FEMALE GENITAL MUTILATION AND REPRODUCTIVE OUTCOME

11(3) 105 – 107

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ABSTRACT:

130 cases of obstructed labour were managed amongst 1,860 deliveries over a period of 2 years. 34 cases were due to vaginal scarring and fibrosis, a complication following female genital mutilation (FGM) in infancy and childhood.

This paper highlights the reproductive outcome of these 34 parturients. Measures aimed at reducing this preventable cause of maternal and perinatal morbidities and mortalities are suggested.

KEYWORDS: Female Genital Mutilation, pregnancy, obstructed labour, Caesarean section, maternal and perinatal mortality.

RUNNING TITLE: Obstructed Labour Caused by Genital Mutilation .

FEMALE GENITAL MUTILATION AND REPRODUCTIVE OUTCOME – A 2 YEAR SURVEY AT FEDERAL MEDICAL CENTRE, BIDA.

INTRODUCTION:

Female genital mutilation (FGM), in the name of female circumcision is a widespread practice in Nigeria and indeed in sub-Sahara Africa and Asia [1,2]. It dates back to 163BC when a Greek papyrus made reference to the practice [3]. It probably originated as an initiation ceremony of young girls into adulthood [4].

In Nigeria depending on the ethnic group, (FGM), is carried out at different age and period for different reasons [5]. The reason ranges from traditional, religious and cultural factors to prevention of female promiscuity and inhibition of clitoral growth. In some cultures there is superstition that any newborn baby that touches the clitories of the mother as it passes through the birth canal will die immediately after birth [6]. The isoko ethnic group of Edo State, and the Hausas in the Northern States circumcise their female just before marriage. The Yoruba in the Western State perform this in infancy and early childhood. The Igbos in Abakaliki celebrate this ritual at puberty and the Ogboru ethnic group in Anambra State perform this practice during the first pregnancy [6].

This practice of (FGM) is often performed by unskilled traditional healers under unhygienic conditions, dressed with various herbal preparations with corrosive tendencies. Documented complications that have resulted include haemorrhage, genital sepsis and septicemia. Others include partial labial fusion, implantation dermoid, introital stenosis and deep vaginal scarred tissues [7,8,9].

The author spent four months as a locum consultant in the obstetrics and Gynaecology unit of the Federal medical Centre, Bida. A major referral centre for Bida and its environs, with a population of about three million people [1]. The presence of many teenagers in the post-caesarean section ward, where indication for surgery was obstructed Labour due to acquired gynaetresia following childhood circumcision motivated this research. In addition, not much is documented in the literature in the past about female genital mutilation as a cause of obstructed Labour.

The aim of this paper was to highlight the magnitude of the problem of female genital mutilation, (FGM), as a cause of obstructed labour and to suggest ways of prevention.

MATERIALS AND METHOD:

Case records of obstructed labour due to acquired vaginal atresia following female genital mutilation seen at the Federal Medical Centre, Bida from 1st January 1997 to 31st December, 1998 were studied. The factors considered were age and parity, educational status, booking status, birthweights and maternal and perinatal outcome.

RESULTS:

During the 2-year period, there were 1,860 deliveries at Federal Medical Centre, Bida. Of these, 130 were complicated by obstructed labour, giving an incidence of 6.98% i.e. 1 in 14 deliveries. During the same period, 465 caesarean sections were performed, giving a rate of 25%. 83 caesarean sections were perform for obstructed labour, giving an incidence of 17.85%

Table 1 shows the indication for caesarean section in obstructed labour. Cephalopelvic disproportion accounted for 45% (59 cases). Surprisingly, acquired vaginal atresia accounted for 26% (34 cases)

All the cases of obstruction due to acquired vaginal atresia (34 cases) were unbooked. 84% (29 cases) actually tried labour at home unsuccessfully before presentation. This is shown in Table II

Table III shows that koranic education is the predominant educational instruction received by 51.7% (18 cases) while only 10% (3 cases) had secondary school education. Importantly all the women had a stint with koranic education.

The age and parity distributions are shown in Table IV. 32 cases (93%) occurred in teenagers and all were primparous.

All the patients with obstructed labour from acquired vaginal atresia were Muslims and the maternal and perinatal mortalities were higher when compared with the overall hospital figures for the same period. These informations are displayed in Tables V and IV respectively.

DISCUSSION:

Obstructed labour has become a major public health problem in Nigeria and in other sub-Sahara Africa and Asia. This is because of its high contribution to maternal and perinatal morbidity and mortality [1-6, 11].

During the period of study, the incidence, 6.98% is much higher than 0.48% reported from Jos [12], 0.56% from Ibadan [13], 2% from Benin City Nigeria 14, 4.7% from Enugu [15] and 2.76% from India [16]. Several factors could account for this high incidence, ranging from poor obstetric management in the environment to the large proportion of cases due to Female genital mutilation (FGM).

That cephalopelvic disproportion was the commonest cause of obstructed labour is in agreement with various authors [1,2,13,14,17]. However, in this study, unlike previous reports, a new trend is emerging whereby acquired vaginal atresia (Vaginal scarring and fibrosis) complicating Female

suggests non-acceptability of modern obstetric care yet in the environment studied. For if they had avail themselves the use of the available health centres, the diagnosis would have been made earlier and referred by the midwives manning those centres thereby preventing the ensued obstruction.

All patients with obstructed labour due to female genital mutilations were primiparous. This is surprising because one would have expected some multips who might have been reluctant to book in hospital because of the fear of repeat cesarean section as reported by previous authors [1,12,13,14]. This finding however is encouraging because, it may mean, the people accept corrective measures readily.

Maternal mortality was higher in women with acquired vaginal atresia following FGM compared with other causes of obstruction. This cause of maternal deaths is highly avoidable.

Perinatal mortality was also unacceptably higher in the patient with obstructed labour secondary to female genital mutilation. The reason for these poor pregnancy outcomes is essentially due to lack of antenatal care and late presentation in hospital even when labour is obstructed with a resultant foetal compromise in many cases. The mother sometimes survives with serious morbidities such as vaginal fistulae, obstetric neuropraxia and so on.

In conclusion, the study shows that the incidence of obstructed labour in the environment studied is high. Also a new trend has emerged whereby hitherto an insignificant cause of obstruction is becoming increasingly significant due to the often song triumvirate factors: - ignorance, disease and poverty.

There is need to educate the people on the importance of adequate antenatal care. Since traditional birth attendants still remain an integral part of maternity care in our environment, with religious and cultural influence they must be incorporated into the health care delivery system. Implementing this will go a long way in promoting prompt referral of parturients with difficult labour to hospital. Improving rural transportation and communication system will also go a long way in reducing the mortality from obstructed labour generally, as prompt referrals are ensured. Religious and more specifically traditional leaders should appropriately interpret the tenets of their religion to their followers and harmful cultural practices, which do not have religious compulsion, be discarded.

ACKNOWLEDGEMENT:

Appreciation is hereby extended to the staff of maternity ward Federal Medical centre, Bida and to Mr. F.I. Oyeniyi for the secretarial work..

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TABLE 1:

INDICATIONS FOR CAESAREAN SECTION IN CASES OF OBSTRUCTED LABOUR

Indications	No	%
Cehpalopelvic Disproportion	59	45
Malpresentation	25	19
Acquired gynaetreasis	34	26
Other – cervical dystocia	12	9
TOTAL	130	100

TABLE II

BOOKING STATUS OF PARTURIENTS WITH ACQUIRED GYNAETRESIA DUE TO FEMALE GENITAL MUTILATION

Booking Status	No	%
Booked	Nil	Nil
Unbooking	34	100
TOTAL	34	100

TABLE III

EDUCATIONAL STATUS OF PARTURIENTS WITH ACQUIRED GYNAETRESIA

Educational status	No	%
No Education	2	7.0
Koranic Education	18	51.7
Primary School	14	31.0
Secondary school	3	10.3
TOTAL	34	100.0

genital Mutilation (FGM) is becoming an important aetiological factor for obstructed labour. This is an indication of the influence of cultural practices and religious norms on the Health of the people.

The area of study is largely populated by Muslims. It is not surprising therefore that the study population were entirely Muslims, whose beliefs about Female circumcision is a rule rather than exception. Interestingly, a respected Islamic Jurist in a paper presented at the National Conference of Islamic medical Association of Nigeria on the July, 1999 states and I quote: As Muslim professionals, you owe it a duty to rise to the challenges of the reckless criticisms which have laid the blame of female genital mutilation (FGM) at the door step of some religious and cultural beliefs and practices. It is irresponsible to direct such attack on Islam because it shows that the sources of such criticisms do not take the minimum required step to know about what they are talking about. Islam did not introduce female circumcision. It makes it optional and equally emphasizes that no damage to the organ should occur [18]. The relevant Hadith said 'oh mother of Atiyyah, reduces the tiptop of the clitoris and cause no damage [19,20]. Wherever circumcision degenerates to mutilation, endangers the health of the person or any damage is caused, it becomes un-Islamic". Also the same cultural and religious influence of the environment is reflected in the age of the patient: 32 (93%) of the patients were teenagers which shows that early marriage is the norm in the environment studied. The need to discourage early marriage may not be relevant here, but at least even if marriage is early, there should be appropriate medical care.

The finding that antenatal care was absent in all the women who had acquired vaginal atresia complicating FGM was similar to the findings of other authors about obstructed labour in our environment [1-14,17]. This