QUALITATIVE EVIDENCE SYNTHESIS

**Surgical or medical interventions for female genital mutilation**

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**Keywords:** Female genital mutilation; FGM; surgical intervention; deinfibulation; qualitative synthesis; health complications

**Synopsis:** This evidence summary suggests that women may not agree to be deinfibulated, and providers find it difficult to discuss and perform the procedure when required.

**Abstract**

Deinfibulation can prevent or treat gynecological and obstetric complications in women living with Type III female genital mutilation (FGM), and subsequently improve childbirth outcomes. Recently published World Health Organization guidelines recommend use of deinfibulation in both circumstances. However, to really impact practice, evidence-based guidance needs to be matched with evidence-based implementation strategies. This qualitative evidence synthesis provides information on the factors that facilitate or act as barriers to use of deinfibulation , and the context and conditions that are necessary for implementing the procedure, including healthcare providers’ knowledge and experience, the service delivery environment as well as broader health system contexts. This information is of great value for policy makers and others considering this as an option for better clinical care of women living with FGM.

**1. Introduction**

Available evidence highlights the benefits of deinfibulation for improved childbirth outcomes and for preventing or treating obstetric complications in women living with female genital mutilation (FGM), and the recently published World Health Organization guidelines recommends use of deinfibulation in both circumstances.1 These recommendations form the basis of standards and guidelines in countries, and will help a range of healthcare providers in contexts where FGM is prevalent to recognise the importance of deinfibulation and implement it as an essential procedure. Yet to really impact practice, evidence-based guidance needs to be matched with evidence-based implementation, including information about on the ground realities that might affect the feasibility and acceptability of the intervention.2 This is where careful summaries of qualitative evidence can help, by providing information on the factors that facilitate or act as barriers to use of deinfibulation. For example, social acceptability and male partners’ views of deinfibulation are likely to be important influences on uptake as well as women’s ability to cope with the social and physical consequences of the procedure.3 Likewise qualitative research can reveal the conditions that are necessary for implementing interventions, including healthcare providers’ knowledge and experience, the service delivery environment as well as broader health system contexts. This commentary summarises available evidence, from a systematic review of the context and conditions surrounding deinfibulation, which will be valuable for policy makers, healthcare managers and planners considering this option for better clinical care of women with FGM.

**2. Summary of the evidence**

Six studies were included in the qualitative synthesis (more detailed methods in Stein et al.4 All identified studies were conducted in the following high-income countries: France (n=1)5, Norway (n=2)6, 7, Sweden (n=2)8, 9, and the UK (n=1)3, and included immigrant women and healthcare providers as participants. Two studies specifically explored women’s experience of deinfibulation, three explored healthcare providers’ experiences of caring for women with FGM during pregnancy and childbirth, and in one the focus was on women’s motivations for clitoral repair.

**3. Context and conditions of implementation**

3.1. Women’s experiences of deinfibulation

Somali and Eritrean women attending a clinic in London seemed disconcerted by and disliked the appearance of their genitalia post-deinfibulation.3 Women described being discontent with the new appearance, describing how they had “got used to what it was before” and following the procedure it was “like an empty place.” Another woman elaborated that, “I think it looks funny and it looks better if it is closed and like this does not look nice. I do not know. It does not look good and I do not feel comfortable with the look of it. Now even the color has changed. Before it was all black but now is pretty much pink.”3

Evidence from several high-income contexts indicates immigrant women do not wish to or do not request to be reinfibulated. Women living in Sweden described how reinfibulation was the norm in their home country, with most women having experienced it after childbirth at least once or twice.8 But living in Sweden women felt differently, opting to “remain open” instead. One woman’s experience illustrates this quite clearly: “I was re-sewed after my first and second child-birth as no one left open and this was normal. But after my third childbirth in Sweden I decided to leave open because I knew that I had the right to do that. In my country all women are circumcised. Therefore no-one feels different and they never think about what would happen.”8 In a study of Somali women living in Norway, most women were opposed to any reinfibulation,7 and in the UK study women expressed a range of views about the prospect of reinfibulation: one requested it but was turned down, others stated they did not wish to be “closed up” again, and those in favor believed that reinfibulation could correct incontinence or was necessary after multiple pregnancies and births.3

In four studies women described being fearful that providers lacked experience dealing with FGM,6,7,8,9 which seemed to heighten their anxiety and put “women under strain and induce fear.”7 Specifically, women expressed fear of not receiving adequate care during delivery due to providers’ lack of experience dealing with infibulation,7 and feeling uncertain and anxious when meeting midwives or doctors without knowledge of FGM.8

3.2. Providers’ experiences of deinfibulation

According to studies conducted with healthcare providers in Norway6, 7 and Sweden,9 providers lack knowledge of deinfibulation and are uncertain how to carry out the procedure. Midwives and obstetricians had different ideas about how to deliver women with FGM. Where, when, and how to perform deinfibulation were unresolved questions for many practitioners in Norway,7 and in Sweden findings indicate little consensus on good care for infibulated women and reliance on personal knowledge and experience rather than scientific evidence.9 This lack of knowledge and disempowerment among providers seemed to promote a variety of solutions for managing childbirth for women with FGM. For example, in some cases cesarean deliveries are performed,6,7 or multiple episiotomies are used to avoid deinfibulation because there is “familiarity with the procedure”: as one midwife put it: “I think I do it [episiotomies rather than deinfibulation] because that’s what I am used to doing.”6 In Sweden the uncertainty around how to conduct deinfibulation prompted “improvisation” and advocacy of deinfibulation at various time points without clear rationale or consensus.9

Consistent with lack of knowledge and capacity to perform deinfibulation, healthcare providers in two studies conducted in Norway described avoiding the procedure.6,7 In one study, providers did not consider it necessary to check if the woman needed to be deinfibulated as this was deemed “too intrusive,” nor did they consider women’s preferences for deinfibulation.7 In both studies, midwives and healthcare workers (gynecologists, general practitioners, and nurses) considered deinfibulation as “difficult or risky”7 and a “technically difficult or impossible” procedure.6 As a result, healthcare providers described avoiding the procedure. Even though national guidelines indicate deinfibulation as an essential procedure, and the new WHO guidelines recommend it, the views of healthcare providers in one study did not accord with this—most appeared resistant to cutting infibulated women.6 The most frequently reported reason healthcare workers gave for avoidance was to provide “culturally sensitive care.”6 In their desire to respect women’s cultural integrity, health workers were concerned about preserving their infibulations, avoiding any cutting assuming this is what women also wanted; on the contrary, Somali women in the study feared not being cut.6

Healthcare workers in Norway and Sweden described the experience of delivering women with FGM as “chaotic” and sometimes “out of control.”6,7,9 Midwives in Norway said they experienced higher levels of fear and pain among the Somali women, saying there is “always some problem,” the deliveries are “always more chaotic,”7 and in their view Somali women are “more expressive in labor and show pain much more.”6 In Sweden, doctors explained the difficulty they faced in assessing progress of labor in women with FGM, and the inability to use common technological aids for fetal monitoring.9 Because of this “lack of control,” doctors seemed to choose to be more expectant than proactive in management of deliveries.9

3.3. Health system and service context

Two studies conducted in Norway and Sweden seemed to suggest a lack of clarity in the care continuum for women with FGM. There was evidence of a lack of communication between outpatient clinics and hospital departments leading to providers’ poor management and care of women with FGM. For example, the study in Norway revealed how outpatient clinic personnel considered it to be the duty of the hospital staff to discuss deinfibulation, but the hospital staff considered it to be part of the prenatal care program: “The women come here to deliver their child and not to discuss circumcision. Our job is to attend the delivery. You can't discuss with a woman when she is in labor pain.”7 Similarly, in the study conducted with Swedish doctors, poor communication and coordination of responsibilities in the care of women with FGM through the trajectory between prenatal, labor, and delivery departments led to less than optimal care for women.9 For example, doctors were unaware of policies to identify women with FGM, there was no consensus of when and how women should be informed of procedures during labor and delivery or what information was important, or an agreement on how information was best conveyed between prenatal care and hospital departments.9

In addition to problems with continuity of care, poor communication also affected women’s experience of care in maternity services. The included studies show that providers in high-income countries are unprepared and lack capacity to talk with women about FGM. Two studies of healthcare workers’ and women’s experiences of care at the time of birth in Norway highlighted that the issue of deinfibulation, the procedure, and the need for intervention were not discussed at all with women,6,7 even though women said they expected healthcare professionals to talk about their FGM during prenatal care.7 One study described this as a “deafening silence” that deprived both health workers of the chance to obtain vital information about the needs and fears of women, and women of the opportunity to better understand their own situation, care procedures, and options.6 In a further study, Swedish doctors expressed “frustration” at women’s lack of compliance with “doctor’s orders,” emphasizing the importance of communicating with men to ensure compliance.9 In these studies, healthcare workers either expressed a desire for “communicative training” to help them to initiate discussions with women7 or, conversely, seemed to blame women’s “language difficulties” and “level of understanding” for taking up too much time in an already time-constrained care context.9

**4. Conclusion**

The barriers identified in this review may have implications for the adoption of deinfibulation, despite its recommendation in the new WHO guidelines. The evidence summarized here suggests that women may not be willing to be deinfibulated owing to concern about physical appearance following the procedure, as well as the social unacceptability of the procedure and fear that providers do not have adequate skills or experience to perform it. At the same time, it may be difficult to get providers, who lack knowledge and skills and who admit to avoiding the procedure, to actually perform it when required.

However, the evidence is derived from studies conducted with migrant populations in high-income countries only. Only one of the six included studies related specifically to women’s experiences of deinfibulation and this included women who had undergone the procedure for any reason not just in pregnancy or during labor or childbirth; other studies tended to touch upon deinfibulation as part of a broader focus on care received during childbirth. The evidence suggests immigrant women giving birth in an unfamiliar environment—where providers are not confident about caring for women, discussing the options, or carrying out deinfibulation—fear they will not receive adequate care and this heightens their anxiety. For these reasons women may feel disconcerted and extra care may be needed. There is a gap in knowledge and understanding of women’s experience of deinfibulation, including acceptability, preferences in relation to when the procedure is done, and their feelings about the outcomes and reinfibulation. In addition, further research on male partners’ views and knowledge of deinfibulation may help to better understand the barriers or factors that may promote uptake of the procedure.

The three studies that include healthcare workers practicing in high-income settings provide some evidence of a lack of knowledge among health workers regarding deinfibulation. This is not only an important reason why providers may avoid performing deinfibulation, and experience a lack of control when delivering women with FGM, but it also affects women who describe feeling fearful of the providers’ inexperience. In such contexts, adequate healthcare provider training in conducting the surgical procedure is crucial. The evidence also suggests that in high-income settings where FGM cases are unusual, poor communication between providers and women and lack of responsibility in the care continuum are barriers to identifying women who need deinfibulation and being able to perform the procedure at a time that is acceptable to the woman. In such contexts it is important that clear referral is established and roles and responsibilities of healthcare providers are defined from the prenatal to postnatal period. There are research gaps in relation to the content of existing training programs on FGM and deinfibulation for healthcare providers, as well as a need to clarify provider knowledge and experience of caring for women with FGM during labor and childbirth, and skills in carrying out deinfibulation.

Deinfibulation is performed to facilitate childbirth and reduce risk of obstetric complications in women with Type III FGM; women often request it or at least expect to discuss the options. However, it is critical that healthcare providers are adequately trained to discuss, offer, and to carry out this surgical procedure as an option for managing women with Type III FGM during childbirth.

**Contributions**

HS designed the qualitative synthesis, led the data extraction, analysis and interpretation of the data and wrote the manuscript. KS contributed to data extraction, analysis and interpretation of data and commented on drafts of the manuscript.

**Acknowledgments**

This review was commissioned and funded by the World Health Organization, Department of Reproductive Health and Research. We thank Michelle Hindin for providing editorial support.

**Conflict of interest**

The authors declare that they have no conflict of interest.

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