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CONFERENCE BACKGROUND PAPER *

SEMINAR ON TRADITIONAL PRACTICES AFFECTING
THE HEALTH OF WOMEN AND CHILDREN

Report prepared by the World Health Organization

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I. ORGANIZATIONAL MATTERS

The Seminar was inaugurated by H.E. Sayed Khalid Hassan Abbas, Minister of Health, Sudan, at the Friendship Hall. (Annex I).

Dr R.A. Khan, WHO Programme Coordinator welcomed the participants on behalf of WHO and Dr T.A. Baasher, WHO Regional Adviser on Mental Health and Secretary of the Seminar, read the message of Dr A.H. Taba, WHO Director, Eastern Mediterranean Region. (Annex II).

The following Seminar Officers were elected:

- Dr hamid Rushwan, Associate Professor, Gynaecology and Obstetrics Department, Faculty of Medicine, University of Khartoum and Chairman of the National Preparatory Committee for the Seminar, was elected Chairman of the Seminar.
- Dr (Mrs) b.C.A. Johnson, Chief Consultant Neuro-Psychiatrist, Psychiatric Hospital Yaba, Nigeria, and
- Dr Afaf Attia Salem, Director, General Directorate Maternity and Child Health, Ministry of health, Cairo, were elected Vice Chairpersons.
- Dr Yahia Ownallan Younis, University of Khartoum, Department of Community Medicine, Sudan, was elected as General Rapporteur for the Seminar.
- Mrs Awatif Osman, Director, College of Nursing, Ministry of Education, Khartoum, and representing the International Confederation of Midwives, was elected as Rapporteur for the first session.

It was agreed that for each day's sessions a rapporteur would be elected.

The Seminar was welcomed by Dr Rushwan, who introduced the speakers.

Following the election of Officers, members moved to the adoption of the Agenda which was presented by the Chairman. Dr B.C.A. Johnson suggested the addition of Menopause to the Agenda. This was given consideration. The Agenda was then adopted by the members. Dr Baasher introduced the programme and the presentation scheduled for each session under items IV to VIII to be discussed during the five days meeting, hoping that the participants would be able to cover most of the topics on the Agenda. Dr Baasher also asked contributors to hand in their working papers and written suggestions and recommendations to be given to the Secretariat or Chairman of the Seminar. He also pointed out that before the closing session, a summary report will be given on the scientific contributions and the deliberations including the recommendations which will come out of the meeting. Twenty minutes (approximately) was the time given for the presentation of each paper.

II. TOPICS DISCUSSED AT THE SEMINAR

A. Nutritional taboos and traditional practices in pregnancy and lactation, including breast-feeding

Dr R.H.O. Bannerman, Programme Manager, Traditional Medicine, WHO Central Office, Geneva, suggested his willingness to present the paper on "Traditional Practices on Confinement and After Childbirth (in the Chinese culture)" by Dr B.L.K. Pillsbury who could not attend the meeting and this was accepted by the members.

The first topic "Nutritional Taboos and Traditional Practices in Pregnancy and Lactation Including Breast-feeding Practice" was then introduced by the Chairman and the first speaker Dr Hafiz El Shazali, Senior Paediatrician, Ministry of Health, Sudan, presented his paper on "Breast and Supplementary Feeding during Early Childhood".

Dr El Shazali pointed out that his main emphasis is on the child. He highlighted the nutritional taboos and traditional practices in pregnancy and lactation in the Sudan. Dr El Shazali classified traditional practices in three categories: harmful, harmless and useful.

Among the harmful practices he listed:

- restriction of food intake during pregnancy;
- failure to remove dirt from the house (infections);
- breast-feeding while lying down (colic);
- using only one breast in nursing (decreases milk formation);
- weaning done suddenly;
- cauterization of children with a big hot needle for diarrhoea, cough, fever, etc.;
- stopping breast-feeding during diarrhoea;
- supplementary foods introduced too late;
- boys should not be fed at sunset or by mother with head uncovered;
- wearing beads and scented necklace to prevent vomiting.

Among good practices were listed:

- neighbours bringing food to nursing mothers;
- breast-feeding for a long period;
- during last month of pregnancy, eating raw liver.

"Dietary Practice and Aversions during Pregnancy and Lactation Among Sudanese Women" was presented by Dr Ali Karrar Osman, Director of Nutrition Division, Ministry of Health, Sudan. Dr Karrar indicated that his paper was more concerned with the child.

Low birth weight is a problem affecting some 20 million newborn infants annually, mainly among the low socio-economic groups of the population.

A survey in MCh centres in Khartoum Province to investigate the nutritional knowledge, attitudes and practices among pregnant women showed that pregnant women of the low socio-economic class are not aware of the importance of the consumption of a balanced diet during pregnancy (67%). This situation is aggravated by vomiting during early pregnancy and by dietary aversions, since 57.4% of the respondents dislike meat, fish and poultry. The effect of under-nutrition, especially low protein intake, is discussed in the light of the results of global research results demonstrating the effect of this on the mental and physical development of the foetus.

93% of the respondents believe that diet should be changed during post-partum while 45% believe this should take place during lactation. High-protein, high-energy diets are consumed. The reasons cited for this change were: to regain strength, to compensate for loss during delivery and to increase milk production. This represents sound nutrition knowledge, attitudes and dietary practices. One food item which is consumed by all respondents is the fenugreek Nasha (Fenugreek + Milk + Ghee + Sugar). This is a high energy recipe and fenugreek is shown to contain a lactogenic factor.

The next paper was on "Traditional Feeding Practices in Pregnancy" - Mrs A.N. Mikhail, Director of Nursing Services, Alexandria Health Directorate, Egypt.

Urban sector and rural sector habits for housewives were examined, showing that economic aspects and education had a major influence as to whether or not the diet was balanced. During puerperium the majority of housewives preferred protein-rich food regardless of income. Reasons given for food consumption patterns showed lack of awareness about nutrition. Breast-feeding was shorter and supplementary feeding better among educated housewives. In the rural areas and among poorly educated mothers, prolonged breast-feeding is customary in the belief that it protects against pregnancy.

Discussion:

A number of important issues emerging from the papers were discussed, as follows:

- morning sickness;
- prevalence of breast-feeding in the rural areas more than in urban areas;

- contraceptive tablets and mothers' complaints of reduced milk output;
- how to deal with harmful practices, e.g. cauterization of children;
- mass media;
- advertisement of powdered milk and advice given to mothers in reference to breast-feeding of babies suffering from diarrhoea, especially within the first 24 hours;
- traditional medicine with reference to puerperal psychosis and its effect on the nutritional condition of the lactating mother and child;
- the emphasis on health education and assistance of mass-media in nutritional health education;
- native drugs during puerperium;
- breast-feeding on demand;
- overweight during lactation;
- traditional cultural ways of thinking in using red-ribbons, shells and beads to protect the child from the evil eye, infection, etc.;
- the practices of excision of the uvula, canines and cauterization of the epiglottis and the micro-organisms in reference to coughing, talking and certain diseases;
- nurseries and breast-feeding problems of working mothers, etc.

On 11 February the meeting opened with a presentation on: "Nutritional Taboos and Traditional Practices in Pregnancy and Lactation Including Breast-feeding Practices" by Dr L.J. Ghulam, Senior Public Health Officer, Ministry of Health, Muscat, Oman.

Two communities of Oman were studied. It was found that most women change their diet during pregnancy and lactation. The reason for diet changes are varied but the most important is the misunderstanding of the proper location of the unborn child. It is believed that the child is located in the stomach and as it grows, the size of the stomach is reduced.

Women eat less fish because they believe that the bones and scales of fish will harden the bones of the foetus and lead to a difficult delivery. A large number of women eat more during breast-feeding to increase their milk and to have better health.

The study shows some bad habits such as women abstaining from cold food such as rice, stew, citrus fruit, salted and fried fish, lamb, veal and sweet potatoes. In both communities some foods were recommended more than other kinds of food.

breast-feeding Practices

The pattern of demand feeding continues from infancy until weaning. 90% of the children are breast-fed up to two years of age. Early weaning is against customs and religious beliefs. Breast-feeding is practised to avoid pregnancy; however, even when the mother is pregnant she continues to feed the baby until the fifth month of her pregnancy.

"Traditional Practices on Confinement and After Childbirth" by Dr B.L.K. Pillsbury, Medical Anthropologist, Bureau for Programme and Policy, Washington, USA, was presented on her behalf by Dr R.H.O. Bannerman, Programme Manager, Traditional Medicine, WHO Central Office, Geneva.

The paper is based on Dr Pillsbury's study in China. The woman is confined to the house for one month after delivery. She is said to be "doing the month". During this period she is expected to refrain from certain practices e.g. washing, domestic work. Regarding diet, she is expected to have a "hot" liberal diet with abundance of protein. At the end of the resting month relatives are invited to drink the full moon wine. In rural China deliveries are undertaken in the home by a midwife. 90% of the obstetricians and gynaecologists are women.

A very interesting discussion followed the presentation of the paper. Similarities between the Chinese experience and various African countries in traditional practices related to confinement were noted, e.g. length of period of confinement after delivery, washing practices, dietary habits etc.

The next paper was on the subject of: "Traditional Practices in Relation to Childbirth in Kenya" presented by Miss Margaret Njoki, Psychiatric Nurse, Nairobi.

Practices vary from one part of Kenya to another, but in essence they are similar. A woman who does not do work is thought of as a lazy person, so even during pregnancy women continue to do hard work with the risk of miscarriage and ill health. Traditional midwives have harmful practices which may lead to infection in both the mother and her child. Some of the useful practices include the good nutrition secured for the mother during confinement and after delivery, and the domestic help offered by neighbours.

Dr O. Modawi presented the next paper on: "Traditional Practices in Child Health in Sudan".

Dr Modawi gave a historical review of the cultural heritage in the Sudan which is a mixture of African, Eastern, Ancient Egyptian and religious cultures - both Islamic and Christian. The common elements forming the traditional practices were discussed. These included spirits and myths, the cultural heritage, the religious background and the supernatural powers represented by the river, the sun, the moon, colours, etc. He explained that the type of food eaten by the pregnant women is determined by social practices and beliefs. He presented a cultural description of food as prestige food, celebration food, food for special groups - especially pregnant women - and religiously defined food. Traditionally, infertility is attributed to various causative factors depending on the part of the country e.g. spirits, religious reasons, witchcraft and the evil eye and the Mushara. Traditional practices in the treatment of infertility were discussed. Dr Modawi explained the different traditional contraceptive methods, described the various positions in labour, the practices during confinement and after delivery and the beliefs about multiple pregnancies and births. Slides were shown.

The topic of the following paper was "Traditional Practices in Pregnancy and Childbirth in Ethiopia" presented by Sister B. Beddada, Instructor, Health Assistant School, Menelik II Hospital, Addis Ababa, Ethiopia.

Traditional practices during pregnancy, labour and post-natal periods were described, e.g. good practices such as taking nutritious food and being at home for long periods during puerperium, and harmful ones such as carrying heavy things during pregnancy. Also practices concerning the newborn and children were described, such as cutting the cord with an unclean razor and cutting eyelids to treat conjunctivitis and avoiding sunshine for fear of the evil eye.

"Traditional Practices Affecting the Health of Women in Pregnancy and Childbirth" was the topic of the next paper presented by Dr (Mrs) M.O. Aromasodu, Assistant Director, Public Health Services, Federal Ministry of Health and Social Welfare, Nigeria.

Traditional care of the pregnant women in Nigeria is described. The traditional healer, through means of certain rituals, claims to be able to forecast the outcome or

a pregnancy. If there is going to be difficulty, he can consult the "gods" through his oracle to find out what sacrifices are to be performed. He also claims to have the means by which he "ties down" the pregnancy and thus ensures that it is carried to full term.

The traditional healer, apart from consulting the "gods", through his oracle, also treats the pregnant woman with herbs. In addition, there are certain taboos which the pregnant woman must observe or else all efforts will be useless. Thus she must not go out at night or at midday to avoid meeting evil spirits, she must also not eat snails or bananas so that her baby will be healthy with no congenital abnormality.

When the woman is in labour, the pregnancy which was "tied down" is released. If it is not vertex presentation, the baby is turned round by supernatural means. Vertex delivery is preferable, although at times breech delivery is undertaken. The woman is delivered on her knees. After delivery the placenta is carefully buried because it is a bad omen for the baby if its placenta is eaten by any animal especially a dog.

After childbirth, the woman is kept indoors for 40 days. During this period, she is massaged every morning with very hot herb water to aid uterine contractions and expulsion of all remaining "bad blood" in the uterus. Sitting on top of a pot with hot herb water also has the same effect.

Twins and other multiple births are said to be a bad omen which is accepted as being the fault of the woman as well as any congenital abnormality.

In order to improve the standard of obstetric practice, traditional healers and birth attendants are now trained. During training emphasis is laid on identifying any deviation from normal and prompt referral to health institutions where patients will be taken over. With intensified health education, even the community now prefers to use non-traditional healers and birth attendants who have been trained by the experts from the Ministry of Health.

Mrs D.V. Kuteyi, Principal Nursing Officer, PH, Federal Ministry of Health and Social Welfare, Lagos, Nigeria, continued where Dr Aromasodu left off by describing

the naming ceremonies for girls and boys. The mother is kept indoors for 40 days after delivery. The naming ceremony traditionally includes tribal remarking, shaving of head and circumcision.

The baby is forcefully fed immediately after delivery with a special herbal concoction which is continued sometimes for one year and is the only food given besides mother's milk. The baby is fed with bap after sixth or seventh month (millet and corn).

Twins: If a mother has twins she must go in the street and sing and dance as well as beg for alms in order that the twins survive.

The diet of the pregnant woman is without eggs or meat and no beans or milk are given. Protein intake is lacking.

Dr S. Coleman, Staff Research Associate, Johns Hopkins Population Information Programme, Baltimore, USA, presented the next paper on: "Tobacco and Reproductive health: Practices and Implications in Traditional and Modern Societies" .

Few women in many developing countries smoke, but the tendency is for an increase; the tobacco market is growing and increased use follows increased income and spending power. Cigarettes are being promoted by tobacco corporations in developing countries, where the prospects for market expansion are greatest and where there are rarely restrictions on advertising and no antismoking educational campaigns. With increasing urbanization and emancipation, more women will soon be smoking in many countries.

Tobacco use during pregnancy lowers birth weight. This has been proven in more than forty-five studies examining over half a million births, in a number of countries. The infant's reduced weight is independent of maternal weight gain during pregnancy, and is not due to reduced length of gestation. More women who smoke, however, give birth before the full gestation period than do non-smokers. The reduced weight of smokers' infants may be due to an attempt to adapt to lack of oxygen. Carbon monoxide and nicotine are two agents in tobacco smoke that may be affecting birth weight. Increased intake of calories during pregnancy cannot counteract their effects.

The woman who smokes during pregnancy is in the greatest danger of losing her newborn infant or having a stillbirth:

- if she has experienced perinatal loss previously;
- if she is older in age;
- if she has had many previous births (high parity);
- if she is anaemic.

The more any woman smokes, the greater is the risk of perinatal mortality. Tobacco use also increases the risk of pregnancy complications. Antepartum bleeding, placental abruptions, placenta previa and premature rupture of membranes have all been found in increased frequency among smokers. Thus, the life of the woman as well as that of her offspring may be threatened, especially if medical facilities are not immediately available.

B. Female circumcision

The thira session was devoted to the discussion of female circumcision.

The Chairman introduced the first speaker in this session, Miss F. Hosken, Editor, women's International Network, Lexington, USA and WHO Temporary Adviser on "Female Circumcision in the World of Today: A Global Review".

Information about genital operations performed on female children, mostly at an age too young to be able to make any decisions on their own, have been concealed for more than 2000 years. As a result these practices have spread all over Africa and are now also practised in the modern sector.

In other parts of the world genital mutilations no longer exist though they have been reported also in the medical literature (Shandall, Verzin, Mustafa, Sequeira and others) up to the present time though no clinical observations are available. In Australia genital mutilations among the indigenous population have been abandoned decades ago. In South America no clinical evidence has ever been available and the few cases reported in the ethnographic literature go back more than 100 years with no medical evidence. All the reports of genital operations on females go back to 1885 (first edition of Ploss Das Weib = Woman).

There is no present day clinical evidence that any form of genital operations are practised anywhere except in Africa and among the Moslem population of Malaysia and Indonesia, where the mildest form of circumcision is reported.

Leading Moslem gynaecologists in Malaysia and Indonesia have offered to make studies concerning any health damage.

In Africa and the Middle East a survey of 36 countries has provided the beginning of a systematic collection of data which should be continued and amplified as more information becomes available. Due to population growth more female children are operated on now than ever before. The operations are performed at a younger age because parents are afraid their daughters will refuse to submit to them when they are able to decide for themselves.

A cost analysis of genital mutilations is supplied showing that the economic costs of doing nothing about these operations are going to increase rapidly and will become a major drain for governments. Prevention campaigns could obviate many expenditures as well as improve the health of females.

This "expenditure" or cost may be listed as follows:

1. The costs due to loss of life.
2. The costs due to making childbirth more hazardous including many added services needed.
3. Costs of work time lost, health insurance and social security.
4. Costs of operations performed in hospitals.

Relevant recommendations include the education of traditional midwives, which should be undertaken on the national scale, keeping the traditional system in place but re-educating the practitioners.

Following the presentation and discussion of Miss Hosken's paper several country reports were presented. Dr Afaf Attia Salem, Director, General Directorate Maternity and Child Health, Ministry of Health, Cairo, presented a paper on "The Practice of Circumcision in Egypt". She said the practice of female circumcision is illegal in Egypt and so there are no confirmed data, but from field work done recently, three types of circumcision could be delineated:

1. Sunna type in which the clitoris is snipped.
2. Second type in which the labia minora and part of clitoris are removed.
3. Total removal of clitoris and labia.

The first type is done in both urban and rural areas and the third one mostly in Upper Egypt. Dr Salem also cited the various complications that may follow the operation.

A second presentation from Egypt on "Mental Aspects of Circumcision" was made by Dr A.S. El Hakim, Head of Mental Health Department, Ministry of Health, Cairo. Dr El hakim indicated that sex before marriage is taboo and the female's virginity before marriage is identified with the dignity of the family. Circumcision is believed to ensure the girl's chastity, hence the man's concern with the circumcision of the female. But the operation leaves a psychological scar in the woman. It is thought that circumcision causes delayed sexual arousal in the female, but there are no direct data on this matter, only indirect information from opium addicts who claim that they resorted to the drug after frustrations from delayed sexual arousal in their circumcised wives.

A third presentation from Egypt was given by Mrs Marie B. Assaad, Senior Research Assistant, The American University, Cairo, who is also representing UNICEF. Mrs Assaad presented a very voluminous document on "Female Circumcision in Egypt". She attempted in her paper to give a critical review of written and oral information on female circumcision in Egypt and to suggest areas where systematic study is needed. Also, she summarized a pilot study which she carried out recently in Egypt with the objective of testing a set of questions and to have insight into the present extent of the practice and how, where and by whom it is done.

Circumcision in Egypt is practised by both Moslem and Christians and there is no religious basis for the practice. It fits into the people's value system about virginity and family honour. The practice existed in Egypt long before Christianity and Islam. The pilot study showed that women of low socio-economic class submit their daughters to the same fate which they themselves underwent when circumcised. Interestingly, the study does not show any correlation between excision and sexual dissatisfaction.

Mrs Assaad concluded by stating that concerted effort is needed now to accomplish the following:

- Multi-disciplinary action - research should be undertaken by psychologists, gynaecologists and social scientists - men and women - with the purpose of defining what information will be persuasive to men and women in eradicating the practice.

- health practitioners, social workers, nurses, family planning workers, feminists engaged in education and outreach programmes, and educated people in general should form the first audience of instruction. They should be informed about the practice, its extent, reasons for its perpetuation, and how traditional and erroneous beliefs of women on women's health and sexuality can be modified. It is important to engage this group first because of their prospective leadership role.
- We need to be creative and imaginative, finding ways to convince the daya (traditional birth attendant) to work with us and not against us. In view of her influential role as a traditional leader we need to exert special efforts to involve her in the new concerns, whether in relation to female circumcision or family planning. We must care for her as a person and guarantee for her other sources of livelihood and importance.
- We should begin now with the knowledge that is already available and experiment with it for educational programmes in family planning centres and health services.

Ungoing evaluations of different approaches will be useful in finding out what is feasible and effective within service constraints.

Then followed a paper from Ethiopia on "Female Circumcision In Ethiopia" presented by Sister B. Beddada, Instructor, Health Assistant School, Menelik II hospital, Addis Ababa. Sister Beddada presented a short report and said that female circumcision is mainly done at home by a traditional midwife and never in a hospital. The main reason given to rationalize the operation is that circumcision lessens the sexual desire in the female and so protects the young girl from any promiscuity.

A report from Kenya on "Female Circumcision in Kenya" was presented by Miss N. Njoki, Psychiatric Nurse, Nairobi. Miss Njoki said she would add an intimate personal experience to the report. The operation is done by a traditional healer and usually done in groups in warm weather, about August. Reasons given for the practice are: to reduce sexual desire in the girl and to initiate the young girl into womanhood. The operation is usually performed on the girl between the ages of 7 and 10 years. Though the practice is still being carried out by some groups of people, it is certainly dying out.

A report from Nigeria on Female Circumcision in Nigeria was presented by Dr (Mrs) B.C.A. Johnson, Chief Consultant Neuro-Psychiatrist, Psychiatric Hospital, Yaba. Dr Johnson said that there is no official attitude to the practice and there are no reliable data. The practice is dying out. When it is done it is done as early as the seventh day after birth and as late as just before marriage. It gives a sense of belonging to the girl, being thus initiated into adulthood. Dr Johnson also cited many of the physical and psychological complications that follow the operation.

A paper was then presented by Ms Raqiya Haji Dualeh, Representative of Somali Women's Democratic Organization on "Female Circumcision in Somalia".

Women are victims of outdated customs and attitudes and male prejudice. This results in negative attitudes by women about themselves.

There are many forms of sexual oppression. These are rooted in the family, society and religion.

In the space of nine years the Somali Revolution has achieved a great deal by building a new generation free of traditional prejudice against women's rights and needs.

Infibulation (Pharaonic circumcision) is still widely practised. It is a horrible practice, fraught with ordeal and danger and is in fact the result of the inability of women to find other ways of establishing virginity.

Children are the centre of life of the Somali family and the whole community. Somali society does everything possible to make sure that a bride is a virgin because of payment of the bride price. Families do not put a stop to the custom, out of fear of the older generation and fanatic religious leaders. The custom can only be abolished through education.

A National Committee coordinated by the Somali Women's Democratic Organization composed of representatives of various Ministries, Unions, Youth Organizations, doctors, etc. has been formed. The Committee is now developing a nationwide campaign.

A report was submitted on "Female Circumcision - Physical and Mental Complications" by Mrs Edna A. Ismail, WHO Temporary Adviser and Director, Department of Training, Ministry of Health, Somalia. Mrs Ismail cited the different forms of circumcision as:

1. Mild Sunna
2. Modified Sunna
3. Partial or total clitoridectomy
4. Infibulation (Pharaonic female circumcision).

The operation is carried out by a woman who earns her living by the performance of such operations or it may be done by paramedical personnel or by the traditional old woman - the operated girls are between the ages of 5 and 8. After the operation the child is bound from the waist to her toes and is made to lie still on a mat. The child's diet is restricted and after the seventh day the thorns used to hold the wound together are removed. After the nineteenth day the child may begin to take some steps with a stick.

The physical and mental complications are delineated. The physical complications include the immediate shock from pain and haemorrhage, lacerations due to the struggling of the child, sepsis, retention of urine, closing of the urethra and failure of the infibulation. Usually in this case another operation is done on the child and sometimes a third. Also at the time of marriage more lacerations are inflicted on the woman by her husband and additional cuts have to be made at the time of childbirth.

Mental complications begin to affect the female child from an early age and remain with her throughout her life. Well before the child is circumcised she sees others who have been recently circumcised or hears tales of horror relating to the act of infibulation. At the same time girls who themselves have been circumcised taunt others with insults and call them unclean.

Each stage of her older life will only add further to her mental injuries: the onset of the menarche with its accompanying discomfort and odors; marriage, the opening up of the infibulation and the agony of intercourse; the birth of the first child and the knowledge that subsequent deliveries are not going to be any easier on her scar-riddled vulva.

A survey was made in 1978 by 3 male medical students including interviews of 290 women in hospitals and among university students.

The report also has tables giving the result of the survey which shows the reasons given, the age of the girls, the complications, the hospital records of complications and much more.

The Histological Study of Normal Vulval tissue (Clitoris, labia majora and labia minora) removed at circumcision from 13 children, showed abundance of nerve fibres and touch organs especially in the clitoris.

Fibrous scar tissue of circumcised vulvae of 10 adult women removed at gynaecological repair operations showed very few nerve endings which were trapped in abundance of fibrous tissue.

Circumcision and infibulation (Pharaonic circumcision) results in destruction of the nerve supply of the vulva, thus rendering it into a sheet of fibrous tissue with minimum function.

This paper will present the normal anatomical layout with special reference to innervation and its loss following circumcision and infibulation.

In the fourth session, Dr Suleiman Modawi, Ministry of Health, Khartoum, gave the first presentation under the country profiles of the Sudanese experience. In his paper "The Obstetrical and Gynaecological Aspects of Female Circumcision" Dr Modawi presented the Sudan profile of female circumcision. He reviewed the world history, the entry of circumcision into Sudan and its distribution and then made a critical review of the social impact of socio-economic factors and the changing aspects of circumcision.

Dr S. Mirghany El Sayed (Sudan) from the Centre Hospitalier de Villeneuve, Saint Georges, Villeneuve Saint Georges, France, presented a paper on female circumcision. The paper was read in French. It is part of an M.D. thesis submitted to the Faculty of Medicine in Paris. The material was collected over two years and the aim of the study was to find out the reasons and motives for female circumcision. These were discussed.

After the paper was read, a film was shown. The film was photographed in Central Africa and it shows how the operation is performed and the ceremonies and celebrations which are performed for the occasion.

A very lively discussion followed the presentation of the first two papers.

1. Mrs Aimal Arbab, Ministry of Social Affairs, Sudan, took up the point about the effectiveness of the law in abolishing female circumcision and said that probably the law was not effective earlier because those who introduced it did not take into consideration the social circumstances and did not provide alternatives, but if legislation is passed with due consideration to these factors, then they will help in reducing the harmful consequences of the practice.

2. Dr R.A. Khan, WHO Programme Coordinator in Sudan said that Moslems in the world number about 600 million, while female circumcision is only practised by about one fifth of them, so if it had any religious basis it would have been practised by a larger proportion. He suggested that it is probable that those who would like to perpetuate the practise give it a religious quality.

3. Dr R.M.U. Sannerup, Programme Manager, Traditional Medicine, WHO Geneva, said that the pattern of circumcision in all country reports was similar and the reasons for it were multiple. He stated that it is clear that our aim here is to abolish the practice; so he suggested that it might be more useful if the participants would dwell a little more on what to do to abolish the practice. He said it may be worthwhile to look into the experience gained in the field of family planning and try to make use of it here.

Dr Mohammed Shaalan, Assistant Professor and Chairman, Department of Neuro-psychiatry, Faculty of Medicine, Al-Azhar University, Cairo, Egypt, then presented his paper "Clitoris Envy: A Psychodynamic Construct Instrumental in Female Circumcision". Dr Shaalan said that the prevalence of the practice of circumcision over so many centuries and in so many areas, indicates that it is no accidental occurrence. Yet its lack of ubiquity and its declining prevalence indicate that the hypothetical belief on which it was based is uncertain and/or that it is ceasing to be verified.

On the basis of clinical psychotherapeutic experience and other sources, this hypothesis may be speculated to be as follows:

Sexuality was associated with reproduction; reproduction required surplus male labour to provide for the offspring; surplus male labour was provided in exchange for female chastity and fidelity; reduction of female sexual desire and excitability was conducive to chastity and fidelity; this reduction was achieved by excision of erogenous genital areas (essentially the clitoris) or circumcision.

With present social changes reproduction is losing primacy in favour of relation and recreational sexuality. Female chastity and fidelity are declining as exclusively female virtues and circumcision is becoming redundant.

Conscious evolution coupled with rapid social change necessitate active intervention to limit circumcision.

Dr T.A. Baasher, WHO Regional Adviser on Mental Health, then presented his paper: "Psycho-Social Aspects of Female Circumcision". Dr Baasher gave a general introduction on psycho-social aspects of female circumcision. He spoke about the psycholinguistics in female circumcision, the meaning and psychological background of the practice, the psychiatric problems of it and its political associations. He said that words to describe female genitalia in our culture are few and they mainly describe the shape of them. Studying the linguistics will help in understanding the psychology of female circumcision. He said that psychological reactions depend on many factors e.g. defence mechanisms, personality factors, past experience, psychological and social support during and after the operation, and described the psychiatric disturbances resulting from the inflicted psychological trauma or manifesting as a sequelae to the physical complication. He further added that there is paucity of prospective studies about psycho-social disorders following female circumcision and the findings are conflicting. Dr Baasher gave two examples from Kenya and Sudan in relation to politics and female circumcision, where the early efforts to abolish the practice were met with resistance from nationals who thought that the colonizers wanted to destroy the code of modesty and national solidarity when they interfere with such practices.

Dr Malik Badri, Dean, Faculty of Education, University of Khartoum, Sudan, in his paper "Sudanese Children's Concepts About Female Circumcision" stated that any wide range programme to effectively change deep rooted customs and children's

attitudes should be studied. Bearing this in mind a pilot study was made with two groups of girls who were also asked to make some drawings. The two groups of 24 and 19 girls respectively had definite concepts of circumcision as their drawings also indicated. The children expressed a variety of reactions including fear of surgical instruments.

"Opinions about female Circumcision" was a paper delivered by Dr Gasim Badri, Ahfad University College, Omdurman, Sudan. The study group consisted of 60 Sudanese gynaecologists, 24 midwives and 190 female college students. A questionnaire including questions about complications of circumcision, attitudes towards the practice, methods suggested for its eradication, if any, was distributed to all participating in the study group. There was a good response. All gynaecologists who responded said that circumcision has bad physical and psychological complications. They said that the factors perpetuating the practice are multiple. 10% of the midwives thought that circumcision is a good practice. 152 of the 190 female college students said that they will not circumcise their daughters. All of them said that they do not think their grand-daughters are going to be circumcised.

Dr Asma Abdel Razim El Dareer, Project Director, Department of Community Medicine, Faculty of Medicine, Khartoum, presented a preliminary report on "A Study on Prevalence and Epidemiology of Female Circumcision in Sudan Today" particularly in the White Nile province. This is a part of a broad study, assisted by WHO, on female circumcision. The objectives of the study are to determine the extent of the practice, people's attitudes towards it, health problems encountered, impact of socio-economic factors and possible ways of dealing with the problem. 90% of women interviewed were illiterate and of the lower socio-economic class. There are 3 types of circumcision: pharaonic - 84%, intermediate - 4% and sunna 1%. 4% do not practise circumcision and they belong to the Falata tribe. 81% of husbands approved the practice and 14% of them said it is prohibited by religion. Health education seems to be the most effective method to stop the practice.

Ms Rachel Mayanja - Special Assistant Secretary General for Social Development and Humanitarian Affairs, United Nations, New York, USA, stated that the question of women's health is a very important one, and the United Nations is interested in co-operating with WHO to ensure that this matter is given adequate attention. With regard

to female circumcision she urged the participants to consider whether or not this is a desirable practice. She stressed the need for the participants to make concrete proposals with a view to either abolishing it or providing it under better conditions. She appealed to the media when presenting the views expressed to the public at large to report accurately placing this sensitive topic in its proper context.

The first morning session was devoted to the discussion of the previous day's papers.

Dr E.C.A. Johnson, Chief Consultant Neuro-Psychiatrist, Psychiatric Hospital, Yaua, Nigeria, chaired this session. At the start she welcomed to the meeting Mrs Alice Tiendregeogon, President, Federation of Women of Upper Volta and Representative of the International Alliance of Women, Ouagadougou, Upper Volta, who arrived the previous day. Then she invited the previous day's speakers to give brief summaries of their presentations to refresh the memories of the participants before starting the discussion. After that was done, the Chairman opened the floor for discussions. At the end of the discussion the Chairman invited Mrs Tiendregeogon to give her country report. Mrs Tiendregeogon addressed the meeting in French.

Commencing with the background of her country Mrs Tiendregeogon stated that the Mossi, the largest ethnic groups, have a patriarchal culture, while other population groups have a matriarchal system where the children belong to the mother's family. About 30% of the population is Moslem, 20% Catholic and the rest animist: all groups practise excision, without infibulation. The operation is done when the girls are 10 - 12 years old and are isolated for four weeks afterwards and taught about their adult responsibilities.

Cultural customs are beginning to disappear, however, excision continues also in the cities and is performed under very bad hygienic conditions. The Voltaic women's Organization started a campaign against excision through a radio broadcast, after asking women why they practised the operation. Most of the women responded "because it is the custom". The women who oppose the excision are the educated ones. Although the Women's Organization dealt only with health problems, the campaign caused an adverse reaction from men as well as women. Therefore the campaign was stopped. This campaign was in 1975; since 1979 is the International Year of the Child abolition of the practice is necessary.

Various points were raised in the discussions; finally it was agreed that a Sub-Committee be formed to draw up resolutions and recommendations in the light of the presentation on female circumcision and the discussion that followed. The following were elected for the Sub-Committee: Dr S. Modawi (Sudan); Dr Afaf A. Salem (Egypt); Sister B. Beddada (Ethiopia); Miss Grace Mbevi (Kenya) and Ms Raqiya Haji Dualeh (Somalia). They were assisted by Dr R.H.O. Bannerman (WHO Central Office, Geneva) and Ms Rachel Mayanja (United Nations, New York).

In the late morning session Dr Afaf A. Salem, Director, General Directorate Maternity and Child Health, Ministry of Health, Cairo, took the chair.

Dr Salem introduced the first speaker, Mrs Mehani Saleh, Maternal and Child health Supervisor, Ministry of Health, Aden, who presented her statement on "Traditional Practices during Pregnancy - Female Circumcision and Child Marriage in Yemen Democratic Republic". Mrs Saleh gave a general introduction about the country and an account of traditional practices during pregnancy and labour. She said that during the post-natal period the nursing mother does not take cold drinks and she is not allowed to take certain food like fish and beans because it is thought that this will pass with the mother's milk and cause abdominal pain in the child. The duration of confinement after delivery is 40 days. She said that circumcision is usually done by the traditional midwife and can take place as early as the seventh day after birth. She also stated that the marriage age for the female is between 15 and 16 years.

Mrs Saleh suggested some measures - such as general education, health education - be taken to abolish practices dangerous for women's health. She made a plea for women's organizations to take a leading role.

C. Early marriage and childbirth

Then Dr L.J. Ghulam, Senior Public Health Officer, Ministry of Health, Oman, presented her paper on "Early Teenage Childbirth and its Consequences for both Mother and Child". Dr Ghulam indicated that in Oman both sexes, especially females, get married when very young, and as a result the infant mortality rate is very high. She presented a summary of a study conducted in Nizwa and Soher communities in Oman regarding early teenage childbirth. 27% of women interviewed in Nizwas were married at the age of 11 and 86% were married by the age of 15. In Soher 9% were married by

the age of 11 and 90% by the age of 15. There is a trend towards marrying at a later age in Somer. Dr Ghulam then listed the complications that result from early marriage, e.g. risk of operative delivery, low birth weight. She ended by recommending a design of a health education programme and passing some legislation to stop the practice.

The third speaker was Sister B. Beddada, Instructor, Health Assistant School, Menelik II Hospital, Addis Ababa and she gave a brief communication on child marriage in Ethiopia. She stated that the marriage age for the female is between 12 - 15 years. The main reason for that in the mind of the people is to prevent pre-marriage pregnancy.

Miss Grace Mbevi, Public Health Nurse, Kenya, presented a paper on "Child Marriage and Early Teenage Childbirth". As mentioned in the past, children were counted as wealth. This was because, for the female children, a brideprice was paid (dowry) and this was a source of income to the family. Child-marriage was also a custom; the main function of a woman was to bear children, hence the custom of early marriage, but this practice is dying out in Kenya. The Government and religious leaders are playing a very significant role on this issue. Miss Mbevi explained how the child is exposed to early responsibility which is difficult to cope with and this leads to mental stress and many other complications. Due to early marriage the female child is deprived of education and this is essential for the developing countries since, as everyone knows, to educate women is to educate the nation.

The fifth paper was presented by Dr M. Warsame, Director, Benadir Hospital, Mogadishu, on "Early Marriage and Teenage Deliveries in Somalia". Dr Warsame stated that the country is divided into 3 economic groups: the nomadic (about 70%), the agricultural (about 15%) and the urban who are the minor component. He said in the nomadic areas a man is not considered mature before the age of 20 years and in these areas marriage is decided by the elder male relatives. Polygamy is practised in this nomadic sector. The nomadic prefer to have children at intervals of 2 years.

In agricultural communities early marriages occur usually at the age of 15. In these communities there is no spacing of pregnancies and the birth rate is very high.

In the urban community only a few still practise child marriage, sometimes at the age of 12, and in this community polygamy is very rare. The average age of marriage is 20 years. .

The Chairman expressed her regret for the absence of Dr Haddad O. Karoun, Head, Department of Obstetrics and Gynaecology, Faculty of Medicine, Khartoum, who was expected to present a paper on "Adolescent Pregnancy and Childbirth". She then introduced Dr O. Modawi, Senior Gynaecologist and Obstetrician, Ministry of Health, Sudan, who made a brief comment on teenage pregnancy. Dr Modawi said that generally early marriage is the mode in many parts of the country. Several factors play their role here e.g. tradition, religion, few chances for education. He said that there are no social difficulties as a result of this early marriage, but mainly health problems to the young primigravidae. He also said that, except for very few tribes in the Southern part of the country, early teenage pregnancy in the unmarried is a stigma and is unwanted.

After the presentations, the floor was open for discussion and valuable comments were made.

Mrs Edna Adan Ismail, WHO Temporary Adviser and Director of Department of Training, Ministry of Health, Somalia, presented a paper on "Child Marriage and Early Teenage Childbirth". Mrs Ismail stated that although child marriages sometimes take place among nomadic and agricultural communities, the practice is very rare now in Somalia. No accurate statistics can be obtained since these communities conduct their marriages and deliveries themselves. Statistics on deliveries at the Mogadishu Maternity Hospital during the last six months show that there have been no deliveries of females under the age of fourteen years. It is not known if the practice was reduced because of the law which was passed on 11 January 1975 which makes it illegal for a female below the age of 16 to be married and a male below the age of 18, or whether the practice is dying out because of economic reasons. In any case, the practice of child marriage no longer presents problems in Somalia.

III. RECOMMENDATIONS

Three categories of traditional practices - useful, harmless and harmful - were discussed by the participants in the Seminar. The following recommendations were proposed in support of useful practices and to abolish harmful ones. Special recommendations were made to correct harmful practices and to replace them with positive actions to promote better health.

National policies should be formulated to promote useful practices and to abolish harmful ones.

A. Useful practices

- Governments should recognize the need for adequate breast-feeding for the health of the child, which reflects on the total well-being of the family and the nation.
- Feeding of expectant mothers should be promoted.
- Day nurseries and crèches for working mothers should be a matter of priority.
- More part-time professional as well as non-skilled jobs should be available for women.
- Intensive nutrition education programmes should be launched by all those involved in the health of mothers and children.
- Nutrition education for women through MCH centres, schools and rural health units should be encouraged.
- Nutrition education should be propagated by the mass media with the widest possible coverage.

In summary, traditional breast-feeding patterns should be supported by giving women the opportunity to continue breast-feeding and by providing them with information on healthful feeding patterns for themselves as well as for their children.

B. Harmless practices

A variety of harmless practices were discussed, such as fumigation and certain charms, amulets etc. to ward off evil spirits. It is envisaged that with health education and socio-economic changes, such practices will disappear and the community will make appropriate use of available modern medical technology.

C. Harmful practices

- (a) Harmful practices, customs and traditions, for example restrictive feeding patterns during pregnancy or abrupt weaning, should be exposed; special educational programmes should be designed concerning the harmfulness of such practices; and positive attitudes towards nutrition, involving useful, locally available foods, should be promoted.
- (b) Other harmful practices, for example the restriction of high-protein diets including fish, chicken, eggs and camel meat in certain communities, should be discouraged because of their ill effects.
- (c) It is the belief among some communities that the milk of pregnant mothers is harmful to the child she is nursing and consequently breast-feeding is abruptly stopped, with ill effects on the child. hence, special educational programmes for pregnant women and mothers should be developed and promoted to stop these harmful practices.
- (d) Special attention should be focused on the insufficiency of appropriate nutritional ingredients of supplementary foods for infants, the tendency to feed low protein-calorie diets to babies, the ill effects of the promotion of artificial and manufactured milk and food substitutes for babies.
- (e) Other harmful practices and remedies were discussed, e.g. cautery (the application of hot iron sticks to certain parts of the body as a curative and preventive measure for diarrhoeal diseases and respiratory infections; cautery of children's gums at the time of teething, etc.).
- (f) Noting the harmful effects associated with the use of tobacco, khat, alcohol, etc. in some countries on pregnancy, it is recommended that concerted efforts be made for the prevention of the use of these toxic agents.

D. Female circumcision

The following recommendations were made:

- (i) Adoption of clear national policies for the abolition of female circumcision.

- (ii) Establishment of national commissions to coordinate and follow up the activities of the bodies involved including, where appropriate, the enactment of legislation prohibiting female circumcision.
- (iii) Intensification of general education of the public, including health education at all levels, with special emphasis on the dangers and the undesirability of female circumcision.
- (iv) Intensification of education programmes for traditional birth attendants, midwives, healers and other practitioners of traditional medicine, to demonstrate the harmful effects of female circumcision, with a view to enlisting their support along with general efforts to abolish this practice.

E. Childhood marriage and early teen-age childbirth

It was recommended to:

- Conduct further research concerning child marriage and early teenage childbirth in all its aspects, i.e. medical, social, psychological, etc., to find out the possible complications.
- Design health education programmes in order to discourage childhood marriage.
- Introduce legislation to stop childhood marriage when and where appropriate.

ANNEX I

ADDRESS OF HIS EXCELLENCY SAYED KHALID HASSAN ABBAS,
MINISTER OF HEALTH, SUDAN, TO THE SEMINAR ON TRADITIONAL
PRACTICES AFFECTING THE HEALTH OF WOMEN HELD IN THE FRIENDSHIP
HALL, KHARTOUM
FROM 10-15 FEBRUARY 1979

Distinguished participants, Ladies and Gentlemen,

Greetings of our eternal and "God Given" victorious revolution. I bring you greetings from our brother President Gaafar Mohammed Numeiry wishing to express our extreme happiness that you have chosen the Sudan as the venue of this important Seminar. I wish to thank the participating brothers and sisters and I greet the institutions and the international, regional and local organizations who have participated in this Seminar, especially the World Health Organization and United Nations Development Programme and their representatives in Alexandria and the Sudan.

Women constitute half the society, carrying the burden of building the family and the society. It is therefore imperative for governments and organizations to protect her in order to ensure development. For this reason it has been our policy in the national health programme to give priority to maternal and child health within the preventive and medical services, thus following what has already been provided for in the Constitution towards the protection of women. Since the mother is the very foundation of the family, to protect her means to provide happiness and peace to the whole family and to the ideal society for which we aim. Despite our ambitions and dreams to provide the best for her, we find that our resources are limited and we, therefore, seek for help from the international organizations in order that they may assist us in achieving our goals and ambitions.

We, as a country with its own history, customs and traditions, originating from the environment must give these customs and traditions much attention. We must also study them to benefit from them. At the same time must study the harmful practices in order that we may avoid them and try and eradicate them and, protect the health and happiness of the women and the family.

The cadres working in the health fields, and especially midwives and dayas, are accepted and respected by mothers. We, therefore, train them and prepare them in the fields of health education in order that they may carry out this role. We hope that the Women's Associations will carry out their active and effective roles in spreading health knowledge.

We, therefore, hope that this Seminar will collect the necessary information concerning the traditional practices, especially in the case of circumcision, traditional nutritional practices, early marriage and traditional practices in the field of pregnancy and child bearing, in order to find the best ways and means to develop and spread the beneficial practices and to eradicate the harmful ones.

We have made many previous efforts to eradicate some of these harmful practices through the legal system, but many of these methods have failed. We must, therefore, turn to health education as the means of spreading health knowledge hoping that we may thus influence the people and make them want to act in a correct and healthy way. These new trials and approaches have shown some hopeful results and we are convinced that health education will be our means to change these harmful traditions to better and beneficial customs.

I wish all success to your Seminar in order that you may reach effective decisions and recommendations and we, in the Ministry of Health, will give your recommendations all our support and will see that they are carried out, and together we hope to reach our aim in building our modern society without forgetting our good and beneficial traditions which may help assist us in growth and development.

ANNEX II

MESSAGE FROM DR A.H. TABA
DIRECTOR
WHO EASTERN MEDITERRANEAN REGION
TO THE
SEMINAR ON TRADITIONAL PRACTICES
AFFECTING THE HEALTH OF WOMEN
Khartoum, 10-15 February 1979

Dear Colleagues, Ladies and Gentlemen,

It gives me particular pleasure, and indeed happiness, to welcome you all, on behalf of WHO, to this important Seminar on Traditional Practices Affecting the Health of Women. Much as I would have liked to be in person with you, due to other official commitments this was not possible. However, I wish your meeting fruitful deliberations and successful discussions.

I am particularly grateful to the Government of the Democratic Republic of the Sudan for hosting this Seminar, and to the Ministry of Health, under the leadership of H.E. Sayed Khalid Hassan Abbas, Minister of Health, for unfailing support and excellent collaboration in the preparation of this meeting.

Furthermore, I am appreciative of the keenness and interest shown by various countries and by a number of UN agencies, non-governmental organizations, institutions and the mass media. This interest is not new nor surprising for, as you are aware, the UN and its Member States have been increasingly concerned with the promotion of the status of women and their role in economic and social development. This was formally acknowledged by declaring 1975 International Women's Year, and by proclaiming the ensuing decade the United Nations Decade for Women. Similarly, the World Health Assembly in 1975 passed a resolution urging governments to widen the range of opportunities for women in all aspects of health and to ensure the further integration of women in health activities.

Furthermore, special attention was given to traditional practices and their effects on the health of women, with the primary objective of fostering a realistic approach to promote useful and proven practices and do away with harmful ones.

In this respect, I am pleased to point out that concerted efforts have recently been made by the WHO Eastern Mediterranean Regional Office to systematically collect information and stimulate interest in this subject. It has also been advocated that the consequences of traditional practices, be they healthy or adverse, be highlighted, wherever appropriate, in training programmes and scientific meetings.

At the international level, it is important to recall that in 1976 the Director-General of WHO drew the attention of the World Health Assembly to the need to "combat taboos, superstitions and practices that are detrimental to the health of women and children, such as female circumcision and infibulation". It has also been considered appropriate to include the latter topic as well as others among the agenda items of this Seminar.

It is obvious that the topics with which you will be dealing are intricately culture-bound and deeply enmeshed in the customs and beliefs of the people and have, therefore, to be appropriately studied within their local contexts and social perspectives.

I feel confident that the distinguished participants in this Seminar, with their multi-disciplinary professional backgrounds and wide experience, will competently contribute to its success and I will, therefore, be looking forward to the recommendations emanating from you, which I sincerely hope will be helpful in the promotion of the health of women and in the proper care of children.

ANNEX III

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ANNEX IV

LIST OF BASIC DOCUMENTS

Agenda	EM/SEM.TR.PR.AFF.HTH.WM/1
Programme	EM/SEM.TR.PR.AFF.HTH.WM/2 Rev.2
List of Participants	EM/SEM.TR.PR.AFF.HTH.WM/3 Rev.2
Nutritional Taboos and Traditional Practices in Pregnancy and Lactation including Breast-feeding, by Dr Hafiz El Shazali	EM/SEM.TR.PR.AFF.HTH.WM/4
Dietary Practices and Aversions during Pregnancy and Lactation among Sudanese Women, by Dr Ali K. Osman	EM/SEM.TR.PR.AFF.HTH.WM/5
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