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Full Length Research Paper

Prevalence of female circumcision among children presenting in a semi-urban Tertiary Teaching Hospital in South West Nigeria

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Abstract

Female circumcision also known as female genital mutilation (FGM) is the total or partial cutting/removal of the external female genitalia or injury to the female genital organ for non-medical reason. This study was to determine the current prevalence of FGM among children brought for medical care and identify the prevailing factors contributing to this practice. The study was carried out among 200 consecutive new female children with age ≤ 15 years presenting at the out-patient (OPD) and children emergency ward (CHEW) of XXXX teaching hospital. Ethical approval from the institution and parental informed consent were obtained. A research proforma was administered on each subject for their bio data, anthropometric, clinical data and questions to determine the prevalence and the factors influencing the act of FGM. Prevalence of female circumcision was 30% as 60 of the 200 subjects were circumcised. Female genital cutting was done during infancy in 50 (81.6%) of the subjects and 42 (70%) of those circumcised had type 1 FGM. Fever, irritability, external genital ulcer and pus discharge were the immediate complications. Health workers were involved in 62.3% instances of FGM. It is still commonly practiced among the study population irrespective of parents' level of education. FGM is an infringement on the physical and psychosexual integrity of the female child and constitute a health hazard. Health education is needed across board to eradicate the practice

Keywords: Female circumcision, Female genital mutilation, Female genital cutting, Psychosexual integrity, Health hazard.

INTRODUCTION

According to the World Health Organization (WHO), Female genital mutilation (FGM) is defined as all procedures which involve partial or total removal of the external female genitalia and/or injury to the female genital organs, whether for cultural or any other non-therapeutic reasons (World Health Organization 1998). Worldwide, government and non- governmental organizations frown at FGM having seen it as an infringement on the physical and psychosexual integrity of the female child. Nigeria was said to have the highest absolute number of cases of FGM in the world, accounting for about one-quarter of the estimated 115–130 million circumcised women worldwide (UNICEF 2001). The prevalence rate of FGM was put at 41% among adult Nigerian women (Okeke 2012).

Nigeria is a country in West Africa bordering the Gulf of Guinea between Benin and Cameroon. It has an area of 923,768.00 sq kilometers with a population of 140,431,790 according to the 2006 National Population census (National Bureau of Statistics 2006). The male constituted 71,345,488 while the female were 69,086,302 (National Bureau of Statistics 2006). This study was done

in a tertiary hospital in Ekiti State, one of the 36 states of Nigeria. Ekiti State has a population of 2,398,957with the male being 1,215,487and the female 69,086,302 (National Bureau of Statistics 2006). It is majorly inhabited by the Yorubas who are noted for high level of literacy in terms of formal education and is reputed to have produced the highest number of professors in Nigeria (Adesina 2008).The 2008 Nigeria Demographic and Health Survey showed that 30% of female surveyed between ages 15- 40years had undergone female circumcision with the Yoruba and igbo ethnic groups having the highest percentage (58.4% and 51.4% respectively) (National Population Commission 2009).Olamijulo et al., reported the prevalence of FGM among children examined at the child welfare clinic, Wesley Guild Hospital, Ilesha, Nigeria to be 66.3%.The following states in Nigeria have prohibited this act since 1999;Abia, Bayelsa, Cross River, Delta, Edo, Ogun, Osun and Rivers. However, with increasing awareness of the complication of FGM, there is a recent ban on the practice in Nigeria as a nation in year 2015. The prevalence rate is therefore expected to progressively decline in the younger age groups.

FGM practiced in Nigeria is classified into four typesas follows; clitoridectomy or Type I, this involves the removal of the prepuce or the hood of the clitoris and all or part of the clitoris. Type II or “sunna” is a more severe practice that involves the removal of the clitoris along with partial or total excision of the labia minora. Type III (infibulation), involves the removal of the clitoris, the labia minora and adjacent medial part of the labia majora and the stitching of the vaginal orifice, leaving an opening of the size of a pin head to allow for menstrual flow or urine. Type IV or other unclassified types include introcision and gishiri cuts, hymenectomy, scraping and/or cutting of the vagina, the introduction of corrosive substances and herbs in the vagina, and other forms. Consequences of female genital mutilation include increased risks of urinary tract infections, bleeding, bacterial vaginosis, dyspareunia, obstetric complications, psychological problems such as depression, anxiety, post-traumatic stress disorder, low self-esteem, etc (Behrendt and Moritz, 2005), Abdulcadir and Dällenbach, 2013), Amin et al.,., 2013), Andersson et al.,., 2012), Andro et al.,., 2014).

This study was:

1. to determine the current prevalence of FGM among children and identify the prevailing factors still contributing to its practice.
2. aimed at finding out the group of people who carry out this practice on the girl child and the complications often encountered and overall
3. to assess the effectiveness of health education so far in increasing the public awareness of the ills of FGM.

MATERIALS AND METHODS

The study was carried out among consenting 200 consecutive female children with age ≤ 15 years presenting at the out-patient and children emergency ward of XXXX teaching hospital over a period of five months. The average attendance at the hospital is about 120 patients in a month which is sometimes subject to the presence of industrial action. Ethical clearance was obtained from the Ethics and Research Committee of the institution. Informed consent was obtained from the parents and assent from the subjects were applicable. A research proforma was administered on each subjects whose parents gave their consent for their bio data, anthropometric, clinical data and questions to determine the contributing factors to FGM.

The proforma contained questions on such details as place and mode of delivery to determine the health seeking attitude of the parents. Questions were asked about the presence and type of female circumcision to determine the prevalence of FGM and classify the various types. The places where circumcisions were done and the personnel/individuals involved were also requested for in order to identify the likely perpetrators of this act. Enquiry was made about the various reasons for this practice, need for hospital admission and blood transfusion and at what age to rule out immediate complications following FGM. The ethnicity and religion of parents were identified to determine the influence of the culture and belief on the decision to have FGM done. The questionnaires were administered and the examination done by medical doctors who had prior teaching and demonstration on recognition of the different types of female circumcision.

The data obtained was analyzed using SPSS version 16. Descriptive statistics showing frequencies and percentages were used as well as comparative statistics using multivariate analysis, Chi-square test for categorical data.

RESULTS

Two hundred consecutive female children presenting to the children emergency and out-patient clinic of the hospital whose age were ≤ 15 years were recruited. The age range of the subjects was three weeks to 15 years. Of these children 69.5 per cent were under five years of age, the pattern of age distribution is seen in Table 1 Majority of them, i.e. 179 (89.5%) were of Yoruba ethnicity, the Igbos were 8 (4.0%), Ibos 7 (3.5%), Urhobos 2(1.0) while the Hausas, Ijaw, Idomas and Binis were one each (0.5%).

The prevalence of female circumcision among

Table 1: Age distribution of the subject

Age (years)	Frequency (%)
≤ 1	64 (32.0)
2-3	42 (21.0)
4-5	33 (16.5)
6-7	12 (6.0)
8-9	13 (6.5)
10-11	15 (7.5)
12-13	10 (5.0)
14-15	11 (5.5)
Total	**200(100.0)**

Table 2: Frequency of female circumcision

CATEGORY	FREQUENCY (%)
CIRCUMCISED	60 (30.0)
NOT CIRCUMCISED	139 (69.5)
PLANS TO CIRCUMCISE	1 (0.5)
TOTAL	**200 (100)**

the subjects is 30% as seen in Table II.

The age group of subjects with circumcision is as shown in figure 1, 30% (18) of the circumcision were done less than 3 years ago. Circumcision was done majorly during infancy (81.6%) as seen in figure 2.Out of the four types of female circumcision earlier described, type 1 FGM accounted for 70% (42) of the circumcision done, followed by type 2 which constituted 30% (18) as seen in figure 3, Type 3 and 4 FGM were not seen in this study.

Ninety eight percent (59) of the children with FGM were of Yoruba ethnicity as seen in figure 4; this is followed by the Igbos, 2% (1). The Yorubas constituted 89.5% (179) of the total 200 subjects recruited for the study because this is the major tribe in the study location. However, 33% (i.e. 59) of the Yorubas recruited had FGM. Among the Igbos, out of the eight subjects recruited, 1 (12.5%) had FGM.

Fever, irritability and external genital ulcer associated with pus discharge were some of the immediate complications seen. In subjects who had female genital circumcision, bleeding, described by the parent as diaper being soaked with blood was reported in 9 (15%), 47(78.3%) had minimal blood stained diaper while bleeding was not noted in the remaining four subjects. None of them had blood transfusion within two months of having FGM. However ten percent of them (i.e. 6 subjects) presented with severe anaemia while they were under the age of five years and had to be transfused. One (16.7%) of those that were transfused had the blood transfusion done at age < 6months while the remaining 5(83.3%) were transfused at an older age (3-5years).Effect of parental level of formal education on the prevalence of FGM is seen in figure 5. In forty one (68.4%) of the subjects that had FGM, highest level of paternal formal education was at least tertiary. There was

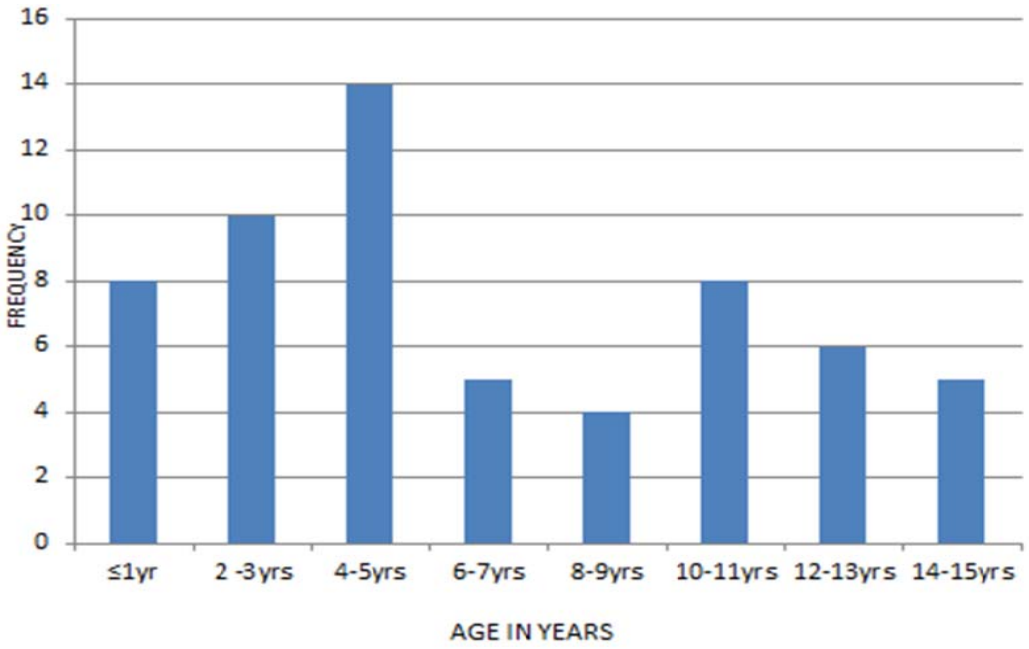

Figure 1: Age group of subject with FGM in year

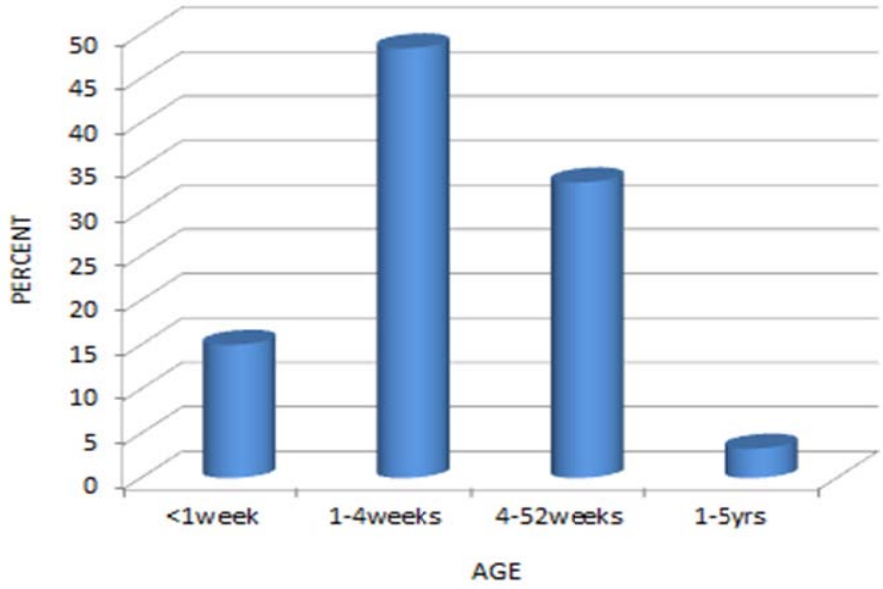

Figure 2: Age of circumcision

no significant correlation between parental level of formal education and the practice of FGM. On cross tabulation of practice of FGM with paternal level of formal education less than tertiary and above tertiary, there was no significant correlation (Pearson chi square value= 1.282 and p =0.257). A similar pattern was observed in the mothers (Pearson chi square value= 1.341 and p =0.247), this shows that FGM was not limited to parents with low level of formal education but it is practiced even by parents with at least tertiary level of education. The

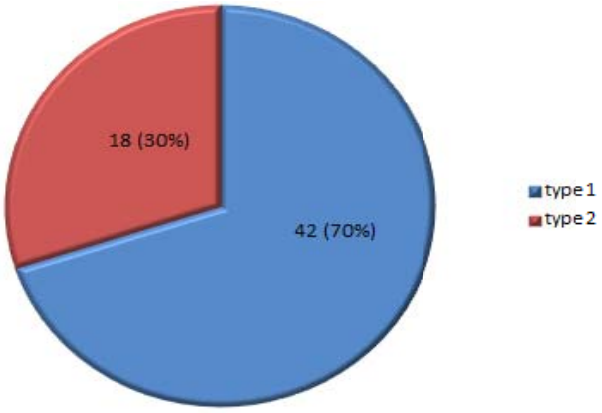

Figure 3: Type of female circumcision

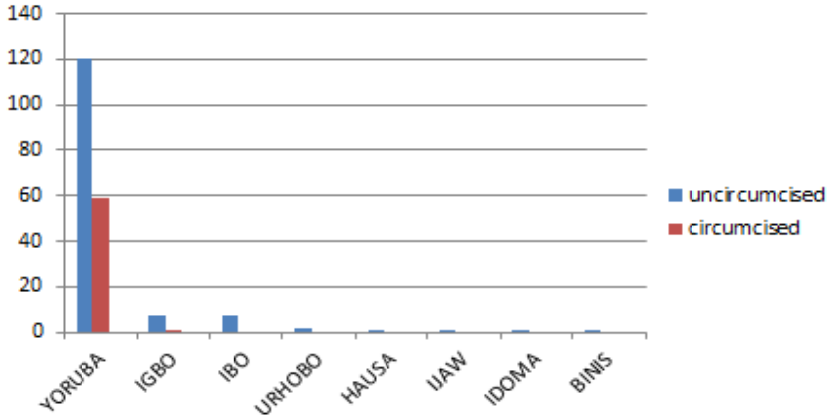

Figure 4: Female genital mutilation and the ethnic group

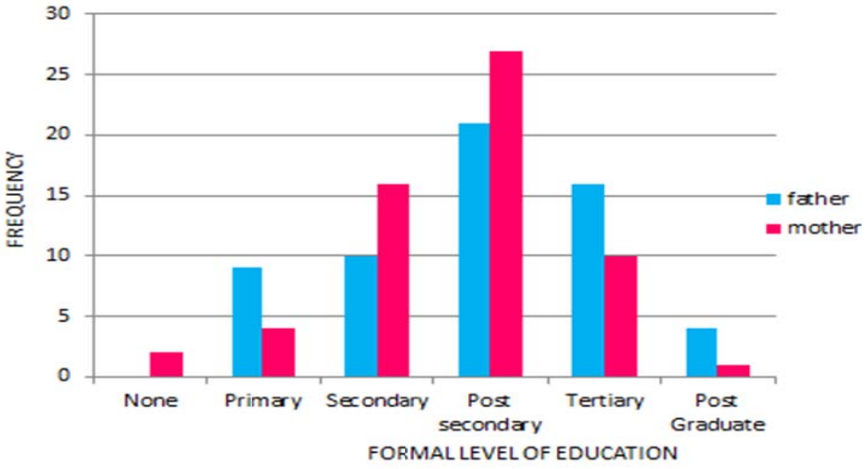

Figure 5: Effect of parental level of formal education on FGM

practice of FGM did not show significant correlation with the religion (Pearson chi square value= 0.071 and p =0.79).

Various reasons were given for female circumcision in

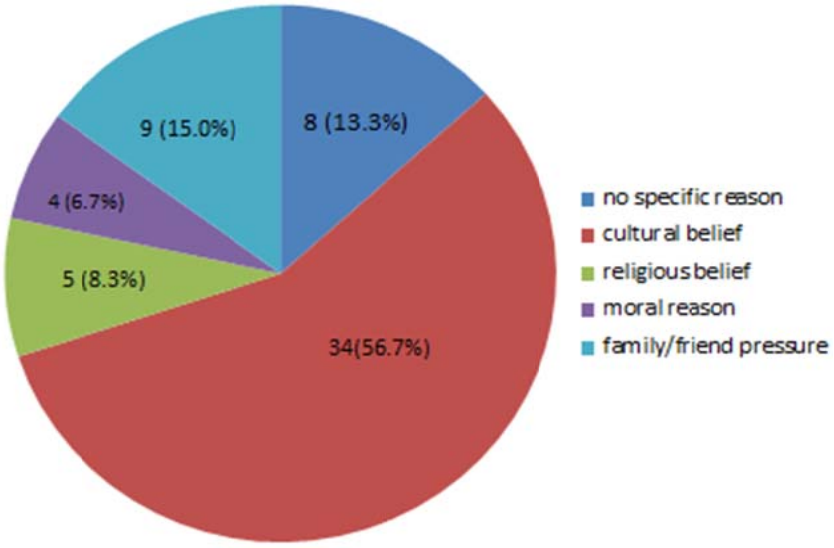

Figure 6: Parental reasons for circumcision

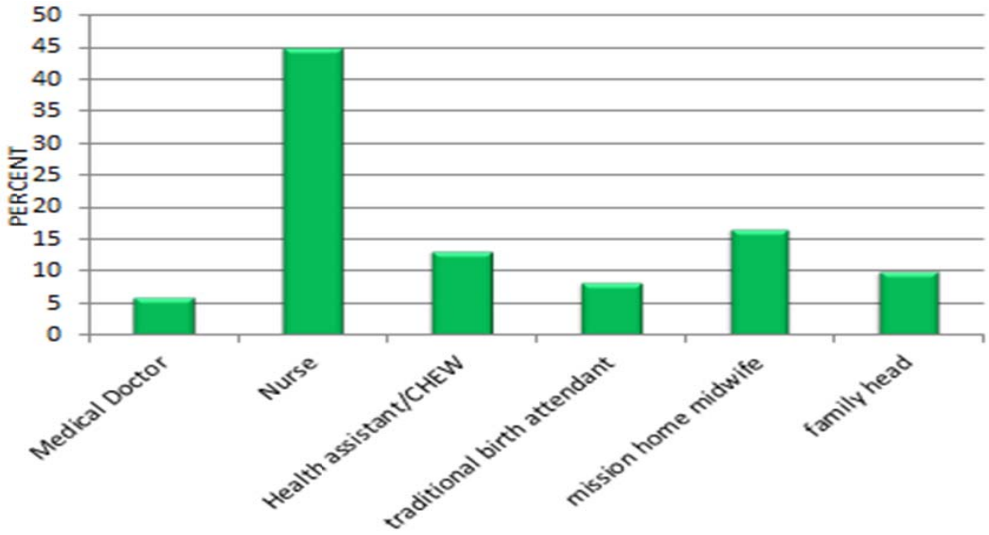

Figure 7: The person who did the circumcision

this study; however, cultural belief was more prominent as seen in figure 1. Other reasons included; moral, family pressure and religious belief. Figure 7 shows that FGM is not limited to mission house midwives and traditional birth attendants; it is practiced by some health workers, probably out of ignorance.

DISCUSSION

Female circumcision also known as female genital mutilation is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death (Convention on the Rights of the Child 1989), Organization of African Unity 1990), Female Genital

Mutilation 2016). It is still being practiced in Nigeria as implied by a prevalence of 30% among children of age less than 15 years in this study. The prevalence in this study is lower than the prevalence of 66.5% reported by Olamijulo et al., among children in Ilesha, south west Nigeria where the major tribe is Yoruba just like in this study. The reason for this could be that the campaign against FGM is gaining ground especially following the recent ban in Nigeria as a nation. Thirty percent of the circumcisions were done less than three years ago which also showed that this practice which has been associated with negative health implication and perceived as a social ill is ongoing though at a reduced rate.

There is a need therefore, to scale up plan for the eradication of FGM which is widespread in Nigeria as reported by Okeke et al., and also observed by UNICEF, that Nigeria contributed about a quarter of circumcised females[2]. Implementation of the law prohibiting this act signed by the former Nigerian President Goodluck Jonathan in May 2015 may help this fight against FGM.

The Yorub as, a predominant ethnic group in the study area, accounted for 98% of children with FGM. This is supported by the 2008 Nigeria Demographic and Health Survey (NDHS) which found that prevalence varies by ethnicity and geographic zone, with the practice being most common in the South East and South West zones, among the Yoruba and Igbo[6]. FGM has been associated with the cultural belief of the people (Simonet 2005). It is seen as part of a girl's initiation into womanhood and as an intrinsic part of a community's cultural heritage. Various myths about female genitalia are woven around the cultural belief of the ethnic group (e.g., that an uncut clitoris will grow to the size of a penis, or that FGM will enhance fertility or promote child survival) perpetuate the practice (UNFPA 2015). Another consequence which has been erroneously attached to not circumcising the girl child includes female promiscuity. As a result of this believe, mothers choose to subject their daughters to the practice to protect them from being ostracized, beaten, shunned, or disgraced (Yoder and Khan, 2007), UNICEF 2003). However, the 1989 Convention on the Rights of the Child identified female genital mutilation as a harmful traditional practice.

Type 1 FGM was the commonest type in this study. This agreed with earlier observation that it is the most widely practiced type in the south-west Nigeria, with extreme forms of FGM prevalent in the Northern part of Nigeria (Okeke 2012). Complications that were associated with FGM in this study included; fever, bleeding from wound site, irritability and infection as suggested by reports of pus discharge from wound site. Similar findings have also been recorded previously (Verzin 1975). The latter complication is expected since the procedure is usually done in non-sterile environment. Pain was not seen by the parents as a complication of FGM. Contrary to the belief by the Yorubas that newborns don't feel pain, irritability and inconsolable cries are the manifestation of pain in them. This may explain why FGM is advocated for during neonatal period as seen in this study. Such children may go into urinary retention due to the pain, tissue swelling and other inflammatory changes. Complications such as damage to the urethra, anus and other gynaecological problems as observed by previous researchers (Hathout 1963) were not identified in this study. This can be explained by the fact that Type 1FGM which has been associated with least morbidity is the most prevalent type in this study. Another plausible explanation could be that the circumcision was done at an early age when the victim is not likely to struggle much during the procedure thereby limiting the extent of the injury which is often dictated in many cases by chance (Hathout 1963).

Ten percent of the children with FGM complicated by bleeding had blood transfusion under the age of five years. This excluded children with predisposing factors to recurrent blood transfusion such as sickle cell anemia and Glucose 6 phosphate dehydrogenase deficiency. The severity of the bleeding was described by the parent as diaper being soaked with blood. FGM has been associated with bleeding (Verzin 1975). It stands to reason that anaemia may be initiated by FGM or exacerbated by it in a child with background moderate anaemia making such children to have increased predisposition to blood transfusion. A comparative study of rate of blood transfusion among female children who are circumcised and those who are not may be more revealing of such health implication of FGM.

Contrary to what was reported by an earlier study (Odoi 2005) that formal education is inversely related to the prevalence of FGM, there was no correlation between the practice of FGM and parental level of formal education. This can be explained by the fact that a man's belief and culture may be stronger determinants of the choices he makes in life as a great number of them carried out FGM based on their cultural belief i.e. 56.7% (34). Other reasons the parents gave included family pressure 15.0 %(9), religious reasons 8.3%(5), moral reasons 6.7%(4) and 13.3% (8) of them could not give any specific reason for circumcising their daughters. This is similar to the findings of Osifo et al., in his prospective study on FGM among female children presenting at the University of Benin Teaching Hospital over a 5 year period where cultural practice was the major indication for circumcision among the Edo people which accounted for 49 (96.1%) of the 51 children seen.

As seen in this study, some health workers participate in this gruesome act. This can be described as part of the phenomenon of "medicalization"[16] which has introduced modern health practitioners and community health workers into this act. This is contrary to the World Health

Organization (WHO) recommendation (Female Genital Mutilation 2016) that FGM must not be institutionalized neither should any form of FGM be performed by any health professional in any setting, including hospitals or in the home setting. In 2010, WHO published a "Global strategy to stop health care providers from performing female genital mutilation" in collaboration with other key UN agencies and international organizations (Female Genital Mutilation 2016).

CONCLUSION

FGM is still of health concern in Nigeria. There is need for continued health education for the general public as well as health workers using the media as a tool to ensure wide coverage. More efforts should be made towards implementation of the law forbidding FGM. There should be an avenue to report individuals engaged in the act to the law enforcement agency. Essentially, there should be regular monitoring and evaluation of the effectiveness of the various tools engineered towards increasing awareness of the ills of FGM in order to exterminate this practice.

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