

Attitudes towards female genital cutting among pregnant women in Owo, Nigeria

Omolase CO, FWACS, FMCoph

Department of Ophthalmology, Federal Medical Centre, Owo, Nigeria

Akinsanya OO, FWACS; Fatureti SO, FWACS; Omotayo RS, MBBS

Department of Obstetrics and Gynaecology, Federal Medical Centre, Owo, Nigeria

Omolase BO, MBBS

Department of Radiology, Federal Medical Centre, Owo, Nigeria

Correspondence to: Oluwale Omolase, e-mail: omolash2000@yahoo.com

Keywords: female genital cutting, pregnant women, attitudes, Nigeria

Abstract

Background: This study aimed to determine the attitudes of pregnant women attending the antenatal clinic at Federal Medical Centre, Owo, Ondo State, Nigeria, towards female genital cutting.

Method: The study was conducted over a period of six months, between November 2010–April 2011, at the antenatal clinic of the hospital. Prior to commencement of this study, ethical clearance was obtained from the ethical review committee of the hospital. The respondents were interviewed by the authors and three trained research assistants, with the aid of a questionnaire. The obtained data were collated and analysed with SPSS® 15.0.1 statistical software.

Results: Most respondents (72; 56.3%) had undergone female genital cutting. The majority (90; 70.3%) were aware of female genital cutting. Less than half supported discontinuation of female genital cutting (63; 49.2%) and legislation against it (57; 44.9%). A quarter of respondents (33; 25.8%) would allow their daughters to undergo female genital cutting.

Conclusion: The majority of the respondents had undergone female genital cutting, which was sometimes carried out by a medical practitioner. Less than half supported the discontinuation of female genital cutting and legislation against it. Medical practitioners should be prevented from performing female genital cutting.

© Peer reviewed. (Submitted: 2011-07-21. Accepted: 2011-11-15.) © SAAFP

S Afr Fam Pract 2012;54(4):363-366

Introduction

Female genital cutting, also known as female circumcision, or female genital mutilation, is an ancient practice that predates the Abrahamic religions.¹ It refers to all procedures involving partial or total removal of external female genitalia, or to injury to female genital organs for cultural or nontherapeutic reasons.² The origin of female genital cutting remains a mystery. However, it is thought to have existed in ancient Egypt, Ethiopia and Greece.³

Female genital cutting practice transcends religion.⁴ It has been reported that female genital cutting is practised in 28 African countries, and some Asian ones.¹ It is estimated that, annually, up to three million girls are at the risk of being subjected to female genital cutting.⁵ More than 130 million women have undergone female genital cutting worldwide.⁵ Typically, girls undergo the procedure between 6 and 12 years of age.¹ It is sometimes performed on newborn babies, at menarche and prior to marriage.¹ Female genital cutting is sometimes performed suddenly, without prior notice, so that the girls suffer emotional trauma.

Despite concerted local and international efforts to end female genital cutting, the practice does not appear to

be in decline.⁶ Reasons given to continue it include the preservation of group identity, femininity, female purity and maintenance of cleanliness and assurance of a woman's marriageability.⁷⁻⁹ Some parents insist that their daughters are circumcised because they fear that they may never marry if it is not carried out.¹ Some societies believe that the clitoris is toxic and that if it touches a newborn baby's head in the course of delivery, the infant might die.¹ Female genital cutting is seen to signify purification.¹⁰ It is believed that clitoral removal improves the baby's chances of survival.

The extent to which female genital cutting is carried out varies from a symbolic nicking of the clitoris to an excision of tissue and partial closure of the vaginal orifice.¹¹ The World Health Organization (WHO) and other United Nations' organisations have broadened the classification of female genital cutting.¹² Type 1, also known as clitoridectomy or *sunna*, involves removing part or all of the clitoris and/or the prepuce. Type II, also known as excision, involves removing part or all of the clitoris and also the labia minora. Type III, also called infibulation, is the most severe form and it entails removal of part or all of the external genitalia, as well as narrowing of the vagina orifice by reapproximating the

labia minora or labia majora. This infibulated scar covers the urethra and most of the introitus, leaving a small hole for menstruation and urination. Type IV is the mildest form and includes any form of harm to the genitalia including pricking, piercing, cutting, scraping or burning.

Common early complications of female genital cutting are uncontrolled bleeding, fever, wound infection, sepsis and death.⁴ Long-term complications include dysmenorrhea, dyspareunia, recurrent vaginal and urinary tract infections, infertility, cysts, abscesses, keloid formation, difficulty in delivering, and sexual dysfunction.^{4,13-17} In view of the harm associated with female genital cutting practice, this study was designed to assess the attitudes of pregnant women attending the antenatal clinic at Federal Medical Centre, Owo, towards it. Hopefully, the findings of this study will guide policymakers to develop strategies to reduce female genital cutting practice to an absolute minimum in sub-Saharan Africa.

Method

This study was conducted over a period of six months, between November 2010 and April 2011, at the antenatal clinic at Federal Medical Centre, Owo, Ondo State, Nigeria. Prior to carrying out this study, ethical clearance was obtained from the hospital's ethical review committee. Informed consent was obtained from each of the respondents. A modification of the questionnaire designed by Affifi in Egypt was used.¹⁸ The questionnaire was altered to suit the study's aim and to conform to the uniqueness of the specific environment. The respondents were interviewed by the authors of this manuscript and three trained research assistants. The information was obtained via a questionnaire and included respondents' demographic data and their attitudes towards and views on the continuation of female genital cutting. Other acquired information included an assessment of their readiness to discontinue the practice, and their identification of female genital cutting information sources. The data were collated and analysed with SPSS® 15.0.1 statistical software. Cross-tabulation, as well as a chi-square test, was carried out. Statistical significance was set at $p\text{-value} \leq 0.05$.

Results

One hundred and twenty-eight pregnant women participated in this study. The respondents' ages ranged between 20 and 45 years. The mean age of the respondents was 29.2 years \pm 5 years.

They comprised 96 Yorubas (75%), 19 Ibos (14.8%) and 13 women (10.2%) from other ethnic groups. Their ethnicity significantly affected the uptake of the female genital cutting practice ($p\text{-value} = 0.02$). Most (120; 93.8%) were married, while 8 (6.3%) were single. The majority were Christian (108;

84.4%), and the rest were Muslim (20; 15.6%). As detailed in Table I, most were traders (43; 33.6%).

Table I: Respondents' occupations

Occupation	Frequency	Percentage (%)
Trading	43	33.6
Civil service	42	32.8
Education	21	16.4
Artisan	12	9.4
Housewife	3	2.3
Unemployed	7	5.5
Total	128	100

The majority of respondents (72; 56.3%) had undergone female genital cutting. As detailed in Table II, most (39; 81.3%) underwent female genital cutting in the first year of life.

Table II: Age when female genital cutting was carried out

Age (years)	Frequency	Percentage (%)
1	39	81.3
4	1	2.1
5	2	4.2
8	1	2.1
12	1	2.1
14	1	2.1
25	1	2.1
26	1	2.1
31	1	2.1
Total	48	100

As shown in Table III, doctors performed some of the female genital cutting (15; 21.7%).

Table III: Persons performing female genital cutting

Persons who performed female genital cutting	Frequency	Percentage (%)
Nurse	18	26.1
Birth attendant	18	26.1
Doctor	15	21.7
Unknown	14	20.3
Traditional healer	2	2.9
Grandmother	2	2.9
Total	69	100

Most respondents (90; 70.3%) had received information on female genital cutting, while 36 (28.1%) had not received information and the remaining 2 (1.6%) were unsure.

As detailed in Table IV, most (34; 37.8%) received information on female genital cutting from health workers.

Table IV: Information sources on female genital cutting

Source of information	Frequency	Percentage (%)
Health worker	34	37.8
Television	14	15.5
Radio	9	10
Neighbour	9	10
Newspaper	7	7.8
Colleague	7	7.8
School	3	3.3
Elder in the family	5	5.5
Church or mosque	1	1.1
Husband	1	1.1
Total	90	100

Table V: Beliefs about female genital cutting

Beliefs about female genital cutting	Agree	Disagree	Don't know
Should be stopped	63 (49.2%)	39 (30.5%)	26 (20.3%)
Would allow daughter to have it	33 (25.8%)	31 (24.2%)	64 (50%)
Prevents promiscuity	51 (39.8%)	46 (35.9%)	31 (24.2%)
Preserves virginity	46 (35.9%)	52 (40.6%)	30 (23.4%)
Reduces sexual desire	49 (38.3%)	37 (28.9%)	42 (32.8%)
Increases men's sexual pleasure	19 (14.8%)	47 (36.7%)	62 (48.4%)
Increases women's sexual pleasure	25 (19.5%)	60 (46.9%)	43 (33.6%)
Upholds tradition	41 (32%)	39 (30.5%)	48 (37.5%)
Improves hygiene	29 (22.7%)	60 (46.9%)	39 (30.5%)
Improves marriage prospects	25 (19.5%)	53 (41.4%)	50 (39.1%)
Can lead to death	36 (28.1%)	50 (39.1%)	42 (32.8%)
Can lead to difficult delivery	15 (11.7%)	64 (50%)	49 (38.3%)
Husbands prefer circumcised wives	37 (28.9%)	38 (29.7%)	53 (41.4%)
Is a religious obligation	34 (26.8%)	59 (46.5%)	34 (26.8%)

As shown in Table V, less than half of the respondents (63; 49.2%) believed that female genital cutting should be stopped.

Discussion

The respondents' ages were reflective of their reproductive abilities. A predominant proportion of the respondents belonged to the Yoruba ethnic group. This was to be expected, as the interviews took place in a Yoruba community in south-west Nigeria. Female genital cutting practice was extensive in the study population. The majority of the study participants were aware of female genital cutting and had undergone it. This finding is consistent with that of other Nigerian studies that reported awareness levels of 97.1% and 91.4% respectively.^{19,20}

In this study, it was quite commendable that health workers were the main source of awareness about female genital cutting. Policy formulators should build on this.

The prevalence of female genital cutting was relatively high in this study. It was higher than the 42.1% reported by Ezenyeaku et al.¹⁹ Another Nigerian study reported a female genital cutting prevalence rate of 66%.²¹ In this study, ethnicity significantly affected female genital cutting practice. This finding is in keeping with that of a similar study that was carried out in Tanzania.²²

In our study, the age at which female genital cutting was performed varied. The average age for female genital cutting in Nigeria is 6.9 years \pm 2.9. Four per cent of the procedures are carried out during pregnancy.^{23,24} It is quite worrisome that medical practitioners performed female genital cutting on some of the respondents. If not curtailed, this may hamper current efforts to eradicate female genital cutting in Nigeria. The WHO has condemned the medicalisation of female genital cutting.²⁵ It is interesting to note that almost half of the respondents wanted the female genital cutting practice to be discontinued. Policy formulators should take cognisance of this development in their endeavours to eradicate female genital cutting. A quarter of the respondents would allow their daughters to undergo female genital cutting. Two other Nigerian studies reported that 14.3% and 20% of respondents had either circumcised their daughters or were willing to circumcise them.^{19,20} Less than half of the respondents in this study were of the opinion that the practice of female genital cutting should be banned. This figure is lower than that reported by another Nigerian study, in which 63.7% of interviewed antenatal patients supported the enactment of legislation against female genital cutting.¹⁹

Examining attitudes towards the discontinuation of female genital cutting and its predictors is imperative if behavioural changes are to be effected. Some respondents felt that female genital cutting practice could reduce promiscuity. Studies carried out by Owuni, Obianyo and Nnodum reported that the act of female genital cutting does not diminish promiscuity.²⁶⁻²⁷ In a survey conducted in brothels in selected cities in Sudan, it was reported that nearly all women who were commercial sex workers had been genitally cut.²⁷ The authors of this study were concerned that this finding raises the suspicion that the practice of female genital cutting could actually promote prostitution. An Egyptian study reported that women who were circumcised had less sexual desire, fewer orgasms and greater vaginal dryness during sex.²⁸

Putting a stop to female genital cutting may prove to be a difficult task. This assertion is supported by the findings of a study by Affifi in Egypt which reported that only 12.4% of the study population intended discontinuing the practice.¹⁸

If the goal of eradication of female genital cutting practice is to be achieved, there is an urgent need to change the strategies geared towards its discontinuation.²⁹ Examining attitudes towards the discontinuation of female genital cutting and its predictors is imperative if behavioural changes are to be effected.¹⁸

Conclusion

The majority of the respondents in this study were aware of female genital cutting. More than half had been circumcised. Medical practitioners performed female genital cutting on some of them. Less than half of the respondents supported the discontinuation of female genital cutting and the enactment of legislation against it. However, only a quarter of respondents would allow their daughters to be circumcised.

It is recommended that the performance of female genital cutting by medical practitioners should be stopped.

Legislation against the practice of female genital cutting should be enacted.

References

- Nour NM. Female genital cutting: a persisting practice. *Rev Obstet Gynecol*. 2008;1(3):135-139.
- World Health Organization. Female genital mutilation: a joint WHO/UNICEF/UNFPA statement. Geneva, Switzerland: WHO, 1997.
- The American College of Obstetricians and Gynaecologists. Female genital cutting: clinical management of circumcised women. Washington, DC: The College, 2008.
- Nour N. Female genital cutting: clinical and cultural guidelines. *Obstet Gynecol Surv*. 2004;59(4):272-279.
- World Health Organization. Female genital mutilation [homepage on the Internet]. c2010. Available from: <http://who.int/reproductivehealth/fgm/index.html>.
- Gage AJ, Van Rossem R. Attitudes towards the discontinuation of female genital cutting among men and women in Guinea. *Int J of Gynecol Obstet*. 2006;92(1):92-96.
- Allam MF, De Irala-Estevéz J, Fernández-Crehuet Navajas R, et al. Factors associated with the condoning of female genital mutilation among university students. *Public Health*. 2001;115(5):350-355.
- Almroth L, Almroth-Berggren V, Hassanein OM, et al. A community based study on the change of practice of female genital mutilation in a Sudanese village. *Int J Gynaecol Obstet*. 2001;74(2):179-185.
- Toubia NF, Sharief EH. Female genital mutilation: have we made progress? *Int J Gynaecol Obstet*. 2003;82(3):251-261.
- The New Shorter Oxford English Dictionary. Oxford: Clarendon, 1999; p. 405.
- Stanley YP, Abderrahim N, Zhuzhuni A. Female genital cutting in the demographic and health surveys: a critical and comparative analysis. Calverton: ORC Macro, 2004. DHS Comparative Report No 7.
- World Health Organization. Eliminating female genital mutilation: an inter-agency statement. Geneva, Switzerland: WHO, 2008.
- Almroth L, Elmusharaf S, El Hadi N, et al. Primary infertility after genital mutilation in girlhood in Sudan: A case-control study. *Lancet*. 2005;366(9483):385-391.
- Aziz F. Gynecologic and obstetric complications of female circumcision. *Int J Gynaecol Obstet*. 1980;17(6):560-563.
- Agugua N, Egwuatu V. Female circumcision: management of urinary complications. *J Trop Pediatr*. 1982;28(5):248-252.
- MacLeod T. Female genital mutilation. *J Soc Gynaecol Can*. 1995;17:333-342.
- Meniru GI. Female genital mutilation (female circumcision). *Br J Obstet Gynaecol*. 1994;101(2):832.
- Affi M. Egyptian ever-married women's attitude toward discontinuation of female genital cutting. *Singapore Med J*. 2010;51(1):15-20.
- Ezenyeaku CC, Okeke TC, Chighu CO, Ikeako LC. Survey of women's opinion on female genital mutilation (FGM) in South East Nigeria: study of patients attending antenatal clinic. *Ann Med Health Sci Res*. 2011;1(1):15-20.
- Abubakar I, Iliyasu Z, Kabir M, et al. Knowledge, attitude and practice of female genital cutting among antenatal patients in Aminu Kano Teaching Hospital, Kano. *Niger J Med*. 2004;13(3):254-258.
- Awusi VO. Tradition versus female circumcision. A study of female circumcision among the Isoko tribe of Delta State of Nigeria. *Benin Journal of Postgraduate Medicine*. 2009;11(1):1-9.
- Klouman E, Manogi R, Klepp KI. Self reported and observed female genital cutting in rural Tanzania: associated demographic factors, HIV and sexually transmitted infections. *Trop Med Int Health*. 2005;10(1):105-115.
- Dare FO, Oboro VO, Fadaiora SO, et al. Debate to female genital mutilation: An analysis of 522 cases in South-Western Nigeria. *J Obstet Gynaecol*. 2004;24(3):281-283.
- Amnesty International. Female genital mutilation: a human rights information pack. Amnesty International Report, 2004.
- United Nations Children's Fund. Benin DHS. Geneva, Switzerland: UNICEF, 2001.
- Owumi BE. A socio-cultural analysis of female circumcision among Urhobos of Delta State. *Your Task Health Magazine*. 1993;2:8-11.
- Obianyo N. Harmful traditional practices that affect the well-being of women. *New Impact*. 1997;1(1):16-19.
- El-Dafrawi MH, Lotfy G, Dandash KF, Refaat AH, Eyada M. Female genital mutilation and its psychosocial impact. *J Sex Marital Ther*. 2001;27(5):453-458.
- Nour NM. Female genital cutting: a need for reform. *Obstet Gynaecol*. 2003;101(5 Pt 2):1051-1052.