BUILDING BRIDGES TO END FGM

Live Webinar Report

Spotlight Initiative

Access to Care Services for FGM Survivors

BUILDING BRIDGES TO END FGM

DESINFIBULATION with
Dr Jasmine Abdulcadir

Spotlight Initiative

The Debates of the CoP

CARE SERVICES FOR FGM SURVIVORS

BUILDING BRIDGES TO END FGM

Our speaker

Dr Jasmine Abdulcadir
Gynécologue
obstétricienne

1. Introduction

On 02 December 2022 a medical training webinar for healthcare professional on defibulation was held, organised by the CoP FGM. The CoP FGM invited Dr. Jasmine Abdulcadir, an obstetrician-gynecologist and specialist in the field, to share her expertise and recommendations with the participants. This training was based on a presentation of defibulation from a medical and surgical point of view, but also from a psychological point of view to be considered in the care of the patient who wishes to have a defibulation. All the recommendations are supported by the WHO (2016, 2018), which plans to renew its guidelines next year.

This webinar was aimed at health professionals (gynaecologists, general practitioners, doctors in training, midwives, student midwives, etc.) who are likely to accompany girls and women affected by female genital mutilation, particularly type III - namely infibulation.

Before proceeding to the detailed report of the webinar, an introduction of our speaker is necessary. Dr. Jasmine Abdulcadir is an obstetrician-gynecologist practicing in Switzerland; in 2010, she inaugurated the first consultations for women and girls affected by female genital mutilation (FGM) in Geneva. Among the services offered is the operation of infibulated women using the defibulation technique. These consultations receive between 20 and 30 women per month, i.e. approximately 300 patients per year, the majority of whom are suffering from type III FGM and come from East Africa.

2. Why hold a medical webinar on deinfibulation?

Infibulation can lead to physical or psychological complications for the infibulated woman. Infections, pain and difficulties during childbirth are among the most common consequences of this practice.

On the one hand, we notice that since last year, the members of the COP FGM have shared a few observations and needs, among others: the difficulty to find doctors who do the defibulation for a type III (infibulation) in Guinea or Senegal ...., the resistance in some cases by medical professionals to proceed to a defibulation, the difficulty to find services offering care to survivors of FGM, suffering from social and psychological consequences in Guinea Conakry, Mali, Burkina Faso,... The difficulty of finding free care services for FGM survivors. Even when there is the possibility of being able to pay for consultations.

In addition, female genital mutilation (FGM) has multiple harmful consequences on the young girls and women affected by FGM. Moreover, FGM involves great violence and causes significant trauma to women that should not be overlooked. This is why it is necessary to question the experiences of these women and the way in which they are cared for as well as their culture and to understand how to combine this with their care.

On the other hand, defibulation is a recommended intervention to reduce obstetric complications and recurrent urinary tract infections (WHO 2018 - WHO Guidelines on the management of complications of female genital mutilation). While it is quite simple and quick from a surgical point of view, it can cause great changes for the woman concerned: fear, changes to the body, stigmatisation by the community, ... Moreover, reports of post-deinfibulation depression, feeling of having been raped, lack of informed consent (no translation into the patient's language) have been noted in Belgium for example but also in several other countries.

3. The health professional's position

Dr. Abdulcadir began this training by stressing the importance of comprehensive support for infibulated patients. This is indeed central since the changes brought about by the operation are major for the latter: physical appearance (visibility of the vulva mucosa), stronger urinary stream (vs. "rainy" urination), more frequent urination, and the need to be able to take care of the patient. The simple act of urinating after defibulation can provoke anxiety attacks due to a reactivation of the trauma linked to the mutilating act; indeed, many mutilated women suffer from post-traumatic stress syndrome. Although rare, this situation has been the subject of a case study by Dr. Abdulcadir.

In this way, the caregiver must also be informed about the cultural myths associated with FGM. Beliefs related to infibulation include, for example the belief that the baby can fall out of the vagina if the vulva is not closed, peeing too fast or too hard is vulgar for women and associated with masculinity, an unsutured vagina is too large and a gateway to disease, infibulation guarantees premarital virginity and a prosperous marriage (even economically), reinfibulation would restore virginity (especially after rape)...

In addition, some women are reluctant to undergo the procedure because of the stigmatising cultural weight: Indeed, women wishing to undergo defibulation are assimilated to prostitutes and promiscuous women.

As a reminder, defibulation is one of the WHO's recommendations for FGM. According to the good practice guidelines, it is essential to inform women about the details of the procedure in the pre-operative period, whether in terms of the technique, the changes associated with it, or the conduct to be adopted in the post-operative period... Some cases of post-defibulation depression have been reported, particularly in Belgium, due to an incomplete approach to care: the informed consent of the women was lacking. The informed consent of the patients is therefore essential for good care.

Video defibulation: a recommended tool for health professionals to support women who wish to undergo defibulation

Good practice identified by WHO (2018)

The WHO recommends this good practice to the professionals concerned: organise a pre-operative meeting to discuss this with the woman who has been excised. Often, the language barrier increases the risk that the woman will not be able to give informed consent and/or will not understand what will be done.

Defibulation is a procedure that can reduce these health problems. In order to help health care personnel inform the women concerned, the FPS Public Health in collaboration with GAMS Belgium and the ULB has produced a video that explains why to have defibulation, when to have it, how it is done, what the post-operative care is and what changes to expect in the body.

The video is available in 9 languages: **French, Dutch, English, Arabic, Tigrynia, Amharic, Fula, Somali and Afar**. It was produced in co-construction with the women concerned and health workers.

Fighting FGM also means talking about it. This video opens the way to raising awareness. With this video, we hope to reduce women's anxiety by improving their understanding of the procedure, reducing post-operative complications and gaining their adherence to the treatment. On the other hand, we offer a quality tool for health care personnel responsible for the management of female genital mutilation (FGM).

We strongly encourage gynaecologists, midwives, etc. to use this video during the consultation with the patient. To explain the procedure to patients, the speaker recommends the use of drawings. Illustration helps to make complicated information accessible to a non-expert audience and can also help in cases of language barriers. Dr Abdulcadir added that the inclusion of the husband in the treatment is crucial as this is often a subject that is not discussed much or at all in the couple. The husband has also been shown to be a positive resource in the use of defibulation.

4. Examination of the vulva

In all gynaecological and obstetric care, the vulva examination undertaken by the health worker is fundamental. It must be systematically included in the care plan, particularly when the health worker receives patients from a country affected by FGM and during an initial consultation.

Recognising the different types of mutilation, especially when the patient is pre-pubescent or adolescent, is one of the skills of the professional in order to make a good diagnosis. Indeed, the appearance of the vulva can vary according to age, skin colour, possible dermatological conditions, sexual activity, obstetrical status (pre/post-partum)... The clitoris and its bonnet can have a diverse anatomy, while the labia minora are particularly small in little girls due to the absence of oestrogenisation. Phimosis of the clitoris may also exist when the vulva is not oestrogenised. In addition, due to this physiological deficit in childhood, spontaneous adhesion or synechia of the labia minora may have the appearance of mutilation. Treatment of this condition consists of the simple application of an estrogenic gel. Thus, the differential diagnosis of FGM may be labia minora synechia or lichen sclerosus. For further reading, Dr Abdulcadir's publication on FGM in girls and adolescents should be consulted; this study is available online in open access

The examination of the vulva of the girl child is performed according to a certain method, where the angle of opening of the legs must be widened; below is an illustration from the above-mentioned book (Abdulcadir, Sachs Guedj, & Yaron, 2022)..

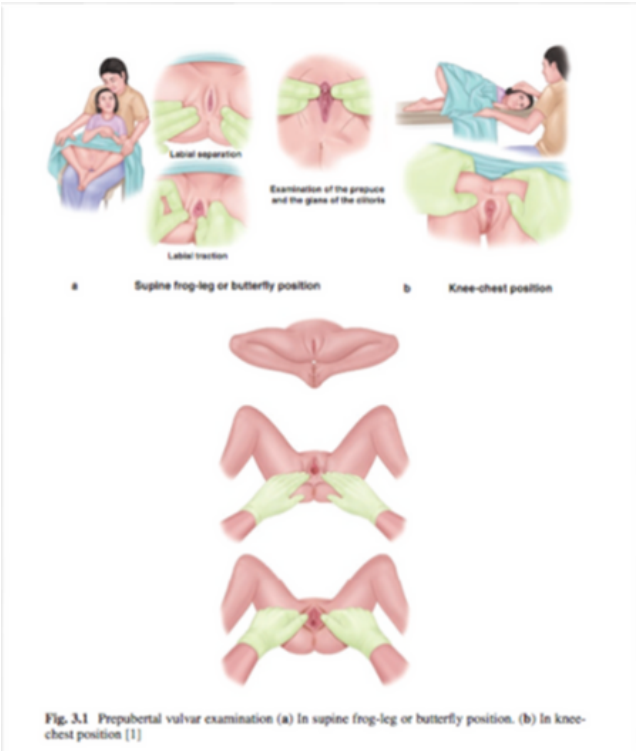


Fig. 3.1 Prepubertal vulvar examination (a) In supine frog-leg or butterfly position. (b) In knee-chest position [1]

In addition, pregnant women are subject to hypervascularisation, which can alter the appearance of the vulva. Finally, the same type of mutilation (especially type III) may also undergo changes depending on the ethnicity, the time of mutilation, the method used, ... For example, the clitoris is not always excised and the inner lips may also remain intact. At the other extreme, double infibulation (suture of the inner labia and then the outer labia), although rarer and not described in the WHO classification, is practiced in Ethiopia .

To conclude this point, Dr. Abdulcadir insists on the importance of knowledge of vulvar anatomy, particularly the clitoris. It is a typical glans, rich in sensory receptors (Krause-Finger), impossible to reproduce identically if it has been excised. The internal clitoris, on the other hand, retains its sensory properties.

Transparency with the patients concerned by the excision of the external clitoris is essential during the consultations. It should be noted that the information circulating on social networks, according to which the clitoris has 8,000 nerve endings, comes from a study conducted on cows! Dr Abdulcadir mentions the number of 10,280 for women. Finally, in case of surgery on the vulva, the dorsal nerve of the clitoris should not be touched.

5. Advantages of defibulation

Consequences of infibulation include obstetric trauma, dyspareunia and "rainy" urination (weak, "dripping" urine stream). Defibulation can address these issues. Indeed, it has been associated with a decrease in psycho-sexual, uro-gynaecological and obstetrical complications (with the exception of bleeding, episiotomies and tears, where risks still exist). Finally, defibulation allows gynaecological-obstetrical examination by carers, particularly for the prevention of cervical dysplasia.

Nevertheless, two recent studies have identified a high risk of episiotomy and/or severe perineal tears (D3 and D4) during childbirth. The first, based in Sudan, reported a 60-70% higher rate of episiotomy and an increased risk of severe tears. Dr. Abdulcadir is cautious about interpreting these results; indeed, she points out that a significant proportion of multiparous women in the study sample were reinfibulated after each delivery. The second study is a Norwegian retrospective study, which reports that second trimester defibulation is associated with a risk of sphincter tears. Details of the modalities of defibulation are not reported; it should be noted that some defibulations are performed only to allow penetration, thus consisting of an opening that is limited to the vagina. This type of defibulation does not meet the requirements of good practice. In addition, FGM is globally associated with a higher risk of third degree and supraurethral tears.

Defibulation is a technically simple surgical procedure, lasting 5 to 10 minutes, although it involves complex changes for the woman (hence the importance of comprehensive support as mentioned above). It can be performed either under local anaesthesia (e.g. Lidocaine 1%), loco-regional anaesthesia (spinal anaesthesia or epidural) or general anaesthesia (laryngeal mask ventilation, without intubation) if the woman is not pregnant. The type of anaesthesia is decided in collaboration with the patient. However, the patient's profile can guide the professional: if the patient suffers from psychological consequences due to the FGM episode, the choice of narcosis is relevant (outside of pregnancy).

In the post-operative period, analgesic treatments are administered, such as Emla ointment applied two hours after the operation. The prevention of pain is of paramount importance because it can reactivate various traumas linked to the excision, rape, obstetrical history, etc.

The operation can take place at any time in the woman's life and the patient chooses the modalities of the operation: she limits the opening of her scar (e.g. to the meatus or to the clitoris) and decides if she wants a reconstruction of the clitoris and/or its bonnet. In any case, her choice must be respected.

In terms of technique, the first thing to do is to feel the clitoris through the infibulation bridge (i.e. the scar).

6. How is defibulation performed?

Locating the urinary meatus is the next step, especially to check for adhesions below the bridge, caused by repeated defibulation/reinfibulation between deliveries. She also advises passing an IN/OUT probe to ensure the correct location of the meatus. Once the landmarks are located, the infibulation bridge can be opened with either scissors or a cold knife; however, scissors are preferred. The incision is median in order to avoid asymmetry of the outer lips. Reconstruction of the labia is sutured with separate stitches or overlocking, using a fast healing suture (Vycril 3.0) as the tissue involved heals quickly. The gynaecologist emphasises the importance of opening the vulva at least 1 cm above the meatus, especially in young patients, because of the occurrence of a small spontaneous closure after 6 weeks. This can cause discomfort, such as tightness during sexual activity or childbirth.

Furthermore, if the procedure is performed during labour, the incision of the infibulation bridge should be made during uterine contraction. To illustrate her point, Dr. Abdulcadir showed an educational video of a defibulation in her hospital.

After the procedure, it is recommended that patients do not have penetrative sex for one month or take a bath. They should also be advised by their health care provider to spread the edges of the outer labia regularly (3x/day) to prevent them from sticking together.

7. Obstetrics and defibulation

In the obstetric setting, defibulation is necessary in the second trimester of pregnancy or before delivery to clear the way for the newborn. The choice depends on the resources available (qualified personnel, organisation of the service, time schedule, etc.) and the number of times the patient is seen in consultation.

It is now recommended that the procedure be performed in the second trimester. This is the preferred time for several reasons: there is no emergency, an experienced professional is available, the tissues are less oedematous and less vascularised (which facilitates the procedure) and finally, any complications will not be associated with the delivery or added to the traumatic obstetrical baggage. In addition, in the first trimester, invasive procedures such as vaccinations and, in this case, defibulation, are avoided because of the risk of miscarriage, thus eliminating the link between the two.

In the past, defibulation was carried out in the second phase of labour - the expulsive phase - but now it is done in the first phase of labour. This alternative has several advantages: it allows monitoring of cervical dilatation via vaginal touch, emptying of the bladder with intermittent catheterisation (IN/OUT) and management of pathological FHR patterns via obstetric instrumentation (e.g. vacuum cup).

Even in the case of caesarean section, defibulation can be offered and performed. It should be noted that caesarean section is not necessary in infibulated women; caesarean section is not an indication for infibulation, although it continues to be performed due to lack of expertise or access to defibulation. In addition, although it used to be performed as a matter of course, mid-lateral episiotomy is no longer recommended; it depends solely on the status of the expulsion. However, in Guinea, the infibulation bridge is difficult to open, so episiotomy is necessary. In Ethiopia, a double episiotomy is performed because of a specific, but rare, form of mutilation, which consists of a double infibulation (suture of the labia minora and majora). It should be noted that in the case of a supra-urethral tear due to childbirth, the reconstruction must be as physiological as possible, leaving the urinary meatus free.

Finally, the postpartum period is a sensitive time after defibulation. As we have already seen, pain relief is the first line of support. Since the latter is global, the changes brought about by the surgical procedure must be followed in close collaboration with the patient. The perineum requires more attention: local care is given and the edges are spread 3x/day. This procedure is particularly important in the postpartum period; midwives must ensure that it is carried out when patients are not mobilised (immediate postpartum, loco-regional anaesthesia, narcosis). Finally, perineal rehabilitation and health promotion in the postpartum period are steps that should be followed.

8. The case of reinfibulation

Reinfibulation consists of closing the vulva after the opening of the infibulation bridge, during childbirth. This practice is not recommended by national and international guidelines; it is denounced as a form of medicalisation of FGM and its uselessness is also underlined.

From her experience in Geneva, Dr. Abdulcadir says that very few women ask to be reinfibulated after giving birth. For those who do, the motivations are the following: feeling of shame and/or impurity, fear of rejection by the community and/or the husband, regaining "normality", a state that is foreign and contrary to one's traditions and values, new sensations and aspects that are difficult to accept (sexuality, aesthetics, etc.), etc.

In the event of a request from the patient, the gynaecologist has established a procedure to be followed, mainly centred on health education. To do this, the contribution of a certified interpreter is required and, as mentioned above, the role of the husband should not be neglected. Accompaniment consists of exploring the myths about intact or defibulated female genitalia, discussing the changes brought about by drawings, clarifying the advantages of defibulation, proposing the possibilities available and respecting the patient's choice (partial or total defibulation). In doing so, time is an essential factor in deconstructing entrenched beliefs.

9. The case of minors

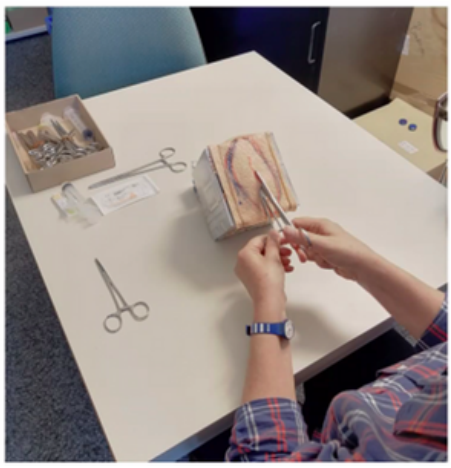
In Switzerland, for example, when minors are willing to undergo defibulation, the age at which the procedure is allowed depends on the complications caused. If the minor patients are asymptomatic, the decision depends on expert opinion, an ethics committee and/or a judge if the parents object.
As a general rule, waiting for estrogenization, i.e. the occurrence of the first menstrual period or following the medical prescription of an estrogen gel, is the minimum to be respected. Nevertheless, the age of 18, the age of consent, is generally the first criterion for validating the procedure. It should be noted that from the age of 16, the capacity of discernment can be assessed.

10. Conclusion

The support of patients requesting defibulation is global; it is not limited to the medical-surgical dimension. Psychological support plays a major role in the follow-up carried out by the health professionals. Patients are seen as a whole; the health care provider does not only focus on the genital area but treats the patient as an individual.

Thus, care includes prevention, and communication with patients is therefore central to obtaining their informed consent. The explanations given to patients are based on EBM (Evidence Based Medicine) and the particularities of type III FGM are known.

Finally, health professionals have a duty to keep themselves constantly informed, both on practices and scientific research and on their updates. Their medical training must include the issue of FGM, particularly type III, and therefore of defibulation. For example, in the Geneva hospital, practical courses are given to midwifery students to learn how to carry out defibulation on personalised cardboard boxes; the issue is thus integrated into their academic curriculum.



HESAV
HAUTE ÉCOLE
DE SANTÉ VAUD

Images of a practical course for Swiss midwives, taken from the slides shared by Dr. Abdulcadir during her presentation at the COP FGM.

Bibliography

Abdulcadir, J. (2018, April 4). Defibulation: a visual reference and learning tool (2018, April 4). [Video]. YouTube. [Video]. YouTube. Retrieved from https://www.youtube.com/watch?v=fbKPqE6Vj_c

Abdulcadir, J., Sachs Guedj, N. & Yaron, M. (Eds.). (2022). Female Genital Mutilation/Cutting in Children and Adolescents: Illustrated Guide to Diagnose, Assess, Inform and Report (1st ed.). Springer Cham. doi: https://doi.org/10.1007/978-3-030-81736-7

GAMS [GAMS Belgium GAMS Belgie]. (2021, 31 May). Desinfibulation - ENGLISH [Video]. YouTube. https://www.youtube.com/watch?v=v5kdrj6oWuk&t=3s