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FACTORS AND PROBLEMS RELATED TO FEMALE GENITAL MUTILATION AS SEEN IN CHILDREN AT ST. GASPAR HOSPITAL, ITIGI, TANZANIA

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FACTORS AND PROBLEMS RELATED TO FEMALE GENITAL MUTILATION AS SEEN IN CHILDREN AT ST. GASPAR HOSPITAL, ITIGI, TANZANIA

C. R . MAJINGE and S. E. NGALLABA

ABSTRACT

***Objective*: To determine the aetiological factors and problems related to female genital mutilation as seen in children at St. Gaspar Hospital.**
***Data source*: Secondary data were obtained from St. Gaspar Hospital, records, registers and patients files or case notes from children ward were retrieved and reviewed, later a special master data sheet was used to collect the required information from the registers.**
***Data selection:* All records of female children who were admitted in the hospital for the past two years were selected however children from outside the region (Singida) were excluded.**
***Data extraction*: A special data sheet was used to collect the required information from the registries, Case note and record, data analysis was done using Dbase IV and SPSS (Version9.0).**
***Data Synthesis*: Retrospective cohort study of 803 female children of which 14.5% had FGM according to statistical confidence review of registers records and case notes. The leading cause of FGM was found to be cosmetic and the performer (expert) of FGM are traditional local people about 92%.**
***Conclusion*: The ratio of FGM was 3:20 women. Nyaturu tribe practice FGM at large and the society have a negative altitude towards girls or women who are not mutilated. Consent for FGM is given by parents and not the child who under go FGM because this is considered to be service to the privileged girls who are expected to undergo FGM, this information was obtained through FGD.**

INTRODUCTION

FGM sometimes erroneously called female circumcision, it is erroneous because circumcision refers to cutting on a round or circular organ, and this is a proper definition for a male organ.

There are more than 100 million women and girls alive to day who are affected by female genital mutilations and majority of them are in African countries, in which Tanzania is one of them. There are three types of cutting procedures performed on external female genitalia.

There are:
Sunna: Cutting of the prepuce or hood of the clitoris, preserving the clitoris, the least commonly practiced form of FGM in Tanzania.
Excision: Cutting of clitoris clitoridectomy together with adjacent or all parts of the labia minor without closing the vulva, this is the type of mutilation commonly done in African countries including Tanzania.
Infibulation: Cutting of the clitoris labia minor and least the anterior two thirds of the labia major. The two sides of the vulva are sewn together, so that only a small opening is left to allow urine and menstrual flow out, the whole process is called infibulation.
The practice of FGM continues to persist because of the common reasons which include:

1. It ensures virginity
2. It is a cultural identity
3. Protect the honor of the family
4. It is the value of spiritual tradition
5. It is considered to be a stage of women accreditation (womanhood)
6. It opens illegibility to within the society.

Consequences for FGM
Short term include; Infection, Haemorrhage, Shock, Trauma etc.

Long term include; Scar formation, Reduction of sexual desire, malformation. Precipitate tear during delivery.

To prevent this problem many international organizations for example UNICEF are supporting local initiatives in the prevention of FGM in many parts of the world. Tanzania is one of the countries with many tribes which practice FGM; the hazards of this practice are not exhaustively known. This study tries to establish or find out the following:

1. The number of female with genital mutilation in Itigi (Manyoni district) as seen at St Gaspar hospital.
2. Factors influencing circumcision among female children
3. Who makes the decision for FGM
4. Who are the mutilators
5. What compel mutilators to mutilate
6. Types of circumcision practiced
7. Common complications.

The study is hospital based in the rural setting of St Gaspar hospital (Itigi) Manyoni, Tanzania. ST Gaspar Hospital is a catholic hospital located in Manyoni District Singida region, Tanzania; it serves a population of approximately 105,238 people. Eighty percent of inpatients and outpatients come from Singida region, one of the reason as to why this hospital receive many patients from Singida is that this is the only hospital in the region with a good number of expertise for example, Gynecologist, Surgeon, Physicians and other experts. Because of the availability of expertise many prefer to use this hospital. A good number of children seen at this hospitals had FGM, some of the children presented with anaemia's, secondary to infections due to female circumcision and some were referred to the hospital following complications.

This was a descriptive analysis of secondary data obtained from St. Gaspar Hospital records for the year 2000 to 2001. Records, registries and patients files or case notes in children ward were retrieved and reviewed, a special master data sheet was used to collect the required information from the registries, data handling was achieved using Database IV which was later statistically analysed using SPSS Software for computation for chi-square test through cross tabulation where used.

Sample size: Included all female children admitted for the year 2000 and 2001, regardless of their illness, the study focused on FGM information retrospectively.

RESULT

A total number of 855 cases of female children were seen at St Gaspar Hospital, for a period of two years, 803 (94%) had complete records comprised of variable including age, sex, tribe, level of education of parents or caretaker, religions, occupation, marital status, reasons for FGM, type of FGM, decision maker for FGM, performers, gender, payment for FGM, motivation for FGM:

Table 1 and 2 shows the leading tribe which practice FGM which is Nyaturu where 51.3% of all the female children had FGM, majority of FGM were done during the first year of life (19%with SD of 5.6%), the rest were circumcised before the age of 12 years.

Table 3 revealed that 94% of the parents or caretaker had no formal education, and religion was found to have no significant influence.

Table 5 shows 94% of the parents were peasant and majority of the parents 78.2% were married. The major reasons for FGM was cosmetic 41% followed by Lawalawa undefined febrile illness (Figure 3) 35.9%.

Table 6, shows that 92% of the performers are specialised traditional performer called Ngaliba, and 98.2% of the FGM performers are female.

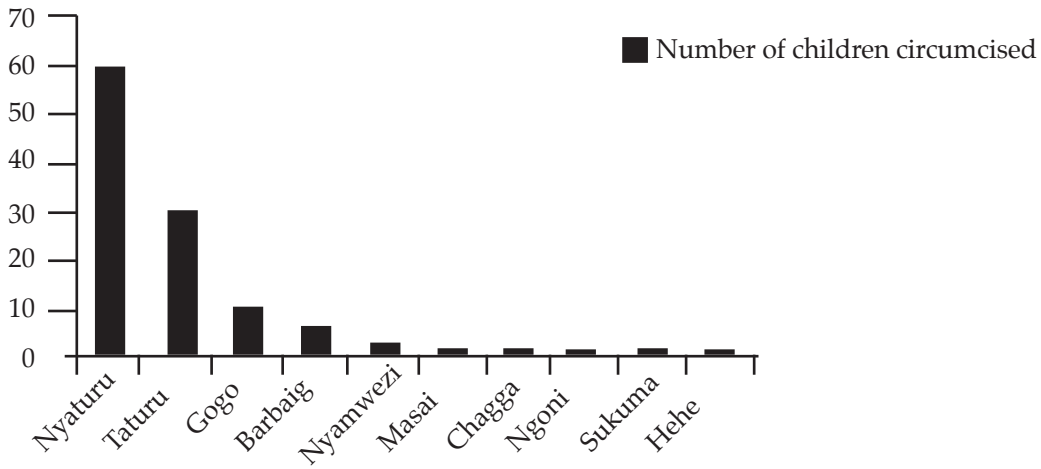
Table 7, shows that 92% of the type of FGM is excision and the common complication reported is severe bleeding leading to anaemia and secondary infection.

Table 1

Shows the distribution of circumcised female children by tribe

Tribe	Number	Percentage
Nyaturu	60	51.3
Taturu	30	27.4
Gogo	11	9.4
Barbaig	6	5.1
Nyamwezi	3	2.6
Masai	1	0.9
Chagga	1	0.9
Ngoni	1	0.9
Sukuma	1	0.9
Hehe	1	0.9
	115	100

Figure 1
Number of children circumcised per tribe



The leading tribe in female circumcision is the Nyaturu where by 51.3% of all female circumcised were from that tribe followed by Taturu 27.4% then G o g o tribe by 9.4% a n d Barbaig by 5.1%

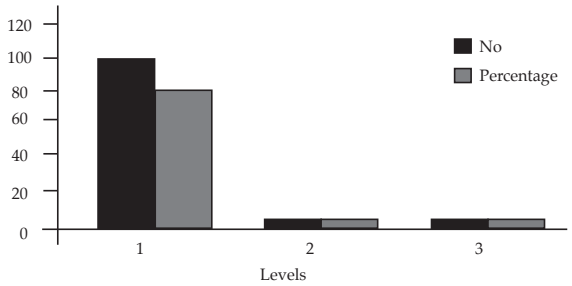
Table 2
Shows the distribution of circumcised children by age

Age in year	Age of children	Percentage
1	17	19
2	4	4.5
3	14	15.7
4	15	16.9
5	5	5.6
6	12	13.5
7	8	9
8	5	5.6
9	3	3.4
10	1	1.1
11	2	2.2
12	3	3.3
	89	100

Table 3
Shows the level of education to parents with circumsiced children

Level	Number	Percentage
No school	110	94
Nursery	2	1.7
Primary school	5	4.3
	117	1

Figure 2
Level of education

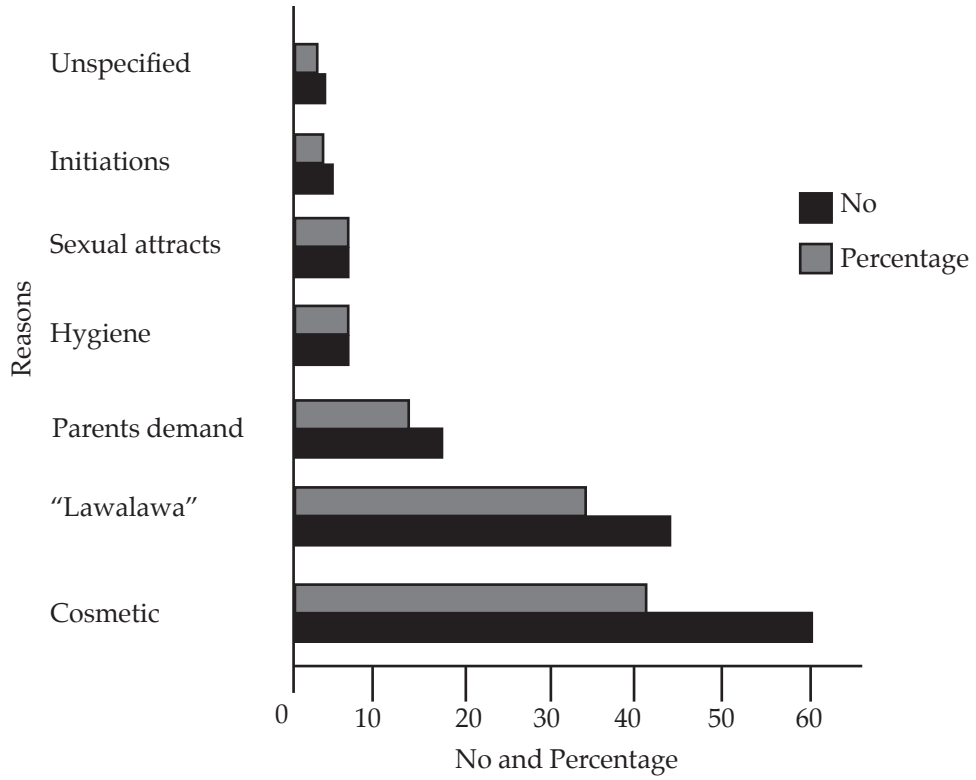


Majority parents with female circumcised chuldren 94% had not received formal education, followed by 4.3% who received primary education

Table 4
Shows the distribution of children by religion

Religion	Number	Percentage
Catholics	49	41,9
Protestant	44	37.6
Moslems	5	16.2
Others	19	4.3
	117	100

Figure 3
Reasons for female cirumcision

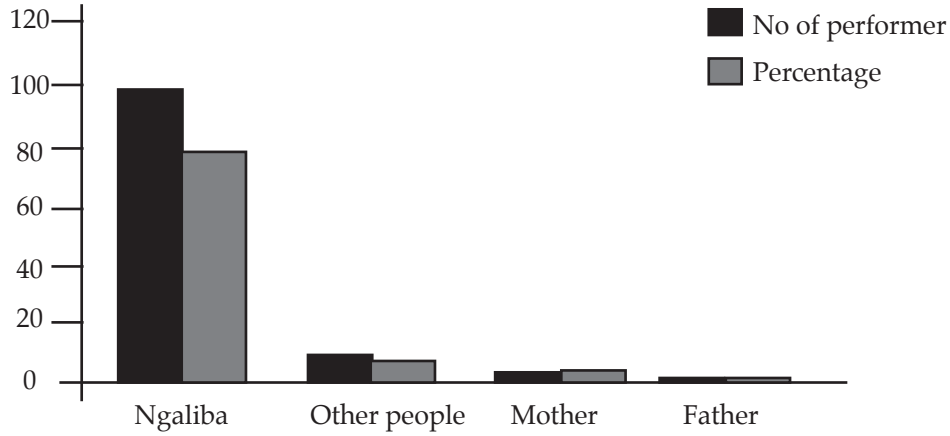


Cosmetic and Lawalawa are the major reasons for female circumcision

Table 5
Shows the distribution of persons who perform circumsion

Perform	Number	Percentage
Ngaliba	107	91.7
Other people	7	6
Mother	3	2.6
Father	0	0
Total	117	100

Figure 4
Distribution of people who performed circumsicion



92% of the performers are the specialised traditional performers called Ngaliba

Figure 5
Distribution of persons who circumcised according to the level of education

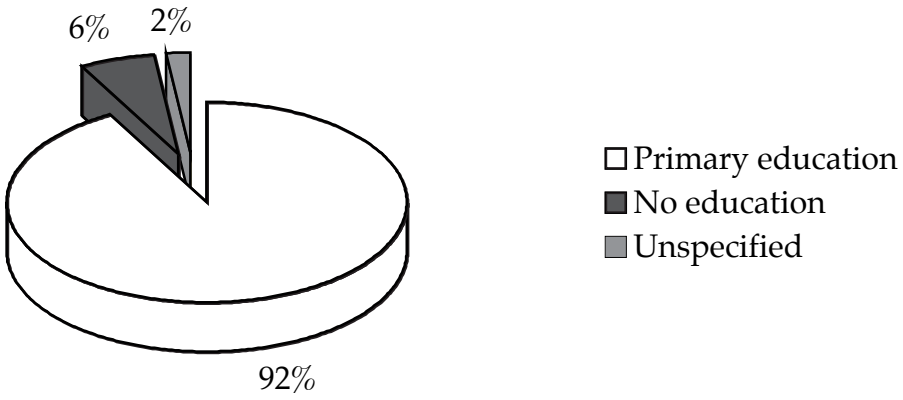


Table 6
Distribution of performer by Gender

Gender	Number	Percentage
Female	115	98.2
Male	1	0.9
Unspecified	1	0.9
Total	117	100

Figure 6
Distribution of persons who performed circumcision by gender

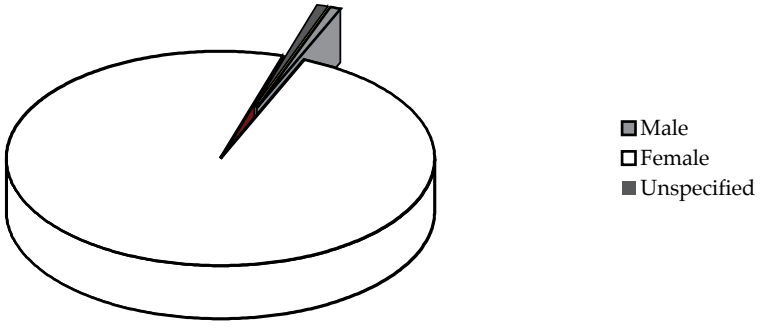
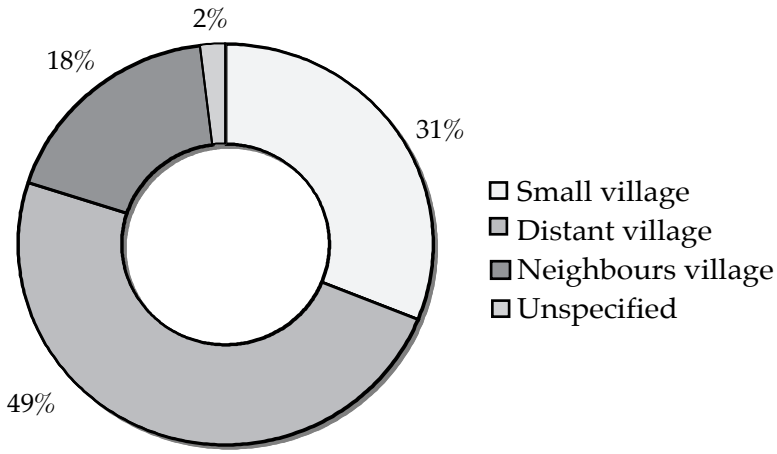


Table 7
Distribution of performer by residence

Residence	Number	Prcentage
Small village	57	48.7
Distant village	37	31.6
Nighbours village	21	1.7
Unspecified	2	1.7
Total	117	100

Figure 7
Residence of person who performed circumcision



Most of the performer came from the same village followed by performer from distant village

Table 8
Shows payments for circumcision

Paid	Number	Percentage
Yes	86	73.5
No	27	23.1
Reluctant	4	3.4
Total	117	100

Figure 8
Payment for circumcision

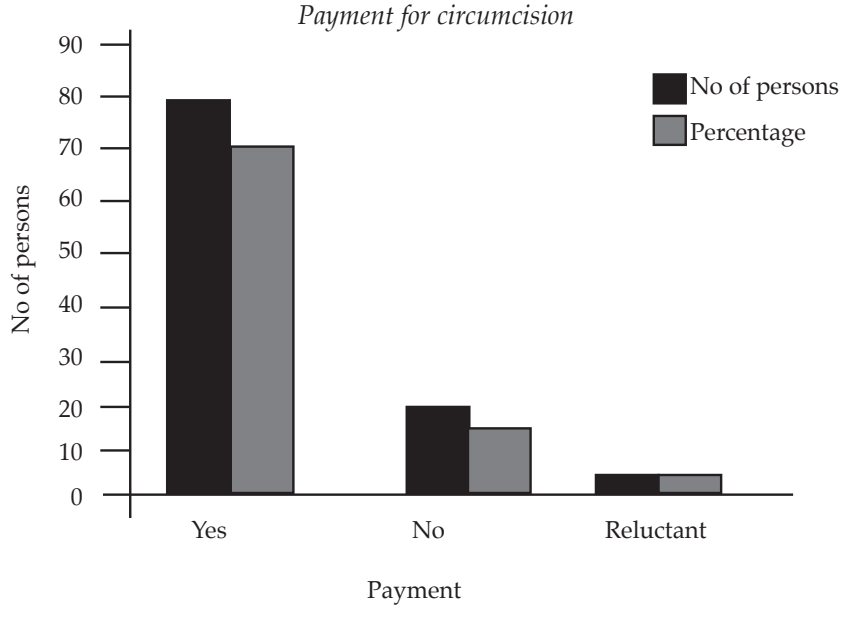
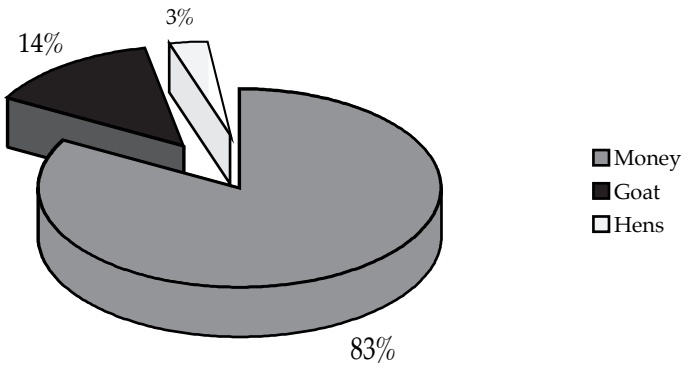


Table 9
Shows the nature of payments

Paid	Number	Percentage
Money	97	83
Goat	16	14
Hens	4	3
Total	117	100

Figure 9
Form of payment



83% received payment in form of money while 14% in form of goat and 3% in form of hens

DISCUSSION

According to this study done at St. Gaspar hospital the prevalence of female circumcision among the female children studies is 14.5%, thus for every 100 female 15 had FGM, this prevalence is high when compared to Uganda and Congo where the prevalence is 5%. But the prevalence of 15% is low when compared to other countries like Mali where FGM is 93% and Djibouti and Somalia where it is 98%.

The prevalence differs from one region which include Dodoma and Singida also Arusha and Mara region. Such region has tribes which practice FGM widely. At St. Gaspar hospital the leading tribe in FGM was Nyaturu leading by 51% followed by Taturu 27% (Figure 1).

Nineteen percent of FGM was done to children below one year, followed by 17% done at the age of four years. So the difference in the age distribution do not vary much, majority ranged from one to eight years while in Mali 44% of FGM was done to children under one year.

Ninety four percent of the parents of children who had FGM were peasants most of them living with their extended families on agricultural income and traditional style of life. So the society in which they lived shared the same traditional cultural values so it was not easy to breach their cultural values. Seventy eight percent of the parents with children who had FGM were married. This percentage is higher when compared to single, separated or divorced marital status. This show that couple shared the same interest on FGM.

Ninety four percent of the parents of children who had FGM had no formal education, the knowledge they had was from within their tribes.

From this study religion seem not to be associated with FGM, children from different religion were equally affected, because such women are not polite, and are too sexy, and it is a prestige to organise FGM ceremony because it shows other people in the society that their daughter has been cleaned and ready for marriage.

This is another way of lobbing advocacy to men who are not married. Ninety two percent of the circumcisers are specialised and well known as traditional performer called "Ngaliba", 98.2% of the "Ngaliba" were female and majority 48.7% are from the same village while 31.1% came from distant villages.

Most of them were influential people in the community. Seventy three point five percent are paid at the end of their work and 83% are paid in form of money, the amount is negotiable some time they pay in kind.

Reason for female circumcision: The leading cause for FGM is cosmetic 41% followed by 35.9% parents demand.

Basic cosmetics majority of the parents believe the FGM is a stage of a girl to a womanhood and is attachment to cultural values which keeps or maintain domestic stability within the society. It is accepted that an unmutilated woman cannot talk sense in front or among mutilated women.

According to focused ground discussion it was revealed that it was unusual for a male to marry unmutilated women.

In conclussion, the prevalence of FGM is still high in this part of Tanzania, thus for every 20 women three had FGM. Nyaturu tribe practice FGM at large. FGM is done to female children before 15 years of age. Since 98.2% of the circumciser (Ngaliba) are female and most of them are influential people in those community. Therefore to address the problem one has to involve the circumciser. The male have a negative attitude towards unmutilated women. This act as a catalyst for women to get circumcised. Because of the event some of the female children have migrated to countries or places where female circumcision is illegal.

Recommendation, this practice should be prevented because of its permanent mental, physical and psychological effect to woman, also because of its irreversible effect once mutilated one remain mutilated for ever. Approach should focus first the circumciser (Ngaliba). Male should also be involved in the campaign. As most the women don't know their human right, therefore they should be taught.

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