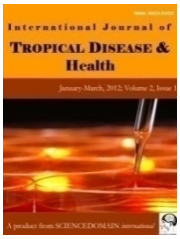

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The Pattern of Female Genital Mutilation in Port Harcourt, Southern Nigeria

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Authors' contributions

This work was carried out in collaboration between all authors. Author IJ conceptualized and designed the study, wrote the protocol. Author DGBK performed literature search, did the statistical analysis, and wrote the first draft of the manuscript. Author CA generally supervised the research and managed the literature searches. All authors were involved in data collection and all read through and approved the final manuscript.

Original Research Article

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ABSTRACT

Aims: Female genital mutilation is a harmful traditional practice which is an infringement on the sexual and reproductive rights of women and girls and has profound psychosocial as well as reproductive health morbidities. This study aimed at measuring the change in the incidence of the female genital mutilation in Port Harcourt, South-South Nigeria.
Study Design: A cross-sectional study.
Place and Duration of Study: Department of ObstetricGynaecology of the University Port Harcourt Teaching Hospital (UPTH) between 1st January and 31st January 2009.
Methodology: Five hundred clients were selected randomly and agreed to participate in the study. They were interviewed using a structured questionnaire and examined clinically. Data management was with SPSS 15.0 for Windows statistical software.
Results: The prevalence of female genital mutilation (FGM) was 34%. Four hundred and eighty one (96.2%) were aware of female circumcision generally. Ninety five (55.8%) of those circumcised, had it done in infancy. Thirty seven percent of the practitioners of female circumcision were traditional birth attendants while 14.7% were trained health

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professionals. The commonest reason for female circumcision included reduction of sexual passion/promiscuity and conformity with tradition. Type 1 female genital mutilation was the commonest (58.2%). Among those clients aged 50 years and above, 78.8% had FGM while 9.1% of those aged 10 – 19 years had FGM. This showed a downward trend.
Conclusion: Female circumcision is a harmful traditional practice which has remained a serious health problem. Its prevalence is still high in our environment. This study suggests that it is on a downward trend.

Keywords: Female genital mutilation; patterns; trends.

1. INTRODUCTION

Female Genital Mutilation (FGM) also known as female circumcision or female genital cutting comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons [1-3]. It is a harmful traditional practice which is an infringement on the sexual and reproductive rights of women and girls [4].

About 130million women and girls worldwide have undergone FGM, and about 2 million girls are at risk each year [1,2,5]. It crosses all religious, racial and social boundaries. In Africa, particularly in countries such as Nigeria, Ethiopia, Sudan, Egypt and Somalia, FGM is widespread and a highly valued ritual [6-8]. In Nigeria, national prevalence rate of 50-60% has been reported and the practice is said to be commoner in the South-East, South-West and South-South regions of the country [9,10].

The World Health Organization (WHO) classifies FGM into four types. Type I involves the removal of the prepuce, with or without removal of part of or the entire clitoris. It is sometimes referred to as clitoridectomy or sunna circumcision. In type II, there is removal of the clitoris with partial or total removal of the labia minora. It is sometimes simply referred to as Excision. Type III involves removal of part or all of the external genitalia (clitoris, labia minora and majora), and stitching/ narrowing of the vaginal opening, leaving a very small opening to allow for the flow of urine and menstrual blood. It is also referred to as Infibulation or Pharaonic circumcision. Type IV (unclassified or introcision) involves pricking, piercing or incision of the clitoris and/or labia; stretching of the clitoris and/or surrounding tissues; scraping of tissue surrounding the vaginal orifice (angurya cuts), cutting of the vagina (gishiri cut) or incision on the cervix in cases of prolonged labour (Zur-Zur cut); 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 of FGM. The most common type of FGM Worldwide is excision of the clitoris and the labia minora, accounting for up to 80% of all cases. The most extreme form is infibulation, which constitutes about 15% of all procedures [1,11,12].

Various reasons have been given for the perpetuation of the practice of FGM. These have been categorized into psychosexual, sociological, hygiene and aesthetic, mythical and religious reasons. These include prevention of sexual promiscuity/infidelity in marriage, identification with cultural heritage, initiation of girls into womanhood, promotion of hygiene and aesthetic appeals of the female external genitalia and enhancement of fertility and child survival [1,7-10].

Female genital mutilation is associated with profound reproductive health morbidities and mortality. Immediate complications include severe pain, haemorrhage, shock, urinary retention, and ulceration of the genital region, injury to adjacent tissues, tetanus and death. Long term complications include cysts and abscesses, keloid formation, urinary incontinence, gynaetresia, sexual dysfunction, infertility, prolonged obstructed labour and higher rate of episiotomy and caesarean sections [13-16].

This study sought to determine the change in the incidence of female genital mutilation in Port Harcourt, South-South Nigeria. It is a hospital based study and offers indispensable opportunities for enlightenment and education and intervention strategy to change the concept and behavior of those who were hitherto naïve or misinformed on the subject. Therefore it seeks to reduce the subsequent rate of female circumcision. Studies that are community based are punctuated by scepticism on candid or true responses to avoid shame and condemnation. This study has physically corroborated interview responses with clinical examination findings.

2. MATERIALS AND METHODS

This was a cross-sectional study carried out among clients seen at the Department of Obstetrics and Gynaecology (antenatal clinic, gynaecology clinic, family planning clinic, labour ward, accident and emergency unit) of the University of Port Harcourt Teaching Hospital, South-South Nigeria. The required sample size was derived using the formula: $n = z^2pq / d^2$ where z is the standard normal deviate, usually set at 1.96 (or more simply at 2.0), which corresponds to the 95% confidence level; p represents the prevalence of FGM set at 50%, q is 1.0 – p and d is the margin of error tolerable (or degree of accuracy desired) which is set at 5%. This gave a sample size of 384. The participants were selected by simple random sampling and informed of the study, and all agreed to participate. Ethical approval was obtained from the Ethical committee of the University of Port Harcourt Teaching Hospital.

Data was collected using an interviewer-administered structured questionnaire between 1st January and 31st December 2009. Information obtained included socio-demographic characteristics, awareness, attitude and practice of FGM. This study had a team who physically examined and reviewed all the clients with a view to corroborating the interview responses with clinical examination findings. The data collected were coded and entered into a computer spreadsheet using SPSS 15.0 for Windows statistical software. Results were presented as means with standard deviations, rates and proportions, graph, tables and figures. Chi-square tests were carried out where necessary. Cross tabulation was performed to establish relationships among variables. These were reported when statistically significant at p value of $\leq$ 0. 05.

3. RESULTS

The sociodemographic characteristics of the respondents were shown in Table 1. The mean age in years was 31.57$\pm$ 9.419. The minimum age was 10 years and the maximum was 76 years. Thirty percent of the respondents were housewives while 79 (15.8%), 56 (11.2%) 101 (20.2%), and 99 (19.8%) were civil servants, teachers, traders and students respectively. Clients who had tertiary education constituted 66.2%. Respondents who were married made up 90.6% while 43% of the respondents were nulliparae. Table 2 shows the ethnicity study

population. Igbos comprised 50.4% while Ijaws and Ikwerres constituted 13.2% and 13% respectively.

Table 1. Socio-demographic characteristics

Characteristics	Number	Percentage %
Age (mean + SD)	31.57years ± 9.42	
10-19	33	6.6
20-29	199	39.8
30-39	192	38.4
40-49	43	8.6
≥40	33	6.6
Parity		
0	218	54.25
1	90	23.50
2	73	13.25
3	51	5.50
4	39	2.75
≥5	29	0.75
Educational status		
No formal education	1	0.2
Primary	18	3.6
Secondary	150	30.0
Tertiary	331	66.2
Occupation		
Housewives	150	30.0
Civil servants	79	15.8
Traders/Business women	101	20.2
Student	99	19.8
Doctor /Nurse / Pharmacist	15	3.0
Teacher	56	11.2
Religion		
Christian	497	99.4
Islam	3	0.6
Marital status		
Married	453	90.6
Single	41	8.2
Divorced	3	0.6
Widowed	3	0.6

Table 2. Tribe / Ethnic group

Tribe/Ethnic group	No.	Percentage %
Ijaw	66	13.2
Igbo	252	50.4
Ikwerre/Etche	65	13.0
Yoruba	20	4.0
Hausa/Fulani	15	3.0
Bini	15	3.0
Others	67	13.4
Total	500	100

Out of the 500 clients who participated in this study, 170 had female genital mutilation this gave a prevalence of 34%. 0.4% of respondents were circumcised but did not know about it.

Majority of the respondents (96.2%) were aware of FGM. It was observed that 55.8% of those who were circumcised had it done during infancy. Thirty seven percent of the practitioners (perpetuators) of FGM were traditional birth attendants while 14.7% were trained health professionals (doctors, nurses and midwives).

The commonest reasons for FGM were reduction of sexual passion and promiscuity (35.9%), and conformity with tradition (30.6%).Other reasons included rite of passage to womanhood (30.6%), ensuring virginity and chastity in marriage and the commonest reasons for FGM were reduction of sexual passion and promiscuity (35.9%), and conformity with tradition (30.6%). Other reasons included rite of passage to womanhood (30.6%), ensuring virginity and chastity in marriage and narrowing/tightening of the vaginal introitus for maximal sexual performance. The commonest complications following FGM were decrease in sexual desire or arousal, dyspareunia, dysmenorrhoea, episiotomies/perineal tears especially during their first deliveries. Some of them had caesarian section for obstructed labour/rigid perineum.

Type 1 (58.2%) was the commonest type of FGM, followed by type 2 (40.0%). None of the respondents had type 3, while 1.8% had type 4.

Majority of the respondents (99%) would not recommend FGM for their daughters or wards. The reasons for not recommending FGM included complications of FGM, knowledge of the efforts of governments and various bodies including NGOs to ban FGM, and the practice not being done in some communities/cultural groups.

The issue of sanctions / benefits from FGM was also studied. Out of the 500 clients, 481 (96.2%) responded that they were not aware of sanctions in their communities against those who refused circumcision, while 19 (3.8%) responded that they were aware of sanctions. The sanctions included payment of fines (money, goats, and yam), ostracism and denial of burial rights. Similarly 487 (97.4%) responded that they were not aware of any benefits in their communities for those who were circumcised, while 13 (2.6%) responded that benefits were accruable to these who were circumcised. The benefits included provision of crops, allocation of land and special burial rights.

It was observed that 48% of the respondents were aware of the efforts of governments and NGOs to eradicate FGM. Also 62.4% of the respondents had other means of livelihood.

Fig. 1 showed the trends in circumcision, where 78.8% of those aged 50 years and above had FGM while 9.1% of those aged 10-19 years had FGM. This showed that the trend is on a decline.

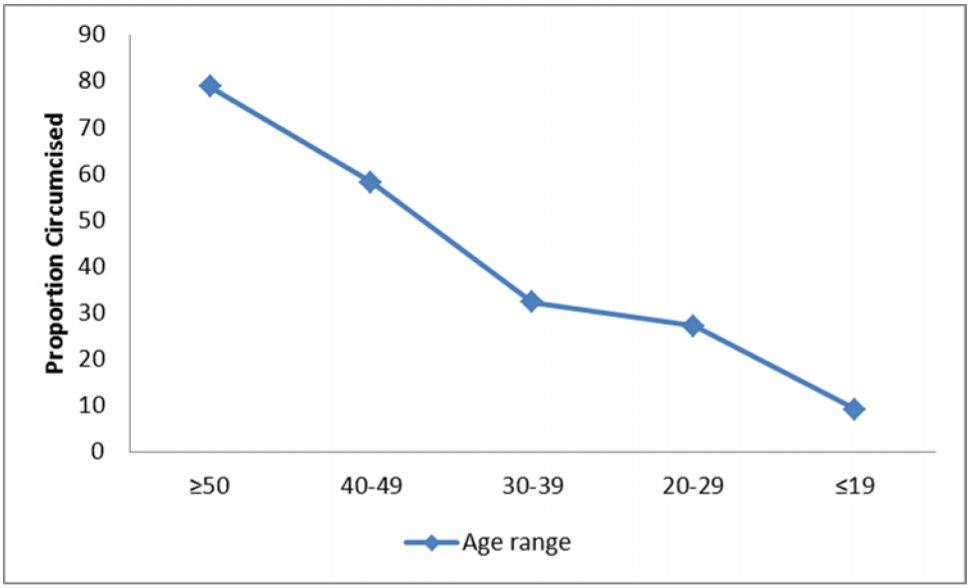

Fig. 1. Trends in circumcision

4. DISCUSSION

The prevalence of FGM was 34%.This is different from other studies [2,9] with higher prevalence. While 78.8% of those aged 50 years and above had FGM, only about 9.1% of those in the 10-19 years age group had FGM. The trend here showed that there is a decline in FGM. This is similar to a study in South West Nigeria [6]. Majority of the respondents had tertiary education. This is similar to other studies [9,13]. This high level of education will impact on their knowledge, attitude and practice of FGM. It is not surprising then that 99% of them would not recommend FGM for their daughters or wards. These were probably empowered to resist the cultural norms/pressure to circumcise their children.

Out of the 500 respondents 96% were aware of FGM. This was similar to a study in Kwara State [17]. Among those who were circumcised 55 % had it done as infants. This is the commonest age group in which it is done in this part of the country. Traditional birth attendants constituted 37% of the practitioners of FGM. However, 14.7% of the practitioners were trained health professionals who included doctors, nurses and midwives. This showed that there was a high level of medicalisation of FGM as was found in a similar study [18]. The world Health Organization has banned medicalisation of FGM [1].

Reduction of sexual passion and promiscuity, and conformity with tradition were the commonest reasons for FGM. However, some studies showed that FGM does not significantly affect women's sexual behavior [19,20].

The common gynecological complications of FGM observed in this study were dyspareunia, dysmenorrhoea and decrease in sexual desire or arousal. However other studies [14,16] showed other complications like chronic pelvic pain, pelvic inflammatory disease, infertility, urinary retention or urinary tract infection, acquired gynaetresia. This may be explained by the fact that only types I and II were mostly performed here. Type 3, which is implicated in most of the severe gynaecological complications was not observed in this study.

Only 48% of the respondents were aware of the efforts of the various governments, organs of the United Nations, International federation of Gynaecology and Obstetrics (FIGO), women organizations and the NGO's to eradicate FGM. This showed that a lot of education and enlightenment of the people have to be done. The religious bodies, traditional rulers, health providers, women organizations, the government and mass media are all stake holders for the mobilisation of the people against FGM.FGM was found to be commoner among the Ibos, Yorubas and Ijaws than the Hausa/Fulani. This was similar to some studies in Northern Nigeria [10,17]. Majority of the practitioners of FGM had other means of livelihood. This is a positive development towards the efforts to reduce the practice as these practitioners do not need to find new jobs when they eventually stop performing FGM. Medical practitioners should be reminded of the ban on medicalisation of FGM by the World Health Organization [1,21].

5. CONCLUSION

Female genital mutilation is a harmful traditional practice, which has remained a serious public health problem. This study suggests that it is on the decline. However, more efforts still have to be made by the governments and other bodies involved in the fight against the practice. Various governments should pass legislation and enforce them. Religious bodies, traditional rulers, community development committees, health providers and the mass media still have big roles to play in this fight.

CONSENT

"All authors declare that 'written informed consent was obtained from the patients for publication of this Research Article''.

ETHICAL APPROVAL

"All authors hereby declare that this study have been examined and approved by the appropriate ethics committee and have therefore been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki."

COMPETING INTERESTS

We declare unequivocally that there was no conflict of interest in the course of carrying out this research.

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