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Mini Review

Female Genital Mutilation: The Next Cut!

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Abstract

Female genital mutilation/cutting (FGM/C) remains a significant global health and human rights issue, affecting over 230 million women and girls worldwide as of 2024. The management of childbirth in women with FGM/C presents complex clinical and ethical challenges, particularly regarding the choice between episiotomy and caesarean section-the so-called "next cut". This manuscript critically examines the latest prevalence data, clinical outcomes, and ethical arguments, advocating for a patient-centred, rights-based approach that respects autonomy, minimises harm, and ensures justice and equity in care.

Keywords: *Female Genital Mutilation/Cutting (FGM/C); Next Cut; Equity in Care*

Introduction

FGM/C is a deeply entrenched practice, now documented in at least 94 countries, with the highest prevalence in Somalia (99%), Guinea (96%), and Djibouti (90%) [1]. Despite international condemnation, the number of affected women and girls has increased by 15% since 2016, now exceeding 230 million globally [2]. FGM/C is associated with significant obstetric complications, including obstructed labour, perineal trauma, and increased rates of emergency caesarean section [3]. The clinical decision between episiotomy and caesarean section in this population is fraught with ethical complexity, demanding a nuanced, evidence-based approach.

Recent statistics on FGM/C and childbirth outcomes

- **Prevalence:** Over 230 million women and girls have undergone FGM/C globally as of 2024, with 144 million in Africa, 80 million in Asia, and 6 million in the Middle East [1,2].
- **Childbirth complications:** Women with FGM/C are more than twice as likely to experience prolonged or obstructed labour, haemorrhage, and are significantly more likely to require emergency caesarean section or forceps delivery. They also have a 4.4 times higher risk of post-traumatic stress disorder and a threefold increased risk of depression or anxiety [3].
- **Global trends:** The overall proportion of women experiencing FGM/C is declining, but absolute numbers are rising due to population growth in practising regions [4].

Clinical outcomes: Episiotomy versus caesarean section

Episiotomy

- **Indications:** Traditionally used to expedite vaginal delivery in cases of fetal distress, instrumental delivery, or to prevent severe perineal tearing. However, routine use has been abandoned in favour of restrictive, clinically indicated use [5,6].
- **Risks:** Episiotomy in women with FGM/C, especially those with extensive scarring (Type III), may result in severe perineal trauma, infection, and prolonged recovery. Evidence suggests that selective episiotomy reduces the risk of severe perineal trauma compared to routine use [6].
- **Patient experience:** Many women report inadequate information and a lack of genuine choice regarding episiotomy, often perceiving the procedure as distressing and disempowering [7].

Caesarean section

- **Indications:** Often considered when vaginal delivery is unsafe due to extensive scarring, obstructed labour, or patient preference to avoid further genital trauma [8].
- **Risks:** Caesarean section is associated with increased maternal morbidity, longer recovery, and potential complications in future pregnancies. However, it may be the safest option in certain clinical scenarios, particularly in women with severe FGM/C [9].
- **Patient autonomy:** Respecting a woman's informed request for caesarean section is ethically imperative, even when not medically indicated, provided she is competent and fully informed [10].

Ethical arguments

1. **Autonomy:** Respect for autonomy is central. Women must be provided with comprehensive, unbiased information about the risks and benefits of both episiotomy and caesarean section. Consent must be informed, voluntary, and revisited as labour progresses [11,12]. The unique challenges of labour, including pain and time pressure, can compromise volitional consent, making antenatal education and planning essential [7].
2. **Nonmaleficence:** Both interventions carry risks. Episiotomy, especially in scarred tissue, may cause more harm than benefit, while caesarean section introduces surgical risks. The principle of "do no harm" requires clinicians to carefully weigh which intervention minimises harm in each individual case, guided by the latest evidence and clinical guidelines [5,13].
3. **Beneficence:** Healthcare providers must act in the best interests of both mother and child, prioritising safety and well-being. This includes addressing physical and psychological complications, providing culturally sensitive counselling, and supporting women's choices [14].
4. **Justice:** Justice demands equitable access to high-quality, culturally competent care. Women with FGM/C may face stigma or inadequate treatment due to lack of provider training or systemic biases. Ensuring that all women receive respectful, evidence-based care is a matter of ethical and social justice [15].

The debate: Individualised, evidence-based, and rights-focused care

- **Episiotomy:** Should be reserved for clear clinical indications, with explicit, informed consent. Routine use is not supported by evidence and may constitute obstetric violence if performed without consent [12].
- **Caesarean section:** Should be available as an option, particularly for women with severe FGM/C or those who request it after being fully informed. Denying a competent woman's request for caesarean section undermines her autonomy and may perpetuate harm [10].
- **Shared decision-making:** Antenatal education, multidisciplinary care, and shared decision-making are essential to ensure that women's preferences are respected and that interventions are tailored to individual needs and values [11].

Recommendations

1. **Comprehensive antenatal counselling:** Provide detailed information on childbirth options, risks, and benefits, tailored to women with FGM/C.
2. **Individualised care plans:** Develop delivery plans that respect women's preferences and clinical needs.
3. **Provider training:** Implement training programmes on FGM/C management, cultural competence, and ethical decision-making [14].
4. **Policy and advocacy:** Support the development and enforcement of guidelines that standardise care while allowing flexibility for patient-centred decision-making [14].

Conclusion

The "next cut" at childbirth for women affected by FGM/C is not merely a clinical decision but an ethical one, demanding a nuanced balance between autonomy, harm reduction, beneficence, and justice. High-quality, respectful, and equitable maternity care is a fundamental human right. Empowering women with information and choice, while supporting clinicians with evidence-based guidelines and training, is essential for ethical and effective obstetric practice.

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