Prevalence and Associated Factors of Female Genital Mutilation among Women Attending Antenatal Clinic at a Tertiary Hospital in Nnewi, South-East Nigeria

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Abstract: ***Background:*** Female genital mutilation, also referred to as “female genital cutting,” has been defined by the World Health Organization (WHO) as “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons”. It has remained largely uninvestigated in Nnewi. This study was carried out to determine the level of practice of female genital mutilation (FGM) and the influence of socio-economic factors on its practice among pregnancy women attending antenatal clinic in this area. ***Materials and Methods:*** The data were collected using a structured questionnaire from 400 pregnant women attending the antenatal clinics of Nnamdi Azikiwe University Teaching Hospital, Nnewi, south-east Nigeria. Vulvar examination was carried out to confirm the presence, type or absence of female genital mutilation using the WHO classification. ***Results:*** The prevalence of female genital mutilation is 167/400 (41.8%). Out of this, 24 (14.4%) had type I mutilation while 143 (85.6%) had type II mutilation. There were no type III and IV mutilation. The lowest trend in female genital mutilation was found in the age of 15-19 years. Female genital mutilation decreased with increasing level of education. Up to 120 (30%) of women were favourably disposed towards continuing the practice. Culture/tradition was the strongest reason for the practice. ***Conclusion:*** The prevalence of female genital mutilation is high in Nnewi and WHO type II variety is the most common. Culture/tradition was the strongest reason for the practice. The eradication of female genital mutilation must involve the identification of issues sustaining the practice in different localities and subsequent action supported both by logical persuasion following aggressive health education and by legislation.

INTRODUCTION

The term "female genital mutilation" (also called "female genital cutting" and "female genital mutilation/cutting" or "female circumcision") refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.[1] It affects the health and rights of women globally, including Nigeria.[2] Between 100 and 140 million girls and women in the world are estimated to have undergone such procedures, and [3] million girls are estimated to be at risk of undergoing the procedures every year[1,3,4]. Despite considerable global attention, the rate of decrease in the prevalence of FGM is lower than the rate of population growth, and therefore the number of girls and women undergoing and at risk of FGM continues to rise.[5] Female genital mutilation (FGM) has been reported to occur in all parts of the world, but it is most prevalent in: the western, eastern, and north-eastern regions of Africa, some countries in Asia and the Middle East and among certain immigrant communities in North America and Europe[6-8]. According to the Nigerian demographic and health survey done in 2018, approximately 20% of Nigerian women between the ages of 15 and 49 years have undergone some form of female genital mutilation.[9] The prevalence maybe higher in certain areas, particularly in the northern parts of the country where the practice is deeply rooted.

The causes of female genital mutilation include a mix of cultural, religious and social factors within families and communities[10,11]. The World Health Organisation (WHO) classified FGM into four types; type I - Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and/or in very rare cases only, the prepuce (the fold of skin surrounding the clitoris); type II - Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the ‘lips’ that surround the vagina); type III - Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris and type IV - Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g., pricking, piercing, incising, scraping and cauterizing the genital area.[12]

The age at which Female genital mutilation is carried out varies, ranging from a few days old to adolescence, adulthood, before marriage and even post-partum. This

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depends on diversity in terms of tribe, country, community or circumstances.[13]

Female genital mutilation has no known health benefits[3,14,15.] On the contrary, it is known to be harmful to girls and women in many ways. First and foremost, it is painful and traumatic. The removal of or damage to healthy, normal genital tissue interferes with the natural functioning of the body and causes several immediate and long-term health consequences.

In every society in which it is practiced, female genital mutilation is a manifestation of gender inequality that is deeply entrenched in social, economic and political structures. Like the now abandoned foot-binding in China and the practice of dowry and child marriage, female genital mutilation represents society's control over women. Such practices have the effect of perpetuating normative gender roles that are unequal and harm women[14].

Circumcisionists can be classified into two broad groups; the traditional and the formally trained health workers. Typically, the traditional circumcisionists perform the procedure without anesthetics: The little girl, entirely nude is immobilized in the sitting position on low stool by at least three women. One of them has her arms tightly around the little girl's chest, two others hold the child's thigh apart by force, in order to open wide the vulva. The circumcisionist takes a razor or sharp knife as and excises the clitoris and or other areas depending on the type of FGM being performed. The little girl screams and writhes in pains, although strongly restrained. The opening left for urine and menstrual blood is very tiny.

Female genital mutilation has remained largely uninvestigated in Nnewi, south-east Nigeria. Against this backdrop, this study was done to determine the level of practice of female genital mutilation (FGM) and the influence of socio-economic factors on its practice.

MATERIALS AND METHODS

This was a cross-sectional study conducted at the Nnamdi Azikiwe University Teaching Hospital, Nnewi, south-east Nigeria. Patients were recruited from the antenatal clinics for the purpose of the study. The first four hundred pregnant women who consented to participate in the study during the study period were recruited.

The full details of what the study entailed were explained to all the women and their verbal and written consent was obtained. The investigator administered the questionnaires.

Information on the questionnaire included the sociodemographic characteristics of the women, their experiences with FGM, their attitudes and beliefs relating to FGM were also explored. Physical examinations were carried out on all respondents.

The vulva was inspected to confirm the presence or absence of FGM using the World Health Organization (WHO) classification outlined above. The type of mutilation was noted.

Data entry and analysis were carried out using SPSS software version 26.

Chi-square test was used where appropriate.

The level of significance was taken as 5% (p=0.05). Ethical clearance was obtained from ethical committee of the institution.

The analytical tables are shown below:

Table 1: Distribution of respondents by age group and circumcision status.

	Circumcised		**Uncircumcised**			
	Freq.	**Percent**	**Freq.**	**Percent**	**Total**	
	N	%	N	%	n	%
15-19	1	5.0	19	95.0	20	100.0
20-24	12	14.6	70	85.4	82	100.0
25-29	43	33.9	84	66.1	127	100.0
30-34	47	48.0	51	52.0	98	100.0
35-39	53	86.9	8	13.1	61	100.0
40-45	11	91.7	1	8.3	12	100.0
Total	167	41.8	233	58.2	400	100.0

Table 2: Distribution of respondents by type of circumcision.

Type of circumcision	Frequency (n)	Percent (%)
I	24	14.4
II	143	85.6
III	0	0
IV	0	0
Total	167	100.0

Table 3: Influence of educational status on respondents' circumcision status.

Highest Educational Attainment	Circumcision status					
	Circumcised		Uncircumcised			
	Freq.	%	Freq.	%	Freq.	%
No formal education	4	80.0	1	20.0	5	100.0
Primary	60	76.9	18	23.1	78	100.0
No formal education	4	80.0	1	20.0	5	100.0
Primary	60	76.9	18	23.1	78	100.0
Total	167	41.8	233	58.2	400	100.0

Table 4: Effect of respondents' educational status on their opinion about female genital mutilation.

Highest Educational Attainment	Respondents' opinion							
	Non-Supportive		Supportive		Indifferent		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
No formal education	1	20.0	4	80.0	0	0	5	100.0
Primary	8	10.3	52	66.7	18	23.0	78	100.0
Secondary	128	60.4	64	30.2	20	9.4	212	100.0
Tertiary	104	99.0	0	0	1	1.0	105	100.0
Total	241	60.3	120	30.0	39	9.7	400	100.0

[x2=56.99; P<0.05]

RESULTS

A total of 400 participants participated in the study, of which 167 had female genital mutilation. Majority were in the age group between 35 and 39 years. Table 1 shows the distribution of respondents by age group and circumcision status.

The distribution of respondents by type of circumcision is shown in Table 2. Table 3 shows the influence of educational status on respondents' circumcision status. Table 4 shows the effect of respondents' educational status on their opinion about female genital mutilation. There was a significant difference between the educational level and respondents' opinion ($p<0.05$).

DISCUSSION

The prevalence of FGM in this study is 41.8%. This is comparable to a rate of 48.5% found by Adinma et al3 and 48% by Igwegbe and Egbunonu[4] in the same geographical area. Although Nigeria had a prevalence of 19% in 2003, a reduction from 25% prevalence of 1999 national survey, it still has high absolute number of cases with wide regional variation. The circumcision trends among various age groups revealed a sharp drop in the 20-24 years and 15-19 years age groups. This may be connected with increased awareness of the dangers of FGM. The results also suggested that education may be the apparent reason for decrease in the incidence of this custom. By extension, this declining rate may mean that at a time period in future, FGM may be completely or near totally wiped in our environment.

In this study, 92.4% of the respondents were circumcised in childhood, while 7.6% were done in adulthood. This is similar to other studies done in this country where infantile circumcision was the commonest[3,4]. The early age of circumcision may explain the continuation of the practice, since the victim cannot revolt against the practice at birth or early childhood, unlike in adulthood where a girl could take effective action to avoid being circumcised.

In most societies, FGM is considered a cultural tradition, which is often used as an argument for its continuation. In some societies, recent adoption of the practice is linked to copying the traditions of neighbouring groups[9]. Sometimes it has started as part of a wider religious or traditional revival movement. It was not therefore surprising that culture/tradition was the commonest reason for circumcision in this study, while medical opinion against the practice was the major reason for opposing circumcision. In most of the studies reviewed, tradition was the main reason for FGM. One main factor behind the persistence of FGM is that it is regarded as a very important part of socialization into womanhood.

There was also no evidence that it is sanctioned by any known religion. It is clearly an outdated cultural practice in most societies, which need to be changed8. Since FGM is fraught with complications and does not check the assumed increased promiscuity at least in our community there is the need to abolish it.

In conclusion, there is high prevalence of female genital mutilation in our society, with culture and traditions being the strongest correlates. Although younger women with some education are less likely to have had FGM it is still extremely common in South-eastern Nigeria. Deep cultural issues and strongly personally held beliefs which are not simple to predict or quantify are likely to be involved in the perpetuation of FGM. An efficient and long lasting solution to eradicating the practice of FGM in our environment might be a global effort by the government and its development partners to make significant progress in the areas of employment, poverty reduction and literacy as well as a concerted effort to encourage repudiation of FGM and support for change by religious leaders.

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