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Original Research Article

Female Genital Mutilation (FGM), Cultural Challenges and Complications during Delivery at Omdurman Maternity Hospital (OMH), Sudan 2015

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Objective: **To determine the prevalence, socio-cultural factors behind the persistence of FGM and its associated complications during labour among primigravidae at Omdurman maternity hospital (OMH), Sudan, during 2015.** ***Methodology:*** **A descriptive study, conducted at OMH, for primigravidae delivered during 2015. After an informed consent, circumcised women, delivered vaginally, were included for the study and uncircumcised were the control. Data was collected by trained data collectors and resident registrars using a structured format.** ***Results*****: A total of 2434 primigravidae, delivered vaginally during 2015 at OMH were studied, 791 (32.5%) were circumcised and 1643 (67.5%) were uncircumcised. Out of the circumcised women, 570 (72.1%) were type II, 190 (24.0%) type I and only 031 (03.9%) were type III (infibulated). Characteristics of the second stage of labour were compared between the two, where women with FGM were significantly affected. They differ significantly in duration of second stage, PPH, Perineal tear, birth asphyxia, neonatal death and hospital stay (P.V = 0.004, 0.003, 0.002, 0.006, 0.003 and 0.005 respectively). There was no significant difference in the mode of delivery.** ***Conclusion*****: Persistence of FGM is due to many socio-cultural reasons deeply rooted in the community. There is a significant reduction in the rate of FGM and shifting from severe to the milder types. However, FGM places women at a greater risk during childbirth, endangering their health and their babies compared to uncircumcised.**

Keywords: Female Genital Mutilation, Cultural challenges, Delivery, Sudan.

INTRODUCTION

Female genital mutilation (FGM), Female genital cutting (FGC) or female circumcision (FC) referred to the partial or total removal of the female external genitalia for cultural, social and non-therapeutic reasons (1). Clitoridectomy, removal of clitoral hood, is type I, excision of the clitoris with partial or total excision of labia minora and or majora is type II and Infibulation, the most severe, removal of external genitalia, stitching and narrowing of the vaginal opening is type III (1). It is a cultural, social tradition, not related to religion, practiced without informed consent on young girls for many socio-cultural reasons, including eligibility for marriage, acceptability and respect in the society, honor of the family, preserving virginity and preventing premarital intercourse. It is thought to enhance beauty, cleanness and male partner sexual pleasure.

FGM is physically invasive, emotionally damaging and associated with serious complications affecting the reproductive health of women. Immediate complications are haemorrhage, pain, shock, acute retention of urine, localized infection, abscess formation, septicemia, tetanus, damage to adjacent organs and psychological trauma. Late gynecological complications include hepatitis, human immunodeficiency virus (HIV), pelvic inflammatory disease (PID), chronic pelvic pain, scar formation, inclusion cyst, vesical stone, chronic urinary tract infection, dysmenorrhea, infertility, difficult first intercourse, vaginal laceration during sexual intercourse, dyspareunia, sexual dysfunction, difficulty during gynecological or obstetrical examination, difficult or obstructed labour, perineal tear and vesicovaginal fistula (2,3).

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An estimated, 100-140 million girls or women, all over the world and 91.5 million in Africa alone, are subjected to FGM and at least two million a year are at risk of mutilation. It is practiced in more than 28 African countries, mainly in the sub-Saharan region including Sudan, some nations in Asia, Middle East, Arab region and among immigrants in North America and Europe (4, 5). Despite efforts to abolish FGM, approximately, two million girls in Africa are at risk of being subjected to FGM each year (6).

In Sudan, FGM is widely practiced with different variations between the states. Sudan is the first African country to outlaw FGM since1924, where type III was prohibited under the 1925 penal code, while less severe forms were ignored (7). After 1970, there were increased efforts from many governmental, non-governmental and civil societies to abolish FGM. There is limited literature on the effect of FGM on labour apart from a study done by WHO collaborative group in six African countries 2006 (8).

Available data in Sudan are mainly from surveys, including many illiterate old women with recall bias. No particular data on young generations particularly during labour. This study targeted primigravidae during labour, with the utilization of registrar's knowledge for determining type of FGM to assess the impact of FGM on labour.

MATERIAL AND METHODS

In this descriptive cross-sectional study, for determining complications of FGM during labour, all primigravidae with term, singleton pregnancy, delivered at OMH, were included after an informed consent. Ethical approval was obtained from ethical review committee (ERC) at OMH. On admission to labour ward, each woman was examined by a trained resident registrar, who determined her state of circumcision and its severity, according to WHO classification and to exclude the presence of massive scarring or inclusion cyst. Vaginal examination was conducted after an informed consent was obtained from all women under study during the first and second stage of labour.

Participants were interviewed after delivery by trained interviewers for socio-cultural characteristics and they were examined by resident registrars for confirmation of episiotomy and recircumcision and followed until discharged from the hospital. Studied variables include socio-demographic characteristics, circumcision among sisters, attitude towards abolition of FGM, difficulties during first coitus, dyspareunia, vaginal examination, and type of FGM and maternal and fetal complications during labour. Women with multiple pregnancies, preterm labour or delivered by emergency C/S were excluded. Data editing was done by a trained person and checked regularly by authors for completeness and analyzed using a microcomputer SPSS program, version 20.

RESULTS

Population Characteristics

In this study, 2434 primigravidae were included for studying the complications of FGM during labour. 2166 (89.0%) were between 20-30 years, teenagers were 73 (03.0%) and 195 (08.0%) were above 30 years of age. Most of them were Muslims, 2399 (98.6%), Christians were 35 (01.4%) and no other religious groups. Circumcised women were 791 (32.5%), 467 (59.0%) were rural and 324 (41.0%) were urban. Uncircumcised were 1643 (67.5%), most of them were urban 1413 (86.0%), while rural were 230 (14.0%). Circumcised sisters of the participants, younger than ten years were 642 (26.4%). Out of the circumcised women, 570 (72.1%) were type II, 190 (24.0%) type I and 31 (03.9%) were type III (infibulated). Literacy was high among uncircumcised group 1511 (98.0%) compared to 709 (89.6%) in circumcised group.

Even husbands' education was higher among husbands of uncircumcised women, 1549 (94.3%) than circumcised group, 699 (88.4%). In the control group, 1492 (90.8%) reported no difficulty during first sexual intercourse, only 151 (9.2%) reported mild difficulty, while in circumcised (study) group, 608 (76.9%) reported no difficulty, 181 (22.9%) reported mild difficulty and dyspareunia and two cases (0.2%) developed post-coital bleeding (PCB), they were infibulated. Vaginal examination was found to be easy for all women under study during the first and second stage of labour and no scarring or inclusion cyst was reported.

All uncircumcised participants declared that they will not circumcise their daughters or encourage female circumcision. Among the circumcised group, 689 (87.1%) stated that they were not going to circumcise their daughters, while 102 (12.9%) would prefer to circumcise their daughters.

Second Stage Characteristics

The characteristics of the study and control groups were comparable to, duration of the second stage, instrumental delivery, perineal tears, postpartum hemorrhage (PPH), birth asphyxia; neonatal death and hospital stay for more than 24 hours, table (1). In the study group, decircumcision, opening of the scar tissue resulting from FGM was done for 744 (94.1%), 709 (89.6%) of them had recircumcision performed for them.

Episiotomy had been done for most of primigravidae, 606 (96.0%) for circumcised and 1258 (94.0%) for uncircumcised (P= 0.107). They differ significantly in duration of second stage (P =0.004), PPH (P = 0.003), perineal tear (P = 0.002), birth asphyxia (P = 0.006), neonatal death (P = 0.003) and hospital stay after delivery for more than 24 hours (P = 0.005), there was no significant difference in mode of delivery (P = 0.018) and performance of episiotomy (P =0.107).

DISCUSSION

Prevalence of FGM

FGM is an important public, social and health problem, violating human and women rights, against young girls, who are unable to decide for themselves and even done without consent. It is of no benefits and may cause undue harm both physical and psychological. In Sudan, numerous studies and reports have been done or published on this issue based on survey (9-11). However, no specific article had been published on its effects during labour.

In this study, the prevalence of FGM is 32.5%, which is mainly types II and I FGM. This rate is relatively low compared to reports of previous surveys, demographic health survey (DHS), safe motherhood survey (SMS) and Sudan household survey (SHHS), where the rate varies between 89-98% and it was mainly Infibulation (12). These surveys are not without recall bias and include all generations, particularly the old and illiterate, where many of them were usually infibulated and they feel shame if they declare being uncircumcised.

However, this rate is consistent with a study done among medical students in Khartoum 2003, where the rate of FGM was found to be 75.3% among medical students and 48.1% among their sisters, mainly type I and II, only 21.1% were infibulated (13).

Table I: Summary of second stage characteristics of circumcised (study) and uncircumcised (control) primigravidae at OMH 2015

Variable	Study group N= 791	Control group N= 1643	Chi square	P.V.
2nd SOL > 2 hours	056 02.3%	022 0.9%	42. 626	0.004
Inst. Del.	031 01.6%	037 01.5%	NS 5.599	NS 0.018
Perineal tear	144 05.9%	061 02.5%	9.553	0.002
PPH	191 07.8%	080 03.3%	85.471	0.003
Birth asphyxia	066 02.7%	024 01.0%	25.279	0.006
NND	034 01.4%	007 00.3%	8.760	0.003
Hospital stay > 24 h	287 11.8%	093 03.8%	29.902	0.005

A similar study done in Kilimanjaro in Tanzania, among young educated women, found the prevalence of FGM to be 17% and was mainly clitoridectomy (14). This low level of FGM and shifting from infibulation to simple types of FGM, I and II, is due to efforts of many partners acting for the abolition of FGMz. It may also be influenced by the younger age and higher education of the study group and the more reliable information collected by trained resident registrars compared to surveys. Participants, their husbands and mothers' education is high in this population, illiteracy is only (2.0%), and this may have a major impact awareness-raising, improving of concept towards abolition and modifying FGM in Khartoum, in this study.

In Sudan, FGM gained attention long time ago among political, religious leaders, health professionals, individuals, families, media and community since 1970. Reproductive health program (RHP) at federal ministry of health (FMOH) has developed early strategies to reduce the practice. As seen in this study, urbanization and women education are important factors for reducing the rate of FGM and modification from severe to milder forms. Male education is high is this study, but usually, their role is limited in abolishing FGM.

Gynecological and Obstetrical Complications

Late gynecological complications including sexual difficulty are limited among this study group, due to the mild forms performed on them. Circumcised women may face a number of difficulties during childbirth, especially among infibulated women when decircumcision is not done beforehand, which may result in severe tearing of infibulated area (12). Scars forming around the wound can lead to prolonged labour, which may increase the rate of fetal distress, stillbirth and vaginal bleeding following vaginal laceration or extended episiotomy. A study conducted by WHO collaborative group in six African countries including Sudan showed that women with FGM ran a greater risk of caesarean delivery, PPH, extended hospital stay, with a greater risk of infants dying at birth, especially when FGM is extensive (8).

This study showed that women with FGM have a higher risk of prolonged 2nd stage of labour, which may have led to perineal tear, PPH, birth asphyxia or early neonatal death (END). This is consistent with that found by WHO; where unusually long duration of second stage due to excessive scarring, may be behind the risk of perineal injury, PPH, birth asphyxia and stillbirth associated with FGM (8). Also, the WHO study demonstrated that mutilated women had 66% chances higher of having babies requiring resuscitation, 55% of babies likely to die after birth and 5% of babies were still born. In this study, there was no extensive scarring, which may explain few neonatal complications.

Episiotomy had been done routinely for all primigravidae, circumcised or uncircumcised, with no significant difference between the two groups, however, the study done by WHO found that the performance of episiotomy in primigravida was 41% in uncircumcised women compared to 88% in women with FGM type III (8). Although this study showed that circumcised women are at greater risk of complications of 2nd stage of labour compared to uncircumcised women, there is no reported mortality or near-miss cases. This may be explained by the modified type of FGM or by the improved obstetric care in this hospital.

Cultural Challenges

In Sudan, FGM is performed mainly by midwives and a limited number of doctors. Doctors who perform FGM justify their practice for reducing associated complications. Although this medicalization of FGM may reduce the incidence of immediate complications, it has no effect on late gynecological or obstetrical complications (5). It is women practice, allowing medical professionals to perform the practice as a logical response of parents who are under social pressure to have their daughters undergo FGM but they want to minimize the harm. The performance of FGM either by midwives or doctors is mainly for personal economic reasons. It is highly rewarding especially when it is forbidden.

Increasing women earning capacity through good proven income generation activities may reduce the practice. Many penal codes have been issued by Sudan medical council against FGM by doctors or midwives, but it is still persisting. The problems are based on families and women who demand circumcision of their daughters. Improving women knowledge and awareness raising among community including men may reduce the incidence. Midwives recruitment within health care personnel will increase accountability, supervision, training and awareness raising for the abolition of FGM.

Considering reduced organic complications of FGM, alone in presence of improved medical care may encourage medicalization of FGM, which means endorsing the practice of FGM by health care providers in a clean and safe setting. This might have an adverse effect on the abolition of FGM. Psychological trauma, violation of human rights and medical

ethics should be addressed to abolish FGM. In Sudan, many religious leaders have spoken out against FGM, however, it is wrongly quoted by some religious leaders who support the practice of FGM, that the basis of performing FGM is a religious instruction. They call the mild forms of FGM “sunna”, related to prophet Mohamed sayings (hadyth). FGM is an old cultural tradition predating Islam and practiced by many other religious populations. Quran does not contain any call for FGM, but few “hadyth” referred to it as an advantage “macramé”. Islam never sanctions harm or pain upon a human being, it is religiously rejected.

FGM is generally women practice; girls are usually under social pressure from their peers and family members to undergo the procedure. Families are threatened to be rejected in the community if they do not follow traditions and circumcise their daughters. It is believed by many that the external genitalia are ugly and a source of dirt and eventually cutting will lead cleanness “tahara or tahour”. It is believed, by males that uncircumcised girls have uncontrollable sex drive so that they lose their virginity early, destroying their families and their chance of marriage. It is also believed by some laymen that the tight vaginal orifice enhances male sexual pleasure. This leads to increased demand for recircumcision as seen in this study, 89.6% had recircumcision performed for them. This is similar to many African countries where FGM is practiced. It is estimated that 6.5-10.4 million women request recircumcision every year in Africa (5). It is most prevalent where type III is prevailing; as in Somalia 98-100%, Sudan 82%, Djibouti 50% and Eretria 34% (5).

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REFERENCES

1. World Health Organization. "Female Genital Mutilation: Report of a WHO Technical Working Group". Geneva: World Health Organization1995; pp. 9.
2. Lightfoot-Klien H. The sexual experiences & marital adjustment of genitally circumcised & infibulated females in Sudan. The journal of sex research 1989; 26(3): 375-392.
3. Royal College of Obstetricians and Gynaecologists. Female genital mutilation and its management Green-top guideline No. 53 May 2009. London: RCOG Press; 2009.
4. Kaine, R. Female genital mutilation: legal, cultural and medical issues. Jefferson, North Carolina, USA 2005: McFarland. ISBN 0-7864 -2167- 3.
5. Serour GI. The issue of reinfibulation. International Journal of Gynae-cology and Obstetrics 2010;109(May (2)):93–6.
6. UNICEF, Innocenti Research Centre. Changing a harmful social convention: female genital mutilation/cutting. Innocenti Digest. Florence: UNICEF; 2005. Available at: http://www.unicef-irc.org/cgi-bin/unicef/Lunga.sql?ProductID=396[
7. Abdel Aziz MI. Changing policy for female genital mutilation and the cause of change: A consensus statement. Sudanese Journal of Public Health. 2009; 4 (2): 236-240.
8. WHO. Study group on; Female genital mutilation and obstetric outcome. WHO collaborative prospective study in six African countries. Lancet 2006; 367: 1835- 41
9. Asim Zaki Mustafa. Female circumcision and infibulation in the Sudan. BJ OG April 1966; Volume 73, Issue 2, pages 302–306
10. ALMROTH, L et al. A community based study on the change of practice of female genital mutilation in a Sudanese village. International Journal of Gynaecology and Obstetrics 2001; 74, 179-185.
11. Dya Eldin M. Elsayed, Rabaa M. Elamin, Suad M. Sulaiman. Female Genital Mutilation and Ethical Issues. Sudanese Journal of public health; April 2011, vol. 6, No 2: 63-67.
12. Central bureau of statistics. Sudan national safe motherhood survey 1999. Statistical yearbook 2000. Khartoum; Sudan 149-153.
13. Umbeli T. M A Abu salab. Female genital mutilation among medical students in Khartoum, Sudan. JABMS 2006: 8(1); 16-21.
14. Msuya SE, Mbizvo E, Hussain A, Sundby J, Sam NE, Stray-Pederson. Female genital cutting in Kilimangaro, Tanzania: changing attitude. Trop Med Int Health 2002; Feb 7 (2): 159- 65.