

# Prevalence and Associated Factors of Female Genital Mutilation among Antenatal Clinic Attendees at Alex Ekwueme Federal University Teaching Hospital, Abakaliki

Onuchukwu Victor Jude Uchenna<sup>1</sup>, Obi Vitus Okwuchukwu<sup>1</sup>, Nwafor Johnbosco Ifunanya<sup>1,\*</sup>, Agu Chidinma Joy<sup>2</sup>, Ibo Chukwunenye Chukwu<sup>1</sup>, Onwe Blessing<sup>1</sup>, Obi Chuka Nobert<sup>1</sup>, Ugoji Darlington-Peter Chibuzor<sup>1</sup>

<sup>1</sup>Department of Obstetrics and Gynaecology, Alex Ekwueme Federal University Teaching Hospital, Abakaliki, Nigeria

<sup>2</sup>Department of Public Health, University of Calabar, Calabar, Nigeria

\*Corresponding author: [nwaforjohnbosco97@gmail.com](mailto:nwaforjohnbosco97@gmail.com)

Received June 04, 2019; Revised July 17, 2019; Accepted July 21, 2019

**Abstract Background:** Female Genital Mutilation is a harmful traditional practice with severe health complications, deeply rooted in many sub-Saharan African countries. Despite its high prevalence, it has remained largely uninvestigated in Abakaliki. **Aim:** To determine the point prevalence of female genital mutilation and to assess the influence of socio-economic factors on its practice among antenatal clinic attendees at Alex Ekwueme Federal University Teaching Hospital, Abakaliki. **Materials and Methods:** This was a cross-sectional descriptive study on 408 pregnant women attending the antenatal clinics of Alex Ekwueme Federal University Teaching Hospital, Abakaliki, Southeast, Nigeria. WHO classification was used to confirm the presence, type or absence of female genital mutilation after vulval examination has been carried out. Analysis was done with Epi Info 7.2.5 (Atlanta Georgia). **Result:** The prevalence of female genital mutilation was 39.0%. Out of this, 29(18.4%) had type I mutilation, 128(80.6%) had type II mutilation, and 2(0.3%) had type II mutilation. There was no type IV mutilation. The lowest trend in female genital mutilation was found in the age of 40-49 years. The sociodemographic characteristics of circumcised women that were of statistical significance were age and educational status with p-value of <0.05. Female genital mutilation decrease could be on account of increased awareness of the impact of the procedure, though cultural beliefs accounted for most of the cases in the study. 67 (42.1%) of women who were circumcised were satisfied with the practice. Culture/tradition was the strongest reason for supporting the practice. **Conclusion:** The prevalence of female genital mutilation is still high in Abakaliki and most common being WHO type II. The strongest reason for the persistent practice of FGM the study was Culture/tradition. Female genital mutilation is a discriminatory act that must be eradicated through the help of communities, religious leaders and health workers; health education and legislation will go a long way to its eradication.

**Keywords:** prevalence, female genital mutilation, antenatal care, Abakaliki

**Cite This Article:** Onuchukwu VJU, Obi VO, Nwafor JI, Agu CJ, Ibo CC, Onwe B, Obi CN, and Ugoji DPC, "Prevalence and Associated Factors of Female Genital Mutilation among Antenatal Clinic Attendees at Alex Ekwueme Federal University Teaching Hospital, Abakaliki." *American Journal of Medical Sciences and Medicine*, vol. 7, no. 2 (2019): 39-43. doi: 10.12691/ajmsm-7-2-4.

## 1. Introduction

Female genital mutilation (FGM), also known as female circumcision/cutting, is defined as all procedures involving the partial or total removal of the external genitalia or other injury to the female organs for cultural or other non-therapeutic reasons [1-6]. FGM is a deeply rooted practice that is carried out worldwide; but it is mostly prevalent in 28 countries in Africa, some countries in Asia and the Middle East and among certain immigrant communities in North America, Australia and Europe [7-12].

It is estimated that 100-140 million girls have undergone FGM worldwide and 3 million girls are at risk of undergoing the procedure every year, which equates to more than 8000 girls every day [13-17]. The prevalence of female genital mutilation has been estimated from large-scale, national surveys asking women aged 15-49 years if they have themselves been cut. The prevalence varies considerably, both between and within regions and countries 18-23; 78.3% in Gambia [2], 77% in Burkina Faso [8] and 49.6% in a previous study in Abakaliki [24] and 12.1% in Northern Nigeria [25].

The causes of female genital mutilation are not well known but there are many reasons and myths for its existence and continuation, associated primarily with

cultural, religious and social factors within families and communities [1,2,6,26]. The World Health Organisation (WHO) classified FGM into four types including type I - the partial or total removal of the clitoris and/or the prepuce (clitoridectomy); type II - Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision); type III - narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation) and type IV - all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization [6,20].

Female genital mutilation is mostly carried out on females between the ages of 0 and 15 years. However it could be done in adolescence, shortly before marriage or just before the birth of the first child. The age at which female genital mutilation is performed varies with local traditions and sociocultural beliefs, but is having a downward trend in some countries [2,3,4,5,6,19,27].

The United Nations condemns female genital mutilation as a form of violence and discrimination against girls and women. In every society in which it is practised, it is a manifestation of gender inequality that is deeply entrenched in the socio-economic and political structure; female genital mutilation represents society's control over women [3,6,28,29].

Female genital mutilation is commonly performed by traditional birth attendants, local women or men, or female family members. The circumcisers do not have any medical training or anatomical knowledge of the vulva and usually perform FGM without anaesthesia or sterilization of instruments. It is not uncommon for those who perform FGM to cut or damage more of the genital area than they intended. Occasionally Female genital mutilation are performed by trained health professionals [6].

The immediate health complications of FGM include shock, haemorrhage, infections (HIV, tetanus etc) and psychological consequences and the long complications consist of chronic pain, infections, cheloids formation, primary infertility, birth complications, danger to the new born, urogenital complications, psychological consequences and death [8]. Despite the severe health complications associated with practice of Female genital mutilation, studies on its prevalence and associated socio-economic factors among antenatal clinic attendees are limited in Abakaliki. Therefore this study aimed to determine the level of practice of female genital mutilation (FGM) and the influence of socio-economic factors on its practice among antenatal clinic attendees at Alex Ekwueme Federal University Teaching Hospital, Abakaliki.

## 2. Materials and Method

This was a cross-sectional study conducted at the Obstetrics and Gynaecology Department of the Alex Ekwueme Federal University Teaching Hospital, Abakaliki over a month period. The hospital serves as a major referral center for Ebonyi, Benue and Cross River states. Patients are usually referred from general hospitals, government owned health centers, private hospitals and

from other department in the hospital. The state has a population of 2.1 million people based on the 2006 national population census and occupies a land mass of 5932 kilometers square [25].

Consecutive consenting pregnant women who presented for booking in the facility were recruited for the purpose of the study. The first four hundred and twenty two (422) pregnant women who consented were recruited. The full details of what the study entailed was explained to all the women and their verbal and written consent were obtained. The investigator assisted by 4 other residents 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. Each questionnaire was validated on site. Only consenting women who presented for booking were recruited for the study, while non-pregnant women and those on return visits were excluded.

The minimum sample size for the study was calculated using Fisher's formula [30]

$$n = Z^2 pq / e^2$$

n: minimum sample size at 95% confidence interval

Z: the standard normal deviate usually set at 1.96

p: prevalence of FGM in a study in Abakaliki = 49.6 %

q: 1-p

e: precision: the difference between the true population rate and acceptable sample rate and it was set at 0.05.

$$n = \frac{(1.96)(1.96)(0.496)(0.504)}{(0.05)(0.05)}$$

$$n = \frac{0.9603}{0.0025} = 384.1 = 384.$$

10% attrition rate was added giving; n = 384+38.4= 422.4 giving a sample size of 422.

Data analysis was done using Epi Info software (7.2.1 CDC Atlanta Georgia). The results were expressed as frequency tables, percentages, mean and standard deviation. Associations between categorical data were analyzed using Chi square ( $X^2$ ), while continuous variables were analysed using the Student t test, with a p-value < 0.05 considered statistically significant. Ethical clearance was sought and obtained from the Health Research and Ethics committee of the Alex Ekwueme Federal University Teaching Hospital, Abakaliki.

## 3. Results

Of the 422 questionnaires distributed only 408 were appropriately filled and were used for this analysis. The mean age of the respondents was 28.5±7.2 years. In the study 159 (39.0%) were circumcised while 226 (55.4%) were not circumcised and 23 (5.6%) did not know whether they were circumcised. Therefore, the prevalence of circumcision in the study population was 39.0%.

As shown in Table 1, 20-29 years age group 211 (51.7%) recorded the highest participants among the respondents, while age group 40-49 years were the least at 12 (3.0%) and 185 (45.3%) in 30-39 years age group. Majority of them 385(94.4%) were married and 23(5.6%) were single, 292(71.6%) have given birth to 1 to 4 children and 20(4.9%) delivered 5 and above. Among those who were circumcised 20-29 years age group 89 (56.0%) had the highest rate of circumcision while age group 40-49 years recorded the least at 09 (5.6%), and 61 (38.4%) in 30-39 years age group. Most of these women were multiparous and Catholics and of the Igbo extraction. Tertiary level of education was the commonest form of educational attainment among the respondents.

**Table 1. Socio-demographic characteristics of the participants**

Parameter	Frequency	Percentage
<b>Age</b>		
20-29	211	51.7%
30-39	185	45.3%
40-49	12	3.0%
<b>Marital status</b>		
Single	23	5.6%
Married	385	94.4%
<b>Parity</b>		
0	96	23.5%
1-4	292	71.6%
≥5	20	4.9%
<b>Religion</b>		
Catholic	192	47.0%
Anglican	63	15.4%
Pentecostal	137	33.6%
Muslim	8	2%
Traditional	8	2%
<b>Education</b>		
Primary	19	4.7%
Secondary	70	17.2%
Tertiary	319	78.1%
<b>Ethnicity</b>		
Igbo	344	84.3%
Yoruba	26	6.4%
Hausa	15	3.8%
Others	23	5.6%

Table 2 shows awareness of practice of FGM among the study population. About 90% of the respondents were aware of FGM, and about 73.3% (299) of them were aware that it is still been practiced. Relatives/friends and family were the commonest source of information while schools and place of worship were the least source of information. 62(42.1%) among those who were circumcised were satisfied with the procedure while the remaining were either not satisfied or were indifferent about the practice. Among those who were circumcised

20-29 years age group 89 (56.0%) had the highest rate while age group 40-49 years recorded the least at 09 (5.6%), and 61 (38.4%) in 30-39 years age group.

**Table 2. Awareness and Practice of female genital mutilation (FGM)**

Parameter	Frequency	Percentage
<b>Are you aware of FGM?</b>		
Yes	366	90.0%
No	26	6.4%
I don't know	16	4.0%
<b>Are you aware if it is still been practiced?</b>		
Yes	299	73.3%
No	74	18.1%
I don't know	35	8.6%
<b>Source of information</b>		
Mass media	152	37.3%
Relatives/friends/family	174	42.7%
Hospital	33	8.1%
School	30	7.4%
Church	11	2.7%
I don't know	8	1.8%
<b>Were you circumcised?</b>		
Yes	159	39%
No	226	55.4%
I don't know	23	5.6%
<b>Satisfaction (Only those circumcised)</b>		
Yes	67	42.1%
No	44	27.7%
Indifferent	48	30.2%
<b>Age of circumcised respondents</b>		
20 - 29	89	56.0%
30 - 39	61	38.4%
40-49	9	5.6%

Persistence and complications of FGM among respondents are shown in Table 3. The persistence of FGM was mostly on account of culture 226(55.4%) and least because of hygiene 7(1.7%). The reasons for not supporting the practice was due to mostly infection 133(33.0%) and infertility 11(2.7%) contributed least. The complication mostly known by respondents was bleeding 181(44.0%), and the practice was performed mainly by traditional female circumcisers 137(36.6%). Most of those circumcised, had it performed on them during the newborn period 92(57.9%); 30(7.4%) of the respondents had their daughters circumcised. Out of 159 respondents who were circumcised, 29(18.4%) had type I mutilation while 128(80.6%) had type II mutilation, 2(0.3%) had type II mutilation. There was no type IV mutilation.

Table 4 showed cross tabulation of those circumcised with some social and demographic characteristics; it was noted that only age and educational status were of statistical significance.

**Table 3. Persistence and Complications of FGM**

Parameter	Frequency	Percentage
Reasons for persistence of FGM		
I don't know	70	17.2%
Hygiene	7	1.7%
Religion	22	5.4%
Easy delivery	26	6.4%
Rite of passage	11	2.7%
Decreased sexual desire	181	44.4%
Culture	226	55.4%
Reasons for not supporting FGM		
Death	118	28.9%
Infertility	11	2.7%
Infection	133	33.0%
Genital scarifications	52	12.7%
Vesicovaginal fistula	93	22.8%
Not biblical	100	24.5%
Barbaric	81	19.9%
Difficult labour	15	28.2%
Knowledge of complications		
Infertility	48	11.8%
Death	59	14.5%
Infection	115	28.2%
Vesicovaginal fistula	85	20.8%
Genital scarifications	70	17.2%
Shock	41	10.0%
Difficult labour	96	23.5%
Bleeding	181	44.0%
When was it done?		
Adolescence	19	11.9%
Childhood	48	30.2%
Newborn	92	57.9%
Who performed it?		
Relatives	30	7.4%
Traditional birth attendant	85	20.8%
Traditional female circumcisers	137	36.6%
Others	59	13.7%
Were you daughters circumcised ?		
Yes	30	7.4%
No	378	92.6%

**Table 4. Comparison of those circumcised with some socio-demographic characteristics**

parameter	Total	circumcised	Not circumcised	X <sup>2</sup>	P-value
Age					
20-29	211	68	143	5.28	0.02
30-39		84	101		
40-49	185	7	5		
Marital status					
Single	12				
Married	23	12	11		
Parity					
0	385	147	238	1.78	0.18
1-4	96	37	59		
≥5	292	105	187		
Educational status					
Primary	20	17	3	1.27	0.25
Secondary	19	15	4		
Tertiary	70	49	21		
Knowledge of FGM					
Yes	319	95	224	50.3	<0.0001
No	366	138	228	2.41	0.11
I don't know	26	12	14		
	16	9	7		

## 4. Discussion

The prevalence of FGM in this study is 39.0%. This is comparable to a rate of 34% that was reported in Port-Harcourt1, though lower than the prevalence of 49.6% previously reported in Abakaliki 24 which could be on account of higher educational level and increased awareness of FGM; lower prevalence rates of 12.1% had been reported in Northern Nigeria [22]. The prevalence in the southern part of Nigeria is alarmingly high, 48.5% was reported by Adinma et al [3] 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. These differences may suggest a decrease in prevalence and practice of FG cutting in our environment. Awareness of FGM is 90% among respondents and about 73.3% of them said it is still being practiced. The major sources of information about FGM were from relative/friends/family and the mass media. This may be connected with increased cultural beliefs or influence from relatives and families in this environment; there is urgent need to abolish some of these obnoxious traditions so that FGM will be completely or near totally removed in our environment.

In this study, 57.9% of the respondents were circumcised in the newborn period, 30.2% in childhood while 11.9% were done in adolescence; a similar trend had been reported in other similar studies carried out in Port-Harcourt Nigeria1, Abakaliki Nigeria [24] and Northern Nigeria [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. 42.1% of the women circumcised in the study were satisfied. The procedure was mostly performed by traditional female circumcisers. This may be another reason for this practice in our environment. Despite the campaign against the practice those who were circumcised would rather keep quiet about the practice than raise concern as they may be considered socially unfit.

In most societies, an uncircumcised woman is seen as unnatural and shameful by both men and women in the community, and therefore unfit to marry and bear children [6,7]. It was overwhelmingly noted that culture/tradition was the commonest reason for female genital circumcision in this study, followed by decreased sexual desire; thereby encouraging its practice, while medical complications like difficult labour and death are the major reasons for opposing circumcision. Some communities believe that FGM is a religious obligation [6]. However, FGM is not mentioned in the Koran or the Bible; it predates Islam and is not practised in many Muslim countries, but is practised in some Christian communities [6]. A study in Gambia indicated that the practice of FGM/C has a significant economic cost as 1 of 3 patients (299 cases of 871) suffered medical consequences requiring treatment2. There is increased awareness of complications associated with FGM among the women, since FGM has been known to cause many medical complications. The assumed reduction in promiscuity associated with FGM is not

objectively attainable hence questioning the continuation of this practice in our environment.

Some sociodemographic characteristics of circumcised women it was noted that only age and educational status were of statistical significance. Younger women are less likely to be circumcised ( $p = 0.0215$ ), least educated women with primary level are also more likely to be circumcised while the more the educated women with tertiary level have the less likelihood of being circumcised ( $p < 0.0001$ ). Other sociodemographic characteristics of circumcised women were of no statistical difference.

## 5. Conclusion

In conclusion, the prevalence of female genital mutilation among antenatal attendee is high although the practice appears to be on the decline compared with findings in a previous study in our environment. Its awareness and knowledge of its complications is also encouragingly high. However the practice has persisted in our environment due to cultural/traditional beliefs. Hence more advocacy is required to decrease the prevalence of the often harmful practice.

## Acknowledgements

None.

## Conflict of Interest

There are no conflict of interest.

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