

Original Research Article

## Female Genital Mutilation among Antenatal Attendees at St. Luke's Hospital Anua, Uyo, Nigeria

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**Abstract:** Prevalence of female genital mutilation/cutting (FGM/C) was studied in Anua, Uyo, Nigeria to determine its status and success of campaigns in the region. Three hundred and sixty four (364) women were interviewed and clinically examined. Eighty two (22.53%) of the women examined had cuts. Type II cutting was common (64.60%), followed by Ia (18.30%) and Ib (15.90%). Type III was the least (1.20%) observed. Female genital mutilation occurred in ten (10) tribes out of eleven (11) observed. There were significant differences ( $P < 0.05$ ) in prevalence among the tribes. Yoruba and Efik tribes indicated highest (75.00%) each while Ibibio/Annang tribe had the least. Secondary school girls were most affected (53.66%). Muslims were more affected (66.66%) than Christians. Cuttings occurred either between infancy and childhood or puberty and marriage. It is done by "Circumcisers" considered experts in the community. Reasons for the practice include reduction of promiscuity and maintenance of virginity enshrined in tradition and religion. Involvement of nurses and other health workers as circumcisers was an attempt to medicalise the practice. FGM/C is still practiced in Nigeria. Efforts in campaigns and routine evaluation should not be abated to achieve the year 2030 eradication target.

**Keywords:** Prevalence, female genital mutilation, antenatal attendees, Uyo, Nigeria.

### INTRODUCTION

Female genital mutilation/cutting (FGM/C) is the full or partial removal of external genitalia of the female genital organ for non-medical reasons as defined by the National Society for the Prevention of Cruelty to Children (NSPCC) [1]. It is common in many countries in Africa, Asia and Middle East with high prevalence in the Horn of Africa [2]. Migrants from these endemic countries take it to some places in Europe, Australia and North America [3, 4]. Over 200 million women have been cut throughout the world and more than 300 girls are at risk every year [5]. More than 6000 females are cut daily [6]. The practice is considered a violation of fundamental human right among women particularly girls [4]. It has some medically and psychologically negative effects on the victims. Serious and persistent efforts are therefore made by World Health Organisation (WHO) and other health/human right related agencies to discourage it.

The highest known prevalence is in Africa [7, 4]. At least 2million girls, a year in Africa undergo this mutilation [8], resulting in an estimation of 130 million Africa girls as victims [9].

FGM is widespread in Nigeria [10]. More than 50% of girls and women have undergone FGM [11]. A study by National Baseline Survey of Positive and Harmful Traditional Practices affecting women and girls in Nigeria in 1997, reported FGM in 5 states; Osun (91.60%), Edo (74.00%), Imo (95.40%), Abia (82.40%) and Anambra (75.50%). High prevalence rates were also reported in Cross River (93.00%), Delta (91.40%), Akwa Ibom (65.00%) and Rivers (58.30%) states [12]. Among the six largest tribes in Nigeria (Yoruba, Hausa, Igbo, Fulani, Ijaw and Kanuri), it is only Fulani that is exempted [13]. About 90% of Yorubas practice FGM/C, but the Ijebus, a major Yoruba group, never do it [14].

FGM is extant in many endemic places including Nigeria despite the campaign against it [15]. Future research should explore effects of intervention strategies to prevent FGM/C [16]. It is a tradition accepted by some tribes and religions. Surveillance is therefore necessary to help assessing the effects of the campaigns against this inhumane practice. Since the prevalence rates can

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easily return to the previous high levels [16], it is also imperative to determine the existing status of the practice in this society to evaluate eradication efforts. These facts became preludes of this study in determining the FGM/C status and success of its intervention strategies in Nigeria.

## MATERIALS AND METHODS

**Study area:** - This study was done in antenatal clinic of St. Luke's hospital at Anua, Uyo, Nigeria. Uyo is the capital of Akwa Ibom state. It's political and administrative status attracts people from other states in Nigeria and beyond for business and administrative activities. St. Luke's hospital was established in 1937 by Medical Missionary of Mary (MMM) in Catholic Church. Its popularity in gynaecological services attracts people everywhere in Nigeria particularly for Vesico Vaginal Fistula (VVF) and other maternity services. It is recognized by medical council in Lagos and London for the training of registered house doctors. It is jointly managed by Catholic Church and the state government.

### Study population

The population consisted of 364 interviewees taken from newly registered pregnant women of antenatal care. This size was determined using the formula:

$$N = \frac{Z^2 \times P(1-p)}{D^2}$$

Where N= desired sample size, Z= standard deviation (1.96 at 95% confidence interval), P= prevalence of FGM/C and d= desired accuracy (0.05 at 5% level of significance). Selection of individuals was done using systematic random sampling.

**Data collection:** - Data was collected through two processes- questionnaire/discussion and clinical examination of the genitals. Pretest of the questionnaire was done before given to the respondents

**Ethical issues:** - Ethical clearance from the Ministry of Health and informed written consent from each subject were obtained before recruiting them into the study.

## RESULTS

Three hundred and sixty four questionnaires were completed and analysed. Clinical examination indicated different types of cuttings with type II as the most common followed by Ia and Ib. Type III was the least observed. Four socio-demographic parameters identified were ethnic groups or tribes, age grades, educational status and religious affiliations.

**Ethnic groups:**-The women examined were from eleven (11) ethnic groups in Nigeria and represented the four geographical cardinals (North, South, East and West) of Nigeria. Female genital cutting was observed in all the tribes examined except Andoni. The highest occurrences of 75.00% each were observed in Yoruba and Efik tribes. Hausa had 66.66%. Other ethnic groups indicated <50% with the least (15.15%) observed in Ibibio/Annang tribes (Table 1). Variations in prevalence among the ethnic groups was statistically significant (P<0.05, F=4.84df6, 60).

**Age grades:**-The respondents were between 17 and 44 years. About 156 (42.86) of the women interviewed were between 21 and 25 years while the least were between 41 and 45 years (Table 2).

**Educational status:**-Female genital cutting was observed among women at different educational categories. More women (76.92%) at primary school level had FGC/C followed by those at secondary school level (30.99%). Women at university level of education had 14.81% of the cutting while those at tertiary level below the university had 11.88% (Table 3). Variations in occurrence among different educational groups was highly significant (P<0.05, F=27.68 df12, 48).

**Religious affiliation:**-Three religious groups (Christians, Muslims and Traditionalist) were identified. Female genital cutting was observed more in Muslim (66.66%) than Christian women (20.79%). Only one person was in traditional religion and she was circumcised (Table 4).

### Rationale for female genital mutilation/cutting

Different reasons were given for the performance of female genital cuttings. Many respondents (58.52%) considered it a traditional or cultural norm while others (24.18%) suggested a means of controlling sexual promiscuity. In some cultures men prefer circumcised women and it is considered a beautification of the genitals and improvement on fertility (Table 5).

### **Mature age for female genital mutilation /cutting**

The common age which FGM/C is done is between 8 days postnatal and 1 year as reported by the respondents (Table 5). Another time is near puberty and marriage i.e. between 15 and 20 years.

### **Practitioners and mode of performance of the cutting**

Female genital cutting was commonly done by traditional circumcisers considered to be specialists within the community. Traditional birth attendants (TBAs), some health workers and herbalist in the community also performed the activity (Table 6).

Most cuttings were done either in the girls' or circumciser's home. Few cases were reported in hospitals and health centres (Table 7).

FGM/C is done either voluntarily or subjectively. About 158(43.40%) of the victims did it voluntarily while 130(35.78%) were under obligation. In most cases, it is the parents; mothers (44.50%) and grandmothers (28.60%) who request for the cutting. The paternal parents (fathers -4.70%, grandfathers – 2.40%) indicated little interests. The consent of the parents is usually required in carrying out this exercise except in few cases.

### **Knowledge of female genital mutilation/cutting among the respondents**

Almost all respondents (343, 94.23%) agreed that they have heard of FGM/C. Many of them (322, 88.46%) understood it as cutting of the female external genitalia. About 186 (51.10%) of the women were aware of the campaigns against FGM/C while 178 (48.90%) were not aware. They got the information through radio, television, newspapers health centre programmes, women meetings, general discussions and peer group interactions (Table 8).

### **Respondents' attitudes towards female genital mutilation/cutting**

The attitudes of the respondents towards FGM/C varied. About 344(94.50%) wanted it to be eradicated while 20(5.50%) wanted it to continue. The anti FGM/C suggested education of the women and men, and promulgations by government as strategies to stop the menace. Few (2.40%) suggested giving the circumcisers alternative jobs. The proFGM/C based their supports on the culture or tradition which may affect their lives if stopped. The number of respondents against FGM/C was very high among the age groups, tribes, religions and educational levels (Table 9).

## **DISCUSSION**

Female genital mutilation cutting was observed in most tribes in Nigeria. This indicates the existence of this practice despite serious campaigns in some parts of Nigeria e.g Edo, Ogun, Cross River Osun, Rivers and Bayelsa states [15]. It is mostly done in Yoruba, Efik and among the Hausas. This is probably due to the adherence of these communities to their culture of initiation into womanhood and controlling promiscuity to retain virginity [17]. The role of tradition could also account for the high prevalence in Efik tribe (75.00%) where fattening is a common practice presently as most FGM/C is done during the fattening period. The influence of tradition in FGM/C has been reported [18]. Another main reason is to prevent indiscriminate sexuality according to the religious beliefs. More Muslims (66.66%) were affected than Christians (20.79%). This could be one of the reasons for high prevalence among the Hausa communities where Islam dominates. Tradition and religion [19, 20], could therefore account for the high prevalence in Yoruba tribe where tradition is unabated and most indigenes are Muslims.

The interviewees were between 17 and 44 years with more than 156 (42.86%) occurring between 21 and 25 years. This shows their maturity in giving the information for this study. The cutting takes place mostly at two stages of life. The first stage is between infancy and childhood i.e. 8 days (postbirth) and 1 year. Another is from puberty during initiation into womanhood as preparation for marriage (12-25 years). These are the preschool, primary and late secondary school years when children are still dependent on their parents. Child's discretion or consent is not required in decision makings especially on important issues as this. About 53.66% of the persons were affected at secondary and 12.20% at primary school levels making 65.60% in sum. It will be difficult for the children at these lower ages to resist their parents. Most females in tertiary institutions are still under parenthood, as such cannot object.

The rationale for FGM/C varies with tribes [21]. However, traditional and moral reasons are the important factors for FGM/C among the tribes and religions. Other reasons supporting it include, the belief to prevent death of mother or baby at delivery, enhancing of easy delivery, beautification of the genitals to the taste of some men and improvement of fertility. These subsequent reasons are beliefs which cannot be proved scientifically. Biologically, clitoris and some external genitalia are sensational for stimulations during sexual intercourse. Removal of some of these parts can reduce stimulations decreasing sexual urge.

Information from the respondents indicates that FGM/C is done mostly by traditional circumcisers, traditional birth attendants and some herbalists. This takes place either in their homes or where the girls' parents live. Since this activity occurs in private homes, surveillance may become difficult, particularly where the community considers it their norm. Abolition may be delayed by this. Few cases were reported done in hospitals and health centres by nurses and community health workers. This could be an attempt for

these medicalists to save the lives of the victims and or reduce the pains since they cannot preclude the act. This does not abrogate the harm and inhumanity of this activity.

A greater number of respondents had knowledge of FGM/C while few were ignorant. More than half of the informed women also acknowledged the different campaign strategies against FGM/C. Majority wanted the practice eradicated.

The proposal to eliminate FGM/C by the year 2030 [22] is feasible if campaigns and evaluations are unabated. Most religious and traditional leaders along with the women support eradication. Results obtained indicate a drastic decline (22.53%) incidence from between 56.90 and 34.00% [1] and 91.00 and 58.30% [12]. There was success in curtailing FGM/C in Ebonyi and Imo states through UNICEF programmes, as such for more efforts was demanded to put an end to it [23]. There is assurance that this psychophysiological menace shall be eradicated soon.

**Table-1: Ethnic groups of antenatal attendees examined for FGC at St. Luke's hospital Anua, Uyo, Nigeria**

Ethnic groups	Number examined	Number affected	Percentage(%) of affected
Andoni	02	00	0.00
Boki	06	01	16.66
Efik	08	06	75.00
Hausa	12	08	66.66
Ibibio/Annang	264	40	15.15
Igala	05	02	40.00
Igbo	51	18	35.29
Kalabari	03	01	33.33
Okrika	05	02	40.00
Yako	04	01	25.00
Yoruba	04	03	75.00

**Table-2: Age of women examined for FGC at St. Luke's hospital Anua, Uyo, Nigeria**

Ages (yrs)	Number examined	Number affected	Percentage(%) of the affected
18-21	52	09	17.30
22-25	156	18	11.54
26-29	45	07	15.55
30-33	05	06	11.75
34-37	41	32	78.05
38-41	19	10	52.63

**Table-3: Educational status of women examined for FGC at St. Luke's hospital, Anua, Uyo, Nigeria**

Educational level	Number examined	Number affected	Percentage (%)of the affected
Primary school	013	10	76.92
Secondary school	142	44	30.99
Tertiary below University	101	12	11.88
University	108	16	14.81

**Table-5: Ages female genital mutilation/cutting is done among different tribes and religions in Uyo, Nigeria**

Tribes/religions	Ages (years)					
	8(days)-1	1-5	6-10	11-15	16-20	>20
Andoni	02					
Boki	06					
Efik	08					
Hausa	02	10				
Ibibio/Annang	73	20	22	33	22	
Igala	00					4
Igbo	11					
Kalabari	03					
Okrika	05					
Yako	00			04		
Yoruba	04					
Christians	111	20	22	37	22	4
Moslems	02	10				
Traditional	01					
Total	226	60	44	74	44	8

**Table-4: Reasons for performing female genital mutilation/cutting among women at St. Luke’s hospital, Uyo, Nigeria**

Reasons	Number of respondents	Percentage (%)
Fulfilling cultural and traditional norms	213	58.52
Prevention of sexual immorality	88	24.18
Beautification/men’s preference	34	09.34
Improved fertility	11	03.02
Increased life expectancy	07	01.92
Easy delivery at birth	05	01.37
Religious ethics	03	00.82

**Table-6: Practitioners of female genital mutilation/cutting**

Practitioners	Number of respondents	Percentage (%)
Traditional circumcisers	192	52.70
TBA	085	24.20
Community health workers	11	03.00
Herbalists	08	02.20
Nurses	05	01.40
Medical doctors	01	00.30
Others	02	00.50

**Table-7: Places in the community where female genital mutilation/cutting usually occurs.**

Places	Number of respondents	Percentages (%)
Girl’s home	171	49.14
Circumciser’s home	131	37.64
Hospital	028	08.05
Health centre	018	05.17

**Table-8: Sources of information on campaign against female genital mutilation/cutting**

Sources	No. of Respondents	Percentages (%) of respondents
Radio	64	37.10
Television	44	23.70
Newspaper	08	4.30
Health centre	10	5.40
Women meetings	19	10.20
General discussions	33	17.70
Peer group interactions	03	1.60

**Table-9: Attitudes of respondents towards female genital mutilation/cutting**

Strata (group) of respondents	Attitudes			
	FGM/C should continue		FGM/C should stop	
Age groups	Yes	No	Yes	No
17-20	0	52	52	0
21-25	0	156	153	3
26-30	1	42	42	1
31-35	2	51	51	2
36-40	10	31	31	10
41-45	4	15	15	4
<b>Subtotal</b>	<b>17</b>	<b>347</b>	<b>344</b>	<b>20</b>
Tribes				
Andoni	0	2	2	0
Boki	0	6	6	0
Efik	3	5	5	3
Hausa	3	9	9	3
Ibibio/Annang	9	255	252	12
Igala	0	5	5	0
Igbo	2	49	46	5
Kalabari	0	3	3	0
Okrika	0	5	5	0
Yako	0	4	4	0
Yoruba	0	4	4	0
<b>Subtotal</b>	<b>17</b>	<b>347</b>	<b>341</b>	<b>23</b>
Religious affiliations				
Christians	15	336	334	17
Muslims	2	10	9	3
Traditionalist	0	1	1	0
<b>Subtotal</b>	<b>17</b>	<b>347</b>	<b>344</b>	<b>20</b>
Educational levels				
Primary	10	132	130	12
Secondary	2	106	105	3
< University	2	11	10	3
University	3	98	99	2
<b>Subtotal</b>	<b>17</b>	<b>347</b>	<b>344</b>	<b>20</b>

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