The Reproductive Health of the Patient in the Presence of FGM

Sexuality, Pregnancy, Childbirth. Focus on: The Infibulated Patient

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Abstract

Women with female genital mutilation (FGM) need personalized and multidisciplinary assistance that takes into account the organic and anatomical aspects of the extent of the damage, depending on the type of excision performed (type I, II, III or IV) but also the psychological, social, cultural and sexual aspects. The first contact with health personnel is essential to provide adequate medical support: women can come into contact with health personnel in various situations, such as emergencies deriving from complications of mutilations or disorders not directly related to them. Taking advantage of the opportunity of first access to address the issue of FGM is crucial, as it is less common to involve these women in prevention and information interventions.

The meaning of FGM varies according to the cultural, relational, and social context the woman lives in, and some studies have shown that women with FGM can still experience sexual pleasure and orgasm: the classification of the type of FGM is not sufficient to fully understand the condition of the patient. It is important to consider that the impact with Western culture and with the extremely medicalized approach of the European context can negatively affect the sexual self-esteem of women with FGM, which is why it is essential to adopt sensitive communication and not excessively problematize the phenomenon.

Taking care of women with FGM from a medical, surgical, psychological and sexological point of view is essential to deal with the consequences of the mutilations. Even when no sexual disorders are present, counselling should be provided to ensure sexual health. There are several tools that can be used in sex therapy, including sex devices that can improve sexual response in all its stages. The complications of FGM vary according to the extent of the organic damage and are divided over time into immediate, medium-term and long-term damage. A particular management concerns pregnant patients with infibulation, for which it is necessary to define the moment of the reparative intervention (deinfibulation) and to plan an awareness and information process for the woman and the family that accompany her during the birth process, as to prevent complications during delivery, such as severe lacerations, bleeding or prolonged labor. Prevention plays a fundamental role, especially in newborn girls, so it is important to establish a structured and authentic dialogue that allows the expectant mother and family to fully understand the dangers and consequences of this practice, in order to independently choose to reiterate it.

Keywords

FGM, sexuality, female circumcision, pregnancy, puerperium.

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1. Sexuality

Sexuality and the protection of sexual health represent one of the fundamental components in the life of an individual and the determinants that characterize them are multifaceted, complex, and related to one another [1]. The main factors that need to be considered in the management of sexual complications in a woman with FGM are:

- The neurophysiological factors.
- The relational factors.
- Cognitive factors (myths, false beliefs, experiences, memories related to FGM).
- Sociocultural factors and context (gender and social identity, social and cultural norms, experiences during migration, other traumatic events).
- Anatomical biological factors (type and method of performing FGM, removal (or not) of the clitoris, complications related to FGM).
- Biochemical factors [2].

The cultural context in which the woman lives, or has lived, can modify the attribution of meaning to the practice of mutilation. The role of FGM is varied and takes on many different meanings depending on the culture of origin (rite of passage into adulthood, guarantee of a good marriage, hygienic and aesthetic standards, control of female sexuality...). When these meanings are perceived positively within the community, the experience of sexual pleasure and orgasm in female victims of FGM is present in a high percentage, as demonstrated by some studies.

This proves the fact that, although there is certainly a directly proportional correlation between the extent of organic damage (based on the type of FGM) and sexual satisfaction (understood as the perception of sexual pleasure and the achievement of orgasm), the mere classification of the type of mutilation is not sufficient to understand and deepen the absolute condition of the patient.

In general, women with mild FGM or who, in any case, have had the excision experience in a positive and indeed functional way for the development of individual and sexual maturity, perceive themselves as healthy, and this is how the healthcare personnel dedicated to their care should perceive them [3].

A second determining factor is the context: women who come from countries with a cutting tradition often become aware of the fact that FGM could have had a negative impact on their lives only through the comparison with Western culture which not only condemns the practice but is even in stark contrast to the theme, often lacking in sensitivity and understanding. The result is sometimes the opposite of the desired one: through the awareness process of the practice, the woman can experience a worsening of the vision of the self (self-body image) with a consequent lowering of sexual self-esteem [4].

In clinical practice, the goal must always be to improve the patient's starting condition; from this point of view it is advisable to allow oneself the dutiful reflections on the best communicative method, avoiding necessarily problematizing the phenomenon and/or excessively medicalizing it.

2. Assistance to the Woman Carrier of FGM

The first contact with the woman victim of female genital mutilation (FGM) is fundamental and decisive for ad-

equate care of the patient. The occasions in which healthcare personnel can come into contact with a woman with FGM are different and often linked to an urgent type of access to the Emergency Department or consulting room. The problems that are treated are not always associated with implications strictly related to female genital mutilation (bleeding abnormalities in pregnancy, miscarriage, vulvovaginal infections, etc.). In other cases and more rarely, access can be specifically linked to a consultation for the complications of FGM or to ordinary preventive visits (pap test, gynecological check-up, etc.).

In most cases, however, patients access for:

- Checkups during pregnancy.
- Request for contraception.
- Request for voluntary termination of pregnancy.

Precisely because it is less frequent and more difficult to involve this user in prevention and information interventions, it is essential to be able to grasp the first access to one of these aforementioned services in order to approach the issue of FGM.

Complicating the management of the excised woman is the difficulty in recognizing, from a clinical point of view, the mutilation and knowing how to classify it, especially if it is a type I or II mutilation (excision of the clitoris, clitoral hood and labia minora), both in women and girls.

A fundamental element in the approach to the female carrier of FGM is the use of a communication method that transmits acceptance, empathy, open and non-stigmatizing dialogue and which does not make the woman feel condemned, victimized or humiliated [5].

Starting from the need to consider the phenomenon of FGM and the women who are its bearers, it is useful to define two welfare objectives:

1. Take charge and treat from a medical, surgical, psychological, sexological point of view, women who have already undergone the mutilation and who report the consequences.
2. Take charge of those who, even if they have undergone mutilation, do not have sexual disorders and therefore need adequate counselling aimed at guaranteeing sexual health (counselling on contraception, adherence to screening programmes, education on menstrual hygiene etc.) [6].

As far as the management of women who report FGM-related damage is concerned, a point must be made. Despite the common-thought understanding that the cutting practice is the incontrovertible cause of permanent and irreversible damage, especially as regards the sexual sphere, the literature on sexual pleasure and orgasm actually refutes this very thought. There is no evidence to support the thesis that "FGM unequivocally destroys sexual pleasure", just as no significant differences in orgasm perception have been observed between women with FGM and women without [7]. Furthermore, the low incidence of negative consequences on desire, pleasure and the achievement of orgasm in women with FGM was verified, in the absence of complications and with awareness and acceptance of the excision undergone [8].

From an anatomical point of view, in type I and II mutilations, where the excision involves the foreskin, clitoris and labia minora, often the

only portion of the clitoris removed is that of the glans, so all the remaining erectile components, like the clitoral roots and crura, remain intact. The erectile structures of the bulbs of the vestibule and the peri-urethral ones remain intact and for this there is the possibility, in case of sexual dysfunction, to rehabilitate women to a complete and satisfying sexual life [3].

Whenever a sexual dysfunction emerges, regardless of what the triggering factor may be (anatomical, functional, relational, psychological) it is necessary to investigate some points and, if necessary, start a supportive psychosexual therapy. Some of the psychological implications that we can find in excised women are:

- Cultural conflict.
- Stigmatization of women with FGM (especially in a context in which the media, health and awareness campaigns invest heavily in the issue of mutilations).
- Negative expectations about sexuality (fear of being different, of not feeling pleasure, destruction of body image).
- Social non-acceptance (greater sharing and/or contrast with Western culture, as, for example, in the case in which the partner has origins in countries with no cutting tradition) [2].

As regards the codified treatments for the management of female sexual disorders, they include exogenous hormonal therapies, central nervous system (CNS) active drugs and psychological therapy.

Other tools that have proved to be significant in the treatment of sexual disorders are sexual devices (sex toys), both in terms of masturbation and sexual activity as a couple, being functional for increasing the probability of orgasm and for reducing the time latency of orgasm itself [9].

Sexual devices, including vibrators, vaginal and/or anal penetrative devices, clitoral pulsators, share a similar mechanism of action, providing stimulation through vibration, pulsation and penetration by acting on different erogenous areas (anus, vagina, clitoris, perineum, nipples). The objective of sexual devices is to improve, accelerate and/or prolong any phase of sexual response and for this reason they are used for therapeutic purposes on some patients. These patients include those with reduced libido, anorgasmia or conditions that inhibit vaginal penetration (dyspareunia, vulvodynia, pelvic pain chronic, sexual function or pelvic floor disorders, partner's erectile dysfunction, etc.). Pregnant women, before and after childbirth, are also candidates for the use of these devices, as are women in menopause, with disabilities or chronic pathologies.

In order to ensure good adherence to therapy, it is essential to provide suitable information regarding the use, cleaning and storage of sex toys [10].

Another valid support tool for counselling and taking care of women with FGM is the use of images and photographs that portray different genitalia and underline the anatomical variety that sees the dimensions and shapes of the labia minora, labia majora and very different clitoris. These supports, such as the online platform The Labia Library, created by the non-profit Australian foundation Women's Health Victoria, allow health professionals to redefine the meaning of

genital physiology away from the mere aesthetic parameter imbued with social, cultural, and religious present in each geographical area in a given historical context.

Having direct feedback on the multitude of different vulvas that may exist, it is easier for patients and their partners to understand, accept and normalize female genital mutilation.

Considering the complexity of the assistance response, the only model capable of providing an adequate one is the multidisciplinary and multiprofessional one which guarantees, possibly in a single center, the evaluation and management of the patient from every point of view (medical, surgical, psychological, of cultural, rehabilitative, sexological mediation, etc.). This model allows evaluation to be made also in relation to various services in the area: hospital birth points, consultants (screening, contraception, IVG, pregnancy, puerperium), paediatricians and general practitioners.

3. Focus on: the Pregnant Patient with Infibulation

Often FGM carriers do not believe that this condition can negatively affect or even compromise spontaneous childbirth.

The focus of assistance to pregnant women with FGM is based on the prevention of complications of excision that may arise at the time of delivery, thus protecting the health of the woman and the unborn child [11].

While not all types of FGM lead to complications in childbirth, it should be noted that there may be an increase in severe lacerations, cases of post-partum hemorrhage, prolonged labor and fetal distress (Tab. 1) [12].

In particular, in women with type III FGM (infibulation), prevention plays a fundamental role in these situations, for which it is necessary to establish a relationship of trust with the patient throughout the pregnancy in

Tab. 1. FGM and obstetric risks.

OBSTETRIC RISKS	DETAILS
Cesarean section	Increased incidence of Cesarean section and associated surgical complications
Post-partum haemorrhage	Blood loss after delivery greater than or equal to 500 ml
Episiotomy	Performed to reduce the risk of severe spontaneous lacerations
Obstetric lacerations	Scar tissue left over from excision can increase the risk of serious lacerations, making the tissue less elastic
Difficult or dystocic labor	The presence of infibulation may inhibit the newborn progression
Prolonged maternal hospitalization	If severe lacerations or caesarean section are present
Perinatal death/neonatal resuscitation at delivery	Prolonged labor can cause fetal distress

order to be able to address some critical issues:

- The timing and methods of defibulation in view of the birth, specifying the risk factors and the benefits deriving from the intervention.
- The impossibility for the Italian law (legge Consolo n. 7/2006) to proceed with the re-infibulation after the birth and, in the same way, to carry out a genital modification (FGM) on the newborn in case it is female.

Furthermore, during health assessments, in the presence of infibulation, the possibility of carrying out a vaginal birth should always be proposed and discussed with the patient, specifying and taking into account the fact that there may be less perineal competence in the expulsive period and that may need to resort to de-infibulation during labor or, sometimes, episiotomy to avoid severe lacerations and facilitate birth.

As regards women with type III mutilation (infibulation), it is necessary to choose the timing for de-infibulation surgery and this may depend on clinical reasons, cultural factors and psychological motivations [13].

In general, literature and experience agree that the best results are obtained when defibulation is performed before delivery as it decreases the risk of birth complications related to a narrowed vaginal canal. Specifically, the Royal College of Obstetricians and Gynecologists (RCOG) recommends deinfibulation in the preconception period or during labour, as does the WHO. The Swiss Society of Gyneacologists and Obstetricians recommends this intervention during labor and pregnancy only if gynecological visits cannot be performed, while the Italian Guidelines recommend defibulation within the first trimester of pregnancy or before delivery in case of late first access [14].

Regardless of the opinion of scientific societies, it is necessary to consider some fundamental factors to decide the timing of female circumcision, including:

1. Preference of the woman.
2. Access to health facilities: in contexts where women may encounter involuntary delays in reaching health facilities (e.g. single woman, without car, caregiver, language barrier, etc.), defibulation should be guaranteed before delivery, so as to schedule it and thus avoid emergency events.
3. Place of delivery: it is important to ensure ante-partum defibulation especially when delivery is planned at home.
4. Skill level of the healthcare worker: if there are not sufficiently trained resources within the structure for the intervention and management of defibulation, it is preferable to carry out ante-partum intervention [15].

After deinfibulation the appearance of the genitals changes, as well as some of the more daily physiological activities such as urinating or menstruating: it is important to address the subject before the operation, also investigating the reaction of the people around the woman (partner, mother, mother-in-law...) making sure that the management of the intervention is clear.

These issues must be addressed gradually and, if possible, involve the partner or family, in order to raise awareness of FGM as much as possible and allow the woman to be surrounded by people who support her and do not stigmatize her for her decisions. It should

be considered, furthermore, that the prenatal period often represents the first contact with the health service by the woman and/or the couple.

All meetings with the woman or the couple must be accompanied by the presence of a cultural mediator, especially in cases where it is necessary to give informed consent [16].

There are several procedures that complicate the management of women with infibulation, especially during labor:

- Vaginal and speculum examination.
- Labor induction which, if necessary, should only be performed after defibulation.
- Evaluation of the stage of labor, for which a rectal examination may sometimes be necessary.
- Catheterization.

The defibulation surgery is performed under local anesthesia (or by exploiting the epidural anesthesia performed during labor) with episiotomy scissors or a scalpel, from bottom to top, along the midline of the scar up to the urethral meatus, trying to locate it and possibly proceeding with catheterization in order to avoid involuntarily affecting it.

When the surgery is done during labor, it is usually done in the second stage, when the emerged part progresses.

The closing suture of the labia majora is done at the end of the third stage, after birth and expulsion of the placenta [17].

One of the most common risks is that serious vaginal/urethral lacerations occur during childbirth, for which it may be necessary, in order to prevent them, to practice a medio-lateral episiotomy. More rarely, it is necessary to resort to bilateral or median episiotomies, due to a greater risk of incontinence and/or anorectal fistulas.

The adhesions and scar tissue around the vaginal canal cause a reduction in the degree of distension of the perineum. In the event that adhesions are present, it is necessary to divide them and, subsequently, to evaluate the possibility of practicing an episiotomy or not [18].

One of the least considered and most often underestimated aspects is the homogeneous coding of the hospital discharge form after hospitalizations.

In order for the mutilation phenomenon to emerge and for the data to be significant, it is essential that shared diagnostic codes are used and that they refer unequivocally to the type of FGM in question.

4. FGM and Puerperium

During the puerperium, the assistance of the woman must be guaranteed through a weekly follow-up, possibly through home assistance. This attention is necessary to moderate the most recurring risks following defibulation surgery, such as those related to urinary tract infections.

The health personnel involved in supporting these patients and their children hold a fundamental position as regards counseling: the post-partum period is in fact optimal for deepening the woman's experience of excision, trying to understand the maternal wishes and cultural and family dynamics.

The support of specialized personnel assumes further importance in the event that the newborn is female in order to sensitize and inform the mother about the main functional and anatomical notions of the genitals so as to be able, possibly, to make a more informed decision on the excision procedure.

A fundamental aspect of post-partum assistance also concerns support with respect to the perception of

one's body and one's genitals, both in terms of aesthetics and physiology. In addition to this, a fundamental step is represented by the attempt to dispel false myths and discuss women's fears and insecurities.

Finally, one last consideration must always be kept in mind: the patient is not only a deinfibulated or mutilated woman but, in this context, her condition in the puerperium and the resulting needs must first of all be considered, such as the evaluation of the pelvic floor for any incontinence or dysfunction, the evaluation of breastfeeding, contraception, sexual health etc. Also in this process it is essential to involve the partner or family and arrange for the presence of a cultural mediator [15].

In conclusion, taking charge of the female victim of FGM presupposes a multidisciplinary approach and close collaboration between various medical, obstetric, nursing, psychological and intercultural mediation figures.

The training of healthcare personnel is essential to ensure satisfactory levels in each of the areas of interest, whether pertaining to hospitals or the territory.

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