Case Report

Transcultural Influence on Female Genital Mutilation Done in Late Pregnancy: A Case Report

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Abstract

A complicated case of female genital mutilation (FGM) type 2b done in late-pregnancy is presented and the interplay of Yoruba and Kwale culture, in this case, is discussed. A Yoruba who grew up among Kwales/Urhobos had FGM at 38 weeks and 4 days gestation (to assure vaginal delivery) and presented with vulvar hematoma, septicemia, obstructed labor, and a distressed fetus. 5 days after FGM procedure, she had an emergency cesarean section (EmCS), repair of FGM site and baby was admitted in special care. There was the obvious synergy of the Yoruba culture of FGM in infancy and Kwale/Urhobo culture of FGM in pregnancy. The patient and her fetus/baby almost became mortalities but for prompt intervention. The role of sociocultural factors in the practice of FGM is recommended to be further investigated as FGM even in educated women and at the dangerous stage of term pregnancy is still prevalent.

Keywords: *Complications, culture, FGM, pregnancy, rights*

Introduction

Female genital mutilation (FGM) is a sociocultural practice in Africa, Asia, and clandestinely in Europe and America. It has no medical or psycho-sexual benefit.[1,2] FGM is "partial or total removal or other injury to the" external "female genital organs for cultural or other nontherapeutic reasons."[3] Two million girls and women suffer this practice yearly with attendant complications.[4]

FGM in adulthood and in pregnancy is practiced among the Urhobo/Kwale in Nigeria.[5] The Yoruba's perform FGM in childhood. To the best of our knowledge, there is no previous case report on FGM done in pregnancy. Those who practice FGM in pregnancy believe it prevents the death of male fetuses and opens the birth canal.[5,6] A case of FGM done at 38 weeks and four days with complications is presented.

Case History

In November 2017, Mrs. MS, a 22-year-old farmer, Yoruba, Muslim with secondary school education at 39 weeks and 2 days gestation presented with vulva pain/swelling, labor pains, and malodorous liquor drainage. Her last menstrual period was 1 February 2017. She grew up in Delta state and was the third wife in a second marriage to a Yoruba Muslim farmer. Only previous delivery was via cesarean section 2 years earlier in Owo. Care in index pregnancy was by a traditional birth attendant in Owo. She returned to Usen, Edo state, to be with her husband and have FGM done "to facilitate vaginal delivery."

Her problems started when FGM was performed at 38 weeks and 4 days gestation by a traditional provider at Usen after pressures from her husband, mother-in-law (Yorubas/Muslims) and her mother, (Kwale/Christian) married to a Yoruba Muslim. Relatives told her she couldn't deliver vaginally previously because she was "uncircumcised." FGM was done in an unsterile environment, with no anesthesia, excruciating pain, and significant blood loss. She developed marked vulva swelling with severe pains a day after FGM. Fever started 3 days after FGM

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and progressively worsened. She developed labor pains 4 days after FGM and later foul smelling liquor drainage (2 days prior to presentation). The patient presented to our hospital 5 days after FGM.

At presentation at our center, she was febrile (38.8°C), pale, dehydrated (dry lips and tongue), pulse 120 beats per minute, and blood pressure 120/80 mmHg. The abdomen had a Pfannenstiel scar with a distressed fetus in a longitudinal lie, two moderate uterine contractions in 10 min lasting 30 s and fetal heart rate 178 beats per minute. The vulva was markedly swollen on the left side with a 10 × 8 cm hematoma obscuring the introitus making cervical assessment difficult with excruciating pain and discomfort. Liquor was malodorous with fresh meconium. The clitoris and two-thirds of the labia minora had been removed. We assessed her FGM to be of type 2b [Figure 1]. Clinical diagnosis of obstructed labor with fetal distress, chorioamnionitis, and vulva hematoma secondary to FGM in a woman with a previous CS scar was made. She was counseled on the need to have an emergency Cesarean section (EmCS) for obstructed labor with fetal distress, and evacuation of hematoma and repair of FGM site. She consented in writing.

Her hemoglobin concentration was 9 g/dL, granulocytosis of 75%, and she was HIV I and II seronegative. Random blood sugar was 73 mg/dL, electrolyte urea and creatinine were within normal values.

She was rehydrated, had broad-spectrum antibiotics (ceftriaxone, gentamycin and metronidazole), tetanus toxoid, and anti-tetanus serum. She had EmCS, evacuation of hematoma (150 mL), and repair of broken down FGM site [Figure 2]. At delivery, the baby had direct suctioning of the larynx and mouth under direct vision with the aid of a laryngoscope before being allowed to take the first breath. A 2.9 kg male neonate with moderate birth asphyxia was delivered. Total blood loss including hematoma was 700 mL. Subsequently, vulva wounds healed well [Figure 3]. She had 10 days of antibiotics and cleansing with antiseptics. The patient received detailed counseling on the fact that FGM was a legally banned and prosecutable cultural practice with no benefit. She understood the fact that her allowing FGM to be done on her almost cost her life and that of the baby.

The baby was admitted for neonatal care at birth, managed for meconium aspiration syndrome, hypoxic-ischemic encephalopathy, and neonatal sepsis and was discharged with mother after 16 days. At discharge, the patient's written consent for publication of her case and use of the pictures without her identification was sought and received after counseling. She was advised to be an ambassador against the continued practice of FGM.

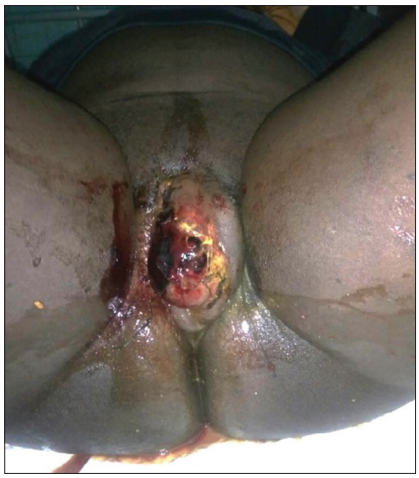

Figure 1: Mrs. MS at presentation (at 39 weeks and 2 days) before the intervention. Previous Pfannenstiel scar can be noticed. Type 2b FGM site with obvious hematoma, broken down site with loose stitch, and liquor drainage (foul smelling) can be seen

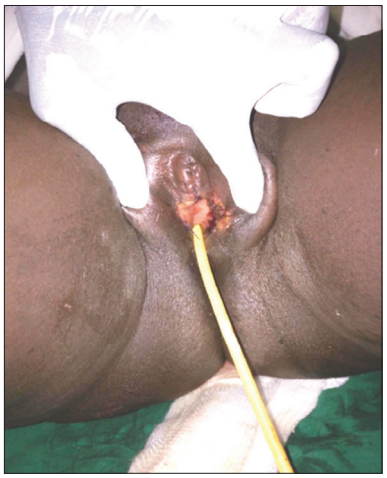

Figure 2: Mrs. MS, first-day post-emergency cesarean section and hematoma evacuation. Note absence of clitoris and lower 2-3rds of labia minora

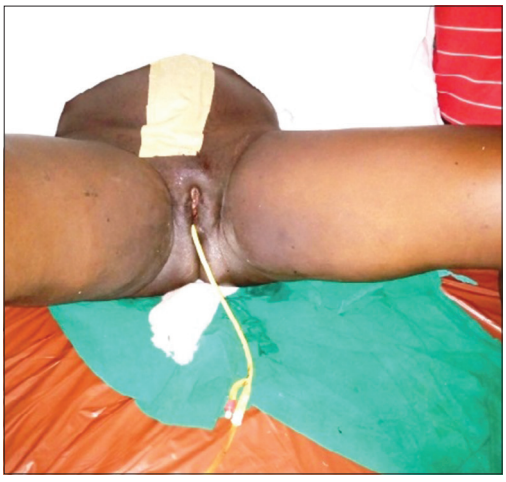

Figure 3: Mrs. MS, 3 days post-female genital mutilation repair

Discussion

The practice of FGM is condemned by the United Nations and WHO.[3,7] It is a violation of the rights of women.[1,5,8] Legislation alone against FGM appears not to be enough to stop the practice.[2] Beyond legislation, more needs to be done.

FGM can result in severe complications.[5] FGM has medical, psychological, psychosexual, and social consequences for survivors.[1,2,3,8] Complications include hemorrhage, shock, septicemia, tetanus, injury to the vulva and perineal structures, and death.[2,4] FGM is a notable risk in HIV and hepatitis B transmission.[5]

Education and empowerment are assumed key strategies in stopping FGM.[5] However, the highest FGM incidence in Nigeria is observed in the South-West and South-East regions with better education and female empowerment.[5] It appears, therefore, that researchers must dig deeper to unearth the sociocultural issues that impact negatively on halting the practice of FGM.

Nigerian ethnicities perform FGM at various stages: Yoruba during childhood, Urhobo/Kwale in adulthood and pregnancy (mainly first), believing it widens the birth canal and prevents male child death from head touching mother's clitoris (hence "circumcision" before delivery).[5,6] Other "justifications" for FGM are prevention of promiscuity, virginity preservation, a cultural rite of passage to womanhood, enhancing marriage prospects, hygiene, and fertility.[3,5] These are myths.

We presented a case report highlighting the synergy of different cultures on reenforcing the practice of FGM resulting in a near-death situation. We believe this case report on a woman who had escaped FGM as a child had secondary school education but, however, finally had FGM done as a married adult at the dangerous stage of term pregnancy will contribute to the discourse of FGM and the role of culture in its perpetuation.

Mrs. MS had type 2b FGM with the whole of the clitoris and 2/3rds of the labia minora removed.[3] FGM in pregnancy has associated complications.[5,8] Mrs. MS suffered immediate complications of hemorrhage, sepsis, chorioamnionitis, fetal distress, and need for urgent surgical interventions. The situation could have been fatal for the mother and fetus (baby).[3,5,6]

Mrs. MS was Yoruba, mother was Kwale, and she grew up among the Kwale/Urhobos. She was told her failure to deliver vaginally previously was due to being "uncircumcised." The Yoruba culture upholds FGM for girls, even when missed in infancy, and the Urhobo/Kwale's practice FGM in adulthood and pregnancy. The combination of these two traditions left little room for escaping FGM, due to the power and influence of culture and tradition.

It would have been assumed that Mrs. MS, having escaped FGM in childhood as a Yoruba, and not married to a man from tribes that perform FGM in adulthood and pregnancy, had escaped this practice. However, this was not the case. Her Yoruba culture and upbringing among the Kwale/Urhobos made it "acceptable" for FGM to be performed in late pregnancy. The synergy of these two "distinct cultural" dispositions toward FGM resulted in an unexpected case of FGM, with grievous consequences to the woman and her child.

Despite laws against FGM in Nigeria,[9,10] Mrs. MS did not know FGM was illegal, and dangerous in late pregnancy. The immediate health complications of FGM performed in late pregnancy were evident and these could have resulted in the death of the pregnant woman and her fetus/baby.

Health care providers should be ready to meet the challenges consequent to FGM. The media and legal authorities must enlighten the population about laws against FGM and its various and grievous consequences.[9,10] Mrs. MS and her baby "lived to tell the story" in the future. It may not be so for the next victim.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given her consent for her images and other clinical information to be reported in the journal. The patient understands that her names and initials will not be published and due efforts will be made to conceal her identity, but anonymity cannot be guaranteed.

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Nil.

Conflicts of interest

Dr. Sodje JDK is a consultant and facilitator to Marie Stopes International Organization, Nigeria, Population Services International, Nigeria and Society for Family Health, Nigeria, organizations that may be involved in the fight against FGM. Dr. Ilevbare FO has no conflicts of interest to declare.

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