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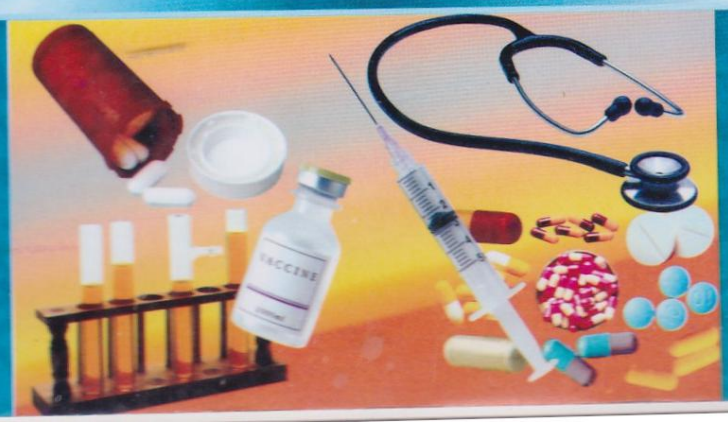

PREVALENCE, TYPES AND PSYCHOPATHOLOGIC CONSEQUENCES OF FEMALE GENITAL CUTTING (CIRCUMCISION) AMONG ANTE-NATAL CLINIC PATIENTS IN A MISSION HOSPITAL IN UYO, SOUTH- SOUTH NIGERIA.

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Contribution of the authors

Alphonsus Idung designed the study protocol, did the literature review, examined the participants and wrote the final manuscript. Sunday Bassey Udo did the statistical analysis and both read and approved the final draft of the manuscript.

Keywords: Female genital cutting, Ante natal clinic, psychopathologic consequences, mission hospital, Uyo.

ABSTRACT

Introduction: Female genital cutting (FGC) or circumcision is an age-long practice perceived as a rite of passage into maturity of womanhood.

Objective: The objective of this study was to assess the prevalence, types and psychopathologic consequences of FGC among pregnant women attending the ante-natal clinic of a mission hospital in Uyo.

Method: This was a prospective descriptive cross-sectional study conducted between August and October 2015. Using systematic sampling technique, 364 newly registered pregnant women were recruited. Using aseptic technique vaginal examination was done for each respondent to determine the presence and type of FGC based on World Health Organization (WHO) classification. Using GHQ-12, Psychopathologic consequence of FGC was assessed among those who underwent FGC.

Results: The prevalence of FGC among respondents in this study was 22.5%. Type 2a (removal of labia minora only) was the predominant type of FGC among respondents accounting for 64.6%; this was followed by type Ia (removal of the clitoral hood or prepuce only) 18.3%; then type 1b (removal of the clitoris with prepuce) 15.9%; and type 3a (removal and apposition of the labia minora) 1.2%. Respondents in this study reported the presence of adverse psychologic experience following their exposure to Female genital cutting (FGC).

Conclusion: Findings from this study shows that FGC is still being practised among different population groups in Nigeria. The types and psychologic sequelae are variable. Education and empowerment of women along with intensifying public enlightenment to outlaw FGC are most imperative now.

INTRODUCTION

Female Genital cutting(circumcision) or Female genital Mutilation (FGC or FGM) comprises all procedures that involve partial or total removal of the female genital organs for cultural, religious or other non-therapeutic reasons [1].

According to the World Health Organization (WHO), female genital cutting can be classified into four types as follows:

Type 1 - partial or total removal of the clitoris and/or the prepuce (clitoridectomy). When it is important to distinguish between the major variations of type 1 mutilation, the following subdivisions are documented: Type 1a- removal of the clitoral hood or prepuce only; type 1b- removal of the clitoris with the prepuce.

Type 2 - Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. When it is important to distinguish between the major variations of type 2 mutilation, the following subdivision are documented: Type 2a- removal of the labia minora only; Type 2b- partial or total removal of the clitoris and the labia minora; Type 2c- partial or total removal of the clitoris, the labia minora and the labia majora.

Type 3 - 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). When it is important to distinguish between variations in types of infibulation the following subtypes are documented: Type 3a- removal and apposition of the labia minora; Type 3b removal and apposition of the labia majora. Type 4 - All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping or cauterization [2].

FGC/FGM is usually performed by an older woman in the community on girls between infancy and age fifteen [3].

The procedure is often performed at night without warning the victim and without any form of anaesthesia using all manner of instrument ranging from a special knife owned by the circumciser. razor blades, sharp rocks or broken glasses without any attention to asepsis [3]

Female genital cutting/mutilation as a cultural practice is often perceived as a rite of passage into maturity of womanhood, but evidently conceived to contain and control a young woman or even a girl's sexuality to ensure virginity before marriage and fidelity after by the brutal method of limiting a woman's sexual pleasure [4].

Among adherents, FGC gives women a lot of power in the household. When girls and families conform to the practice, they acquire social position and respect.[4]

It is estimated that 140 million women are suffering from the ramification of FGC today, and that at least 3 million undergo a subtype of the procedure each year[5].

In Nigeria, the prevalence of FGC varies among different geo-political zones, a reflection of cultural and ethnic affiliation.

According to the National Demographic and Health Survey (NDHS), the reported National Prevalence of FGC/FGM is 30.0 % and zonal prevalence include 53.4% (South-west); 34.2% (South-South); 100.0 % (North- West) respectively [6].

In Akwa Ibom State, South- South Nigeria, a prevalence rate as high as 65.0 % has been reported [5]. Female genital cutting (circumcision) /mutilation causes permanent, irreparable changes in the external female genitalia.
Girls who undergo FGC/FGM are at increased risk of developing severe pain, bleeding, shock, difficulty in passing urine and faeces in the short run and chronic pain and infections in the long run [1].
Similar to the general physical consequences, FGC/FGM greatly impacts on the psychological, social and sexual health of the victim.

Mutilation of the genitalia, the intense pain felt during sexual intercourse, and the inability to achieve sexual gratification cause feelings of inadequacy, subjugation and incompleteness thereby leading to depression in circumcised women [7].

Another report has it that circumcised women most time experience feelings of intense fear, horror, helplessness and severe pain with majority reporting that they continued to have traumatic re-experience of the procedure [8].

On the other hand, however, some women who underwent FGC/FGM report feelings of pride and being a better person thereafter [9,10].

Female genital cutting or circumcision is a deeply entrenched social convention among many ethnic groups in Africa including Nigeria [3,5,6]. The reason is that it carries consequences both when it is and when it is not practised.

When girls and families conform to the practice, they acquire social respect and position but when they refuse, this might lead to difficulty in finding a husband for the girl, shame, stigmatization, as well as loss of social position, honour and protection, resulting in the family's social exclusion in the community [10,11].

In low and middle income economic regions with poor coverage of quality maternal health care such as Nigeria, the heightened risks that FGC imposes on expectant mothers present an added danger to child birth especially among those who underwent the more extensive FGC procedure [12].
FGC is a dangerous, harmful and unnecessary cultural practice, a physical assault that causes grievous bodily and psychological harm [7,8].

Because of the persistence of the practice in spite of the well documented harm, this study was designed to assess the prevalence, types and psychopathologic consequences of FGC among pregnant women attending the antenatal clinic of St. Luke's Hospital, a secondary health institution in Uyo, Akwa Ibom State.

It is hoped that findings from the study will assist health care providers to further appreciate the scope of FGC as an enduring trauma as well as guide policy makers to develop strategies aimed at increasing awareness toward a greater understanding of the risks with a view to eliminating the practice completely.

SUBJECTS, MATERIALS AND METHODS

This study was carried out in the ante-natal clinic of St Luke's Hospital, Anua in Uyo Local Government Area of Akwa Ibom State. St. Luke's Hospital is a foremost missionary hospital established in 1937 and run by the medical missionary of Mary, a medical evangelism arm of the Catholic Church in Uyo, Akwa Ibom State, Nigeria.

It had an initial capacity of twelve beds but presently has three hundred and sixty beds. It was the first hospital that was approved for the training of Nurses in the whole of the then South Eastern State of Nigeria in the 1970s. The hospital was also approved for the training of pre-registration medical graduates and presently trains nurses and mid-wives to fill the manpower needs of Akwa Ibom State in particular

and Nigeria in general.

At present the hospital is managed by the Catholic Church in collaboration with Akwa Ibom State Government and offer maternity, surgical, medical and emergency services to members of the public. Ante-natal clinic services are held in the hospital on Mondays, Wednesdays and Fridays while Thursdays are reserved for registration of new clients.

SUBJECTS

A total of 364 newly registered pregnant women who attended the antenatal clinic between August and October 2015 took part in the study. Sample size for this study was calculated using the formula $n=z^2pq/d^2$, where 'n' is the desired sample size 'z' represents standard normal deviation set at 95% confidence level which corresponds to 1.96, 'p' is the reported prevalence of female genital cutting (circumcision) in Akwa Ibom state, Nigeria [5], 'd' is the precision which at 95% confidence interval is 5%. [13] The calculated sample size was 350. About eight hundred and thirty nine (839) newly registered pregnant women were expected to enlist for care during the study period based on records available for the previous three months of May to July 2015. Eight hundred and thirty nine (839) respondents were sampled during the study period. They were recruited using a systematic sampling method with a sampling internal of two. Numbers ranging from one to two were assigned to the first two respondents who met the inclusion criteria. The first respondent was chosen by simple balloting which was done by randomly picking one of the numbers from a basket containing the assigned numbers.

Thereafter, every second respondent was recruited for the study. Where, however, such a respondent did not consent to take part in the study, such a respondent was dropped, then the next respondent that met the inclusion criteria was recruited.

Inclusion criteria included all newly registered pregnant women who consented to take part in the study. Exclusion criteria included all critically ill pregnant women as well as those who refused to take part in the study.

Ethical approval for this study was obtained from St. Luke's hospital health research and ethical committee as well as the ethical and research department of Akwa Ibom Ministry of Health

METHODS

This was a prospective descriptive cross-sectional study conducted between August and October 2015. Three hundred and sixty-four (364) newly registered pregnant women who enlisted for care during the study period were recruited for the study.

A structured and pre-tested interviewer-administered questionnaire was used to obtain information about socio-demographic profiles of the respondents. Respondents' level of income was determined using the Nigerian national minimum wage Act passed by the Nigerian Parliament [14]

The Act stipulates a maximum basic monthly salary of sixty thousand naira only for low income earners between salary grade levels 01 and 07; middle level income earners range from salary grade levels 08 and 15 with a maximum basic monthly salary of one hundred and sixty-five thousand naira only, while high level income earners range from salary grade levels 16 to 17 with maximum basic monthly income of two hundred and ninety-five thousand naira only. At present about four hundred naira exchanges for one American dollar.

Information about psychopathologic consequences of FGC/FGM was collected using the 12- item general health questionnaire (GHQ-12) [15,16]

The GHQ-12 is a self-administered screening questionnaire designed for use in clinical settings for the purpose of detecting individuals with a diagnosable psychiatric disorder. The GHQ-12 is the most extensively used screening instrument for common mental disorders in addition to being a general measure of psychiatric well-being.

The GHQ-12 is a measure of current mental health and focuses on two major areas namely: the inability to carryout normal functions and the appearance of new and distressing experiences. The most common methods of scoring the GHQ-12 are bi-modal (0-0-1-1) and the Likert scoring style (0-1-2-3) [16].

For the purpose of this study, the bi-modal scoring method was used. Since the GHQ-12 is a brief, simple, easy to complete questionnaire, its application in research setting is well-documented in many countries including Nigeria [17,18]

This was administered by the interviewer to those who underwent FGC/FGM. The vagina of each respondent was examined by the lead researcher using sterile technique to determine if the respondent was circumcised and to characterize the extent of the procedure in order to determine the type of FGC.

DATA ANALYSIS

Statistical analysis was done using the statistical package for social sciences (SPSS) version 18.0.

Distribution and cross-tabulation was generated, chi-square was used to compare proportions. The p-value of 0.05 was used to determine the level of statistical significance.

RESULTS

A total of 364 respondents were recruited into the study. The average age of the respondents was 28.3 ± 4.3. Table 1 shows the socio-demographic characteristics of the respondents.

The prevalence of FGC among respondents in this study was 22.5%. FGC was more prevalent among those who were forty-five years and older (8.2%); followed by those who were between 35 and 44 years of age (7.4%).

Female genital cutting (circumcision) was seen to occur more among married respondents (16.8%) as well as the most highly educated; (that is respondents with post-secondary school education) (12.9%).
FGC was more prevalent among those in the low income cadre accounting for 10.7% (n = 39).

Figure 1 shows the types of Female genital cutting among circumcised respondents in this study.
Type 2a (removal of the labia minora only) was the commonest type of FGC seen in this study accounting for 64.4%. This was followed by Type 1a (removal of the clitoral hood or prepuce only) 18.3%; Type 1b (removal of the clitoris with prepuce) was 15.9%, and type 3a (removal and apposition of the labia minora) was 1.2%.

Table 2 shows the GHQ-12 scores of respondents in the study. A total of 91 (25.0%) respondents had scores of ≥ 2 indicating likelihood of co-morbid psychopathology (2 is cut-off). Of this number 70 (19.2%) respondents underwent female genital cutting (FGC), while 21(5.8%) respondents with similar GHO-12 scores did not undergo female genital cutting.
The mean GHQ-12 score was 3.42 + 2.56 and range was 0-12.

Table 1: Socio-demographic Characteristics of the respondents and FGC

Variables	Subjects		Total n(%)
	With FGC n(%)	Without FGC n(%)	
Age in years			
15- 24	11[3.1]	113[31.0]	124[34.1]
25- 34	14[3.8]	75[20.6]	89[24.4]
35- 44	27[7.4]	70[19.2]	97[26.6]
45 and above	30[8.2]	24[6.6]	54[14.8]
Marital Status			
Single	7[1.9]	27[7.4]	34[9.3]
Married	61[16.8]	182[50.0]	243[66.8]
Co-habiting	8[2.2]	61[16.8]	69[19.0]
Separated/Divorced	6[1.6]	12[3.3]	18[4.9]
Educational level			
No formal education	6[1.6]	69[19.0]	75[20.6]
Primary school	12[3.3]	98[26.9]	110[30.2]
Secondary school	17[4.7]	61[16.8]	78[21.4]
Post-secondary school	47[12.9]	78[21.4]	125[34.3]
Level of income			
Low level	39[10.7]	69[19.0]	108[29.7]
Middle level	24[6.6]	84[23.1]	108[29.7]
High level	19[5.2]	124[35.1]	143[39.3]
Ethnic group			
Ibibio	48[13.2]	184[50.5]	232[63.7]
Annang	12[3.3]	59[16.2]	71[19.5]
Yoruba	6[1.6]	12[3.3]	18[4.9]
Others	16[4.4]	27[7.4]	43[11.8]
FGC			82[22.5]
No FGC			282[77.5]

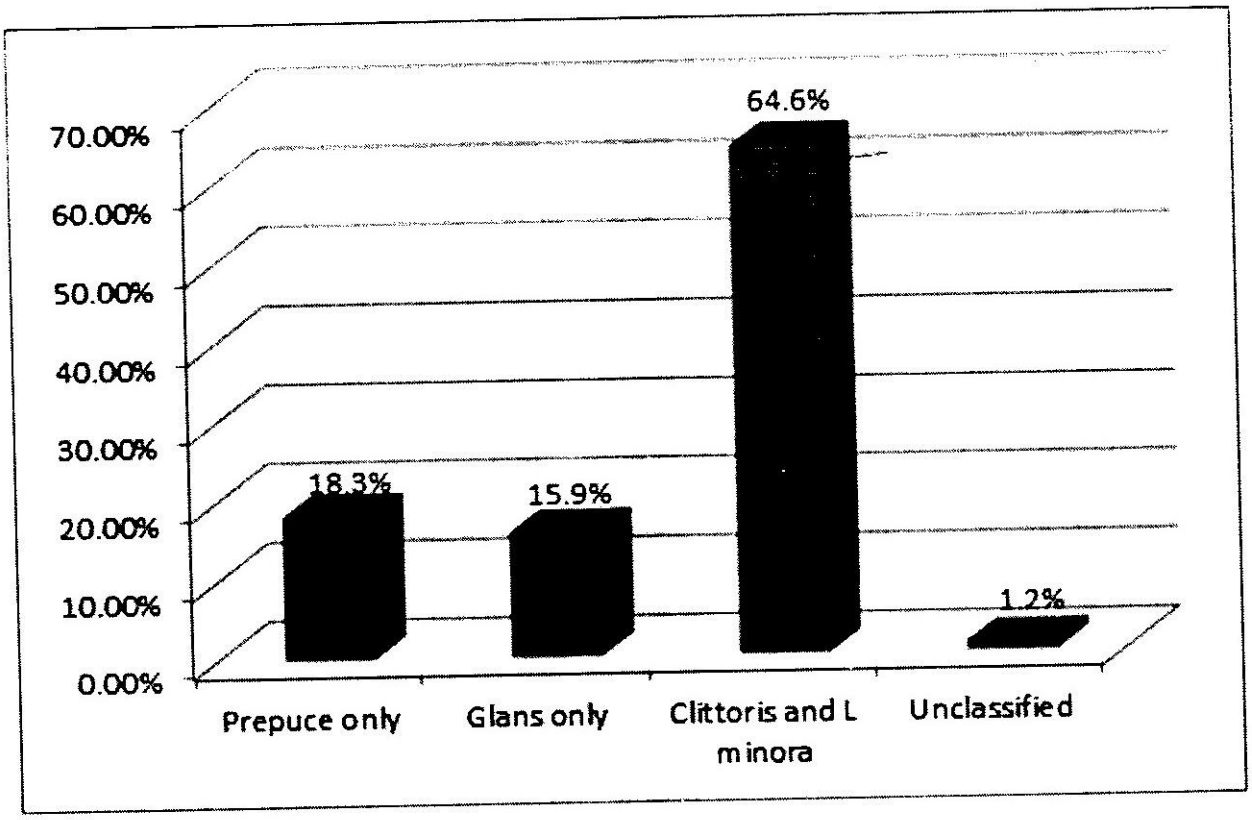

Figure 1: Types of Female Genital Cutting (circumcision) among respondents.

Keys:

Type 1a:	=	Removal of the clitoral hood or prepuce only
Type 1b	=	Removal of the clitoris with prepuce
Type 2a	=	Removal of labia minora only
Type 3a	=	Removal and apposition of the labia minora

Table 1: General Health Questionnaire – 12 (GHQ-12) Scores of Respondents

Variable	Subjects		Total n(%)
	With FGC n(%)	Without FGC n(%)	
GHQ -12 SCORES			
≤ 2	12[3.3]	261[71.7]	273[75.0]
≥ 2	70[19.2]	21[5.8]	91[25.0]
TOTAL	**82[22.5]**	**282[77.5]**	**364[100.0]**

DISCUSSION

The prevalence of female genital cutting among respondents in this study was 22.5%.

This prevalence rate is lower than 30.0% reported by National Demographic and Health Survey workers in Nigeria; 65.0% reported among some population groups in another part of Akwa Ibom State as well as 53.4% and 100.0% reported by some studies in the South-West and North- West geo-political zones of Nigeria respectively.[5,6,19,20]

The reason for the variation in prevalence rates among different workers might be a result of the differences in the study design and characteristics of the population studied while some studies are community-based, the present study is hospital-based.

The declining prevalence might also suggest that the practice is perhaps beginning to lose glamour among advocates; nonetheless, FGC is still being practised among different population and communities in Nigeria in spite of the fact that Nigeria is a signatory to the Maputo protocol that sought to outlaw female genital cutting[21]

The mean age of respondents in this study was 24.3 ± 4.3 years. This is comparable with the mean age of

29.2 ± 5.0 reported by some workers in South-West Nigeria [22]

This represents the peak child bearing period among women. The implication here is that health care providers must be prepared to handle any complications that may arise during child birth as a result of FGC. [23]

Female genital cutting was more prevalent among married respondents in this study. This is similar to a report from Northern Ghana. [24] The reason may be that circumcised women are readily preferred by men because of the belief that they are likely to be more chaste than their uncircumcised counterpart.
Finding from this study shows that FGC was more prevalent among respondents who were highly educated compared to those who were not. This is similar to a report from Edo State.South-South, Nigeria. [25]

The finding is baffling however, since better educated women are expected to have parents who are better educated and as such better informed about FGC. This finding may actually mean that better educated women exhibit better health seeking behaviour which could explain why they appear more in number among respondents in this study.

Finding from this study also shows that type 2a (removal of the labia minora only) was the most dominant type of FGC among respondents accounting for 64.4%. This was slightly higher than 62.2% reported by another study which also showed that type 2a was more prevalent among their study participants. [25] There is no reasonable explanation for this since there is no known indication for performing any type of FGC. Respondents in this study reported appreciable psychopathology years after they underwent female genital circumcision (FGC).

This is similar to reports from other studies which showed that women who were subjected to FGC later developed depression, anxiety-related disorders, post-traumatic stress disorder (PTSD) arising from flashback to the FGC event. [7,8]

CONCLUSION

In conclusion, findings from this study have shown that the practice of FGC is complex, the prevalence, types and complications both in the short and long term are many. These complications also include significant psychopathology. FGC clearly violates the right of the woman and belittles their dignity. Efforts at eradicating it must be intensified through massive public enlightenment.

Harmful effects of FGC must be highlighted, alternative means of livelihood for practitioners must be provided and the girl child must be empowered through good education. Laws aimed at enforcing the eradication of FGC must be invoked and applied.

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