



PREVALENCE AND COMPLICATIONS OF FEMALE GENITAL MUTILATION AMONG PATIENTS AT THE UNIVERSITY OF BENIN TEACHING HOSPITAL, BENIN CITY.

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ABSTRACT

The high prevalence of Female Genital Mutilation (FGM), also called female circumcision, continues to be worrisome; especially in view of its complications. It has very negative effects on the reproductive, physical and mental health of the victims. A questionnaire consisting of items from the Demographic and Health Survey and the Multiple Indicator Cluster Survey was administered on 300 consecutive female patients attending the General Practice Clinic of the University of Benin Teaching Hospital, Benin City, Nigeria. Genital examination was also carried out on them. The prevalence of FGM was 64% while the prevalence was 39.7% for the children of the respondents. FGM was significantly associated with genital scar, keloid and cyst. Vagina discharge was also significantly commoner among those who were circumcised. Pain during sex and recurrent dysuria were commoner among the uncircumcised; sexual satisfaction was commoner among the circumcised; recurrent vulva abscess, dysmenorrhoea and difficulty getting pregnant were commoner among the circumcised; although these were not statistically significant. The reduced prevalence of FGM among the children of the respondents may be an evidence that the society is gradually doing away with FGM; but still high enough to warrant sustained efforts at its prevention.

Key words: Prevalence, complication, female, genital, mutilation

INTRODUCTION

Female genital mutilation (FGM), also known as female genital cutting (FGC), female circumcision (FC), or female genital mutilation/cutting (FGM/C), is any procedure involving the partial or total removal of the female external genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons (WHO, 2007). When the procedure is performed on and with the consent of an adult it is generally called clitoridectomy or it may be part of labiaplasty or vaginoplasty (Cheryl, 2005).

The World Health Organisation recognises 4 types of FGM (WHO, 2007). Type I is the partial or total removal of the clitoris (clitoridectomy) and/or the prepuce. This is the mildest form, Type II is partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora while Type III is the excision of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening. The type IV is also known as unclassified. It includes all procedures or incisions made into the vagina.

The Nigeria Demographic and Health Survey (NDHS) (2013) reported the prevalence of FGM based on different ethnicities in Nigeria as follows: Ekoi: 56.9%, Fulani: 13.2 %, Hausa: 19.4%, Ibibio: 12.8%, Igbo: 45.2%, Ijaw/Izon: 11.0%, Yoruba: 54.5%, others: 13.4%. According to NDHS report, the national prevalence was quoted as 25% (NDHS, 2013).

The reasons given to justify the practice of FGM are numerous. They include: custom and tradition, purification, family honour, hygiene, aesthetic reasons, protection of virginity and prevention of promiscuity. Others include increased sexual pleasure for husbands, fertility enhancement, giving a sense of belonging to a group and increasing matrimonial opportunities (Onuh, Igberase, Umeora et al., 2006).

FGM has immediate and long term health consequences. It has very serious implications on the reproductive, physical and emotional health of girls and women. The immediate physical

health consequences include severe pain, injury to adjacent tissue of urethra, vagina, perineum and rectum as well as bleeding, shock, fracture or dislocation of the upper or lower limbs due to restraints, risk of contracting infections such as HIV and Hepatitis B, failure to heal e.t.c. The long term health consequences include difficulty in passing urine, recurrent urinary tract infection, infertility, scar tissue and keloid formation, cysts and abscess on genitalia, difficulty with menstruation, fistulae formation, painful intercourse, problems during child birth, mental and psychosomatic disorder e.t.c. (Family health department, Federal Ministry of Health of Nigeria, 2007).

This study was carried out to update the knowledge on female genital mutilation; determine its prevalence and complications among patients attending the general practice clinic of the University of Benin Teaching Hospital, Benin City, Nigeria.

MATERIALS AND METHOD

Setting

It was a cross sectional descriptive study that was carried out at the General Practice Clinic of the University of Benin Teaching Hospital (UBTH), Benin City, Nigeria. This location was chosen because there is a relative paucity of data on FGM from the South-South Nigeria and UBTH is one of the largest teaching hospital in this geopolitical zone.

Instruments

The data was collected over a 2-month period, using a semi-structured questionnaire that was adapted from the Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS) questionnaire (DHS and MICS, 2007) on FGM/C. This contained already validated questions but it was pre-tested on selected respondents from the General Outpatient Clinic of Irrua Specialist Hospital, Irrua, Edo State. Face-to-face interview was conducted using the questionnaire which contained both open and close-ended questions. It was used to assess questions on FGM, based on self-description and examination of genitalia.

Procedure

The sample size was calculated using the formula, $N = z p q / d^2$ (Araoye, 2004). Where N is the desired sample size, z is the standard normal variant set at 1.96 (which corresponded to 95% confidence level). P is the proportion in the target population estimated to have a particular characteristic. Prevalence of FGM in Nigeria is 25% (NDHS, 2013), Hence $p = 0.25$. Q is the proportion in the target population estimated not to have a particular characteristic ($q = 1 - p = 1 - 0.25 = 0.75$). D is the degree of accuracy desired, and it was set at 0.05. Thus, calculated sample size was 288 and it was approximated to 300.

Consecutive female patients of age 18 to 40 years who gave written informed consent were recruited into the study. Exclusion criteria were those who did not give consent and those who presented as emergency to the clinic.

Ethical considerations

Ethical approval was obtained from Ethical Committee of the University of Benin Teaching Hospital. Informed written consent was obtained from the participants. The purpose of the study was explained to them. A chaperon was present during the examination of the genitalia. The vaginal examination was conducted in a well screened consulting room to ensure the privacy of the respondents. Anonymity and confidentiality were observed and the data was pass-worded and stored in a computer.

Data analysis

Analysis was done using the statistical package for social sciences SPSS. Univariate and Chi-square test were used and a p-values less than 0.05 was regarded as significant. Fisher's



exact test of significance was used when more than 25% of expected cell frequencies were equal to or less than 5.

RESULTS

All 300 questionnaires were analysed and the results are presented in tables 1 through 3.

Table 1: Prevalence of FGM among the respondents, n = 300

Status	Frequency	Percentage
Uncircumcised	108	36.0
Circumcised	192	64.0

Table 2: Prevalence of FGM among the children of the respondents, n = 156

Status	Frequency	Percentage
Uncircumcised	94	60.3
Circumcised	62	39.7

Table 3a: Comparison of gynaecological variables (reported by the respondents) between uncircumcised and circumcised respondents

	Uncircumcised n(%)	Circumcised n(%)	P value
Sexual satisfaction			
Present	17(18.3)	35(19.0)	1.00
Don't know	0(0.0)	1(0.5)	
Total	93(100.0)	184(100.0)	
Pain during sex			
Present	31(33.3)	45(24.5)	0.80
Total	93(100.0)	184(100.0)	
Vulva scar			
Present	2(1.9)	10(5.2)	0.22
Total	108(100.0)	192(100.0)	
Recurrent vaginal discharge			
Present	40(37.0)	80(41.7)	0.25
Total	108(100.0)	192(100.0)	
Recurrent dysuria			
Present	8(7.4)	13(6.8)	0.50
Total	108(100.0)	192(100.0)	
Recurrent vulva abscess			
Present	3(2.8)	10(5.2)	0.25
Total	108(100.0)	192(100.0)	
Painful menstruation			
Present	12(11.1)	27(14.1)	0.3
Total	108(100.0)	192(100.0)	
Difficulty getting pregnant			
Present	2(3.3)	12(8.4)	0.16
Total	60(100.0)	143(100.0)	

Table 3b: Comparison of gynaecological variables (from genital examination) between uncircumcised and circumcised respondents

Examination	Types of FGM				Total
	Uncircumcised	Type 1	Type 11	Type 111	
Findings	n(%)	n(%)	n(%)	n(%)	
None	101(93.5)	64(90.1)	60(52.6)	4(57.1)	229
Discharge	7(6.5)	5(7.1)	8(7.1)	0(0.0)	20
Scar	0(0.0)	2(2.8)	42(36.8)	3(42.9)	47
Keloid	0(0.0)	0(0.0)	3(2.6)	0(0.0)	3
Cyst	0(0.0)	0(0.0)	1(0.0)	0(0.0)	1
Total	108(100.0)	71(100.0)	114(100.0)	7(100.0)	300

Fishers exact test = 0.000***

*** = significant

DISCUSSION

The study shows that the prevalence of FGM was 64%; this is similar to the prevalence of 58% reported from a study in Gambia (Morison, Caroline, Gloria et al., 2001). The similarity between the two studies may be due to the fact that the two samples were drawn from women with multiple characteristics, not limited to a sect of women, like pregnant women. In contrast, a study from Nigeria, involving only women attending antenatal and family planning clinics in Edo State, reported a prevalence of 45.9% (Snow, Slinger, Okonofua et al., 2002). This variance may be due to the fact that their sample was drawn from tertiary health care facilities involving only pregnant women and those attending family planning clinic. A study among only pregnant women from South-East Nigeria found a prevalence of 42.1% based on self report (Ezenyeaku, Okeke, Chigbu et al., 2011). Self report may not be reliable; the present report of prevalence was base on examination of the genitalia.

The prevalence of FGM among the children of the respondents was 39.7%. It indicates that their may be a gradual abandonment of the procedure, though it is still unacceptably high. Other studies from Nigeria also reported reduced prevalence of FGM among the daughters of their respondents (Dattijo, Nyango & Osagie, 2010; Ezenyeaku, Okeke, Chigbu, et al., 2011).

Complications of FGM determined from physical examination of the genitalia included scars, keloids and clitoral cysts. All the respondents that had scars in their vulva were circumcised and it was the commonest complication found on physical examination. Its prevalence was 24.5% (47 out of 192). Also, the 3 respondents that had keloids were all circumcised and its prevalence was 1.6% (3 out of 192). Various studies have reported that keloid and scar tissue can result from excessive tissue cut during circumcision (Okonofua, Larsen, Ornsaye et al., 2002; Almroth, Bedri, Elmusharaf et al., 2005b; Osifo & Evbuomwan, 2009). All the keloids were found among respondents with type II FGM. Among the total respondents with scars, 89.4% (42 out of 47) were found among those with type II FGM, while 6.4% (3 out of 47) were



found among the respondents with type III FGM and only 4.3% (2 out of 47) were found among those with type I FGM. These support the fact that scars and keloids could result from excessive tissue removal during the procedure of FGM. The only cyst found was in a respondent with type II FGM.

Out of the total respondents, 6.7% (20 out of 300) respondents had vaginal discharge on examination and 65% (13 out of 20) of them were circumcised. This gives the prevalence of discharge among circumcised respondents as 6.8% (13 out of 192 circumcised respondents). Osifo and Evbuomwan (2009) reported similar findings in their study from Benin, Edo-state. They reported 5.9% prevalence of vaginal discharge but higher clitoral cyst prevalence of 43.1% among their sample.

The complications of FGM as reported by the respondents were not significantly associated with FGM. The absence of the sexually related complications might be due to the fact that less genital tissue were removed from the vulva of the circumcised respondents as type I and II were the commonest types of FGM in the sample. Elnashar and Abdelhady (2007) reported that extensive removal of, or damage to highly sensitive genital tissue, especially the clitoris, may affect sexual sensitivity and lead to sexual problems, such as decreased sexual pleasure and pain during sex. Scar formation, pain and traumatic memories associated with the procedure can also lead to such problems. Thabet and Thabet (2003) reported same reasons for difficulty in achieving sexual satisfaction and painful sexual intercourse. Painful menstruation and urination were not common among the circumcised respondents probably because they were not infibulated or possibly those infibulated were already de-infibulated as at the time of the study. Other studies have shown that slow and painful menstruation and urination usually result from the near complete sealing off of the vagina and urethra (Almroth, Bedri, Elmusharaf et al., 2005b; Nour, Michels & Bryant, 2006).

CONCLUSION

The prevalence of FGM was quite high, even among the daughters of the respondents. FGM was significantly associated with gynaecological complications. However, the reduced prevalence of FGM among the children of the respondents may be an evidence that the society is gradually doing away with FGM; but it was still high enough to warrant improvement and consolidation of efforts aim at ameliorating it.

Limitations

The prevalence of FGM from this study may not be representative of the prevalence in the rural area, UBTH being located in an urban center. It is likely that the majority of patients who use the hospital may belong to the elite.

Recommendations

There is need to continue to create awareness on the complications of FGM. FGM should be incorporated into primary and secondary school curricula. It should also be made an integral part of health programs such as safe motherhood and child survival strategy. Health care workers must be kept abreast of the complications of FGM. Future studies should be community based.

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