

Correlates of Female Genital Mutilation and Its Impact on Safe Motherhood

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Abstract

Objective: This study investigates the correlates of female genital mutilation and its impact on safe motherhood among 500 women aged 15-45 years in Southwest Nigeria.

Materials and Methods: The data were collected using a structured questionnaire from five hundred consenting subjects. Vulvar examination was carried out by the investigators to confirm the presence or absence of female genital mutilation using the WHO classification.

Results: The incidence of female genital mutilation is 85%. Out of this, 86.8% had type I mutilation, while 13.2% had type II mutilation. There were no type III or IV mutilation. The lowest trend in female genital mutilation was found in the age of 15-19 years. Culture/tradition was the strongest reason for the practice. Female genital mutilation decreased with increasing level of education. Only 11.7% of those with type I mutilation compared to 48.2% of those with type II mutilation had long term complications. The mode of delivery was spontaneous vaginal delivery in majority of them with no major fetomaternal complications. The absence of serious morbidity may be attributed to milder form of the female genital mutilation practiced in our communities.

Discussion: The absence of major obstetric complications may be reflection of milder form of female genital mutilation performed in this environment.

Keywords: obstetric complications, fetomaternal complication, female genital mutilation

Özet

Kadın Sünnetinin (Genital Mutilasyon) Tipleri ve Perinatal/Obstetrik Sonuçlara Etkisi

Amaç: Bu çalışmada güneybatı Nijerya'da 15-45 yaş arasında 500 kadında, kadın sünnetinin tipleri ve perinatal sonuçlara etkisi araştırılmıştır.

Materyal ve Metot: Aydınlatılmış, onamları alınmış 500 kadından sistematik bir ankete ait veriler toparlandı. Tüm kadınlarda vulvar muayene bulguları, Dünya Sağlık Örgütü sınıflandırmasına göre sünnetin tipinin belirlenmesi amacıyla, kaydedildi.

Sonuçlar: Kadın sünneti insidansı %85 olarak saptandı. Bunların %86.8'inde tip I, %13.2'sinde tip II sünnet yapılmıştı. Tip III ve IV sünnete rastlanmadı. En az sünnet olan yaş grubu olarak 15-19 yaşları saptandı. Kültür/gelenekler sünnetin yapılmasında ana sebep idi. Eğitim seviyesi arttıkça sünnetin yapılma oranlarında azalma saptandı. Tip I sünnette karşılaşılan uzun vadeli komplikasyonlar (%11.7) tip II sünnete göre (%48.2) daha az idi. Hastaların yaptıkları doğumların büyük kısmı spontan vajinal doğumlar idi ve majör fetomaternal komplikasyon kaydedilmedi.

Tartışma: Majör obstetrik komplikasyonlara rastlanmamasının sebebi, bu bölgede yapılan kadın sünnetlerinin genellikle hafif formlarının uygulanmasına bağlı olabilir.

Anahtar sözcükler: obstetrik komplikasyon, fetomaternal komplikasyon, kadın sünneti

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Introduction

Female genital mutilation (FGM) encompasses a number of traditional operations that involve cutting away parts of the female external genitalia or other injury to the female genitalia whether for cultural or any other non therapeutic reasons (1). Recognition of its harmful physical, psychological, and human rights consequences had led to the use of the term “female genital mutilation” a term that more accurately describes the consequences of the procedure and distinguishes it from the much milder male circumcision.

Female genital mutilation is considered to be a violation of human, women’s and children’s rights (2-5). In Southwest Nigeria the procedure is done among many female children as part of a traditional christening ceremony during the neonatal period (5-6). Attachment of genital mutilation to cultural practices has made it difficult to abolish it despite many complications associated with it (6).

The problem of FGM are shrouded in secrecy, and systematic research into the magnitude and immediate or late consequences of the procedure is scarce (2,7). However it has been estimated that more than 100 000 teenagers die from complication of FGM (2). Mortality from tetanus, septicemia and hemorrhage as well as hepatitis B and AIDS are major risk (8-10). It has also been reported that the most important long-term complications for FGM is its association with high maternal and infant mortality during child birth (10-14). In addition obstetric complications due to obstruction to the birth canal from scar tissue and severe perineal tears may result even if an appropriate episiotomy is performed. Post-partum hemorrhage is also said to be common for the same reason (12).

FGM is common in this part of Nigeria. However, how common is the above fetomaternal complications among circumcised women? This study was designed to determine the correlates of female genital mutilation and the fetomaternal outcome in Southwest Nigeria.

Materials and Methods

This was a cross-sectional study conducted at the Obafemi Awolowo University Teaching Hospital Complex, Ile-Ife. The following clinics were purposely selected-family planning clinic; Gynecology Clinic, Ante-Natal Clinic and General Outpatient Clinic based on their relevance to the study. The first five hundred women in reproductive age (15-45 years) 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 patients and their verbal and written consent was obtained. The investigators and other trained personnel administered the questionnaires. The educational classification used in this study was based on previous study done by Oyedeki (15):

- Class I : University graduate or equivalent.
 - Class II : School Certificate (O’Level GCE) holders who also had teaching or other professional training.
 - Class III : School Certificate or Grade II Teachers’ Certificate holders or equivalents.
 - Class IV : Modern Three or Primary Six Certificate
 - Class V : Could both just read and write or were illiterate.
- Information on the questionnaire included the socio-demographic characteristics of the women, their experiences with FGM and its complications, their reproductive and birth histories, their attitudes and beliefs relating to FGM were also explored. Physical examinations were carried out on all respondents.

The vulva were inspected to confirm the presence or absence of FGM using the World Health Organization (WHO) classification. The evidence of abnormal features such as labial adhesion, implantation dermoid, introital scarring or stenosis was noted. The WHO categorized FGM into four main groups or types (1,2). In type I FGM, the prepuce (clitoral hood) is removed, sometimes along with part or the entire clitoris. In type II FGM, both the clitoris and part or all of the labia minora are removed. In type III FGM, the clitoris is

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

(Age in years)	Circumcised		Uncircumcised		Total	
	Freq. n	Percent %	Freq. n	Percent %	n	%
15-19	37	62.7	22	37.3	59	(100.0)
20-24	89	78.1	25	21.9	114	(100.0)
25-29	118	84.9	21	15.1	139	(100.0)
30-34	78	91.8	7	8.2	85	(100.0)
35-39	56	98.2	1	1.8	57	(100.0)
40-45	45	97.8	1	2.2	46	(100.0)
Total	423	84.6	77	15.4	500	(100.0)
$X^2=59.50$ df=30 p value<0.001						

removed, some or all of the labia are amputated and incisions are made on the labia majora to create a raw surface. These raw surfaces are either stitched together and/or kept in contact until they seal as a “hood of skin” covering the urethra and most of the vaginal opening. In type IV FGM, the circumcision encompasses a group of other operations on the external genitalia including introcision, for example “gishiri cuts”, piercing or incising the clitoris and/or labia, cauterization, scraping and/or cutting the vagina, introduction of corrosive substances and herbs into the vagina.

Circumcisionists can be classified into two broad groups; the traditional and the formally trained health workers. Among the former are the traditional healers (Akola), traditional birth attendants, mission house care givers while the later include doctors and nurses. The formally trained health workers perform the procedure in a hospital setting under anesthesia in the theatre but 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 the case may be 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 held down. The opening left for urine and menstrual blood is very tiny.

Data entry and analysis were carried out using SPSS software. Student’s and Chi-square tests were used where appropriate. The level of significance was taken as 5% ($p=0.05$). Data were presented as mean, percentages and standard deviations where appropriate. Ethical clearance was obtained from ethical committee of the institution.

Results

The mean age was 27.5 ± 7.5 years. Of the 500 respondents, 423 (84.6%) were circumcised while 77 (15.4%) were not.

Table 2. Distribution of respondents by ethnicity, circumcision rate and type

Ethnicity	N	Type of circumcision				% Circumcised	
		I		II		n	%
		n	%	n	%		
Yoruba	412	341 (96.9)	11 (3.1)	352 (85.4)			
Igbo	70	11 (19.6)	45 (80.4)	56 (80.0)			
Hausa	18	15 (100.0)	-	15 (83.3)			
Total	500	367 (86.8)	56 (13.2)	423 (84.6)			

Hence, the prevalence of circumcision in the study population was 84.6%. The circumcision trend among various age groups revealed that the highest rate of circumcision was in the 40-45 years age group while age group 15-19 years had the lowest (Table 1). Of the 423 circumcised women, 94.6% were circumcised at childhood, while 5.4% were circumcised at adulthood. About eighty percent had the procedure done at home by traditional circumcisionist known as Akola, while 13.9% had it done in the hospital and 6.4% in the church.

According to WHO classification used in this study, 86.8% of the circumcised respondents had type I FGM while 13.2% had type II FGM. There was no type III FGM or IV FGM. While 11.7% of those that had type I FGM had complications, 48.2% of those that had type II FGM had complications. The complications observed in type I FGM was mostly labia minora adhesions while introital scarring/narrowing was the commonest in type II FGM.

About 53.2% of the respondents were of the opinion that FGM should continue while about 43.2% considered it as an undesirable procedure. The rest were indifferent. FGM was acceptable to more than 50% (267) of respondents’ spouses while about 40% did not accept the procedure. The rest were undecided. Less than five percent felt the question was absurd. Three hundred (60%) of the respondents were Christians while 200 (40%) were Muslims. Of these 249 (83.0%) of the Christians and 174 (87.0%) of the Muslims

Table 3. The frequency and type of complacations among 423 circumcised respondents

Type of circumcisionist	Circumcised respondents		% of circumcised respondents with complication		Type of complications			
	Freq.	%	Freq.	%	Labia minora adhesion		Introital scarring/narrowing	
					Freq.	%	Freq.	%
Akola	326	77.1	53	16.3	15	28.3	38	71.7
Nurse	39	9.2	4	10.3	2	50.0	2	50.0
Mission House Caregiver	27	6.4	10	37.0	6	60.0	4	40.0
Doctor	20	4.7	2	10.0	1	50.0	1	50.0
T.B.A.	11	2.6	1	9.1	1	100.0	-	0.0
Total	423	100.0	70	82.7	25	35.7	45	64.3

Table 4. Influence of paternal and maternal educational status on respondents circumcision status

Educational status*	Paternal respondents' circumcised status			Maternal respondent's circumcision status		
	Circumcised		Total	Circumcise		Total
	n	%		n	%	
I	7 (26.9)	19 (73.1)	26 (100.0)	-	11 (100.0)	11 (100.0)
II	8 (50.0)	8 (50.0)	16 (100.0)	10 (58.8)	7 (41.2)	17 (100.0)
III	23 (67.6)	11 (32.4)	34 (100.0)	14 (58.3)	10 (41.7)	24 (100.0)
IV	145 (90.6)	15 (9.4)	160 (100.0)	73 (89.0)	9 (11.0)	82 (100.0)
V	240 (90.9)	24 (9.1)	264 (100.0)	326 (89.1)	40 (10.9)	366 (100.0)
Total	423 (84.6)	77 (15.4)	500 (100.0)	423 (84.6)	77 (15.4)	500 (100.0)

$X^2=212.92$; $df=8$; p value=0.00001
*According to Oyedeji (1985)

Table 5. Effect of respondent's educational status on their opinion about female genital mutilation

Educational status*	Respondents' opinion				
	Non-Supportive	Supportive	Indifferent	Total	
	n	%	n	%	n
I	241 (100.0)	-	-	24 (100.0)	
II	119 (80.4)	26 (17.6)	3 (2.0)	148 (100.0)	
III	68 (58.1)	49 (41.9)	-	117 (100.0)	
IV	23 (21.3)	85 (78.7)	-	108 (100.0)	
V	5 (4.9)	98 (95.1)	-	103 (100.0)	
Total	239 (47.8)	258 (51.6)	3 (0.6)	500 (100.0)	

$X^2=212.92$
 $df=8$
 p value=0.0000
*According to Oyedeji (1985)

were circumcised. However, none of the respondents supported the prescription of the practice with Bible or Koran. There was no statistically significant difference between religions groups in relation to circumcision status ($p=0.1957$).

Table 2 showed that circumcision rate was high in all the three ethnic groups but was highest among the Yoruba respondents. The most frequent type of circumcision observed among the Igbo ethnic group was type II FGM compared to type I FGM among Yoruba and Hausa ethnic groups. Two type of long-term complications were seen in which 45 (64.3%) was introital scarring/narrowing and 25 (35.7%) were labia minora adhesions. Only 70 (16.6%) of the 423 circumcised respondents had complications. While the Akolas performed the highest number of circumcision, the highest complication rate was encountered with the mission house caregivers (Table 3). Culture or traditions were the main reasons for being circumcised (94.6%). These were followed by concern about promiscuity (48.9%), unsightly vulva (18.2%), prevention of future death of male child (11.0%), pressure from relatives (9.2%) and religion (6.1%) while religion

Table 6. Effect of respondent's educational status on performance of genital mutilation for their female children

Educational status*	Circumcision of female child		
	Yes	No	Total
	n	%	n
I	-	24 (100.0)	24 (100.0)
II	26 (17.6)	122 (82.4)	148 (100.0)
III	49 (41.9)	68 (58.1)	117 (100.0)
IV	92 (86.0)	15 (14.0)	107 (100.0)
V	98 (94.2)	6 (5.8)	104 (100.0)
Total	265 (53.0)	235 (47.0)	500 (100.0)

$X^2= 227.65$
 $df=4$
 p value=0.0000
*According to Oyedeji (1985)

was the least commonly mentioned. Most respondents gave multiple reasons. Medical opinion against the practice was the major reason for not being circumcised (58.4%). This was followed by no longer popular (50.7%), no particular reason (31.2%), parental disagreement (5.2%). The practice was observed to decrease with increasing level of paternal and maternal education ($p=0.0001$) (Table 4). Majority (95.1%) of those who supported the practice had lower educational status. This finding was highly significant ($p=0.0001$) (Table 5). Circumcision among respondents' female children decreased with increasing education of the respondents ($p=0.0001$) (Table 6). Two third of the married respondents were in support of the practice while higher percentages of the single were not ($p=0.0001$) (Table 7). Respondents' circumcision status was positively associated with circumcision of their female offspring ($p=0.0001$) (Table 8).

There was no strong significant different in term of the mode of delivery, the need for episiotomy, caesarean section, low Apgar scores, postpartum hemorrhage and vaginal tears (Table 9).

Table 7. Effect of marital status on opinion about female genital mutilation

Marital status	Opinion					
	Non-supportive		Supportive		Total	
	n	%	n	%		
Single	132	(73.3)	44	(24.6)	3 (1.7)	179 (100.0)
Married	107	(33.3)	214	(66.7)	-	321 (100.0)
Total	239	(47.8)	258	(51.6)	3 (0.6)	500 (100.0)

X²= 84.08
df=1
p value=0.0000

Table 8. The relationship between circumcision status of the respondents and that of their female children

Respondents' circumcision status	Circumcision status of female children		Circumcision status of female children		Total
	Circumcised		Uncircumcised		
	n	%	n	%	
Circumcised	259	(61.2)	164	(82.8)	423 (100.0)
Uncircumcised	6	(7.8)	71	(92.2)	77 (100.0)
Total	187	(53.0)	235	(47.0)	500 (100.0)

X²=84.08
df=1
p value=0.0000

Discussion

The prevalence of FGM in this study is 84.6%. This is similar with an incidence of 85.8% reported in rural Egyptian communities (13). The Yoruba tribe formed the major ethnic group with few pockets of non-Yorubas, which is not surprising since the study was carried out in Ile-Ife, the cradle of Yorubas. 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

Table 9. Mode of first delivery of the circumcised respondents and type of circumcision

Mode of delivery	Type of circumcision			
	I		II	
	n	%	n	%
SVD with episiotomy	62	(98.4)	1	(1.6)
SVD without episiotomy	153	(82.3)	33	(17.7)
Caesarean section	10	(90.9)	1	(9.1)
Total	226	(81.0)	35	(12.5)

X²=13.22
df=6
p value=0.0397
SVD: Spontaneous Vaginal Delivery

that education may be the apparent reason for decrease in the incidence of this custom. As the parents' educational status increased, the tendency to circumcise their female children decreased.

The age of circumcision varies and depends on the ethnic group. In this study, 94.6% of the respondents were circumcised in childhood (mostly Hausas and Yorubas), while 5.4% were done in adulthood (mostly Igbos). This is similar to other studies done in this country where infantile circumcision was the commonest. 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 can frankly refuse without significant penalties from either the parents or the community especially where they can escape into bigger cities. In fact in Ilesa, Nigeria, the decision to circumcise the female child is made while the child is yet unborn (6).

The traditional circumciser known as Akola performed most (77.1%) of the circumcision in this study. This is probably because Akolas are more accessible and affordable, compared to Nurses and Doctors. The cultural set up of an average Yoruba family favours Akola more than orthodox medical/paramedical staff. The implication of this is that cultural ties are stronger than any persuasion of medical knowledge. In Somalia, most female circumcisions were similarly performed by non-medical personnel (13).

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. Also in Sudan, tradition was the main reason for FGM (13). One main factor behind the persistence of FGM is that it is regarded as a very important part of socialization into womanhood (1).

In this study, there was no significant difference in the circumcision status of Christians and Muslims and neither could specify any section of the Koran or Bible that prescribed the practice. It seemed apparent that FGM is not a religious practice as persons of all religious persuasions engaged in it as shown by the findings of this study. There was also no evidence that it is sanctioned by any known religion (14). It is clearly an outdated cultural practice in most societies, which need to be changed (14). 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.

Most of the married respondents supported the practice unlike the single respondents. This may be because a higher percentage of the married were of lower educational class coupled with pressure from in-laws. The apparent lack of support by the singles could be connected with their educa-

tional level. The practice of FGM was significantly lower among daughters of uncircumcised mothers (7.8%) compared to those in circumcised mothers (61.2%). These findings have implications when considering strategies for the elimination of this harmful tradition.

The impact of female genital mutilation on safe motherhood has not been investigated in our communities with regard to the types of female genital mutilation performed. Previous studies suggested that prolonged labor and its consequences of urinary fistula are common (1,2,10). In this study, we compared the mode of delivery in relation to the type of circumcision among those circumcised. There were no significant obstetric complications. This may be connected with the milder forms of circumcision performed in our society. In areas where types III FGM and IV FGM were predominantly performed, there is likely to be more cases of complications (1,2). Most of the patients had spontaneous vaginal delivery (SVD) even without episiotomy. There were few cases of caesarean section due to obstructed labor. There was no reported perinatal mortality.

Despite a favorable obstetric outcome, the right of the women and female children should be respected by advocating for abolition of the practice of female genital mutilation either in its mild or severe forms.

In conclusion, there is high prevalence of female genital mutilation in our society, with culture and traditions being the strongest correlates. The predominance of milder forms of the mutilation may be the reason why there was no associated adverse impact on safe motherhood.

References

1. Karungari Kiragu. Female Genital Mutilation: A reproductive Health Concern. Supplement to population Reports. Meeting the needs of Young of Adults Series J, No 41, Vol XXIII, No 3, October 1995. Page 1-4.
2. World Health Organisation. Management of Pregnancy, Childbirth, and the Postpartum Period in the Presence of Female Genital Mutilation. Report of a WHO Technical Consultation, Geneva WHO 1997.
3. World Health Organization. Female Genital Mutilation: Report of a WHO Technical Working Group, 17-19 July 1995, Geneva, World Health Organization (WHO) 1995.
4. Olatunbosun OA. Female Genital Mutilation: a model for research on sexual and reproductive rights. Afr. J Reprod. Health, 2000;4:14-6.
5. Momoh C, Ladhani S, Lochrie DP and Rymer J. Female genital mutilation: analysis of the first twelve months of a South East London Specialist Clinic. Obstet. Gynaecol 2001;108:186-91.
6. Ogunlola IO, Orji EO, Owolabi AT. Female genital mutilation and the unborn female children in southwest Nigeria. J Obstet Gynaecol 2003, Vol 23(2):143-5.
7. Dare FO, Oboro VO, Fadiora SO et al. Female genital mutilation: an analysis of 522 case in South-Western Nigeria. J Obstet Gynaecol 2004;24(3): 281-3.
8. Dirie MA and Lindmark G. A hospital study of the complications of female circumcision. Tropical Doctor, 1991;21:146-8.
9. Dirie MA and Lindmark G. The risks of medical complications of the female circumcision. East Afr. Med. J. 1992;69:479-82.
10. Aziz FA. Gynaecologic and Obstetric complication of female circumcision. Int J. Gynaecol Obstet. 1980;17:560-3.
11. McCaffrey M, Jankowska A, and Gordon H. Management of female genital mutilation: the Northwick Park Hospital Experience Br. J. Obstet Gynaecol 1995;102:787-90.
12. Mc Swiney MM, and Saunders PR. Female circumcision: a risk factor in postpartum hemorrhage. Journal of Postgraduate Medicine. 1992;38:136-7.
13. Sayed GH, Abd El-Aty, MA, Fade KA. The practice of female genital mutilation in Egypt. Int. J. Obstet Gynaecol. 1996;55:285-91.
14. Osemwenkha AP. Female genital mutilation: Definition and prevalence. In: Women's Health Forum. A publication of the Women's Health and Action Research Centre (WHARC). Nigeria. Vol 3, No 2.4-6.
15. Oyedeji GA. Socio-economic and cultural background of hospitalized children in Ilesha. Nigerian Journal of Paediatrics;12(4):111-7.