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Type III Female Genital Mutilation and Obstetric Complications: A Case Report and Literature Review

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Abstract | **Case Report**

Female genital mutilation (FGM) constitutes a harmful traditional practice representing both a major global public health issue and a serious violation of fundamental human rights. According to recent epidemiological data, more than 230 million girls and women are affected worldwide, with prevalence concentrated primarily in sub-Saharan Africa, the Middle East, and Southeast Asia. The practice is most often perpetrated before the age of 15 years, thereby exposing minors to medical risks without the possibility of informed consent. From a nosological perspective, FGM is defined as all non-medically indicated procedures resulting in partial or total alteration of the female external genitalia. The World Health Organization distinguishes four distinct anatomoclinical types, none of which presents demonstrated therapeutic benefit. Regarding complications, FGM is associated with an extensive spectrum of lesions including acute complications severe pain, hemorrhage, and infections as well as chronic sequelae including uro-gynecological disorders, obstetric complications, increased neonatal mortality, and long-term psychological repercussions. The persistence of this practice is explained by a complex set of sociocultural determinants, including the weight of social norms, community pressures, mechanisms of female sexuality control, and persistent erroneous beliefs. Furthermore, the growing phenomenon of medicalization of FGM consisting of entrusting its performance to healthcare professionals does not reduce the inherent risks of the practice and, on the contrary, contributes to its social and institutional legitimization, thus constituting an additional obstacle to eradication efforts. Given these challenges, an effective prevention strategy requires a multidimensional and intersectoral approach, articulating community awareness interventions, strengthening national and international legal frameworks, as well as holistic and integrated care for affected individuals, including somatic, psychological, and social dimensions.

Keywords: Female Genital Mutilation; Infibulation; Obstetrical Complications; Cesarean Section; Defibulation; Case Report.

INTRODUCTION

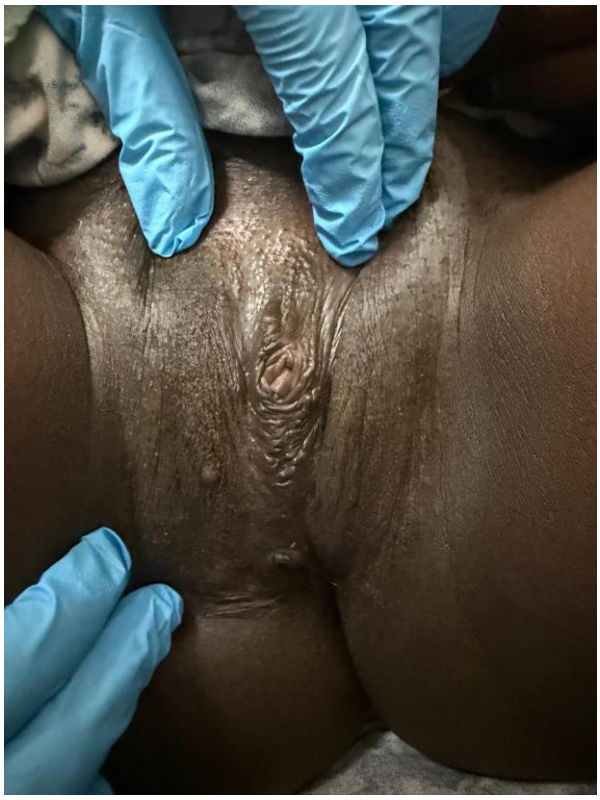
Female genital mutilation (FGM) constitutes a major global public health problem, affecting more than 230 million women. Severe forms, particularly type III infibulation, are associated with significant obstetric complications, including increased recourse to cesarean section.

PATIENT AND OBSERVATION

A 27-year-old patient, G2P1, with no notable medical or surgical history, originally from Sudan and residing in Morocco for two months, presented with type III female genital mutilation performed at age 9 without consent in a non-medicalized setting. Her obstetric history included a vaginal delivery following deinfibulation, followed by reinfibulation.

Admitted at 39 weeks of amenorrhea in spontaneous labor with an unmonitored pregnancy, clinical examination revealed type III FGM with major reduction of the vulvar orifice due to labial adhesion and clitoral excision. The initial obstetric evolution was favorable, with an engaged cephalic presentation and reassuring fetal heart rate. Given the patient's categorical refusal of any deinfibulation and vaginal delivery, a

decision for cesarean section was made in agreement with the obstetric team. The procedure proceeded without complications, with the birth of a living female newborn weighing 3100 grams, with an Apgar score of 10/10 at one minute. The postoperative course was uneventful.



Type III female genital mutilation (infibulation): characteristic anatomical features including labial fusion, clitoral excision, and severe narrowing of the vaginal introitus

DISCUSSION

Female genital mutilation (FGM) refers to a set of traditional practices consisting of partial or total removal of the female external genitalia, or any other alteration of these structures in the absence of medical indication. They constitute a major global public health issue due to their multiple consequences, particularly physical, obstetric, psychological, and social [1,2].

Classification and Diagnostic Limitations

According to the classification proposed by the World Health Organization (WHO), female genital mutilation is divided into four categories. Type I corresponds to partial or total removal of the clitoris; type II combines excision of the clitoris and labia minora; type III infibulation is characterized by narrowing of the vaginal orifice by suturing the labia; while type IV includes all other harmful practices [1]. Our patient presented with type III FGM, the most severe form, associated with the most significant obstetric complications in the literature.

This classification nevertheless presents limitations in clinical practice. Some patients undergo successive anatomical modifications during their lifetime, such as deinfibulation procedures followed by reinfibulation a situation precisely reported in our observation. These transformations can complicate precise classification during clinical examination and constitute a potential source of bias in studies evaluating obstetric outcomes [3].

Anatomical Consequences and Immediate Complications

The clitoris is a highly vascularized and richly innervated organ, composed of erectile structures formed by cavernous bodies. The labia minora contain spongy structures the vestibular bulbs that participate in sexual response. The clitoral glans contains specialized sensory receptors, notably Krause-Finger corpuscles, involved in erogenous sensitivity. Furthermore, Bartholin's glands ensure lubrication of the genital tract.

Damage to these structures during FGM results in major functional consequences. Immediate complications include severe acute pain that may be accompanied by shock, accidental lesions of adjacent anatomical structures, sometimes severe hemorrhages threatening vital prognosis, as well as urinary disorders such as burning on micturition or reflex urinary retention [11].

Procedure Implementation

FGM is most often performed by mature women, commonly called "excisers," without medical training, their knowledge being transmitted traditionally. The instruments used are rudimentary and non-sterile. The procedure is performed without anesthesia and in the absence of aseptic conditions, exposing children to increased risk of infectious and functional complications [2,4]. Our patient underwent this procedure at age 9, without consent and in a non-medicalized setting, which illustrates the particular vulnerability of minors in this context.

Sociocultural and Religious Dimensions

FGM is frequently, but incorrectly, associated with certain religions, particularly Islam. The scientific literature clearly indicates that no religion prescribes these practices. Their maintenance relies primarily on cultural, social, and community determinants, including representations related to purity, femininity, sexuality, as well as social and matrimonial integration [5]. The distribution of types varies by region: the most severe forms, particularly type III, are more frequently observed in East Africa, which corresponds to the profile of our patient from Sudan [9].

Impact on Pregnancy and Childbirth

The impact of FGM on obstetric outcomes constitutes a major issue. Type III FGM may lead to mechanical complications during childbirth: narrowing of the vulvar orifice can hinder clinical examination, complicate labor monitoring, and impede fetal descent, leading to situations of dystocia, increased risk of severe perineal tears, and more frequent recourse to episiotomy or cesarean section. Some studies nevertheless suggest that FGM is not systematically associated with significant prolongation of labor duration, although these results must be interpreted with caution due to methodological variations between studies [3,7].

Factors Influencing Obstetric Complications

Beyond anatomical modifications, several factors modulate obstetric outcomes. Maternal factors age, parity, gravidity play a determining role, with primiparous women presenting increased risk of complications independent of FGM. Metabolic factors, such as gestational diabetes, may indirectly increase recourse to cesarean section in cases of fetal macrosomia. Finally, insufficient prenatal monitoring as in our observation limits anticipation of complications and planning of scheduled deinfibulation, thus constituting an independent aggravating factor [7].

Mode of Delivery and Recourse to Cesarean Section

The literature reports an overall increase in cesarean section rates among women who have undergone FGM, particularly for types II and III [7]. This increase cannot be explained solely by strict medical indications. As illustrated by our case, the patient's categorical refusal of any deinfibulation and vaginal delivery may itself constitute the primary indication for cesarean section, independent of any objective mechanical obstacle. Other explanatory factors are proposed in the literature: difficulties in clinical evaluation, healthcare provider apprehension, absence of standardized protocols, and organizational constraints [7].

Psychological Dimension

The psychological impact of FGM on the childbirth experience is often underestimated. Affected women may present significant anxiety related to previous traumatic experience, with childbirth being perceived as a reactivation of initial pain. This mechanism directly influences their behaviors and choices, particularly refusal of certain interventions or preference for cesarean section an attitude observed in our patient [6]. Some studies suggest that adapted psycho-educational support during the prenatal period could contribute to reducing this risk, emphasizing the importance of integrated care from the first trimester [10].

Management and Deinfibulation

Excision constitutes an irreversible procedure. Nevertheless, in cases of infibulation, deinfibulation can significantly reduce functional consequences: menstrual pain, urinary disorders, recurrent urinary infections, dyspareunia, and obstetric complications [12]. It can be performed during the prenatal period or during labor. Recourse to cesarean section is not systematic in infibulated women; vaginal delivery is generally possible after appropriate deinfibulation. However, as in our observation, the patient's refusal must be respected within the framework of an approach centered on her autonomy and informed consent.

Management must be comprehensive, individualized, and culturally adapted, based on early screening during prenatal follow-up, clear information on therapeutic options, respect for consent, adequate training of healthcare professionals, and a multidisciplinary approach integrating medical, psychological, and social dimensions [9].

Synthesis

Our observation illustrates the complexity of obstetric management of women with type III FGM in a migratory context, marked by absence of prenatal follow-up, refusal of deinfibulation, and the psychological dimension of traumatic experience. It underscores the necessity of specific training for obstetric teams, systematic prenatal screening, and a multidisciplinary approach capable of articulating medical imperatives, respect for autonomy, and cultural sensitivity. Given the increasing prevalence of FGM in migrant populations in Morocco, these issues call for the development of standardized management protocols adapted to local realities.

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