FEMALE GENITAL MUTILATION: OPINION OF OUTPATIENTS OF A DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY IN NORTH CENTRAL NIGERIA

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Background Female genital mutilation is known to exist especially in developing countries like Nigeria. This study aimed to determine women's views on aspects of female genital mutilation, types of female genital mutilation, reason for and attitude towards female genital mutilation.

Method: A Pretested questionnaire was administered to women attending the antenatal clinic in Jos University Teaching Hospital from October 2013 to February 2014. The data obtained were analysed using SPSS version 20

Result The prevalence of FGM from this study was 21.9%. In total, 429 respondents (97.9%) reported the existence of FGM at the time of the interview. Majority of respondents [(283) 66.0%] said that the clitoris was the main part removed. The main reason given for genital cutting was to prevent sexual promiscuity in sexual practice, and was the response of one hundred and thirty two (30.8%) of the women, while thirty five (8.2%) women responded that it was done to preserve virginity. Three hundred and eighty four(89.5%) were aware of the campaign against female genital mutilation and two hundred and ninety eight(69.5%) were in support of the legislation against FGM. Seventy nine(18.4%) were not in support of the legislation out of which nineteen(24.1%) feel that to stop is to interfere with the norm.

Conclusion Female genital cutting/mutilation is still practiced in our environment and some of the women knew the negative reproductive health consequences of FGM and had experienced them during sexual intercourse and childbirth. However, with regard to stopping FGM, majority had not taken any steps towards stopping the practice. There should be public enlightenment about the dangers of FGM and policies against this harmful practice should be enforced.

INTRODUCTION

Female Genital Mutilation (FGM) or female circumcision is one of those traditional practices whose origin can be traced to antiquity. Even though it was first discovered in Egyptian mummies about 200BC, it is practiced on all the continents of the world.[1,2] WHO (1997) reported that Female Genital Mutilation is a practice which involves cutting off part or whole of a clitoris and some other parts of her sex organs whether for cultural or any other non–therapeutic reasons.[3]FGM is practised as a cultural ritual by ethnic groups in 27 countries in sub–Saharan and Northeast Africa, and to a lesser extent in Asia, the Middle East and within immigrant communities elsewhere. However, the worst types of FGM are practiced in Sudan, Egypt, Mali, Ghana and Nigeria.[4] All the four types of FGM are practiced in various areas of these geographical locations.

It is typically carried out, with or without anaesthesia, by a traditional circumciser using a knife or razor. The age of the girls varies from weeks after birth to puberty; in half the countries for which figures were available in 2013, most girls were cut before the age of five.[5,6]

A World Health Organization interagency group has classified female genital cutting into four types: type 1, partial or total removal of the clitoris and/or the prepuce (clitoridectomy); type 2, partial or total removal of the clitoris and labia minora, with or without excision of the labia majora (excision); type 3, narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation); and type 4, all other harmful procedures to the female genitalia for nonmedical purposes, for example, pricking, piercing, incising, scraping, and cauterization. Herein, the term "female genital mutilation" (FGM) is used, because this term is recommended by the World Health Organization and all UN agencies.[6]It is estimated that about 100–140 million girls and women worldwide have undergone FGM, and each year a further two million girls and women are at risk of this practice. It is performed on girls aged 4–12 years and in some cultures as early as a few days after birth or as late as just before marriage.[5] As at 2013, FGM is found in many African countries with great variation in its prevalence between and within countries reflecting ethnicity and tradition.[7,8,9] According to the 2013 Nigeria Demographic and Health Survey (NDHS),about 25% of Nigerian women have experienced at least one form of female genital mutilation.[10]The prevalence of female circumcision in Southeast Nigeria based on a study done by Ezenyeaku et al was 42.1% , 53.0% by Adeokun *et al* in the Southwest Nigeria, 23.3% by Abubakar *et al* in Kano and 53.2% found by Ugboma *et al* in Port–Harcourt.[11,12,13] Various reasons have been given for the practice of FGM in these different geographical and cultural settings ranging from culture, religion to superstition.[14]

Among the reasons practitioners cite as benefits of FGM, according to UNICEF in 2013, are hygiene, social acceptance, marriageability, preservation of virginity/reduction of female sexual desire, male sexual pleasure, and religious requirement.[7] Infibulation is said by several sources to enhance male sexual pleasure; Gruenbaum reported that men seem to enjoy the effort of penetrating their wife's infibulation.[8]Most often cited is the promotion of female virginity and fidelity.[15] Infibulation almost guarantees monogamy because of the pain associated with sex and the difficulty of opening an infibulation without being discovered.[16] In Kenya, 30% of women supporting continuation of the practice agreed that FGM helped to preserve virginity and avoid immorality. In Nigeria, similar rates (36%) were reported by women, while 45% of

men supporting continuation of the practice agreed with this statement. FGM was believed to be proof of a girl's virginity, thereby improving the marriage prospects of unmarried girls who have undergone the procedure. In Côte d'Ivoire, "improved marriage prospects" was cited by 36% of women favouring continuation of the practice once married. FGM is also believed by some communities to ensure that a woman is faithful and loyal to her husband. For example, 51% of women in Egypt believe that FGM prevents adultery.[9]

FGM is outlawed in several African countries It is also outlawed in 33 countries outside Africa and the Middle East,[7] including across the European Union, North America, Scandinavia, Australia and New Zealand.

We therefore sought to determine women's views on aspects of female genital mutilation, types of female genital mutilation, reason for and attitude towards female genital mutilation and to determine the prevalence among the study population

Method:

A Pretested interviewer administered questionnaire was administered to women attending the antenatal, gynaecology and family planning clinics of the Jos University Teaching Hospital after obtaining informed verbal consent. The questionnaires contain questions aimed at obtaining basic socio–demographic characteristics. Questions related to awareness of the practice of female genital mutilation (FGM), awareness of the campaign against FGM, perceived reasons for FGM, complications experienced from the procedure and acceptance of the legislation against FGM were asked.

Sample size determination

The minimum sample size for the study was obtained using the previously reported prevalence of FGM from this environment with the following formula:

$n = p \times (1-p) \times (Z^2/d)^2$. This is same as $n = Z^2pq/d^2$

where Z=1.96 (coefficient of Z statistics for normal distribution table),

p = prevalence from previous studies,

q = 1−p,

p= Prevalence of 42% (Ezenyeaku CC et al. Enugu 2010)[17]

d= Desired degree of accuracy; here taken to be 0.05

$$\text{Sample size (n)} = \frac{(1.96)^2 \times 0.42\ (1-0.42)}{0.05 \times 0.05}$$

$$n = \frac{3.84 \times 0.42 \times 0.58}{0.0025} = \frac{0.935}{0.0025}$$

$$= 374$$

The sample size, was adjusted to compensate for an attrition rate of 10%

Therefore 10% of 374 = 37.4 ˜ 37.

Minimum sample size = 374 + 37 = 411 = 411

Another 10% of 374 was added because of those that will not fill the questionnaire properly = 411 +37 = 448.

Sample size of 448 was chosen

The data collected were analyzed using the SPSS statistical package version 20.0 (SPSS Inc, Chicago,IL).

Results

Questionnaires were distributed to 448 women. However, 10 questionnaires were not properly filled. Therefore a total of 438 questionnaires were analysed

The age group 20–44 years comprised 74.0% of participants. Fifty nine(13.5%) had no formal education, twenty four(5.5%) had Islamic education only, two hundred and one(45.9%) had primary education, ninety seven(22.1%) had secondary education and fifty seven(13.0%) had tertiary education (Table 1). Housewives (33.6%) and peasant farmers (29.2%) made up the majority of the respondents

In total, 429 respondents (97.9%) reported the existence of FGM at the time of the interview (Table 2). Majority of respondents [283, (66.0%)] said that the clitoris was the main part removed (Table 2). The

prevalence of FGM from this study was 21.9% (Table 3).The main reason given for genital cutting was to prevent sexual promiscuity in sexual practice, and was the response of one hundred and thirty two (30.8%) of the women, while thirty five (8.2%) women responded that it was done to preserve virginity (Table 4). Furthermore, 94 (21.9%) of participants had been circumcised and of these, 42(44.7%) reported having suffered some form of reproductive health and psychological problems after the procedure, during delivery and during sexual intercourse(Table 5). The participants were asked about the role of women in stopping the practice of FGM. The majority of women (397[92.5%]) had not tried to prevent FGM in the community but some (18 [4.2%]) had attempted to stop it (Figure 2). Three hundred and eighty four(89.5%) were aware of the campaign against female genital mutilation and 298 (69.5%) were in support of the legislation against FGM..Seventy nine (18.4%) were not in support of the legislation out of which nineteen (24.1%) felt that to stop is to interfere with the norm (Figure 1).

Table 1 Sociodemographic characteristics of the respondents (n = 438).

VARIABLE	FREQUENCY	PERCENT
AGE		
15–19	44	10.0
20–24	56	12.8
25–29	76	17.4
30–34	77	17.6
35–39	65	14.8
40–44	50	11.4
45–49	31	7.1
50+	39	8.9
RELIGION		
Christianity	329	75.1
Islam	109	24.9
MARITAL STATUS		
Married	396	90.4
Single	21	4.8
Divorced	2	0.5
Widowed	19	4.3

EDUCATIONAL STATUS		
No education	59	13.5
Islamic education only	24	5.5
Primary education	201	45.9
Secondary education	97	22.1
Tertiary education	57	13.0
OCCUPATION		
Housewife	147	33.6
Student	27	6.2
Salaried employee	39	2.7
Business	85	19.4
Peasant farmer	128	29.2
Others	12	8.9

Table 2: Awareness about the specific types of FGM being practiced among respondents who knew about this practice(n = 429).

Most of the respondents[429(97.9%0] are aware of the practice of female genital mutilation and the clitoris is the commonest site involved

TYPE OF GENITAL CUTTING	FREQUENCY	PERCENT
Clitoris only	283	66.0
Clitoris, labia	84	21.5
Clitoris,labia and surrounding part	41	10.5
Clitoris,labia,surrounding part and stitching	17	4.4
Others	4	1.0
Total	**429**	**100.0**

Table 3: Prevalence of female genital mutilation in the study population

	FREQUENCY	PERCENT
Circumcised	94	21.9
Uncircumcised	299	69.7
Don't know	36	8.4
Total	**429**	**100.0**

The prevalence of FGM is 21.9% while 8.4% do not know if they had been circumcised

Table 4: Perceived reasons for female genital mutilation (n = 429)

VARIABLE	FREQUENCY	PERCENT
Reasons for FGM practice		
Preserves virginity	35	8.2
Maintains hygiene	40	9.3
Religion	78	18.2
Tradition/culture	107	24.9
Prevents promiscuity	132	30.8
Aids future childbirth	5	1.2
Dont know	28	6.5
Others	4	0.9
Total	**429**	**100.0**

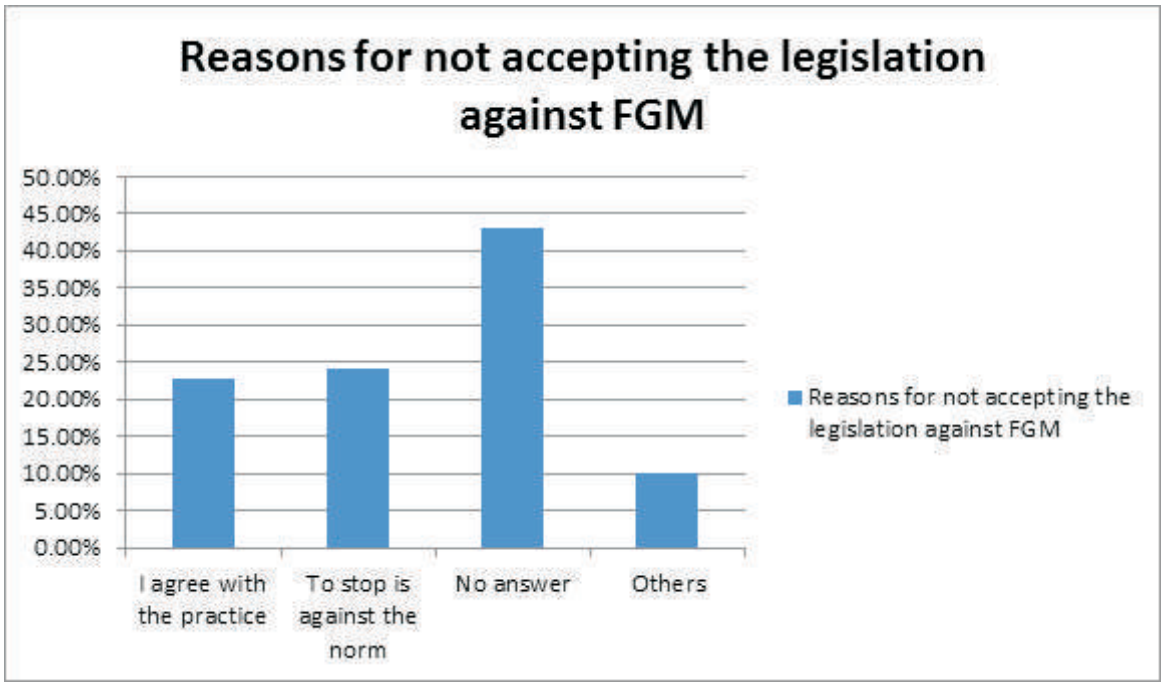
Table 5: Negative effects on the circumcised respondents (n = 42)

42 (44.7%) out of the 94 circumcised respondents had negative effects (complications)

NEGATIVE EFFECTS	FREQUENCY	PERCENT
Feeling of incompleteness	7	16.7
Reduced sexual satisfaction	16	38.1
Difficult childbirth	3	7.1
Pain during sexual intercourse	8	19.0
Pain during menstruation	2	4.8
Genital infection	2	4.8
Bleeding after the procedure	4	9.5
Total	**42**	**100.0**

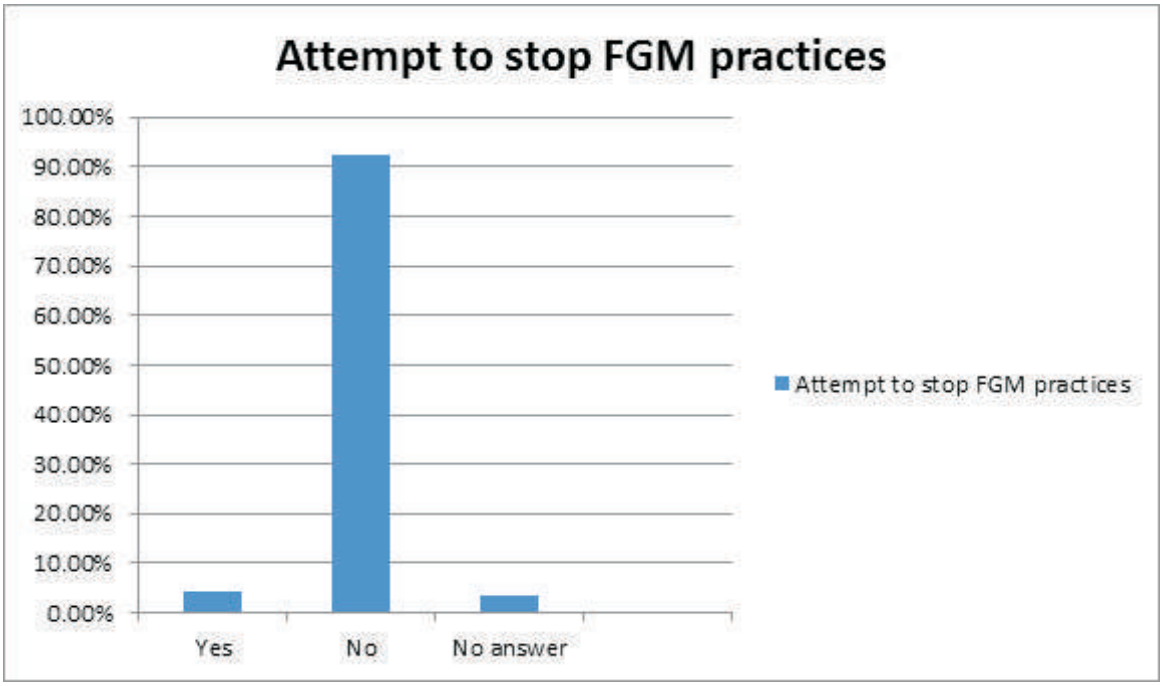
Among respondents aware of female genital mutilation, three hundred and eighty four (89.5%) are aware of the campaign against female genital mutilation while forty five (10.5%) are not aware. Most of the women are in support of legislation against female genital mutilation [289(69.5%)], seventy nine(18.4%) are not in support and fifty two (12.1%) are indifferent.

Figure 1: Reasons for not accepting the legislation to stop female genital mutilation(n= 79)



Among women that are not in support of the legislation against female genital mutilation, about 43% have no reason.

Figure 2: Women's behaviour and attitudes to stopping female genital mutilation. All 429 participants that are aware of the practice of female genital mutilation were asked general questions about FGM practices



About 92.5% of the women have made no attempt to stop the practice of FGM

DISCUSSION:

In this study, the prevalence of FGM was 21.9%. This is similar to the prevalence obtained from a study done by Abubakar et al. in Kano in 2004 (23.3%).[12] It is however lower than the findings of 53.0% by Adeokun, *et al*. in the Southwest Nigeria[11], 53.2% found by Ugboma *et al*. in Port-Harcourt[13] and 42.1% by Ezenyeaku et al. in the Southeast Nigeria[17]. In a similar study in the Somali region of Ethiopia, an even higher prevalence of 97% was reported.[18] The prevalence of FGM in this study is also less than the finding of the 2013 Nigerian Demographic and Health Survey report(25%)[10]. It appears that the rates vary across regions.

Majority of the respondents (97.9%) were aware of the practice of FGM and the level of awareness is higher than the level reported following the 2013 Nigerian Demographic and Health Survey which revealed that 68% of Nigerian women have heard of female circumcision.[10] This shows that majority of the study population are already aware of this practice.

The type of FGM most commonly practiced from this study was clitoridectomy (66%) and the least practiced was infibulation(4.4%). Garba et al. also found out that clitoridectomy was the commonest form practiced accounting for 96.2% of FGM in Kano.[19] This is similar to the findings in most countries in Africa where clitoridectomy is the commonest practiced form of FGM. Yirga et al. found out that clitoridectomy accounted for 78.9% of the types of FGM and infibulation accounted for 10.4% in the Kersa district of Ethiopia where the prevalence of FGM is very high(94%).[20]

Prevention of promiscuity (30.8%) was the commonest reason for the practice of FGM among the respondents for the procedure followed by culture/tradition (24.9%). This is not in keeping with the finding of Garba et al. and Anuforo et al who found culture/tradition as the most common reason.[19,21] This shows a trend towards shift from blind adherence to culture to the respondent 's own conviction. This is an important finding because practices based on individual conviction are easier to eradicate than those based on culture. The implication of this is that advocacy campaigns should be stepped up with more emphasis on educating these women on the harmful effects of FGM. About 8.2% of the respondents gave preservation of virginity as the reason for the practice of FGM. This is higher than the finding of Garba et al where only 3.8% gave preservation of virginity as a reason.[19] However, higher values were obtained from some African countries. Yirga et al. reported that 25.1% of women who knew about the practice gave preservation of virginity as the reason for the practice.[20] In another study, similar findings were reported by 30% of Kenyan women who supported this practice to preserve female virginity.[4] Similarly, more than half of Egyptian women believed that FGM would prevent adultery and that it is proof of a girl's virginity.[9] This erroneous impression held by 8.2% of the respondents in this study means obviously that more work is needed to be done as regards educating the women.

The study enquired about the negative effects/complications experienced among those who had undergone FGM (n = 42). Reduced sexual satisfaction was the commonest reported negative effect (complication) of FGM (38.1%). Ezenyeaku et al. also reported reduced sexual satisfaction as the commonest complication (50%) while Abubakar *et al.* reported 25.7% of their study population with FGM having sexual dissatisfaction.[12,17] Most studies recognized that this practice has negative consequences for delivery as shown in this study where 7.1% reported that they had difficult

deliveries in pregnancies following the procedure. Difficult deliveries following the procedure was also reported by Abubakar et al. (8.6%) and Ezenyeaku et al.(22%).[12,17]FGM also has negative consequences on sexual intercourse and menstruation as shown in this study where 19% and 4.2% of the women that had FGM developed dyspareunia(painful intercourse) and dysmenorrhea (painful menstruation) respectively which is higher than reported by Yirgisa et al. (6.2% and 1.5% respectively)[20]. These results are consistent with findings from other countries where FGM is common. About 16.7% of the respondents that had FGM reported feeling of incompleteness. This is not in keeping with the finding of 23.8% by Ezenyeaku et al.[17] The above findings show that women who have undergone any form of FGM are traumatized and likely to develop physical, psychological, and social problems associated with it.[20] The feeling of incompleteness has the potential of affecting the psyche of these women leading to feelings of physical violation and low self esteem. These may lead to psychosexual problems.[17]Studies on the psychological effects of FGM are scarce and need to be given due emphasis, given that FGM is one of the reported risk factors for post-traumatic stress disorder in women.[22-27]

Majority of the respondents (89.5%) were aware of the campaign against FGM. Abubakar et al reported 91.4% awareness among antenatal patients in their study at Aminu Kano Teaching Hospital Kano, Northern Nigeria and Ezenyeaku et al. reported 97.1% in Southeast Nigeria.[12,17] Of the total respondents that are aware of the practice of FGM, 69.5% would accept legislation against FGM while 18.4% would not. This is in keeping with the study by Ezenyeaku et al. who reported that 63.7% would accept the legislation against FGM while 19.3% would not.[17]

Among the respondents that would not accept the legislation, 43% had no reason for not accepting. This is in keeping with the finding of 41.7% by Yirgisa et al.[20] This further buttresses the fact that even though 97.9% of the study population are aware of the practice, there is limited knowledge of the procedure and its impact on women's reproductive health and social life.

The study also showed that majority of the respondents that are aware of the practice have not attempted to stop the practice (92.5%) and only 4.2% have attempted to stop the practice. Yirgisa et al also found out that most of the respondents (76.2%) have not attempted to stop the practice and only 23.2% attempted to stop the practice. If there was good knowledge and understanding of FGM, motivation towards stopping the practice would have been greater. The finding that the majority of women took no action and knew little about stopping the practice might be due to inadequate knowledge and lack of information. Therefore, information, communication, and integration are very important in the community.

A limitation to this study is that due to the sensitivity of the topic, some respondents may not volunteer genuine answers to the questions.

CONCLUSION

Female genital cutting/mutilation is still practiced in our environment. It is clear that there is a knowledge gap because a reasonable number of women that are not in support of the legislation against this harmful practice have no reason. Some of the women knew the negative reproductive health consequences of FGM and had experienced them during sexual intercourse and childbirth. However, with regard to stopping FGM, few of them had tried to do so and the majority had not taken any steps towards stopping

the practice. The principal reason for performing FGM is to prevent promiscuity. This perception has no scientific justification and hampers women's self–determination in the area of sexuality. Therefore, FGM violates the right of girls and women to determine their own reproductive health and sexuality. Health education as well as implementation of policies against this harmful practice should be done.

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