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Original Research Article

Does female genital mutilation/cutting have any effect on normal birth?

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ABSTRACT

Background: World Health Organization's (WHO) defines female genital mutilation (FGM) as all procedures involving the total or partial removal of female external genitalia without any medical reasons. It is estimated that about 100 million women worldwide are circumcised. After circumcision complications such as bleeding, infection, shock, menstrual irregularity, dysuria, frequent urinary tract infections, pelvic pain and difficulty in sexual intercourse occur with varying frequencies.

Methods: In this article, we aimed to discuss normal vaginal delivery results of 45 term pregnant cases with 3 types of female genital mutilation/circumcision. We know that the vaginal entrance is closed as a result of adhesions in the genital area due to circumcision and secondary complications may develop.

Results: The mean age of 45 patients included in the study was 26.2±8.78 years. Considering the postpartum complications, bilateral labial tissue ruptures in 15 cases, followed by vaginal hematoma in 9 cases, anal sphincter damage in 11 cases, deep episiotomy tears in 8 cases, periurethral tears in 8 cases, deep cervical tears in 8 cases, vulvar epidermoid cyst ruptures in 4 cases and 4 cases. perineal body ruptures were seen in 4 cases, vulvar hematoma in 4 cases, and vaginal mucosal damage in 9 cases.

Conclusions: It has been shown once again that FGM/C is a method that completely changes the female vaginal anatomy and has very serious delivery complications. It is obvious that serious educations and studies need to be done in the countries where this method is applied.

Keywords: Female genital mutilation/cutting, Normal birth, Circumcision

INTRODUCTION

According to the definition of the World Health Organization (WHO), Female Genital Mutilation (FGM) is defined as all procedures involving the total or partial removal of female external genitalia for non-medical reasons.¹ FGM is a common practice in Middle Eastern and African countries. It is generally applied to girls between the ages of 5-12 and sometimes to young girls of adult age.² This procedure is performed using a knife, razor, or piece of glass after holding the girls tightly, with or without local anesthesia. Female genital mutilation type

1 by WHO; total or partial clitorrectomy, type 2: excision of labia and/or clitorrectomy, type 3; suturing the cut labia and wound lips (Infibulation), type 4; it is classified as drilling, cutting, piercing or cauterization operations performed without removing parts 1.

The most severe form of infibulation occurs in countries such as Djibouti, Eritrea, Ethiopia, Somalia, and Sudan.³ After infibulation, that is, after the wound lips are stitched together in the labia, the feet of the girls are tied together to support the adhesion of the incision sites.⁴ Complications of female genital circumcision vary

according to the hygiene of the environment, the tools used, the experience of the person performing it, or the type of circumcision performed.^{1,5} In patients undergoing type 3 FGM/C, problems such as inability to have intercourse, infertility, and narrowing of the outlet canal, such as dysmenorrhea, endometriosis, and voiding difficulties are experienced.⁶

After female genital circumcision (FGM/C), difficulties in normal vaginal delivery due to significant stenosis in the vulva and vagina exit and increased complications are encountered, especially after epidermoid cysts, keloids, scar defects that may develop in the vulvo-vaginal region, and adhesions due to poor wound healing. In our article, we aimed to discuss the adverse effects of FGM/C application, which causes many complications in the female pelvic region and is banned all over the world, on childbirth, in the light of the literature.

METHODS

In this retrospective study, 45 pregnant patients 37 weeks and older who applied to the delivery and delivery room of Nyala Sudan Turkey hospital between September 2019 and September 2021 due to labor pains were included in this study. All 45 patients were found to have female genital circumcision (FGM/C). It was noticed that the anatomy of the genital area had changed while performing a vaginal examination for normal delivery. The criteria for inclusion in our study were patients with a history of FGM/C and subsequent normal delivery in their pregnancies and their consent was obtained. The exclusion criteria were the cases who did not have FGM/C and did not have a history of birth and did not want to participate in the study voluntarily. We obtained the necessary consents from all patients and the hospital ethics committee. We aimed to write down all the complications that may develop in these cases after labor. The patients' age, gravida, parity, abortion, education level, age at circumcision, circumcision type, complications related to circumcision, body mass indexes, comorbidities, smoking,

delivery types were retrospectively screened. Mean, standard deviation, median, min-max values and frequencies were used for descriptive statistics by checking whether there was a normal distribution or not. Categorical data were expressed as numbers and percentages (%). Statistical Package for the Social Sciences (SPSS) 23 program was used to analyze the data.

RESULTS

The mean age of 45 patients included in the study was 26.2 ± 8.78 years, and the median value for gravida was 3 (1-9) and the median value for parity was 1 (0-7). It was determined that 80% of the patients with a mean BMI of 26.2 ± 5.98 were illiterate and the median age at which FGM/C was performed was 5 (4-9). While 20% of the cases were FGM/C type 1, it was seen that Type 3 was the most severe and worst type with a high rate of 57.8%. Complications caused by FGM/C in patients were examined and it was observed that the most common complications were dyspareunia in 19 cases, vulvar keloid in 14 cases, vulvar epidermoid cysts in 9 cases, vulvo-vaginal adhesions in 11 cases, dysuria in 7 cases and stress incontinence in 6 cases and 2 in dysmenorrhea. It was seen that only 12 multiparous cases who had episiotomy before had normal spontaneous vaginal delivery. The remaining 33 cases had operative vaginal delivery with episiotomy. When we look at the types of delivery, the rate of those who gave normal spontaneous vaginal delivery was 17.7%, while 82.3% of them had operative vaginal delivery by opening an episiotomy. When the birth weights of the newborns were examined, it was seen that the mean birth weight was 3167 ± 345.3 g. Considering the postpartum complications, bilateral labial tissue ruptures in 15 cases, followed by vaginal hematoma in 9 cases, anal sphincter damage in 11 cases, deep episiotomy tears in 8 cases, periurethral tears in 8 cases, deep cervical tears in 8 cases, vulvar epidermoid cyst ruptures in 4 cases and 4 cases. perineal body ruptures were seen in 4 cases, vulvar hematoma in 4 cases, and vaginal mucosal damage in 9 cases (Table 1).

Table 1: Clinical And demographic characteristics of patients.

	Mean \pm SD/ median (min-max) n=45	Frequency/ Percentage
Age	26.2 \pm 8.78	
Gravida	3 (1-9)	
Parity	1 (0-7)	
BMI	26.2 \pm 5.98	
FGM/C age	5 (4-9)	
Education status	No	36
	Yes	9
Birth type	OVB+E	37
	NSVB	8
FGM/C type	Type 1	9
	Type 2	10
	Type 3	26
		80
		20
		82.3
		17.7
		20
		22.2
		57.8

Continued.

		Mean±SD/ median (min-max) n=45	Frequency/ Percentage
FGM/C complications	Dyspareunia	19	42.2
	Vulvar keloid	14	31.1
	Vulvar epidermoid cyst	9	20
	Vulvo-vaginal adhesion	11	24.4
	Dysuria	7	15.5
	Stress incontinence	6	13.3
	Dysmenorrhea	2	4.4
Infant weight (Gr±SD)		3167±345.3	
Birth complications	Bilateral labial tissue rupture	15	33.3
	Vaginal hematoma	9	20
	Anal sphincter damage	11	24.4
	Deep episiotomy	8	17.7
	Periurethral tears	8	17.7
	Deep cervical tears	8	17.7
	Vulvar epidermoid cyst	4	8.8
	Perineal body rupture	4	8.8
	Vulvar hematoma	4	8.8
Vaginal mucosal damage	9	20	

Note: BMI: Body Mass Index, FGM/C: Female Genital Mutilation/Cutting, Gr: Gram, SD: Standart Deviation, OVB+E : Operative Vaginal Birth with Episiotomy, NSVB: Normal Spontaneous Vaginal Birth

DISCUSSION

Female circumcision (Female Circumcision) is defined as the methods that involve cutting the female genital organs for non-medical reasons (Female Genital Cutting) or mutilating the female genital organs (Female genital mutilation (FGM)) or the deliberate alteration or injury of the female external genitalia.⁷ The number of women who have circumcision has decreased in recent years as a result of both European-supported studies and the struggles against it in the countries where this procedure is carried out. However, it is still a common practice in African and Middle Eastern countries.³ FGM/C has many early and late complications.⁸⁻¹⁰ The short-term complications include shock, haemorrhage, infections and psychological consequences.^{8,9} The long-term complications consist of chronic pain, infections, cheloids formation, primary infertility, birth complications and psychological consequences.^{11,12} The incidence of these complications varies according to the circumcision type. Problems such as fibrosis, keloid and synechia have been reported more frequently in type 3 patients. Depending on these, it is stated that vaginal birth causes increased genital lacerations in labor and they cause long-term complication such as incontinence in operative deliveries.¹³ Depending on the anatomical defects in the genital area after previous FGM/C, it is stated that it may cause prolongation of vaginal birth and negative neonatal and maternal outcomes. It is recommended that and genito-urinary evaluation should be performed. Long-term urogenital infections due to anatomical defects may increase these compclctions.^{14,15} Studies have shown that scars or adhesions in the vulvar region do not need to be opened before labor. These genital area defects do not affect the

labor process but may cause stenosis in the outlet only in the second stage of labor. It has been stated that the appropriate defects can be revised and, if necessary, an episiotomy can be performed, and vaginal delivery can be performed without the need for cesarean section.^{15,16} Analysis of 24-year data from Norway in 2021, they revealed that Type 3 FGM/C increased the complications of birth but did not increase the risk of cesarean section. It has been observed that especially opening the adhesions by revising the genital area (deinfubulation) before labor or opening the episiotomy did not decrease the cesarean section rates. Deinfubulation can reduce deep genital lacerations in vaginal delivery.¹⁶

When we examine the results of our study, we see that especially our young patients have milder FGM/C type such as type 1, 2. The legislative measures taken by countries are effective and that radical FGM/C types (type 3) are avoided but it still continues, especially in societies that are not developed socio-culturally. All of our patients had a vaginal delivery. We observed that deep lacerations and sphincter injuries were more common in cases who had only type 3 FGM/C. We found more frequent labor lacerations even in multiparous cases. It should not be ignored that poor healing of iatrogenic or spontaneous incisions in these patients in their previous deliveries increases complications. We can say that all pregnant women with a history of FGM/C do not need for any surgical revisional intervention before labor. They should be followed up in experienced centers in operative delivery.

When we look at the limitations of our study, while it is important that it is retrospective and the number of cases

is low, it can be presented as its advantages that it mentions the harms of FGM/C, which is banned all over the world, and reveals it one by one on a case-by-case basis.

CONCLUSION

Although female genital mutilation has been accepted as a violation and attack against women's rights, it is still a widely used method in many countries. It has been shown once again that FGM/C is a method that completely changes the female vaginal anatomy and has very serious delivery complications. It is obvious that serious educations and studies need to be done in the countries where this method is applied.

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