Raising the awareness of infant ora mutilation - myths and facts

The earliest literature report on infant oral mutilation (IOM) was recorded in the year 1932 and related to the Nilotic people of Sudan. Since then, there have been more reports on the practice of IOM coming from more countries in the Eastern region of Africa. Among these countries mentioned in relation with this practice are Sudan, South Sudan, Ethiopia, Somalia, Kenya, Tanzania, Uganda, Democratic Republic of Congo, Burundi, and Rwanda. Other than Eastern Africa countries that have reported on the practice of IOM, the other countries are Burkinafaso and Chad. Many studies have not been extensively done on this practice, but few that have been done have shown the prevalence of this practice to be relatively high, with Uganda having reported a prevalence of 35% in the Acholi tribe and Tanzania reported a prevalence of between 5.2% and 16.9% in some of the tribes. In Kenya, a study in 1988 showed the prevalence of IOM in the Maasai tribe to be 35%. Indeed, IOM appears to be an issue that needs addressing by the dental fraternity.

The most commonly practiced IOM is the extraction of the primary canines. It is believed that by extracting the primary canines in children, the children will be rid of all childhood illness and fevers. These illnesses include diarrhea and fevers in the child. The myths behind IOM lies in the fact that the people in these tribes believe that the swelling in the gum pads of the child, corresponding to the developing primary canines, is growing ñwormsò or ñmaggots,ò and that this should be removed to heal or prevent the child from having diarrhea and fevers. To them, if the removal of the canine buds is not done, the child will suffer from this illness caused by the ñwormsò and will lead to premature deaths of the children.

The traditional healers within the tribes that practice the IOM are the ones who are responsible for advising the parents on this and also in the removal of the ñworms.ò These traditional healers have no background medical training, but within the communities in which they live, they are regarded as the most competent advisers on health matters and the ones to provide the best medical care for the children in the community. They are, therefore, respected by the community and provide various cures to many of the diseases found within the community they serve. Given that, most people from the countries where IOM is practiced are poor and live in the rural areas with poor communication networks; their first call for any medical help will be at the traditional healer home. The community will most likely take the advice given by the traditional healer as the Bible, and since the majority of these people are unlikely to financially or on grounds of communication technicalities afford proper medical consultation.

Nonetheless, sometimes the tradition in some tribes is so entrenched that, in a study done in Kenya in 2010, the results showed that even the traditional birth attendance, who have had some education and awareness training in health care, also provided IOM services to the communities that they served. It can only be speculated that they were probably doing this because they believed and wanted to be associated with their traditions and cultures, and or the financial benefits derived from the service helped alleviate their livelihood.

How infant oral mutilation is undertaken and its consequences

The age at which the canine mutilation is undertaken has been around 5 months of age of the child. This is also the time that the growing primary canine buds show clear bulges within the gum pads of the child. It is also the time that the growing child is establishing its humoral immunity, transitioning from the humoral immunity provided by the mother through the placenta at birth. During this period, the child is susceptible to infections and fevers. This could be the reasons for the practicing people who believe that the child will have fevers caused by the ñworms.ò And that by removing this worm, the child become cured of the diseases.

Prior to the mutilation of the canines, the mother will normally be advised to rub certain herbs on the gum pads of the child and also rub the same on her breast for a week. On the day of the removal of the teeth, the mother assisted by an assistant helps to pin down the child and at the same time force to open the child's mouth. With the use of unsterile traditional instrument, in the form of a chisel-shaped instrument made from nails or other metals, the traditional healer excavates the bud out, after which some other herbs are rubbed on the areas where the removal has been done, presumably to help in the control of bleeding and the healing of the wound. During the surgical procedure to remove the primary canines, no kind of anesthetic is used to prevent the pains. After the removal, the mother/parent is shown the milky looking extracted canine that nearly resembles a worm, and told that the child would be free from all the childhood diseases and fevers. In some tribes, the disposal of the extracted teeth is important, and proper disposal should help other children in the family not to get the childhood diseases. The assumption of a connection between the ñwormò and the common symptoms of childhood is febrile illness and diarrhea, and in particular, as it relates to the eruption of primary teeth, it has been with these traditional people for many years.

Arising through the manner, IOM is conducted including the unhygienic environment, in which it is undertaken, the child becomes susceptible to inflammation, swelling of the affected areas of surgery, various infections, septicemia, Ludwigs angina, tetanus, and even disease transmission such as HIV/AIDS. Further, there is the likelihood of the child contracting anemia due to the blood loss through the procedure or infections thereafter, and also the expenses arising from the hospitalization that may ensue.

The practice can also result in the damage to the permanent canines, later impaction of permanent canines due to space loss. This early loss of the primary canines can result in a general loss of space for the Succedeneous teeth with the child ending up with expensive orthodontic treatment later on in life.

Conclusion

The reasons why IOM is becoming a major concern for the world are because of the recent movement of people from areas where the practice is rampant to areas where this is unheard of. Legal or illegal migration is taking place today, and many of the children from the affected areas are moving with their families to the United States of America, Europe, Australia, and New Zealand. In these countries, IOM is not practiced and therefore; the oral health workers are unaware of the phenomenon. Further, the parents may be unwilling to disclose the phenomenon

to the health worker. There is even a possibility that the practice is still so entrenched in some tribes, that even the migrants could continue to practice clandestinely in their new home country or return newborn children to their original homes to undertake the practice before return back to their new homes. Some of the countries that have large populations of migrants from areas where IOM is being practiced are Sweden, the United Kingdom, Germany, Denmark, Norway, Finland, the Netherlands, Australia, and New Zealand.

Therefore, the dental professionals should be aware of this practice and be prepared to deal with its consequences, besides providing advice on stemming the practice. This can only be done through equipping the people who still believe in IOM with the requisite knowledge ï done through education programs geared to understanding why they should not do it and how to stop the practice. Through such programs, a change of practice will ensue, and the children from these tribes will have been saved from the sufferings of IOM and the fatalities arising from IOM.