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Research Article

Obstetric Outcomes of Parturients with Female Genital Mutilation in a Tertiary Hospital in Nigeria

^{1,2}C.O. Njoku, ^{1,2}C.I. Emechebe, ²A.N. Njoku, ^{1,2}E.E. Efiok and ^{1,2}C.U. Iklaki

¹Department of Obstetrics and Gynaecology, University of Calabar, Calabar, Nigeria

²Department of Obstetrics and Gynaecology, University of Calabar Teaching Hospital, Calabar, Nigeria

Abstract

Background and Objective: Female genital mutilation (FGM) is a scourge on womanhood. The aim of study was to determine the socio-demographic features, types and obstetric complications of parturient with FGM Calabar, Nigeria. **Materials and Methods:** This was a cross-sectional case-control study done in the labour ward of University of Calabar Teaching Hospital, Calabar, Nigeria between 20th December, 2018 and 19th June, 2019. There were 150 pregnant women with FGM in first stage of labour recruited as case and 300 pregnant women without FGM who were also in first stage labour as controls. A structured questionnaire was used to obtain demographic data, obstetric and vaginal examinations were done before and after delivery. Statistical analysis was done using SPSS Version 22. **Results:** Majority of the women had Type I (51.3%), cultural rite (77.3%) was major reason for FGM and were mostly performed by traditional birth attendants (54.7%). FGM was significantly lower among parturients aged 40 years and above ($p = 0.015$) and higher among those from low social class ($p < 0.001$). There was a significant higher odd of primary postpartum haemorrhage (AOR = 0.210, CI = 0.105- 0.419), first degree perineal tear (AOR = 5.000, CI = 3.529- 7.083) and delayed second stage of labour (AOR = 0.104, CI = 0.057- 0.191) among parturients with FGM. **Conclusion:** Women with female genital mutilation have higher risk of primary postpartum haemorrhage, first-degree perineal tear and delayed second stage of labour. There should be increase awareness and education in order to eradicate this cruel act.

Key words: Mutilation, perineal tear, postpartum haemorrhage, delayed second stage of labour

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Corresponding Author: C.O. Njoku, Department of Obstetrics and Gynaecology, University of Calabar, Calabar, Nigeria Tel: +2348033424267

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Data Availability: All relevant data are within the paper and its supporting information files.

INTRODUCTION

Female genital mutilation (FGM), is a major form of violence against women and also an infringement on the fundamental human rights of girls and women¹. It is an ancient practice that has survived various phases of human civilizations despite its negative impacts on women's lives and reproductive function. FGM is the total or partial removal of the external genitalia or other injuries to the female genital organs for non-medical reasons¹. More than 200 million girls and women are living with female genital mutilation and about 3 million are at risk of undergoing the procedure annually¹. It has been reported in about 30 countries, mainly in Africa, middle East and Asia. Also, with increasing migration, significant number of girls and women who have undergone FGM or may be at risk of being subjected to the practice now live in Europe, Australia and North America².

Eighteen African countries have prevalence rates of 50% or higher, the highest prevalence is in Somali and Djibouti with about 98% prevalence^{3,4}. However, Nigeria has the highest absolute number of residents who has undergone FGM, with more than 20 million girls and women (10% of the global prevalence) having undergone some types of FGM^{5,6}.

World Health Organization (WHO) classified FGM into 4 types: Type 1 (clitoridectomy) is the partial or total removal of the clitoris and/or the prepuce, type 2 (excision) is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora, type 3 (infibulations) is the narrowing of the vagina orifice with creation of a covering seal by cutting and opposing the labia minora and/or the labia majora, with or without excision of the clitoris. A small hole is left to allow for urinating and menstrual bleeding and type 4 include various practices in the genital area, with a varying degree of severity and without any therapeutic purpose (piercing, dry sex, stretching, cauterizing the clitoris, etc)¹.

Several reasons have been given by various cultures and regions for the practice of female genital mutilation. These include cultural rites to initiate a girl into womanhood, religious rituals, prevention of difficult childbirth and early neonatal deaths during delivery by preventing the fetal head from touching the clitoris, prevention of promiscuity by controlling excessive female sexual desires, enhancement of the girls femininity by excision of the clitoris which make female more of a male. Other reasons include personal hygiene, esthetics, better marriage prospect, to protect family honour and to increase sexual pleasure of the husband⁷⁻⁹.

Many complications have been reported to be associated with FGM, ranging from psychological effects, such as feeling

of incompleteness, fear, inferiority, chronic irritability, nightmares, psychiatric and psychosomatic diseases to obstetric complications, including perineal tear, postpartum haemorrhage, caesarean delivery, prolonged second stage of labour, need for neonatal resuscitation and fresh still birth/early neonatal death¹⁰⁻¹⁴. Other complications are dyspareunia, risk of infections like HIV, hepatitis and tetanus¹⁰⁻¹⁴. Nigeria is leading in the absolute number of females with FGM, yet there are paucity of reports on the reproductive health impact on the affected women, moreover from this environment with reported high prevalence rate, (56.9%), study have shown strong cultural affiliation of the people to FGM evidenced by the fact that in some areas of the state, more than 85% of women are forced into having the operation without prior knowledge and knowledge of the health consequences^{5,15}. This study is therefore aimed at determining the socio-demographic characteristics and the obstetric complications of parturient with FGM in University of Calabar Teaching Hospital. This will provide a framework to increase awareness on the maternal health implications.

MATERIALS AND METHODS

This was a cross-sectional case-control study of 450 pregnant women in first stage of labour: 150 parturient with FGM and 300 parturient without FGM as controls. Study period was 6 months, from December, 20th, 2018 to June 19th, 2019. Before the commencement of the study, ethical approval from the Ethics Committee of the University of Calabar Teaching Hospital, Calabar was obtained. Informed consent was gotten from each participant. Systematic sampling was used to recruit participants, for each parturient with FGM who consented that was recruited, 2 consecutive parturients that consented were recruited.

Type of FGM and sociodemographic data: The vulva of each participant was examined to determine the presence and type of FGM (based on WHO classification). A structured questionnaire was used to obtain socio-demographic data. The social classes of the participants were determined using the Olusanya *et al.*¹⁶ classification, making use of the educational status of their mothers and their fathers' occupation¹⁶.

Obstetric outcomes: The labour of each parturients was monitored, using partograph and labour management was based on departmental protocol. Parturients were admitted to labour ward in active phase labour and monitored by resident

doctors and midwives, using partographs. Fetal heart rate was monitored by intermittent electronic monitoring, cardiotocography was used for fetal heart rate abnormalities or high-risk cases. Decision for any interventions in labour (augmentation, caesarean delivery) were based on abnormalities in progress of labour or fetal heart changes. Vaginal deliveries of parturients were conducted by skilled attendants. Perineum was carefully inspected after delivery. Intrapartum and postpartum complications were noted and managed.

Statistical analysis: Data was analyzed with SPSS Statistics (IBM Corp. version 22) program for data analysis. Statistical comparison was done using Chi-square (χ^2) test at level of significance p-value taken at $p < 0.05$.

RESULTS

Type of FGM and sociodemographic data: Figure 1 shows the prevalence of the various types of FGM. Type 1 was the commonest type (51.3%), the second commonest was type 2 (44.7%) and the least was type 3 (4.0%).

Figure 2 shows reasons for FGM. Cultural practice was the most common reason for FGM (77.3%). Other reasons were prevention promiscuity 24 women (16.0%), safe delivery during pregnancy 5 women (3.3%), spiritual cleanliness (1.3%) and no reason (2.0%).

Figure 3 shows the attendants that performed the female genital mutilation. Most of the FGM among the participants were performed by the TBA/local surgeons (54.7%), followed

by the grandmother (34.0%). Nurses/midwives performed FGM 5.3% cases, medical doctors (4.0%) and the participants' mother performed the least FGM (2.0%) of cases.

Socio-demographic features of participants is shown in Table 1. FGM was higher among the age groups 19 years and below (33.3%), 20-29 years (33.3%) and 30-39 years (38.8%) compared with 40 years and above (7.1%) and the difference is statistically significant ($\chi^2 = 10.449$, $p = 0.015$). FGM was commonest among participants from social class families (47.2%) ($\chi^2 = 21.259$, $p < 0.001$).

Obstetric outcomes: Table 2 shows the multivariate regression analysis of obstetric complications of FGM. Women with FGM had an increased odd of having primary postpartum haemorrhage (AOR = 0.210, CI = 0.105-0.419), first degree perineal tear (AOR = 5.000, CI = 3.529-7.083) and delayed second stage of labour (AOR = 0.104, CI = 0.057-0.191).

DISCUSSION

This study observed prevalence with mainly types 1 and 2 FGM. The major reason for FGM was for cultural practices, significant proportion of parturients with FGM were young and came from low social class family. Parturients with FGM had higher odd of primary postpartum haemorrhage, first degree perineal tear and delayed second stage of labour. Female genital mutilation causes numerous physical and psychological complications as well as negative implications on obstetric performance¹⁰⁻¹⁵.

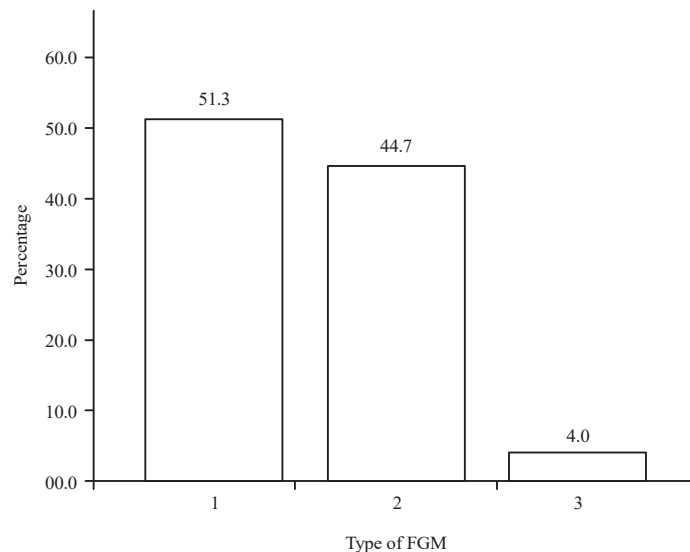


Fig. 1: Types of FGM among parturients

Table 1: Socio-demographic features of participants

Variables	Total	FGM present	Percentage	FGM absent	Percentage	p-value
Age (years)						
≤19	69	23	33.3	46	66.7	$\chi^2 = 10.449$
20-29	219	73	33.3	146	66.7	Df = 3
30-39	134	52	38.8	82	61.2	p = 0.015
≥40	28	2	7.1	26	92.9	
Parity						
1	194	64	33.0	130	67.0	$\chi^2 = 3.644$
2-4	224	80	35.7	114	64.3	Df = 2
≥5	32	6	18.8	26	81.2	p = 0.162
Educational level						
Primary	74	22	29.7	52	70.3	$\chi^2 = 1.161$
Secondary	225	73	32.4	152	67.6	Df = 2
Tertiary	151	55	36.4	96	63.6	p = 0.559
Marital status						
Single	90	26	28.9	64	71.1	$\chi^2 = 1.000$
Married	360	124	34.4	236	65.6	Df = 1
Tribe						
Efik	142	46	32.4	96	67.6	$\chi^2 = 1.017$
Igbo	121	39	32.2	82	67.8	Df = 6
Ibibio	50	16	32.0	34	68.0	p = 0.985
Ejagham	88	32	36.4	56	63.6	
Bete/Ogoja	12	4	33.3	8	66.7	
Hausa	23	9	39.1	14	60.9	
Yoruba	14	4	28.6	10	71.4	
Social class						
Low	159	75	47.2	84	52.8	$\chi^2 = 21.259$
Middle	147	39	26.5	108	73.5	Df = 2
Upper	144	36	25.0	108	75.0	p < 0.001

Table 2: Multivariate analysis of obstetric complications of FGM among parturients

Variables	Adjusted odds ratio	95% CI	p-value
Primary postpartum haemorrhage			
No	Reference		
Yes	0.21	0.105-0.419	<0.001
First degree perineal tear			
No	Reference		
Yes	5.000	3.529-7.083	<0.001
Second degree perineal tear			
No	Reference		
Yes	0.507	0.254-1.012	0.054
Delayed second stage			
No	Reference		
Yes	0.104	0.057-0.191	<0.001

The prevalence of female genital mutilation among women in labour in this study was 35.9%, which is lower than 41.9% among young girls in south-west Nigeria and 47.8% among infant in northern Nigeria but higher than 25% reported among reproductive age women in south-west Nigeria¹⁷⁻¹⁹. The prevalence of FGM among parturients is high, however, this value may not be the true representation of the burden of this problem among girls and women because this is a hospital-based study, a community-based study in this environment where culture exerts great influence may give higher prevalence.

Type I FGM was the most common type in this study, Anikwe *et al.*¹⁴ reported that type II FGM was the commonest among parturients in south-east Nigeria. Ojo and Ijadunola¹⁷ and Makinde *et al.*¹⁸ reported similar findings in south-west Nigeria. These geographical variations in type of FGM may be influenced by the local cultural practices.

Cultural rite was the main reason for the practice of FGM in this study, other reasons were prevention of promiscuity and difficulty in labour. Similar findings were reported in previous study Makinde *et al.*¹⁸. Most FGM were performed by local surgeons or traditional birth attendants and

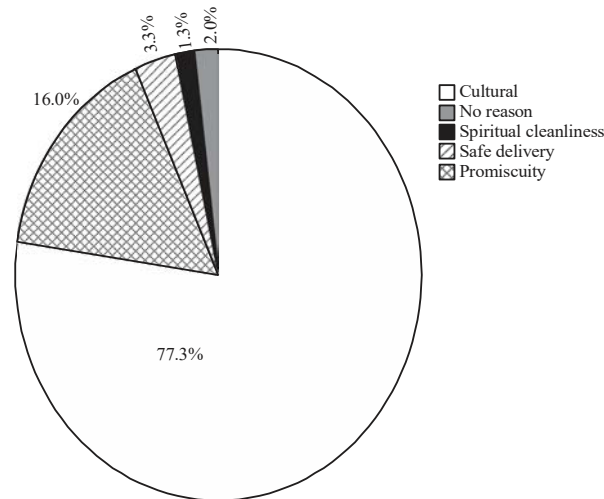


Fig. 2: Reasons given for FGM among parturients

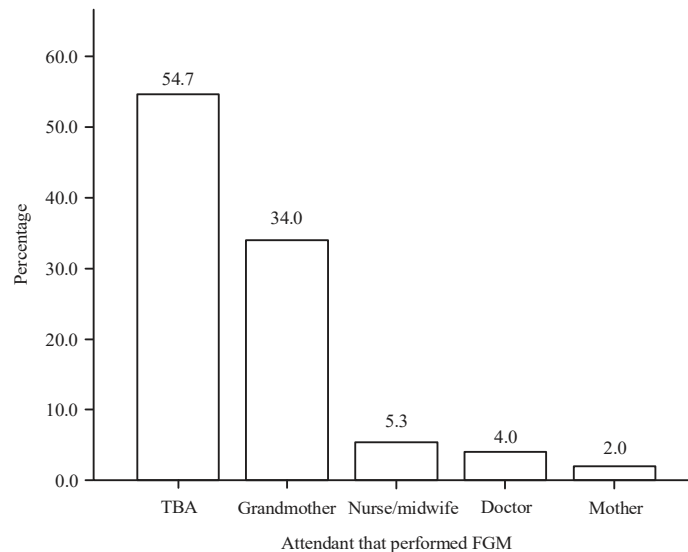


Fig. 3: Attendants that performed FGM among study participants

grandmothers. The potential to transfer diseases including viruses is high. This finding is in line with previous studies^{18,20}.

In the present study, FGM was significantly higher among younger parturients than older pregnant women in labour. However, Ojo and Ijadunola¹⁷ in south-west Nigeria reported that women between 45-49 years were twice likely to have undergone FGM compare to women between 15-19 years. This suggests that the practice of FGM is still in existence in this environment in recent times and may be even more than the practice in the past.

There was no significant difference in parity, educational level, marital status and tribe in parturients with FGM in the present study. However, previous study

found significant variations in of risk of FGM among women from different ethnic groups¹⁷.

Female genital mutilation was significantly higher amongst parturient from low social class families. This is similar to findings from previous studies^{14,19}. People from low socio-economic background may be uninformed on the physical, medical and psychological complications of female genital mutilation on a girl child, they are also likely to succumb to cultural influence such as the practice of FGM.

In the present study, labour in women with FGM had significantly higher odd of complications, such as first-degree perineal tears, primary postpartum heamorrhage and prolonged second stage of labour. Similar findings were

reported in previous study from South-East Nigeria¹⁴. This confirms that FGM is a violence against women's health and obstetric health in particular²⁰. These findings can be explained by scarring and fibrous tissue formation caused by removal of the clitoris and labia as seen in female genital mutilation operations. During second stage of labour, the fibrous tissues are difficult to stretch and more likely to tear, resulting in prolonged second stage of labour, perineal lacerations and primary postpartum haemorrhage.

CONCLUSION

Female genital mutilation is in this environment mainly to fulfill cultural rites. Type 1 FGM is the commonest and principally performed by TBAs, whereas younger parturients are the greatest victims. Subjects whose parents were of low socio-economic status were at higher risk of having FGM from this study. The magnitude of the obstetric complications especially genital lacerations, primary postpartum haemorrhage and delayed second stage associated with FGM outweighs the presumed benefits. This underscores the need to strengthen the preventive measures in order to eradicate this cruel assault against motherhood.

SIGNIFICANCE STATEMENT

The study discovered that female genital mutilation increases intrapartum and postpartum complications and morbidities of parturients and so the reproductive health of females. This finding could be beneficial in educating the public on the dangers of FGM on its victims and the need to stop this cruel act. This study will help researchers uncover the critical areas such as the effect of FGM on reproductive health and advance the awareness of its posture as a public health problem.

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