to develop a birth plan with the expectant mother, preparing her with what to expect at the hospital once in labor, as well as listening to and respecting her wishes for treatment.
- Women with Type 1 and 2 are unlikely to experience prenatal, intrapartum, or postpartum complications. Women with Type 3 FGC, also called *infibulation*, are at heightened risk for complications during a vaginal delivery, especially if they are left with a very narrow neo-introitus. If they remain infibulated throughout the pregnancy, vaginal monitoring is not possible or complicated.
- Deinfibulation should be discussed as early as possible with women who are infibulated.
- Explore any other complications the woman may have experienced due to FGC including vaginal infections, urinary problems, or past experiences with deinfibulation or childbirth.
- Always ask permission to examine the patient and keep her exposed for a minimal amount of time.
- During the examination, assess the elasticity of the tissue around the vaginal opening and the size of the vaginal opening. As a general rule, if the size of the vaginal meatus is visible and if two fingers can pass into the vagina without discomfort, there are unlikely to be physical problems during pregnancy. If not, deinfibulation is necessary to facilitate a vaginal birth.

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## *Intrapartum Care*

Always take time to explain things such as the need for labor induction and cesarean sections. These practices are not common, and often avoided in some cultures. It is important to explain the need for such care and to respect the patient's wishes regarding such practices.

- It may not be customary for the woman's spouse or partner to be in the delivery room. In some cultures it is more appropriate to have a close female (mother, sister, friend) in the room with them. The absence of the male is not necessarily a sign of involvement or care of the spouse or partner.
- Women still infibulated at the intrapartum stage are at heightened risks for complications during childbirth, including perineal tears, wound infections, separation of the episiotomy, and postpartum hemorrhaging. Fetal complications are rare due to fetal monitoring, however obstructed labor can cause brain damage, intrauterine death, or babies delivered with lower Apgar scores.
- Deinfibulation is usually required for infibulated women to facilitate a vaginal birth. Infibulation does not cause complications during stage 1 of labor, but will cause complications later on, including prolonging of labor at stage 2.
- Infibulated women should be allowed to undergo a trial of labor; cesarean sections should only be performed for maternal and fetal health reasons or maternal preferences.
- Some experienced physicians have used rectal examinations to monitor cervical dilation with infibulated women.

## *Postpartum Care*

Women experience various health complications postpartum related to FGC, especially Type 3, including hemorrhaging, urine retention, infection, vesical-vaginal fistulae, or psychological problems.

- It is important to examine women after childbirth to assess for these complications or the likelihood of them occurring.
- Sensitively inquire the woman's intentions regarding FGC for any daughters she may have. Provide education about the laws criminalizing FGC in the U.S. as well as information about the health implications of the practice. If needed, refer the patient to a social worker in the hospital or clinic if further assistance is needed.
- If a woman expresses intentions to have her daughter cut, in addition to providing education, it may be important to inform child protective services and the social worker in your clinic or hospital setting.

## Deinfibulation

Deinfibulation is the incision of the vulva to open the vagina and can prevent gynecological and obstetric complications caused by infibulation. It is recommended to deinfibulate as early on in the pregnancy as possible to allow time for healing, monitoring, and for increasing the chances of a vaginal birth.

It is possible to deinfibulate intrapartum and should be performed as early as possible in labor. Sometimes an episiotomy must also be performed to reduce vaginal tearing and to facilitate the birth due to inelasticity of the skin. If needed it should be performed after deinfibulation.

Opening up an infibulated vagina should only occur once a woman has been properly counseled on the procedure, unless in an emergency. Health providers should spend adequate time with the patient, and her spouse if desired, along with visuals showing the difference between an infibulated and deinfibulated vagina.

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## Deinfibulation Procedure

- Deinfibulation should be performed by experienced gynecologists.
- General or regional anesthetics should be used, as local anesthetics are painful and may trigger memories from the circumcision.
- An anterior incision is made at the center of the scar to create labia majora and not beyond the urethra opening as hemorrhaging could result from further cutting.
- Raw edges should be sutured in a subcuticular fashion.
- Full deinfibulation requires opening up to the clitoris.
- Partial deinfibulation is possible and includes opening up to the urethral meatus.
- After the procedure, women should be given vaginal analgesics, instructed to perform sitz baths, urinate in warm water, and informed of the increased urinary stream.
- In post-operative appointments it is important to check in with the patient regarding the new appearance and physiology of her genitalia.

### Counsel of deinfibulation should include:

- ◇ The spouse present (if the woman consents)
- ◇ Explanation of the physical anatomy and physiology of the woman, including visual images.
- ◇ Education of the advantages and physiological changes associated with deinfibulation. This includes differences urinating, menstruating, having sex, as well as a decreased risk for infection.

## Reinfibulation

Some women may request to be reinfibulated after childbirth. This is the re-stitching of a scar caused by infibulation or suturing of the labia after delivery or gynecological care.

- Reinfibulation in the U.S. is not illegal, as informed adult women are given the right to make this decision. However, physicians should counsel against it, promoting women's health and explaining the health implications of reinfibulation.
- Continued follow up and medical counseling with women requesting reinfibulation (and her spouse upon seeking permission) is an effective way to prevent the practice.
- Follow up should include listening to the patient and her spouses concerns as well as providing continued education of the gynecological, obstetric, and sexual health implications of reinfibulation.
- Physicians may feel uncomfortable performing reinfibulation due to cultural differences, medical and legal concerns, as well as unfamiliarity with how to perform the procedure. Refer to another physician if this is the case.
- Ultimately, the patient's wishes should be respected. Only experienced gynecologists should perform reinfibulation.

### *Helpful Resources*

[Care of women and girls living with female genital mutilation: a clinical handbook](#). Geneva: World Health Organization; 2018.

Abdulcadir J, McLaren S, Boulvain M, Irion O. Clinical article: Health education and clinical care of immigrant women with female genital mutilation/cutting who request postpartum reinfibulation.

Abdulcadir J, Marras S, Catania L, Abdulcadir O, Petignat P. [Defibulation: A visual reference and learning tool](#) [video].

Chalmers, B. & Omer-Hashi, K. *Female Genital Mutilation and Obstetric Care*. Bloomington, IN: Trafford Publishing; 2003.

Nour N. Female genital cutting: clinical and cultural guidelines.

# Obstetric Care for Women Affected by Female Genital Cutting

## Common Misperceptions Health Providers

### May Have

#### ***Women know their anatomy and physiology.***

This is often NOT the case. In some cultures topics such as sex, FGC, and human anatomy are seen as very private topics and are not discussed.

#### ***Women trust healthcare providers and will speak freely about FGC.***

Women may not have experience with healthcare providers, especially in obstetric care. They may be more familiar working with midwives or other caregivers. Additionally, FGC is not discussed openly or privately in their communities, making discussions with a doctor even more challenging. Trust is essential in the process.

#### ***Health care providers can spare women from a difficult experience of childbirth with FGC.***

Women who have undergone FGM not only face the physical complications of childbirth, but also the difficulty of having cultural norms and practices that may not be understood in the U.S. regarding childbirth and prenatal and postpartum care.

#### ***Women will attend prenatal care appointments and birthing classes.***

This type of care and classes may not be customarily offered in their communities therefore it's important to provide information and education about prenatal care, the birthing process, etc.

#### ***Cesarean sections are necessary for women who have undergone Type 2 or 3 FGC.***

Women who have undergone any form of FGC can give birth vaginally, especially if they undergo deinfibulation. Vaginal births are more likely when deinfibulation is performed prenatally.

## Common Misperceptions Women Seeking

### Care May Have

#### ***Cesarean sections are a sign of weakness, a curse, or a sign of unfaithfulness.***

Because of this, some women have limited knowledge of why they may occur and the health risks of not having one. It's important to talk to women about C-sections prior to the birth.

#### ***Dieting during pregnancy is normal and will help reduce the size of the baby increasing chances for vaginal birth***

Some women avoid certain nutritious foods such as eggs, milk, or greens due to beliefs about their impact on the fetus and pregnancy.

#### ***Prenatal and postnatal care are not necessary or only require a couple of visits***

In many cultures prenatal and antenatal care are not common beyond maybe a couple of visits. Take time to explain the type of care women in the U.S. receive during pregnancy and after birth.

#### ***FGC does not have negative health implications***

Women may have little knowledge with regard to their anatomy or to the impact of FGC. They may not connect any complications related to FGC to FGC.

#### ***Deinfibulation is not necessary for a vaginal childbirth***

Women may refuse deinfibulation during antenatal care simply because they don't understand the complications caused by infibulation.

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COMMUNITY CONVERSATIONS

Collective Voices for Improving the Care and Reducing the Risk of FGC

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