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O. N. MAKINDE, J. B.E. ELUSIYAN, A. B. ADEYEMI and O. T. TAIWO

ABSTRACT

***Background*: For more than 25 years, efforts have been geared towards curtailing the practice of female genital mutilation (FGM) in countries like Nigeria. This study was designed to see if all these efforts have made any impact in reducing the prevalence of FGM appreciably in the south-West of Nigeria.**
***Objective*: To determine the prevalence of female genital mutilation and profiling the trends of FGM affected patients.**
***Design*: A prospective study based on direct observation of the external genitalia by health-care workers .**
***Subjects*: Five hundred and sixty five females less than 15 years of age.**
***Setting*: The children emergency and gynaecological wards of the Obafemi Awolowo University Teaching Hospitals Complex, Ile-Ife, Nigeria from 1st of January to December 31st 2007.**
***Results*: Forty one point nine percent of the patients examined had female genital mutilation, 93.2% of these had the procedure before attaining the age of one year. Type 2 FGM predominated (58.22%). The procedure was performed predominantly (64.6%) by traditional birth attendants. The decision to have the procedure done was influenced in 78% of cases by mothers and grandmothers. In 35.4% of cases, there were immediate and short term complications. Demands of tradition predominated (59.1%) as the most important reason for the practice of female genital mutilation.**
***Conclusion*: The practice of FGM appears to be still highly prevalent and resistant to change probably due to deep rooted socio-cultural factors. Strategies such as public education campaigns highlighting its negative impact on health and disregard for human rights should be evolved.**

INTRODUCTION

Female genital mutilation (FGM) is defined as "the partial or total removal of the female external genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons" (1). Globally, it had been a pressing public health and human rights issue that necessitated the gearing up of efforts in eradicating it for over three decades by various countries, international health and developmental agencies (2). In spite of all these efforts at eradicating it, FGM continues to be practiced in many parts of the world and even now in countries that hitherto it was non- existent due to large migrant populations from areas of high prevalence (3). FGM is practised widely in 28 countries in Africa and the Middle East spanning the West coast of Africa, Ethiopia, Somalia Kenya , Sudan and Egypt to the North. Recent survey data in 18 of these countries reveal the prevalence of FGM to range from 5% to 97% of the female population (4,5). A household survey conducted by the Women's Health and Action Research Centre, in the south-western part of Nigeria showed a prevalence rate of 89% (6).

It is glaring that FGM is a public health issue in that it is associated with short-term complications like haemorrhage, anaemia, pain, vaso-vagal shock due to pain, urinary tract infection and urinary retention. The long term sequelae of FGM are genital abscesses, infertility, cysts, hypertrophied or keloidal scars which may be problematic in subsequent pregnancy and child birth. A WHO collaborative group has revealed in a study conducted in six African countries including Nigeria, that FGM is associated with obstetric problems both for the mothers and their new born infants (7).

The practice of FGM is a clear violation of the

rights of the girl-child as the fundamental issue at stake is the absence of an informed consent for a procedure that is not therapeutic and with potential complications. FGM is also a form of violence against women in that there is an infringement of physical and psychosexual integrity of the affected females.

Many countries in Africa are signatories to Article V of the United Nations Universal Declaration of Human Rights and the African Charter on the Rights and Welfare of the child for over two decades yet the practice of FG appears unabated despite various advocacy programmes to eradicate it (6). In view of this, this prospective study was designed to profile the trends of FGM in a Teaching Hospital setting.

MATERIALS AND METHODS

This is a prospective study carried out at the Obafemi Awolowo University Teaching Hospitals Complex, Ile-Ife, Nigeria from 1st of January to 31st of December, 2007. All females aged less than 15 years of age who were admitted consecutively to the children emergency and gynaecological wards were recruited into the study after obtaining informed consent from the parents or guardians. Direct observation of the external genitalia by the physician (registrar / intern) on duty was carried out. These physicians had been trained in recognising types of FGM based on WHO categorisation. Categorisation of FGM into 4 types was done (1). Type I- excision of the prepuce, with or without excision of part or the entire clitoris. Type II - excision of the clitoris with partial or total excision of the labia minora. Type III- excision of part or all of the external genitalia and stitching / narrowing of the vaginal opening (infibulation). Type IV – pricking, piercing or incising of the clitoris and / or labia; stretching of the clitoris and or labia; cauterisation by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice or cutting of the vagina; introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above.

A designed questionnaire was filled by each parent / guardian as appropriate. Each questionnaire contained socio-demographic data and parameters highlighting the trend of FGM among the patients as depicted in Tables 1 and 2. Thereafter, descriptive analysis of the data were carried out.

RESULTS

Table 1(a)
Socio-demographic data of patients

	Year	Number	%
Age	<1	153	27.0
	1-5	275	48.7
	6-10	76	13.5
	11-15	61	10.8
	Total	565	100
Religion			
	Christianity	428	75.8
	Islam	137	24.2
	Traditionalist	0	0
	Total	565	100
Ethnicity			
	Hausa	23	4.1
	Ibo	23	4.1
	Yoruba	481	85.1
	Any Other	38	6.7
	Total	565	100

Table 1(b)
Formal education of attending parent/guardian (up to primary level)

	None	46	8.0
	Yes	519	92.0
	Total	565	100

Table 1(a). shows the socio-demographic data of the 565 patients seen during the study period. Four hundred and twenty eight (75.8%) were under the age of six years, and by religion, Christians predominated with a total number of 428(75.8%).As regards ethnicity, Yorubas (85.1%) predominated, being the predominant ethnic group in Ile-Ife in the south-western part of Nigeria. Table 1(b) 519 (92%) of the parents and guardians of the admitted patients had formal education at least up to primary school.

Table 2
Trends in the practice of fgm

Evidence of FGM		Number	Percentage(%)
	No	328	58.1
	Yes	237	41.9
	Total	565	100
Type of FGM	Type 1	84	35.44
	2	138	58.23
	3	15	6.33
	4	0	0
	Total	237	100
Age when FGM was performed			
Year/s	<1month	99	41.7
	1month- 1	122	51.5
	>1 – 10	8	3.4
	>10	8	3.4
	Total	237	100
Category of person who performed FGM			
	TBA	153	64.6
	Midwife/Nurse	84	35.4
	Doctor	0	0
	Total	237	100
Who influenced the decision to have FGM done?	Grand Mother	53	22.36
	Grand Father	1	0.42
	Mother	132	55.69
	Father	5	2.10
	Other close relations	20	8.43
	Midwife	26	11.0
	Chemist	0	0
	Doctor	0	0
	Traditional Ruler	0	0
	Religious Leader	0	0
	Total	237	100
Complications	Immediate	61	25.7
	Short Term	23	9.7
	Long Term	0	0
	None	153	64.6
	Total	237	100

Cont. next page.

Most important reason for the practice of FGM	Demands of Tradition	140	59.1
	Prevention of Promiscuity	45	18.9
	Prevention of IntrapArtum Perinatal death	37	15.5
	Prevention of excessive growth of the clitoris	3	1.3
	Prevention of vulva infection	12	5.2
	Total	237	100
Is Fgm Harmful?	No	104	44.0
	Yes	107	45.1
	No opinion	26	10.9
	Total	237	100

Table 2 shows the trend in the practice of FGM in Ile-Ife. Two hundred and thirty seven (41.9%) of the patients admitted during the study period had female genital mutilation. One hundred and thirty eight (58.23%) of these had Type II FGM, 84(35.4%) Type I, 15(6.33%) had Type III and there was none with Type IV.

Two hundred and twenty one (93.2%) of the patients had FGM done at an age less than one year. The procedure of FGM was carried out predominantly (64.6%) by Traditional birth attendants (TBAs) and 35.4% by midwives and nurses. It is noteworthy that in 185(78.05%) of the patients who had FGM, their mothers and grandmothers influenced the decision to have the procedure done while fathers and grandfathers were responsible in only six (2.52%). Of the patients who had FGM, 61(25.7%) had immediate complications like pain, haemorrhage and vaso-vagal shock. Short term complications like infections including tetanus, urinary retention and anaemia were present in 23(9.7%). Long term sequelae were not seen in any of the patients who had FGM. There was no obstetric complication seen in any of the patients since all were nulligravidae and majority (89.2%) were pre-pubertal. When asked for the most important reason for the practice of FGM, 140(59.1%) of the parents and guardians of affected patients responded that it was due to " demands of tradition", 45(18.9%) responded that it was for " prevention against promiscuity" and 37(15.5%) responded that it was for the prevention of intrapartum perinatal death. Of the respondents who were parents/guardians of patients with FGM, 104(44%) responded that the practice was not harmful and 107(45.1%) thought it was a harmful traditional practice.

DISCUSSION

FGM had been widely practised in Nigeria for ages, and with its large population, Nigeria had been estimated to have the highest absolute number of cases accounting for about a quarter of estimated 115-130 million genitally-mutilated women globally (8). Within the geo-political zones of Nigeria, the South-South zone had the highest prevalence rate of 77% among adult females followed by South-East zone with 68% and South-West by 65%.Paradoxically, in the Northern zones the rate is lower but the more severe types are practiced. The national prevalence rate of FGM was 41% (9). Efforts at eradicating FGM had been on for decades by WHO, UNICEF, Federation of International Obstetrics and Gynaecology (FIGO),African Union, The Economic Commission for Africa, many gender-based Non-governmental organizations(NGOs) among many other concerned groups. However, there is no Federal law banning the practice in Nigeria.

From this study ,the practice of FGM still appears to be highly prevalent as 237 (41.9%) of the in-patients who were less than15 years of age (Table 2) were noticed during the study period to have had the procedure despite the campaigns and public enlightenment concerning the practice for over two decades. This may be due to deep-rooted socio-cultural reasons highlighted in Table 2. It is note worthy to see that 519(92%) of the parents/guardians had a form of formal education at least up to primary level (Table1). Thus it appears formal education may not be a deterrent to this practice. FGM was carried out on most of the patients before the age of one year(93.2%).This is a human right issue as each girl-child involved could not at such a tender age give an informed consent for the procedure which is not for any medical reason. Informed consent is a process involving autonomous authorisation by the individual concerned after full comprehension of the procedure.

It is not surprising to find out that Traditional Birth Attendants (TBAs) performed FGM predominantly (64.6%) since they have very close relationships with people in their communities at the grass-root level. The practice of FGM by trained healthcare personnel (medicalisation)should be discouraged and in this study, 84 (35.4%) were performed by midwives/nurses. " Medicalisation" which has

been reported to be high in Egypt (94%), Yemen(76%), Mauritania(65%),Cote d'Ivoire(48%) and in Kenya(46%) may obscure the human rights aspect of the procedure and also may hinder the development of long-term solutions for ending the practice (10).

In the study, mothers and grandmothers predominated (78.05%) in influencing the decision to have FGM done on the girl-children. This is note worthy in that adult females predominate in families in taking the decision to have the procedure performed despite many of them being aware that it may be harmful as depicted in Table 2. As a result of this, social scientists have opined that there may be deep-rooted socio-cultural reasons for the un-ending practice of FGM (11). This is buttressed in this study as shown in Table 2 where majority of the respondents (59.1%) responded that "demands of tradition" was the most important reason for the practice of FGM. Some of these deep-rooted socio-cultural reasons are: (a). It is part of a mother's duties in raising a girl "properly" and preparing her for adulthood and marriage, (b). The practice helps in preventing promiscuity, (c). It helps in preventing intra-partum perinatal death as it is believed that if the parturient's clitoris touches the foetal head during delivery, the baby may die,(d). It imparts on a girl "a cultural identity" as a woman, and confers on her a "sense of pride", a coming of age and admission to the community.

Table 2 shows that 35.4% of the patients who had FGM had immediate, short and long-term complications which have been previously highlighted. Eighty nine point two percent of the patients were pre-pubertal, consequently, would not be expected to manifest some long term complications such as infertility and obstetric difficulties. However, during the study, psychological and psychosomatic complications (12), such as disordered eating and sleeping habits, mood changes and impaired cognition were not highlighted.

FGM has also been noted to have adverse impact on a girl's education such as absenteeism at school, poor concentration and low academic performance (13).

During the study period, direct observation of the external genitalia by the healthcare worker on duty was carried out after obtaining consent from the parent/guardian of each patient. Thus accurate categorisation of the type of FGM done was possible. Thankfully in this study, majority of the patients had Type II (58.22%) for if the more extensive types had been performed generally, the complication rates would have been worse. The limitation in this study is that it was hospital based. Consequently, the prevalence rate observed could have been a "tip of the ice-berg" of what truly obtains in the community. This is buttressed by the finding of 89% prevalence in a house- hold survey carried out in the same region of Nigeria in 1998 (6). This may suggest that there had not been much change in the practice of FGM within the last decade between that study and the present one. Furthermore, the true extent of mortality associated with the procedure will remain a conjecture unless a community based study is carried out.

It appears that from this prospective hospital-based study that all stakeholders are not yet winning as regards the practice of FGM despite all that have been done to eradicate it for over two decades. The vision of the International Federation of Gynaecology and Obstetrics (FIGO) is that" Individual Obstetrician/ Gynaecologist would be aware of human rights issues related to women's sexual and reproductive health; would practice in concert with these rights; and would be a force at the community, national and international levels to promote the respect, protection and implementation of these rights"(14). This study is an attempt to keep this vision alive viz a viz FGM in our community and has brought to fore that it is still an on-going practice with all the public health and human right issues attached to it. It is believed that with the implementation of the following recommendations , FGM would later be eradicated:

(a). Large-scale community based studies should be carried out to give a better understanding of socio-cultural underpinnings of FGM which eventually would help to halt the practice as deep-rooted reasons for its practice would be unearthed and dealt with.
(b). Domestication and enforcement of international charters, declarations, laws and conventions at the local government levels
(c). Discouragement of "medicalisation" of FGM.
(d). Advocacy for the eradication of FGM stressing its public health and human right issues should be geared up in all strata of society.
(e). Religious leaders may be co-opted in the attempts to eradicate FGM since from this study, the practice of the procedure cuts across religions.
(f). The opportunity should be seized to educate ante-natal clinic attendees concerning the public health and human right issues of FGM.
(g) Where FGM is regarded as a rite of passage for the girl-child into womanhood, a programme to serve as an alternate rite of passage(ARP) can be evolved suited to local taste (15).
(h). As a last resort, there should be prosecution/ sanctioning of parents, guardians, Traditional birth attendants, healthcare workers and groups found culpable of FGM practice.

In conclusion, the practice of FGM appears to be still highly prevalent in our community despite decades of advocacy to eradicate it. A clarion call is being made to eradicate this unnecessary harmful traditional practice by introducing an alternative rite of passage suited to the local populace where the practice of

FGM is viewed as a" rite of passage from girl-hood to woman-hood". Furthermore, criminalising the practice of FGM through strong legislation and prosecution/sanctioning of offenders.

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