

Short Communication

Health Workers' Knowledge of and Experience with Female Genital Cutting in Southwestern, Nigeria

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ABSTRACT

Female genital mutilation with its attendant complications has been a harmful traditional practice that is difficult to eliminate despite all efforts by various government and non-governmental agencies in Nigeria. The aim of this study is to assess the experience and the knowledge of the health workers practicing in our environment on Female genital cutting (FGC). Two hundred and fifty were interviewed with self-administered structured questionnaire. Their mean age was 35.2 ± 8.3 years. Type I 82(66.6%) was the commonest FGC seen by the health workers, type II 31(25.2%), type III 9 (7.3%) and type IV constituted 0.8%. Two hundred and two (202) (80.0%) of the respondents admitted to having sufficient knowledge in preventing FGC while 42 (16.8%) did not have. One hundred and twenty one (121) (48.4%) had been asked to perform FGC. It was concluded that female genital cutting is still a major health problem in Nigeria. There is need for all concerned to step up efforts in the elimination of the practice.

Keywords: Experience, Female Genital cutting, Health workers, Knowledge, Nigeria

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INTRODUCTION

Female Genital Cutting (FGC) consists of all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons (WHO, 1998). Female Genital Cutting is a potentially harmful practice associated with both short-term and long-term complications (Behrendt and Moritz, 2005). It is common in several countries, predominantly in Africa, and more than 100 million women and girls are estimated to have had FGM worldwide (WHO, 2006).

Female genital cutting has been classified into four types, I-IV. The severity and risk are closely related to the anatomical extent of the cutting, including both the type and amount of tissue that is cut, which may vary between the types. Genital tissue cutting generally increases from Type I to III. Type IV (Unclassified) comprises a large variety of practices that does not remove tissue from the

genitals. Though limited research has been carried out on most of these types, they appear to be generally less associated with harm or risk than types I (Clitoridectomy), II (Excision) and III (Infibulation), that all consist of removal of genital tissues (WHO, 2008)

Although there is evidence of FGC decline, it is still widely practiced among many ethnic groups in Nigeria (Snow *et al.*, 2002; Abubakar *et al.*, 2004) and varied prevalence rate exists among the various regions in Nigeria. This ranges from 56% in Southwest, 23.3% in the North to 56% in the Eastern part (Okonofua *et al.*, 2002; Slinger *et al.*, 2002; Abubakar *et al.*, 2004). However, there is overwhelming consensus that FGC in any form is an unnecessary procedure that has no clear benefit (Behrendt and Moritz, 2005).

In Nigeria, there are socio-cultural beliefs that encourage this harmful practice. It is believed that uncircumcised women are potentially promiscuous,

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unclean and unmarriageable. Also, it is assumed that uncircumcised women put the lives of their male child in danger at delivery, that is, if the head of the male child touches the clitoris, the child will die (Babalola *et al.*, 2006).

The age at which girls undergo FGC varies enormously according to the ethnic group practicing it. The procedure may be carried out when the girl is a newborn, during childhood, adolescence, at the time of marriage or during the first pregnancy. The most extreme type of FGC, infibulation, comprises around 15% of all procedures. The highest rates for infibulation are found in Djibouti, Somalia and northern Sudan (WHO, 1996). Female Genital Cutting is usually performed by an elderly woman of the village specially designated this task, by village barbers or by a traditional birth attendant (TBA). In some countries, more affluent families seek the services of medical personnel, in an attempt to avoid the dangers of unskilled operations performed in unsanitary conditions (WHO, 1996).

Various studies had been done among the categories of people that had one form or the other of FGM, but none to the best of our knowledge about the actual experience of health workers on the complications relating to this harmful traditional practice in Nigeria. The objective of this study is to assess the knowledge and experience of the health workers in obstetrics and gynaecology, paediatrics and private facilities where there is higher chance of coming across this problem.

METHODOLOGY

Study Design

This study was a descriptive cross-sectional study, using structured questionnaires containing socio-demographic characteristics, knowledge of Female Genital Cutting (FGC), types of FGC seen, associated complications treated and their ability to control the practice. The study was carried out among health workers at all levels of Health Institutions in South-western Nigeria including Osun, Oyo and Ogun States over a period of three months. A Tertiary health facility was selected in each state, one secondary health facility and convenient sample for private health facilities. The questionnaires were designed by the authors based on the current government passage of bill against FGC to assess the effectiveness of this bill on the populace. The questionnaires were distributed and administered by medical students in the department. The identity of the participants was

preserved by using only code numbers. All consenting health workers available in these facilities were interviewed. Ethical approval was obtained from the Ethic Committee of each Institution.

Data Analysis

Data were entered into Social Package for Social Science version 15 for cleaning and analysis. Mean and standard deviation to summarise normally distributed continuous variable while frequency and percentage for categorical variables were calculated. Measure of association was carried out using chi-square for categorical variables; at *p* value less than 5%.

RESULTS

There were two hundred and fifty (250) respondents with the mean age 35.2±8.3 years (20 – 60 years). There was no age difference across the professional cadres (specialist doctors 36.7±7.7, medical officers 33.3±7.9, nurse /midwives 35.3±8.7 (F = 2.14, *p* = 0.120). One hundred and sixty-one (64.4%) were female health workers while 89 (35.6%) were males. Majority of the respondents 98 (39.2%) were practicing in tertiary health facilities (Table 1).

Table 1: Socio-demographic Characteristics of the Respondents

Variables	No (%)
Age(years)	
20 - 24	6 (2.4)
25 - 29	57(22.8)
30 - 34	66(26.4)
35 - 39	40(16.0)
40 - 44	32(12.8)
≥ 45	37(14.8)
Not indicated	12(4.8)
Sex	
Males	89(35.6)
Females	161(64.4)
Religion	
Christianity	192(76.8)
Islam	46(18.4)
Traditional	1(0.4)
Not indicated	11(4.4)
Professional Cadre	
Specialist/Consultants	15(16.0)
Specialist in training	31(12.2)
Medical officers	58(23.3)
Nurse / Midwives	146(58.4)
Hospital of Practice	
Tertiary facility	98(39.2)
Secondary facility	58(23.2)
Primary facility	38(15.2)
Private facility	40(16.0)
Mission	16(6.4)

Table 2: Professional Cadres and Female Genital Cutting

Variables	Specialists Number (%)	Medical Officers Number (%)	Nurse/ Midwives Number (%)	P-value (χ^2 ; df)
Had seen patients with complications				
Yes	29(64.4)	20(36.4)	63(45.7)	0.017(8.09;2)
No	16(35.6)	35(63.6)	75(54.3)	
Ever treated FGC				
Yes	41(91.1)	27(52.9)	89(69.0)	0.000(16.61;2)
No	4(6.9)	24(47.1)	40(31.0)	
Ever asked to perform FGC				
Yes	22(52.4)	20(37.7)	75(57.3)	0.056(5.76;2)
No	20(47.6)	33(62.3)	56(42.7)	
Knowledge of FGC prevention				
Yes	36(86.7)	42(73.7)	117(84.8)	0.128(4.11;2)
No	6(13.3)	15(26.3)	21(15.2)	

χ^2 = Chi-square, df = degree of freedom

Years of practice according to professional cadres- 50 percentile: specialist doctors 6.5 years (interquartile range 10.0), medical officers 3.0 years (interquartile range 6.5) and nurse/midwives 8.0 years (interquartile range 12). The respondents were predominantly Christians 192(76.8%). The majority of the respondents 146 (58.4%) were nurse/midwives while 15(16.0%) were consultants in the specialities. One hundred and twenty one (121) (48.4%) had been asked to perform FGC and Nurse /Midwives (57.3%) were mostly asked to carry out the procedure ($\chi^2 = 5.76$, $df = 2$, $p = 0.056$). Majority of the health workers {161 (64.4%)} had treated one form of complications or the other arising from FGC and the complications were treated more by the specialist doctors (91.1%) ($\chi^2 = 1.61$, $df = 2$, $p = 0.000$). These complications were seen more by the specialist doctors (64.4%) and least by the medical officers (36.4 %) ($\chi^2 = 8.094$, $df = 2$, $p = 0.017$). Type I (82(66.6%)) was the commonest FGC seen by the health workers and type four constituted 0.8%.

Most of the specialist doctors (86.7%) had sufficient knowledge of preventing FGC while medical officers {73.7% ($\chi^2 = 4.11$, $df = 2$, $p = 0.128$)} had least experience (Table 2). Among the respondents who had come across the complications associated with FGC. One hundred and four (104)(90.4%) had seen labial agglutination, 6(5.2%) had seen clitoroidal cysts while rest { 5 (4.4%)} were bleeding.

DISCUSSION

In Nigeria, since the inception of current democratic government in 1999, various bills have been passed both at federal and state levels against female genital cutting, however, the impact of this legislation is yet to be felt, thus the need for this study especially among the health workers who

eventually treat the complications that arise from this harmful traditional practice. The mean age of the nurse/midwives who participated in this study was 35.3±8.7 years which were comparable to mean of 37 years in similar study conducted in the middle belt of the country, but they had lower duration of postgraduate practice experience of years compared to 14.5 years (Onuh *et al.*, 2006). Majority of the health professionals admitted to have recently seen FGC-related problems while only a few health professionals had similar experience in a study conducted in Sweden (Tamaddon *et al.*, 2006), this is not surprising due to fact that FGC is mainly practiced among the Africans including Nigerians.

Type 1 FGC (82%) constituted the majority of the FGC seen by the respondents and this was in support of high prevalence of type 1 FGC reported among the antenatal and family planning clinic attendees in the Southwestern Nigeria (Snow *et al.*, 2002) and antenatal clinic attendees in the Northern part of the country (Abubakar *et al.*, 2004). However, their experience with type III was very low (7.3%). This corroborates other studies done in the country (Snow *et al.*, 2002) which was at variance with reports from other African countries such as Sudan, Ghana and Burkina Faso where higher prevalence of type III FGC has been documented (WHO, 1998). This may be due to socio-cultural differences among Africans of different ethnic groups.

Most of the respondents had met patients seeking help for problems associated with FGC performed long time prior to presentation. These were mainly labial agglutination and clitoroidal cyst thus corroborating reports from other studies (Dirie and Lindmar, 1992; Obermeyer, 2003).

The treatments of long term complications were mainly carried out by specialists in obstetrics and gynaecology since they are better trained to handle these complications. A significant proportion of the respondents, mainly Nurse/Midwives, had been requested to carry out FGC especially female circumcision. This was higher than that of Swedish study (Tamaddon *et al.*, 2006). The higher prevalence of FGC in our environment could explain this disparity. The reason for Nurse/Midwives being the principal health professionals usually approach for these procedures might be due to easy accessibility to them as shown in this study. In addition, they had the longest years of post-graduation practice compared to other health professionals.

Most of the respondents, irrespective of the professional cadres claimed to have sufficient knowledge in preventing this harmful practice though subjective assessment. This was in contrast to Swedish study where only the gynaecologists claimed to have sufficient knowledge (Tamaddon *et al.*, 2006). This might be due general awareness of the condition in our environment. Besides, some of the female health workers had been circumcised as observed by a Nigerian study (Onuh *et al.*, 2006).

In conclusion, female genital cutting is still common in our society despite various legislations as evidenced in the experience of these health workers. There is urgent need to continue community awareness of the harmful consequences of this practice through the mass media, religious leaders and opinion leaders. Policies that would ensure the implementation of the legislation against FGC should also be put in place by the government. Health workers in Nigeria need to put in more efforts in educating mothers at all contacts such as antenatal and infant welfare clinics on the harmful consequences of this practice.

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