Abstract- This paper examined the practice of subjecting young baby girls and women to either partial or total removal of external female genitalia for non-medical reasons; female genital mutilation (FGM) in Nigeria. Plethora of studies showed the prevalence of FGM and its significant health consequences which include shock; fear; excessive haemorrhage; severe pain; infertilitiy, psychosomatic urine retention out of fear and pain; painful sexual intercourse, risk of VVF and RVF, abdominal cramps and painful menstruation; recurrent urinary tract infection, increase risk of Caesarean section; prolonged and obstructed labour and even maternal and neonatal mortality. The paper discussed the concept, classifications, prevalence, and the health consequences involved in the FGM practice. It was recommended among others that intensive health education and sensitisation campaigns should be maintained to keep the general public informed on the significant health consequences involved in the FGM practice thus heeding them to adopt positive health behaviour.

Keywords- FGM, health Consequences, clitoral disgust

I. INTRODUCTION

Female Genital Mutilation (FGM) has been defined as all procedures that involve total or partial removal of external female genitalia or other injuries to the female genital organs whether for cultural or any other non-therapeutic reasons (Edna Adan University Hospital, 2010). This is one of traditional practices that are detrimental to health. It has no known health benefit and has been practiced for centuries in Africa for over 2000 years ago (Sanusi, 2011). This traditional procedure has a number of names which includes: female circumcision; female excision; female genital alteration; female genital surgery; female genital modification; female genital cutting and female genital mutilation (Lewness, 2005). The name Female Genital Mutilation (FGM) was adopted by World Health Organisation (WHO) in Addis Ababa, Ethiopia during the third conference of Inter-Africa committee on traditional practices affecting the health of women and children and United Nation recommended it use in 1991 (Momoh, 2005).

Classifications of Female Genital Mutilation

Several authorities have attempted to classify the FGM practice into different categories even the classifications given by WHO was criticised by many scholars. However, practice is categorised into four classes by WHO in Cabral (2004) and was further broken down with sub-divisions, these include:

Type 1: Excision of the prepuce with or without excision of part or the entire clitoris

- these are the removal of the clitoral hood as (Type Ia);
- Partial or total removal of the clitoris, also known as Clitoridectomy as (Type Ib).

Type 2: Excision of the clitoris with partial or total excision of labia Minora

- Type IIa is the removal of inner labia only;
- Type IIb, partial or total removal of the clitoris and the inner labia; and
- Type IIc partial or total removal of the clitoris, and the inner and outer labia.

Type 3: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (Infibulation)

Type 4: Unclassified, piercing, pricking, incision or stretching of the clitoris or labia; introduction of corrosive substance into the vagina, any other procedure that falls under WHO definition

The practice of FGM has many health consequences. However, the U.S. Department of State (2009) added that in some countries where FGM is performed, leaders have tried to lessen the physical problems caused by FGM by asking the hospitals and doctors to do the surgery. This mediatisation of FGM offends the international medical community, and is seen as a way for FGM support to continue the practice. Advocates have charged that doctors should not perform FGM, as their profession require them to do no harm to their patients, despite cultural beliefs and the practices. Olubayo-Fateregun (2007) reported in Orenuga (1997) that the operators of the FGM are categorised into three categories in Nigeria, these are:

I- The Ololas in Yoruba speaking south-west of Nigeria;
II- The Osiwus in Edo who regarded circumcision as a family trade and has thereby constituted themselves into a cult/guild; and
III- The Ngozomas and the local barbers who are regarded as the custodian and the perpetrators of the practice among Hausa/ Fulani in Northern Nigeria.

Prevalence of Female Genital Mutilation

Warries (2011) reported that there are approximately 100 to 140 million women have undergone female
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The majority of cases are carried out in 28 African countries (Gale encyclopaedia of medicine, 2008; Isah, 2012). In some countries such as Egypt, Ethiopia, Somalia and Sudan with high prevalence rate as high as 98% while in Nigeria, Kenya, Togo and Senegal, the prevalence varies from between 20-50 percent (Waries, 2012). Although health workers may circumcise females using antisepsic techniques, medically trained personnel usually perform the circumcision without anaesthesia in non-medical setting. Circumcisers may be skilled in traditional medicine, but their lack of training in surgery, their poor equipment, and the fact that the girl may struggle, all suggest that it is difficult to be precise in excision (Horowitz and Jackson, 1995). Macnair (2011) stated that in Kenya, a 1991 survey found that (78%) of teenagers had been circumcised, compared to (100%) of women over 50 years of age. He further added that in Sudan the practice dropped by (10%) from 1981 to 1990. Koustuv, Stephen and Bjarne (2010) added that despite the banning of the FGM by the Egyptian high court in 1997 22 recent reports indicated that (97%) of Egyptian women had the experience the practice of FGM.

Nigeria is a vast and the most populous country in Africa with over 250 ethnic groups and with an estimated population of over 160 millions, a national estimate of this harmful practice in such a country is very difficult. However, the demographic and health survey that was carried out in the country in 1999, revealed that (25.1%) of the 8,205 women selected to participate in the study have undergone one of this harmful procedures (U.S. Department of state, 2001). Many studies found no significant difference between self-reported and observed status of female genital mutilation. In Nigeria, (45%) of women of circumcised based on medical examinations, compared with (43.5%) from self-reports. There was a collaborative study conducted in Nigeria, a state by state study of the practice of FGM by Nigerian National Committee, the Inter-African Committee of Nigeria on Harmful Traditional practices Affecting Health of Women and Children (IAC), WHO, UNICEF, UNDP, UNFPA, Federal Ministry of Women Affairs, Federal Ministry of Health and Centre for Gender and social policy studies of Obafemi Awolowo University Ile-Ife. The result is tabulated as follows:

<table>
<thead>
<tr>
<th>State</th>
<th>% of Women</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abia</td>
<td>n/a</td>
<td>-</td>
</tr>
<tr>
<td>Adamawa</td>
<td>60-70</td>
<td>IV</td>
</tr>
<tr>
<td>Akwa Ibom</td>
<td>65-75</td>
<td>II</td>
</tr>
<tr>
<td>Anambra</td>
<td>40-60</td>
<td>III</td>
</tr>
<tr>
<td>Bauchi</td>
<td>50-60</td>
<td>IV</td>
</tr>
<tr>
<td>Benue</td>
<td>90-100</td>
<td>II</td>
</tr>
<tr>
<td>Borno</td>
<td>10-90</td>
<td>I, II, III</td>
</tr>
<tr>
<td>Cross Rivers</td>
<td>n/a</td>
<td>-</td>
</tr>
<tr>
<td>Delta</td>
<td>80-90</td>
<td>II</td>
</tr>
<tr>
<td>Edo</td>
<td>30-40</td>
<td>II</td>
</tr>
</tbody>
</table>

genital mutilation worldwide. However, some study revealed that more than 135 million women have undergone the practice with an incidence rate of 3 million globally and 2.2 million girls at risk every year in Africa alone. This is quietly pathetic. Moreover, Nora (2010) added that 8,000 girls are being subjected to the FGM practice worldwide per day. The widespread of the FGM practice has been estimated to amount 92 million girls over age of ten in Africa (Mitike & Deressa, 2009) with few cases as among the immigrants and refugees in USA, Canada, Europe, Australia and New Zealand. Moreover, Macnair (2011) further added that it is estimated that as many as 2 million girls are subjected to FGM every year.

Some documented studies have also shown that the FGM practice take place in some parts of Middle East, in Yemen, Oman, Kurdistan, among some Bedouin women in Israel and also among some Ethiopian Jews. Similarly, Edna Adan University Hospital (2010) said that limited few cases are reported to be practiced in Saudi Arabia, United Arab Emirate and even fewer in some certain communities, particularly among Bohra in India and Pakistan and among some population in Malaysia and Indonesia. But the practice is mainly in 28 countries stretching across the centre of Africa north of equator; it is not found in southern Africa or in the Arabic-speaking, with the exception of Egypt. Bognar (2007) outlined the following African countries that are practicing female genital mutilation are, Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Djibouti, Egypt, Ethiopia, Eritrea, Gambia, Guinea, Guinea Bissau, Ghana, Ivory Cost, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Somalia, Somaliland, Sudan, Tanzania, Togo and Uganda. Frances (1997) revealed that national data was collected in the demographic and health survey programme for six countries- the Central African Republic, Cote D’Ivoire, Egypt, Eritrea, Mali and Sudan showed that the prevalence varies from (43-97%) of reproductive age have been circumcised and Sudan and Congo (formerly Zaire) with the prevalence rate of (5%) and Somalia and Djibouti with (98%). According to Gale encyclopaedia of medicine (2008) stated that WHO reported the following countries that have the highest number of the occurrences of FGM: Djibouti, (98%), Egypt (97%), Eritrea, (95%), Guinea, (99%), Mali, (94%), Sierra Leone, (90%) and Somalia, (98-100%).
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Prevalence of Female Genital Mutilation in Nigeria
Source: Individual Countries Reports U.S. Department of State

Several studies were conducted in Nigeria to determine the prevalence rate of the practice, according to United Nation developmental system study showed that 32.7 million women and girls were genitally mutilated in the country. Moreover in a study carried out by Kandala, et al (2010) revealed that (22.0%) among the interviewed women had the practice and (22.4%) whom daughters had undergone the FGM.

An Overview of Health Consequences of Female Genital Mutilation

The condition in which FGM is generally perform particularly in Africa, even the less extensive types of genital mutilation can lead to potential fatal health consequences, such as haemorrhage, infection and shock (Ayena, 2012). The consequences vary depending on the degree and the type of the mutilation (Warries, 2012). The more extensive FGM procedure places women at higher risk of obstetrical problems which could lead to the development of vesico vaginal and recto vaginal fistulae (VVF & RVF), holes that allow urine and faeces to seep into the vagina (Cabral, 2004; WHO, 2006). Auta (2004) added that it is difficult to obtain clear urine sample as part of prenatal care for making the diagnosis of some certain conditions such as pre-eclampsia, urinary tract sequele and damage to the urethra and the bladder can occur as a result of the practice. However, some authorities stated that the removal of clitoris, the sensitive erectile female genitalia, desensitise it and reduces the woman’s sexual libido and thereby making her difficult to achieve orgasm during coitus. For infibulated women the consummation of marriage is likely to be painful because of the small opening and the lack of elasticity in the scar tissue that forms it. Tearing and bleeding may occur, or the infibulation scar may have to be cut open (De-infibulation) to allow penetration during intercourse (Achalu, 2007; Kaplan, Hechavarria, Martin, & Isabelle, 2011).

It is common to have inability to pass urine because of pain, swelling and inflammation due to the operation and it may even lead to urinary tract infection. Kandala, Nwakeze and Kandala (2010) showed that the long-physical health consequences include urine retention and associated urinary tract infections, obstruction of menses and related reproductive-tract infections as infertility, painful intercourse, psychological and sexual problems and, prolonged and obstructed labour, formation of scar tissues, dysmenorrhea, dyspareunia, shock, instant bleeding, risk of transmitting HIV/AIDS, increase risk of caesarean section, urine retention, vesico vaginal fistula and recto vaginal fistula, prolonged and obstructed labour, de-infibulation, extensive vaginal and perineal lacerations, post-partum haemorrhage, sexual dysfunction, development of vulva keloid among others (Abdullahi, Saidu & Bala, 2012).

Sunday, Gabriel, Joaness, Sylvanus, Valentin and Etedate (2006) opined that the cutting can lead to formation of keloid on the vulva, this can be so large to obstruct walking, coitus and labour. He further reported that effects may include the formation of dermoid cyst which may lead to vulva abscess; infertility due to blocked fallopian tubes by infections; heavy bleeding, distress in infant and stillbirth as a result of obstruction which can lead to prolong labour or tearing of tissue around the vagina. WHO (2006) pointed out that women subjected to FGM have an average of 30% more caesarean section compared to their counterpart who have not undergone the procedure.

Koustuv, et al. (2010) viewed it in different perspective as gynaecological, urinary tract, marital, psycho-sexual and obstetrical implications of the practice. WHO (2004) reported that the immediate physical effects of FGC include horrendous pain;
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injury to the adjacent tissue or urethral vagina; perineum; and rectum; heavy bleeding shock and acute retention of urine; fracture or dislocation cause by restraints; pelvic inflammatory diseases; risk of contracting infections such as HIV/AIDS and Hepatitis B; failure to heal; and maternal distress and death. Some of the health consequences of FGM include deinfibulation or deinfibulation, these are surgical techniques to reverse the closure of the vaginal opening, after a type III infibulation, and consist of vertical cut opening up normal access to vagina and it may be accompanied by removal of scar tissue and labial repair (Abdullahi, Saidu, Bala & Shehu, 2013). Moreover, some women may request reinfibulation after giving birth and some just before marriage, after divorce or even in elderly women to prepare them for death (Kouba and Muasher, 2011).

According to Morison, Schert, Ekpo, Paine, West, Coleman and Walraven (2001) revealed that female genital mutilation has the following physical and emotional health consequences (problems), these include fear; submission; inhibition and suppression of feelings; repeated feeling during the intercourse; and menstruation; constant feeling of betrayal; bitterness. Similarly, Snow, Slanger, Okunofua, Oronsaye and Wacker (2002) added that anger; mental and psychosomatic disorder; social stigmatisation; and rejection of uncircumcised girl by communities; and painful and difficult labour during child birth; risk of caesarean section; dangerously heavy bleeding after the birth of the baby and prolong hospitalisation after child birth are some of the effects of FGM.

Women who have undergone Infibulation type III may require de-infibulation. De-infibulation is a procedure in which the sewn vulva is cut open for sexual intercourse or childbirth (Kouber & Muasher, 2011). Without de-infibulation before birth, obstructed labour may occur, causing the life threatening complications for both mother and the infant, because birth rate are high in many countries where infibulation is practiced, a woman’s infibulation scar may have to be cut and re-sewn many times during her reproductive years and death may occur (Frances, 2009). In addition to that, the amputation of clitoris and other sensitive tissue reduces the woman’s ability to experience sexual pleasure. For infibulated women the consummation of marriage is likely to be painful because of the small opening and the lack of elasticity in the scar tissue that forms it. Tearing and bleeding may occur, or the infibulation scar may have to be cut open (De-infibulation) to allow penetration.

Moreover, WHO (2008) stressed that the effects of infibulation (FGM) brings about haematocolpus, which may need surgical intervention and further added that dribbling of urine is common among infibulated women, probably due to both difficulties in emptying the bladder and the stagnation of urine under the hood of scar. WHO (2006) report had shown that women who have had FGM are significantly more likely to experience difficulties during child birth and that their babies are more likely to die due the practice. Studies have shown that the varying amount of scar tissue contributes significantly in prolonging and obstructing the birth process. Though that it is not clear why FGM leads to increased complication during childbirth, but one possible explanation is that, this scar tissues are relatively inelastic and can lead to obstructed and prolonged labour (Yount, 2000). Boyle (2002) further posited that the risk of haemorrhage and death from female genital cutting during labour is high.

Adeneye, Oke and Adeneye (2006) stressed that the cutting can lead to formation of keloid on the vulva, this can be so large to obstruct walking, coitus and labour. He further reported that effects may include the formation of dermoid cyst which may lead to vulva abscess; infertility due to blocked fallopian tubes by infections; inability to enjoy coitus; Dysmenorrhoea; Dyspareunia; frigidity and many others. Moreover, Banks, Bathija, Meirik, Farley, Akande and Ali (2006) and WHO (2006) reported that FGM increases the risk of caesarean section (CS), heavy bleeding, distress in infant and stillbirth as a result of obstruction which can lead to prolong labour or tearing of tissue around the vagina. WHO (2006) pointed out that women subjected to FGM have an average of 30% more caesarean section compared to their counterpart who have not undergone the procedure.

Akin (2012) reported that it is very likely that after mutilation the girl may suffer excruciating pain and severe bleeding and if perpetrators waited too long before they take the girl to the hospital, by which time little will be done to save the live of the FGM victim. Abusharaf (2001) also asserted that female genital cutting accounts for 70% increase in the number of women who suffer from post-partum haemorrhage in those with type III (infibulation) compared to those with FGM, third degree laceration and anal sphinter damage. However, some authorities stated that the removal of clitoris, the sensitive erectile female genitalia, desensitise it and reduces the woman’s sexual libido and thereby making her difficult to achieve orgasm during coitus.

Summary and Conclusion

The practice of female genital mutilation has been in existence for a long period of time and several studies revealed that it has significant health consequences which include shock; fear; excessive haemorrhage; severe pain; infection, urine retention; post-traumatic oedema of the vulva; development of vulva keloid, obstruction of urethra; painful sexual intercourse, risk of VVF and RVF, abdominal cramps and painful menstruation; recurrent urinary tract infection,
increase risk of Cesarean section; prolonged second stage labour; extensive vaginal and perineal lacerations; obstructed labour; uterine inertia; uterine; impacted foetus; maternal distress and even maternal and neonatal death among others. 

Recommendations

Based on this, the following recommendations were proffered:

- Intensive health education and sensitisation campaigns should be maintained to keep the general public informed on the significant health consequences involved in the FGM practice thus heeding them to adopt positive health behaviour.
- Collaborative efforts from both governmental and non-governmental organisations should be made in to educate populace on the significant health consequences of FGM in Nigeria;
- Advocacy visits to both religious and traditional leaders should be done at regular interval to discuss with FGM perpetrators and provide them with alternative means of livelihood.

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