Survey of obstetricians' approach to the issue of reinfibulation after childbirth in women with prior female genital mutilation

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BACKGROUND: The procedure of reinfibulation is the resuturing (usually after vaginal childbirth) of the incised scar tissue in women with previous female genital mutilation. Many authorities do not recommend the practice of reinfibulation.
OBJECTIVE: We sought to assess physicians' approach to the practice of reinfibulation.
STUDY DESIGN: A structured online, anonymous questionnaire was sent to 130 practicing obstetricians and gynecologists through Survey Monkey.
RESULTS: The questionnaire was completed by 98 respondents (75.4%).This survey showed that 76% of obstetricians (74 of 98) agree with a standard policy of not performing reinfibulation. However, 37% of those who refused to perform reinfibulation (27 of 74) would agree to undertake it if the woman insisted because she feared marital problems or divorce, and 73% of them (54 of 74) would offer treatment from an obstetrician with a different view.
CONCLUSION: The complex nature of reinfibulation is discussed and an alternative approach is suggested.

Key words: deinfibulation, female genital mutilation/cutting, FGM/C, reinfibulation/RI, survey

Introduction

Worldwide, more than 200 million women and girls in 30 countries have been subjected to the harmful practice of female genital mutilation (FGM).[1] The physical, psychological, and psychosexual sequelae of this practice are many, with resultant short- and long-term morbidity in the affected women.[2]

The World Health Organization has divided FGM into 4 different types, and this classification is widely used and accepted.[3]

Deinfibulation refers to a minor surgical procedure to divide the scar tissue that seals the vaginal introitus in type 3 FGM.[4]

Although deinfibulation is required in some types of FGM, the procedure of reinfibulation (RI) (resuturing [usually after vaginal childbirth] of the incised scar tissue in women with previous FGM) is not recommended.[2,5] The reason for this recommendation is the potential to recreate the tight vaginal introitus of the original infibulation. A firm stance on the issue of RI does not take into account the woman's view of her own body image, her marital relations, and her wishes.

We sought to assess physicians' approach to the practice of RI.

Materials and Methods

A structured online, anonymous questionnaire was sent to practicing obstetricians and gynecologists through Survey Monkey. The invitations were sent out via email and WhatsApp, and the addresses derived from the hospital's database. A total of 130 consultants, registrars, and trainees, from diverse backgrounds, were invited to participate in this online survey. Of the 130 respondents, 98 (75.4%) completed the questionnaire. The questionnaire had been validated by a focus group and piloted among doctors and midwives (some of the doctors were part of the study group).

Results

Demographics

A total of 98 doctors completed the questionnaire; however, some respondents did not complete all of the questions. Notably, 62% of the respondents were females. The majority (37%) had completed their primary medical qualification from Africa whereas 32% from Middle East and South East Asia, 21% from Europe, and a further 10% from North America.

With regard to postgraduate obstetrical training, 55% had European training, 10% each from North America and Africa, and the remaining 25% were trained in either the Middle East or South East Asia. A number of doctors were dually trained in Europe in addition to Africa, Middle East, and South East Asia.

The mean number of years since completion of postgraduate training was 13.3 (range, 1−40 years).

Response to female genital mutilation management questions

Of those surveyed, 88 (89.8%) reported having had experience of managing antenatal patients with previous FGM. The majority (n=73, 74.5%) cited culture as the main reason behind the

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AJOG MFM at a Glance

Why was this study conducted?

This study aimed to assess obstetricians' approach to the practice of reinfibulation after childbirth.

Key findings

Approximately 76% obstetricians agreed with a policy of not performing reinfibulation, 37% of those who refused would perform reinfibulation if the woman insisted, and 73% would refer for a second opinion.

What does this add to what is known?

Obstetricians' perceptions and views about reinfibulation are less researched, especially in the Middle East. This survey of obstetricians' approach to reinfibulation in Qatar aimed to bridge the gap between obstetricians' approach and women's expectations and to explore reasons behind women's request for reinfibulation.

practice of FGM whereas some (n=13, 13.3%) reported both culture and religion as reasons for this practice.

A total of 60 respondents (61.2%) described managing patients with complications related to previous FGM. A summary of the primary complications noted by the 60 obstetricians are presented in Table 1.

A total of 65 respondents (66.3%) had received previous formal or informal (clinical supervised) training in FGM management, 75 (76.5%) said they could perform an anterior episiotomy in labor, and 60 (61, 2%) reported they could perform an elective deinfibulation procedure.

In response to situations where RI is requested by a patient after a vaginal delivery, the majority of the 92 respondents (n=74, 80.4%) said they would not perform RI whereas 18 of the obstetricians (19.6%) said they would agree to patient's request for RI. Of note, none of the obstetricians said they would undertake RI at the husband's request alone.

The respondents (n=92) cited various reasons for not performing RI, as documented in Table 2.

Interestingly, approximately a third of those who would not perform RI (27 of 74, 37%) said they would change their management, if the patient expressed fears about marital problems or divorce as a consequence of not being reinfibulated. Approximately two-thirds of the abovementioned group (54 of 74, 73%) said they would seek a second opinion by asking a colleague with a different opinion to manage the case.

Most physicians (n= 53, 54%) were interested in both classroom and e-learning sessions related to FGM management.

Most of the respondents (n=78, 80%) said they felt comfortable in counseling expectant mothers about not subjecting their young daughters to FGM.

TABLE 1
Summary of complications noted by 60 obstetricians

Sexual difficulties	10
Urinary tract infections	10
Psychological and psychosexual issues and emotional trauma	12
Delivery issues and fear of childbirth	11
Dysmenorrhea	5
Bleeding (brisk life-threatening bleeding in a prepubertal girl; postcoital; during delivery owing to lacerations)	5
Infertility	3
Inclusion cysts	2
Multiple problems	2

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Discussion

Our survey consisted of responses from obstetricians with past and present experience of managing patients with a history of FGM. A significant proportion of these obstetricians have had their undergraduate and or postgraduate training in Africa or the Middle East and North Africa region and therefore have practical experience in managing women with history of FGM and their complex background. Of note, a large number of obstetricians have also had European training and therefore have experience of managing such women according to professional guidelines and policies in the western setting.

The obstetrical population in Qatar is diverse, coming from various cultural backgrounds. Women from countries such as Sudan, Egypt, Ethiopia, and Somalia who reside in Qatar may present with a history of FGM. Women do not always disclose their FGM history during the antenatal course, and the diagnosis is mostly made by direct examination of the vulva during labor, thus limiting the opportunity for detailed counseling in nonacute settings. Requests for RI immediately after delivery are common in our experience, and the reasons cited by women for this request vary from " being accustomed to their infibulated appearance all their adult life" and "fear of marital disharmony/divorce," if RI is not performed.

Currently, there are no laws in Qatar addressing FGM or RI so guidance is sought from other bodies. Although the American College of Obstetricians and Gynecologists has no current guidelines on RI, the Royal College of Obstetricians and Gynecologists, the Society of Obstetricians and Gynecologists of

TABLE 2
Reasons for not performing RI as stated by 92 respondents

Reasons for not performing RI	Number of respondents (%), N=92
a) Do you think RI is medically inappropriate?	23 (25%)
b) Do you consider RI is an assault?	6 (6.5%)
c) Do you consider RI unethical?	17 (18.4%)
d) Do you feel unskilled to do the surgery?	4 (4.3%)
a+b+c	12 (13%)
a+b	1 (1.1%)
a+c	9 (9.7%)
a+b+c+d	2 (2.2%)
Not applicable	18 (19.6%)

RI, reinfibulation.

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Canada, and the Royal Australian and New Zealand College of Obstetricians and Gynecologists state that RI should not be performed under any circumstances. The basis for this recommendation are that, in most of the FGM cases, RI is not medically indicated and is thought to be akin to FGM or medicalization of FGM and a violation of the medical code of ethics.[6,7]

When asked about the option of RI, majority of obstetricians (n=74) in our survey reported that they would not perform this procedure, at a patient's request. Interestingly, approximately a third of these doctors (n=27) said they would change their decision, if women stated that by not performing RI this would lead to divorce or marital problems. Alternatively, two-thirds (n=54) said they would request a colleague with a different opinion to manage the patient.

Various studies have looked at women's motives for subjecting themselves to the practice of RI whereas some have also sought to understand it from a gender perspective, involving the views of both the women and their husbands. Some of these reasons include "viewing oneself as being normal, after undergoing RI"; "avoidance of marital disharmony/divorce"; and "feeling in control of important decisions such as their genital appearance."[6–8]

The argument for "normality" for these women lies in the fact that they have known themselves in the infibulated form all of their adult lives and if they do not undergo a degree of resuturing, especially after delivery, they reportedly feel "abnormal," "loose," and "wide." This can have consequent implications on their perceptions about self-esteem and their marital relationships. There would seem to be a need for education of women, their spouses, and healthcare workers on this aspect of normal anatomy and the disadvantages of RI.

An alternative approach involving a small degree of approximation of the scar tissue might be reasonable. This would not be to the same extent as RI, leading to major narrowing of the introitus, possibly resulting in menstrual and or sexual difficulties. A minimal approximation of the scar tissue might help women feel and look "near normal" as they have known themselves all their adult lives. It would help them feel empowered and listened to and have a positive impact on their marital relationship.

Our survey of the views of a group of experienced obstetricians reveals variation of opinion on the subject of RI. It has revealed a tendency to listen to the woman and either to acknowledge her wishes on the subject or to request a second opinion from a colleague.

Conclusions

In an era where women are experiencing an ever-increasing societal pressure and expectation for undergoing cosmetic genital surgery, especially after the consequences of childbirth, it is worth considering and discussing different approaches to the predicament of these women where the actual damage has already taken place.

This survey shows that 76% of obstetricians agree with a standard policy of not performing RI, but 37% of this group would perform RI if the woman insisted and 73% of them would offer treatment from an obstetrician with a different view. ■

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.xagr.2021.100010.

REFERENCES

1. United Nations Children's Fund. Female genital mutilation/cutting: a global concern. 2016. Available at: https://data.unicef.org/resources/female-genital-mutilationcutting-global-concern/. Accessed September 30, 2020.

2. Royal College of Obstetricians and Gynaecologists. Female genital mutilation and its management (Green-top Guideline No. 53). 2015. Available at https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg53/. Accessed September 30, 2020.

3. World Health Organization, Department of Reproductive Health and Research. Eliminating female genital mutilation: an interagency statement - OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. Available at: https://www.who.int/reproductivehealth/publications/fgm/9789241596442/en/. Accessed September 30, 2020.

4. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Female genital mutilation (FGM). 2017. Available at https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Female-Genital-Mutilation-(C-Gyn-1)-Nov17.pdf?ext=.pdf. Accessed September 30, 2020.

5. World Health Organization. Global strategy to stop health-care providers from performing

female genital mutilation UNAIDS, UNDP, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, FIGO, ICN, IOM, MWIA, WCPT, WMA. 2010. Available at: https://apps.who.int/iris/bitstream/handle/10665/70264/WHO_RHR_10.9_eng.pdf;sequence=1. Accessed September 30, 2020.

6. Lane JL, Johnson-Agbakwu CE, Warren N, Budhathoki C, Cole EC. Female genital cutting: clinical knowledge, attitudes, and practices from a provider survey in the US. J Immigr Minor Health 2019;21:954–64.

7. Mishori R. On reinfibulation: part of the female genital mutilation/cutting discussion that rarely gets mentioned. Huffington Post. 2017. Available at: https://www.huffingtonpost.com/entry/on-reinfibulation-part-of-the-female-genital-mutilation_us_59a85813e4b096fd8876c15e. Accessed September 30, 2020.

8. Safari F. A qualitative study of women's lived experience after deinfibulation in the UK. Midwifery 2013;29:154–8.