Tracy Slanger
Dr.sc.hum.

Female genital cutting in Edo State, Southwest Nigeria: its prevalence, social correlates, and association with obstetric morbidity

Geboren am 03.02. 1968 in Palo Alto, California, USA
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Vordiplom am 15. 06. 1990 an der University of California, Santa Cruz, CA, USA
Diplom am 05.05. 1997 an der University of Michigan, Ann Arbor, MI, USA

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Doktorvater: Prof. Dr. H. Becher

Female genital cutting (FGC) has been defined by the World Health Organization as all procedures involving partial or total removal of the external female genitalia and/or other injury to the female genital organs for cultural or other non-therapeutic reasons. It is categorized, based on severity, into a range of types, from removal of the clitoral foreskin and clitoris (excision) to complete genital dissection and narrowing of the vaginal opening (infibulation). Estimates show that in 28 countries of Africa, and parts of the Middle East and Indonesia, 100-130 million girls and women are currently living with female genital cutting, and that 2 million girls and women undergo some form of the procedure each year.

This study examines the association between obstetric morbidity and female genital cutting in an urban and peri-urban setting in Edo State, Southwest Nigeria. Between August 1998 and March 1999, a cross-sectional study was conducted among 1,851 women attending either family planning or antenatal services at one of three public hospitals in and around Benin City. Demographic, obstetric history, and self-reported FGC status information was gathered using an interviewer-administered questionnaire, while data on FGC clinical prevalence and type were gathered by means of a physical exam. Additional problems analyzed in the study include the clinically-determined prevalence of FGC, the social correlates of FGC, and the accuracy of women's self-reporting of FGC status in the population.

The findings, based on both univariate and multivariate statistical analyses are as follows:

a) Clinically-established FGC prevalence among the entire sample was nearly 46%. Among cut women, clinical exam revealed that 71% had undergone type I FGC, 25% type II, 3% type III, and 1% type IV. Age-specific prevalence rates showed a secular decline by five year birth cohorts.

b) The accuracy of women's self-reporting of FGC status among this population was relatively high, with 79% of women having their reported status confirmed by clinical exam, 14% reporting 'don't know' or 'no answer', and 7% incorrectly reporting their status.

c) FGC was found to be correlated with each of the survey's major socio-demographic factors. In a multivariate analysis, FGC was associated, in rank order, with ethnic group, age, religion, and education.

d) A secular decline was found both in overall FGC prevalence, and by major ethnic, religious, and education groups.

e) An analysis of delivery experiences revealed that, whether or not a woman experienced procedures or complications with her first live birth was highly associated with *where* and *with whom* she delivered, independent of other social correlates.

f) Cut women were proportionately more likely than non-cut women to deliver outside of modern health institutions.

g) While a univariate analysis showed an association between FGC and episiotomy, cesarean section, hemorrhage, and the aggregate variable 'no complications', when controlling for the effects of social correlates and delivery place and assistant, there was no difference found in the rates of first delivery complications or procedures between cut and non-cut women. The exception to this finding was the association between FGC and episiotomy, in which cut women were less likely than non-cut women to report episiotomy when delivering at a private hospital.

That place and assistant continue to be statistically significantly associated with obstetric complications, even when additional social factors such as education and religion are controlled for, indicates that place and assistant are not simply proximate determinants for a woman's socio-economic status, and that they exert an independent effect not accounted for by classic measurements of socio-economic status. The findings of this research show that any contribution of type I FGC to obstetric morbidity is questionable, and assertions of such associations deserve close scrutiny for potential confounders by place of delivery.