Module 3: Management of FGM-related complications

Session 4

Caring for women with FGM during pregnancy, labour, and postpartum

Overview of the session

This session will cover management of:

- ✓ **Obstetric risks associated with FGM**
- ✓ **Care of women with FGM during pregnancy, labor and post partum**

Learning objectives

By the end of this session, participants will:

- ✓ Be sensitized to health risks of FGM affecting pregnant women
- ✓ Know how to manage women with FGM during
  - ✓ pregnancy
  - ✓ labor
  - ✓ post partum
- ✓ Special considerations for FGM type 3

Pregnant women with FGM seeking ante-, intra- and postpartum care services

- ✓ May have not received any FGM related care before and may suffer long-term, psychological, sexual health complications- **Do not make any assumptions, actively check in and manage accordingly taking into consideration pregnancy status**

- ✓ Are at risk of obstetric health complications **so be vigilant** to avoid any adverse events

Long-term risks associated with FGM – a recap

Genital tissue damage	With consequent chronic vulvar and clitoral pain
Vaginal discharge	Due to chronic genital tract infections
Vaginal itching	
Menstrual problems	Dysmenorrhea, irregular menses and difficulty in passing menstrual blood
Reproductive tract infections	Can cause chronic pelvic pain
Chronic genital infections	Including increased risk of bacterial vaginosis
Urinary tract infections	Often recurrent
Painful urination	Due to obstruction and recurrent urinary tract infections

Sexual functioning and psychological risks associated with FGM – a recap

Sexual functioning risks

Dyspareunia (pain during sexual intercourse)	There is a higher risk of dyspareunia with type III FGM relative to types I and II *(6)*.
Decreased sexual satisfaction	
Reduced sexual desire and arousal	
Decreased lubrication during sexual intercourse	
Reduced frequency of orgasm or anorgasmia	

Psychological risks

Post-traumatic stress disorder (PTSD)
Anxiety disorders
Depression

Obstetric risks associated with FGM

Caesarean section	
Postpartum haemorrhage	Postpartum blood loss of 500 ml or more
Episiotomy	
Prolonged labour	
Obstetric tears/lacerations	
Instrumental delivery	
Difficult labour/dystocia	
Extended maternal hospital stay	
Stillbirth and early neonatal death	
Infant resuscitation at delivery	

Women with FGM have increased risk of obstetric complications

- Recurrent reproductive tract infections (RTIs) and urinary tract infections (UTIs) resulting from FGM can interfere with the normal progress of pregnancy and sometimes lead to preterm labor and childbirth

- FGM type III (infibulation), scarification and vulvar adhesions from FGM can result in a tight vaginal opening affecting the ability to adequately assess and/or manage labor or other obstetric complications

Caring for women with FGM during antenatal care

- ✓ **ANC visits** may be the **only opportunity to support and provide appropriate care to women with FGM**
  - ➢ Identify whether she has undergone FGM and identify the type
  - ➢ Assess and treat long-term, sexual and psychological health complications of FGM as described in previous sessions taking into consideration pregnancy status
  - ➢ Discuss obstetric complications and creating an appropriate birth plan
  - ➢ Promote FGM prevention

History taking approach *(1)*

✓ Clinical history during **ANC –** suggestions for taking a good clinical history:

- **Do not immediately ask** the woman about her **FGM status**
- Start by taking a full history that includes asking general questions about her physical and mental health as you would do for every pregnant woman presenting for ANC
- A **good time to ask about FGM** is when you ask about her surgical or **reproductive history**:
  - ✓ *"I know many women from your community have experienced some form of **genital cutting**. Do you know if this was done to you?"*

History taking approach *(2)*

- ✓ Clinical history during **ANC –** suggestions for taking a good clinical history cont'd:
  - ➢ Make the woman feel welcomed & respected, and always respect her privacy
  - ➢ If the woman **discloses** that she has undergone FGM, ask her about:
    - ✓ Complications related to FGM, such as **RTIs, UTI** symptoms and signs
    - ✓ Previous complications during pregnancy and childbirth
    - ✓ Past experience of **deinfibulation and/or re-infibulation**

Genital examination

- ✓ **Identify** the type of FGM after permission and explaining the purpose of the examination

- ✓ Look for conditions that are likely to interfere with future vaginal (PV) examinations, or cause problems during pregnancy and childbirth:
    - Infibulation (type III FGM)
    - Tight vaginal opening, scar tissue or vaginal adhesions
    - Signs of RTIs, such as abnormal vaginal discharge
    - Abscesses
    - Epidermoid inclusion cysts and keloids

- **Share** your PV findings with the woman and discuss a **birth plan** with her/partner

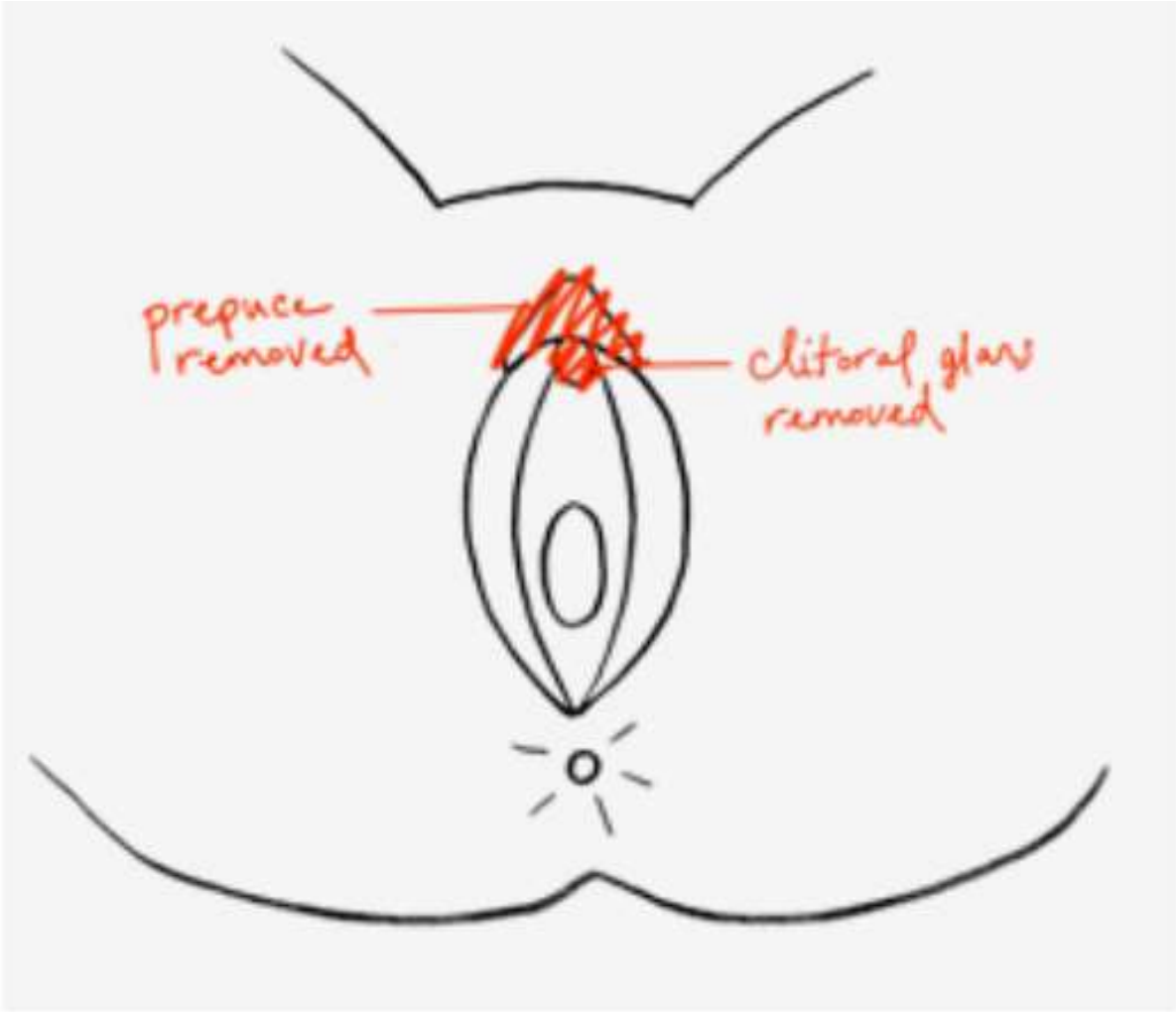
Visual recording of FGM

- The identification and recording of FGM can **sometimes be challenging** especially when a girl's or woman's genital cutting **does not look the same** as that described in the **WHO typology**
  - If you **cannot determine exactly the type of FGM** your patient has, you should at least record that she has undergone FGM
  - Start by making a simple drawing of the female genitalia in your patient's medical record

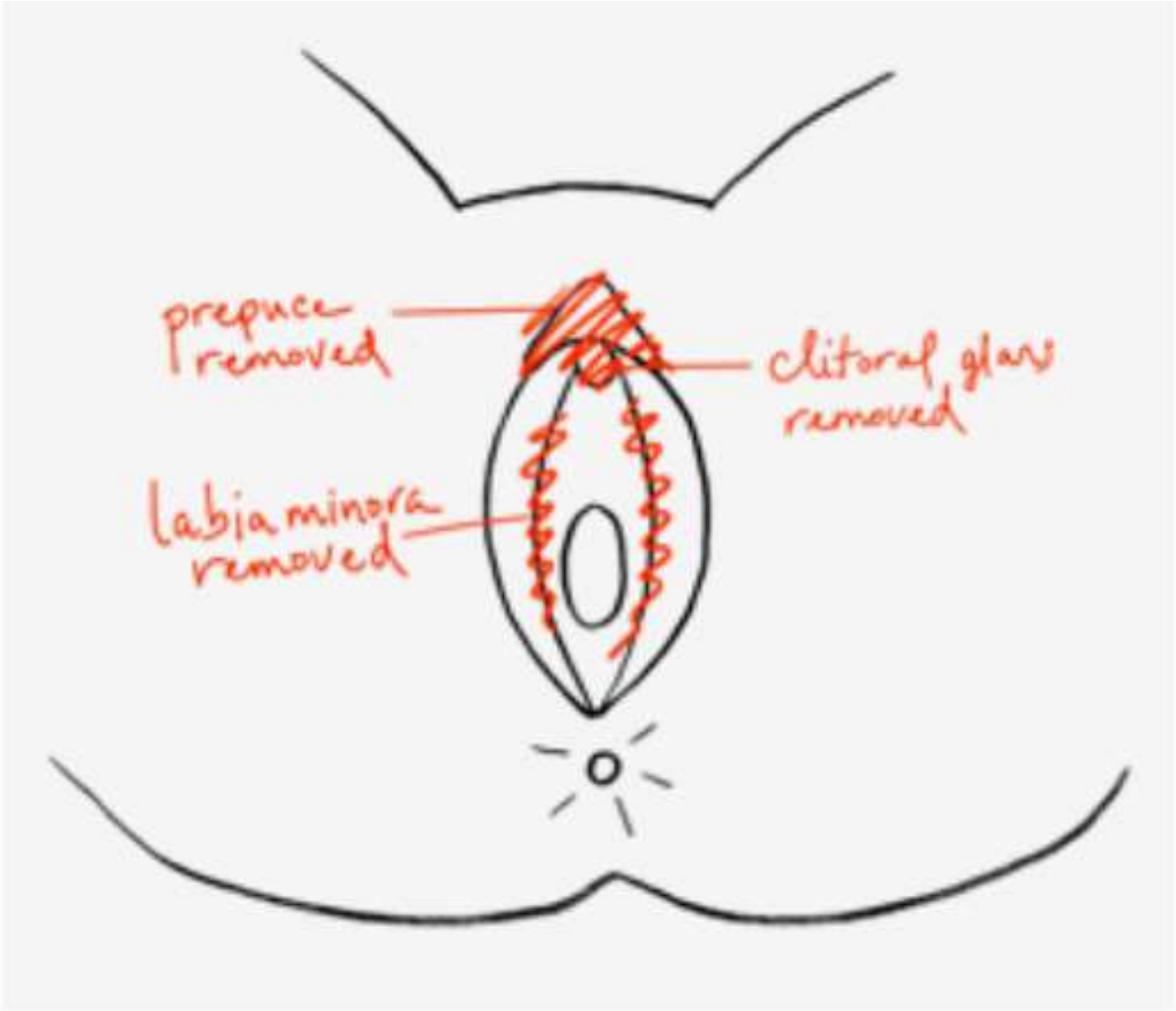
- Based on the findings of PV examination, specify which anatomical structures were removed or altered by **marking and labelling** these with a pen or pencil ***(See Fig 1 on next slides)***
  - Some girls or women may have **different forms of FGM** and therefore you should always **develop your own drawings** to put in the patient's medical record

Visual recording of FGM type example *(1)*

Type I: Prepuce and clitoral glans removed

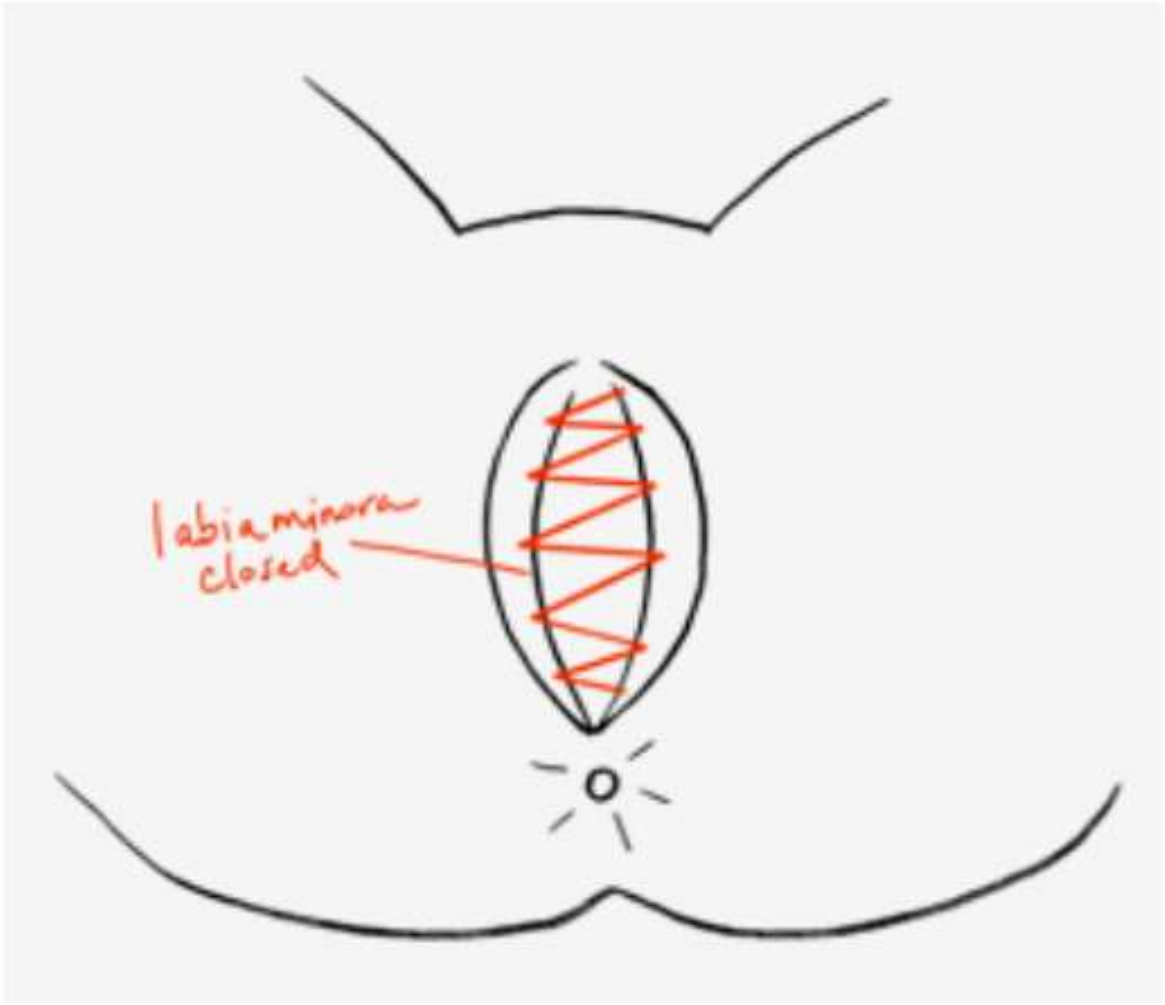


Type II: Prepuce, clitoral glans & labia minora removed

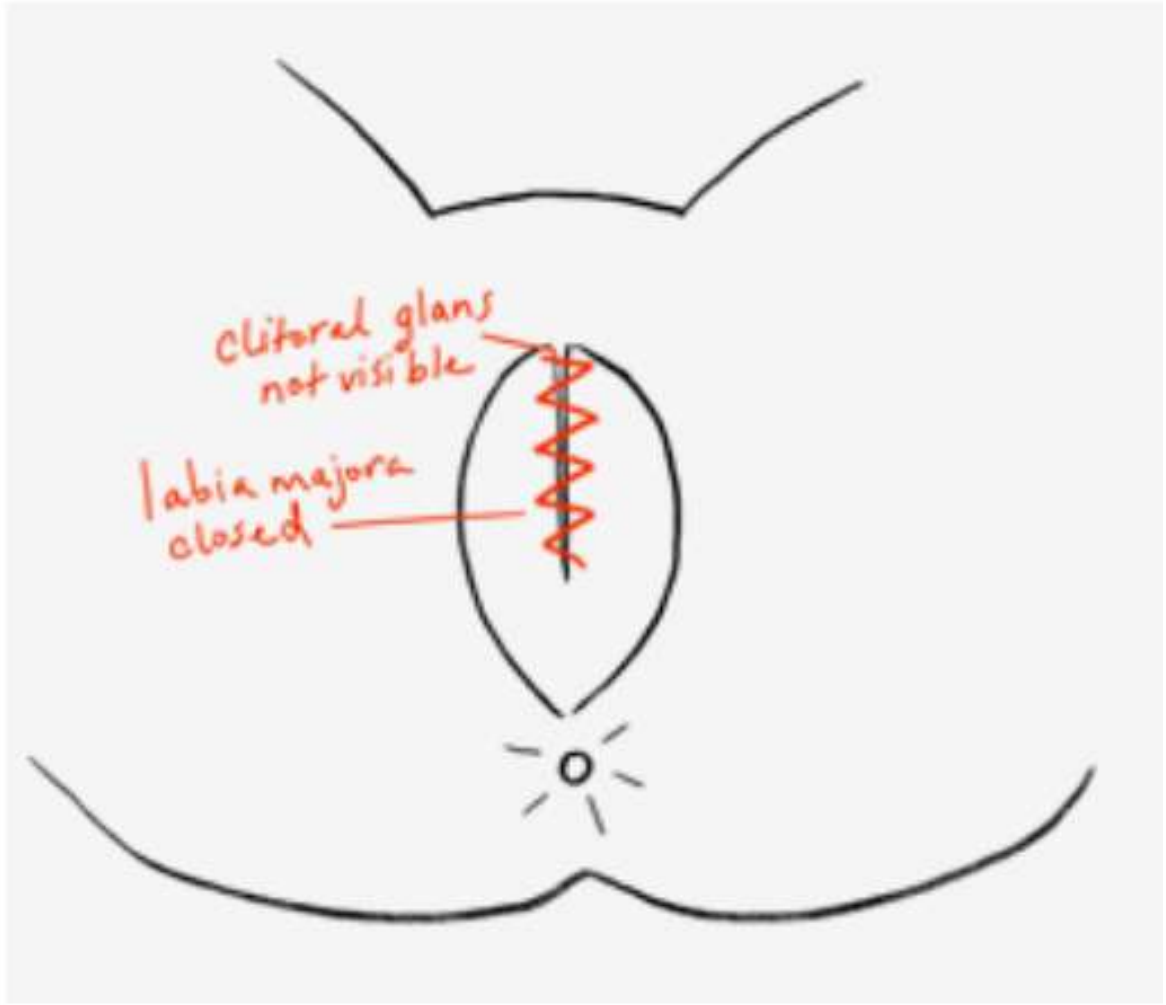


Visual recording of FGM type example *(2)*

Type IIIa: Labia minora closed



Type IIIb: Labia majora closed



Assessment and management during labor *(1)*

- ✓ Women with **type I, II and IV FGM without complications**, and women who undergo **deinfibulation**: are likely to require **routine management** of labor

- ✓ Initial assessment of woman with FGM during labor:
  - ➢ If this is the **1ˢ encounter** and she has **type III FGM**, discuss at the earliest opportunity the need for **deinfibulation before or at the time of childbirth**

Deinfibulation should **always precede the performance of an episiotomy.** It helps to enlarge the vaginal opening, allowing the decision regarding episiotomy

Assessment and management during labor *(2)*

- ✓ Women with **type I, II and IV FGM without complications**, and women who undergo **deinfibulation**: are likely to require **routine management** of labor

- ✓ Management of woman with FGM during labor:
  - ➢ If **intrapartum deinfibulation** is required, the procedure need to be performed **during 1st stage of labor (rather than during childbirth)** to make **monitor of the progress of labor easier**
  - ➢ **Deinfibulation,** if it has not been performed during pregnancy or during 1st stage of labor, can be performed during childbirth after the **administration of a local anesthetic (or epidural anesthesia) and at the height of a contraction**

Management of Women with FGM in the Postpartum Period *(1)*

- ✓ Certain health complications related to FGM may also occur after childbirth:
  - **PPH** from an **atonic uterus**, which is more common after **prolonged labor**
  - **Excessive blood loss & injury** to neighboring structures**,** due to extensive perineal tears
  - **Urine retention** if the urethra has inadvertently been sutured during repair of tears
  - **Damage to neighboring structures** such as the **urethra and bladder** if an incision (**episiotomy or deinfibulation**) has been incorrectly performed

Management of Women with FGM in the Postpartum Period *(2)*

- ✓ Certain health complications related to FGM may also occur after childbirth cont'd:
  - **Infection of sutured perineal tears** that may lead to wound breakdown and, in severe cases, **septicemia**
  - **Extensive perineal tears and/or vesico-vaginal fistulae (VVF) or recto-vaginal fistulae (RVF) –** complications that a woman with type III FGM may have suffered if **deinfibulation was not performed**
  - **Psychological problems** if childbirth has been difficult**,** especially in the **loss of her baby**

The postpartum period is an ideal opportunity to advocate for the prevention of FGM!

Considerations for FGM Type III

Assessment of women with type III FGM during pregnancy

- ✓ Women with **type III FGM (infibulation)** are at increased risk of **obstetric complications** during childbirth due to the obstruction.

- ✓ Perform PV examination to develop an appropriate birth plan:
  - ➢ Make sure the woman understands the need for and agrees to undergo a genital examination
  - ➢ Carefully assess the elasticity of the tissue with your index/middle fingers or a cotton swab

IMPORTANT!

- ***It is not necessary to perform PV examination (insertion of a speculum or fingers) to confirm infibulation, as this condition can be identified by visual inspection of the external genitalia***
- ***If your assessment shows that the woman has a tight vaginal opening due to her infibulation, you should discuss the need for deinfibulation with her/husband/partner***

Deinfibulation: Indications and contraindications *(1)*

- ✓ **Deinfibulation** is a surgical procedure that **reverses infibulation** by opening the closed genital scar tissue in a girl or woman who has undergone type III FGM

- ✓ **WHO RECOMMENDATION**: WHO recommends deinfibulation for preventing and treating obstetric complications in women living with type III FGM

- **Indications for deinfibulation:**
  - Personal **choice** of the woman
  - During the **second trimester** of pregnancy or during **labor** to allow childbirth
  - To facilitate **gynecological procedures** requiring manual or speculum examination or treatment vaginally

Deinfibulation: Indications and contraindications *(2)*

- **Indications for deinfibulation cont'd:**
  - To **treat** conditions such as:
    - ✓ Urinary retention
    - ✓ Recurrent UTIs and/or kidney infections
    - ✓ Recurrent RTIs
    - ✓ Menstrual problems, such as haematocolpos & dysmenorrhea (especially in adolescents)
    - ✓ Dyspareunia (painful sexual intercourse)
    - ✓ Difficult penetration during sexual intercourse
    - ✓ Incomplete abortion
    - ✓ Other gynecological conditions such as cervical cancer

Deinfibulation: Indications and contraindications *(3)*

- **Indications for deinfibulation cont'd:**
  - To allow termination of pregnancy if needed
  - For the use of certain contraceptive methods

- **Contraindications for deinfibulation:**
  - Refusal of the woman
  - Scar tissue cannot be lifted and cut

Decision-making and counselling for deinfibulation *(1)*

- ✓ You must always offer comprehensive **information and counselling** to women prior to deinfibulation – and to their husbands/partners also, if appropriate:
  - ➢ It is the woman's **choice** to decide if she would like to **undergo the procedure** and **when**

- ✓ The options for the timing of deinfibulation include:
  - ➢ **Antepartum** (preferably during the **second trimester, 20th-28th weeks**) OR
  - ➢ **Intrapartum** (during the **first stage of labor** or **during childbirth**)

Decision-making and counselling for deinfibulation *(2)*

- ✓ Both antepartum and intrapartum deinfibulation have **advantages and disadvantages**
- ✓ Women who wish to be deinfibulated **during labor/childbirth rather than during pregnancy** should be advised to give birth in **a hospital**
- ✓ Preferably you should **not perform** deinfibulation during **1st trimester of pregnancy**, as during this period there is generally an increased risk of **spontaneous abortion**.

Decision-making and counselling for deinfibulation *(3)*

- ✓ If a woman arrives at the health facility already in **advanced labor: explain the procedure as you perform the deinfibulation**

Re-infibulation: A procedure to narrow the vaginal opening again in a woman who has been **deinfibulated**. If it is done, it is usually done **after childbirth**. It is also known as **“re-suturing”**

Decision-making and counselling for deinfibulation *(3)*

- ✓ A woman/her husband/partner/family members, may request that she be **re-infibulated after childbirth**: provide information about the **health risks** of re-infibulation

[...] The **risks of re-infibulation:**

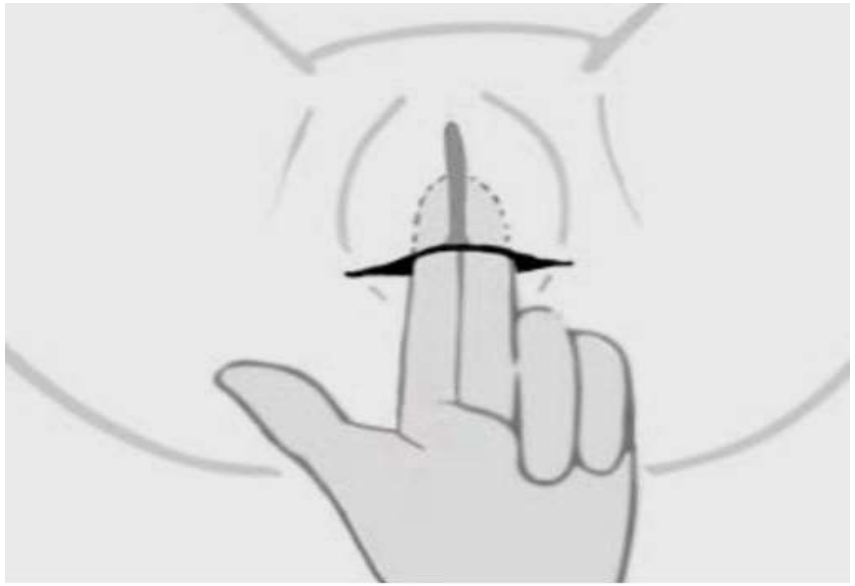
- ➢ It is a **painful and unnecessary procedure** (not recommended)
- ➢ It can cause **severe health problems to the mother during the postpartum period** – including pain/infections/obstruction to the urinary flow and vaginal secretions
- ➢ Children born in future pregnancies will be at risk of difficult labor

Deinfibulation: The procedure for opening up type III FGM *(1)*

- ✓ Start by palpating the scar **tissue** in order to **identify underlying structures (urethral meatus)**

- ✓ Gently introduce your **index finger or both your index and middle fingers – or a dilator – under the hood of skin anteriorly** and **slightly lift the scar tissue** ***(Fig-2 below)***

Figure: 2



Deinfibulation: The procedure for opening up type III FGM *(2)*

- ✓ Infiltrate local anesthetic into the area where the cut will be made, along and on both sides of the scar ***(Fig 2).*** If epidural anesthesia was used, no need of local anesthesia

- ✓ With your finger or dilator under the scar, carefully introduce the scissors **in front of your finger and cut the scar alongside your finger to avoid injury to the adjacent tissues *(Figs 3 and 4-next page)***:
  - ➢ The cut should be made along **the mid-line of the scar towards the pubis to expose the urethral opening**

IMPORTANT!

- *Do not incise **beyond the urethra**. Extending the incision forward may cause **haemorrhage***
- *Take care **not to cause injury to the structures underneath the scar (urethra, labia minora and clitoris).** It is possible with type III FGM to find these structures below the scar intact*

Deinfibulation: The procedure for opening up type III FGM *(3)*

Figure 3

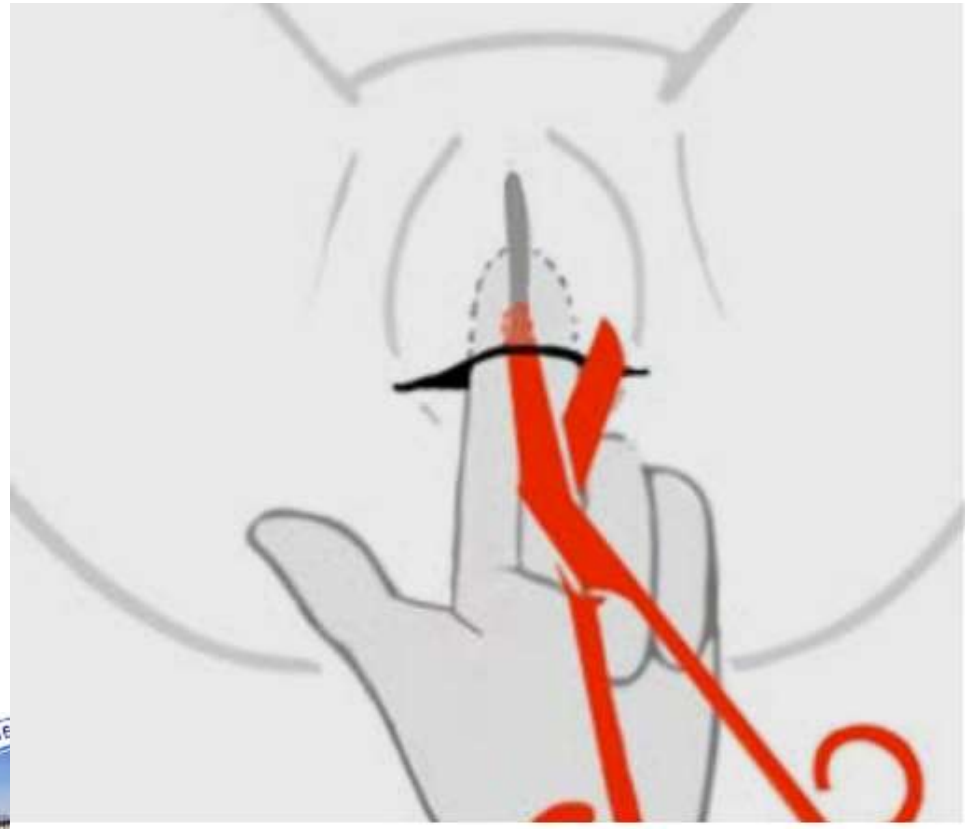
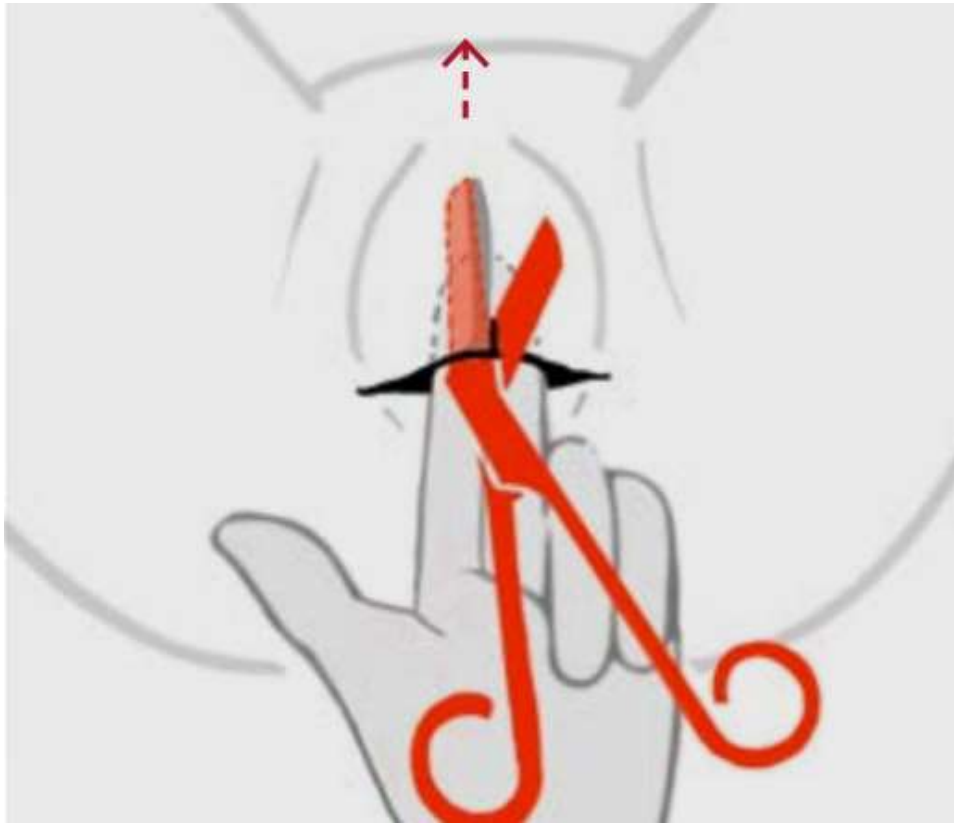


Figure 4



Deinfibulation: The procedure for opening up type III FGM *(4)*

- ✓ **Suture** the raw edges separately with individual stitches. Use fine 3-0 plain, **absorbable suturing material** to secure haemostasias and prevent adhesion formation ***(Figs 5 & 6)***

Figure 5

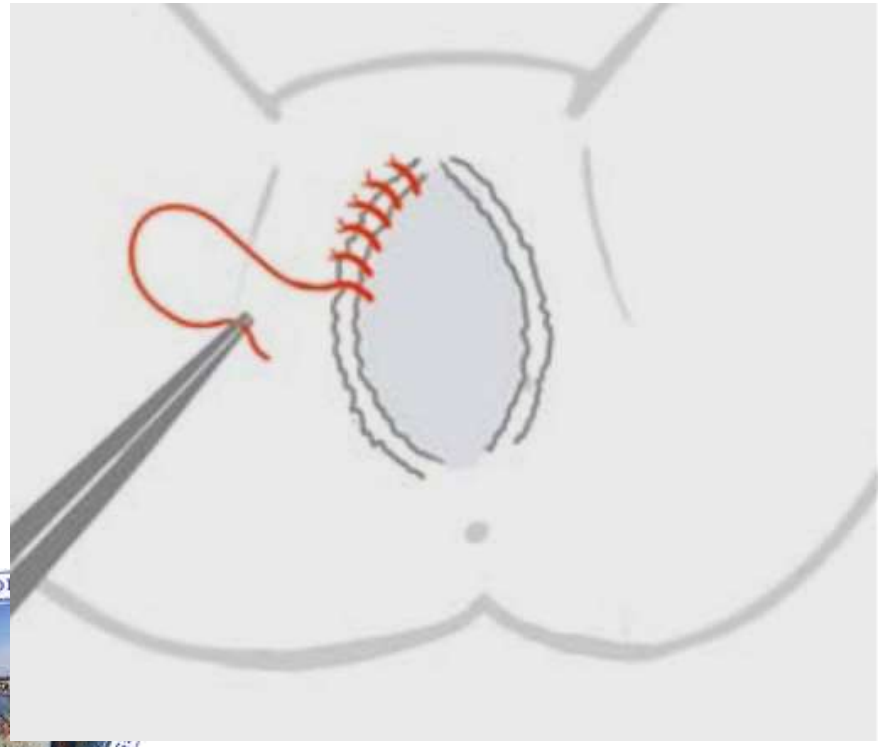
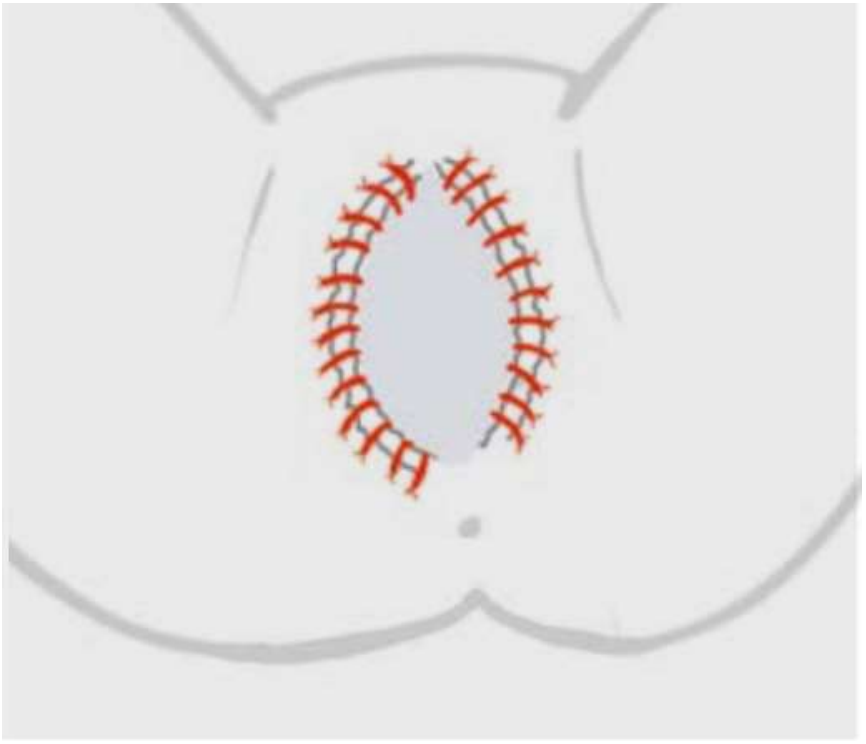


Figure 6



Deinfibulation: The procedure for opening up type III FGM *(5)*

- ✓ **Intrapartum deinfibulation during labor or childbirth:**
  - ➢ The incision should be made at the **height of a uterine contraction to minimize pain**, and after the administration of a local anesthetic
  - ➢ The suturing of the deinfibulated labia can be **delayed until after childbirth**
- ✓ Following deinfibulation, the woman should remain in the health center for 2–4 hours: monitor for **potential bleeding** and the woman's **postoperative pain level**

Deinfibulation: The procedure for opening up type III FGM *(6)*

- ✓ Advice and counselling regarding sexual matters require **great sensitivity**, and should be carefully tailored according to the needs of the woman and to what is **culturally appropriate**

- ✓ **NOTE OF REFERRAL**: In cases where the woman is referred to a different health-care facility for follow-up, you must provide a **clear referral note** to the health-care provider who will be responsible for follow-up to ensure continuity of care

Summary

- ✓ Women with FGM who access ante-, intra- and post-partum care services may have not received any FGM related care before and may suffer long-term, psychological, sexual health complications that would need to be assessed and managed accordingly

- ✓ Women with FGM have higher risks for obstetric complications requiring vigilance for timely clinical management

- ✓ Women with FGM type III require some additional considerations in management related to de-infibulation and it is important to know this procedure

References

- WHO guidelines on the management of health complications from female genital mutilation. Geneva: World Health Organization; 2016. https://apps.who.int/iris/bitstream/handle/10665/206437/9789241549646_eng.pdf
- World Health Organization. Care of women and girls living with female genital mutilation: a clinical handbook. WHO; 2018. https://apps.who.int/iris/handle/10665/272429