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Research Article

Attitude and Perception on the Impact of Female Genital Mutilation on Health and Sex Drive among Married Women in Ebenebe, Awka North L.G.A., Anambra State

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Abstract

Background: Female Genital Mutilation (FGM) is a kind of practice which involves the partial or complete removal of female genitalia for non-medical reasons and it leads to so many health problems like infection, keloid formation, difficulty in delivery, shock, etc.

Objective: This study therefore, aimed to investigate the attitude and perception of Female Genital Mutilation in Ebenebe, Awka North L.G.A., Anambra State, Southeastern Nigeria.

Materials and Methods: A cross-sectional descriptive survey was employed in the study and well-structured questionnaires were developed and administered on the respondents. Data obtained were analyzed using descriptive and chi-square statistical analysis.

Results: The result obtained showed that 189 (94.03%) of the interviewed women were aware of the practice of female circumcision in their community. Majority 102 (51.52%) of them reported that FGM practice usually carried out at their native homes and 176 (89.34%) were aware of the health implications of female circumcision. And 68.2% of respondents perceived that FGM is a bad practice and the practice should be abolished. In conclusion, women perceived that FGM is a bad practice because its health implications were relatively high. Therefore, efforts should be made by relevant bodies to encourage policies and programs relating to FGM in terms of abolition, awareness campaign and possible sensitization of the female folks.

Keywords: Attitude; Perception; Female genital mutilation; Traditional birth attendant and knowledge

Introduction

Female Genital Mutilation or circumcision (FGM) or female genital cutting is defined as a partial or total removal of some or all external female genitalia, or other injury on the female genital organs for non-therapeutic reasons [1]. The female circumcision is typically carried out by a traditional circumciser or Traditional Birth Attendant (TBA) using a blade, with or without anaesthesia. Female genital mutilation, which involves the partial or complete removal of female genitalia for non-medical reasons, considered illegal in the UK since 1985 and has been banned in most countries. There are no health benefits rather than harm the female's genital organs. FGM is mostly carried out on girls between the ages of 0 and 15 years. However, adult and married women are also subjected to the female genital mutilation procedure. The age at which female genital mutilation is performed varies with local traditions and circumstances, but is decreasing in some countries [2].

The World Health Organization estimates that between 100 and 140 million girls and women have been genitally mutilated and that every year 3 million girls are at risk of being subjected to FGM (WHO, 2008). Currently, FGM continues to be practiced in 28 countries and in several Asian countries [3,4].

In some African countries and the Middle East where FGM is widely performed, poor hygiene is recorded. There is no anaesthesia, no sterilised equipment to replace rusting blades, which can lead to haemorrhage, shock, septicaemia and tetanus. If the victim survives, she may be left infertile, or suffer complications during childbirth, cysts and recurrent urinary tract infections may always be observed. The FGM was classified into four types depending on the extent of tissue removed. Type I (Clitoridectomy) which is the partial or total removal of the clitoris and in very rare cases only the prepuce (the fold of the skin surrounding the clitoris). Type II (Excision) is the partial or total removal of the clitoris and the 'labia minora' with or without excision of the 'labia majora'.

Type III (Infibulations) is the narrowing of the vaginal opening through the creation of a covering seal formed by cutting and repositioning the inner or outer labia with or without removal of the clitoris and Type IV includes all other harmful procedures to the female genitalia for non-medical purposes such as pricking, piercing, incising, scraping, and cauterizing the genital area. The procedure of infibulation derives its name from the Roman word fibula (clasp), which was fastened through the prepuce of men and labia of women to enforce chastity. While a range of socio-religious issues foster the practice, to this day a conviction that FGM is necessary to control

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women's sexuality exists in many practicing communities [5,6].

There are many reasons for FGM practice. These may be sexual and reproductive reasons which include; inhibiting women's sexual desire and heightening that of men, to increase fertility and assist childbirth [7]. Also, to enhance hygiene and provide aesthetic condition on female purifying the female genitals and removing some part which serve as ugly to male, and they constitute a male organ in a female body; another one is socio-cultural reason social pressure, cultural identity, social status of the family [8] and lastly, religious or related to myths [religious ruling, the clitoris is home to an evil spirit which can grow and become dangerous to men or foetus at birth [9].

In the context of this study, attitude refers to women's opinion or feelings about female genital mutilation, expressed through their behavior. Oxford dictionary [10], defines perception as an understanding and awareness of female genital mutilation, as opposed to practices relating to it or the customary, habitual or expected procedure or way of doing it.

The prevalence of female circumcision, there are relative increase in female genital mutilation in Europe, Australia, Canada and the USA, primarily among immigrants from these countries. According to Ofor and Ofole [11], Countries with high prevalence rates (>85%) are Somalia, Egypt and Mali. Low prevalence rates (< 30%) are found in Senegal, Central African Republic and Nigeria.

Female circumcision is widespread in Nigeria. In Nigeria, a study carried out by Onuh et al. [12] showed that medical knowledge on female genital mutilation/circumcision was limited in nurses and their tendency to support its continuation. It is estimated that more than 50% of Nigerian women have undergone the procedure which are being made to discourage the practice. It is performed among adherents of Islam in the North and among Christians in the South. For example, female genital cutting is rite among the urhobos of Delta State [13,14] and among the Owu Yoruba in Abeokuta [15].

According to World Health Organization [16], stated that female genital mutilation in some countries are usually practiced by trained and untrained personnel who perform the procedure of FGM and untrained personnel used unsterilized equipment such as razor blades and shards of glass. Places where anesthesia is unavailable, the pain is excruciating, it causes physical, psychosexual and sexual problems. The severity of health effects depends on the type of female genital mutilation performed and it is also dependent on the skill of the circumciser, the cleanliness of the tools and setting used, and the physical condition of the girl or woman [16]. According to Ofor and Ofole, [11] the immediate consequences of FGM include: severe pain and bleeding, shock, difficulty in passing urine, infections, injury to nearby genital tissue and sometimes death. In addition to the severe pain during and in the weeks following the cutting, women who have undergone FGM experience various long-term effects which may be physical, sexual and psychological.

Furthermore, FGM is practiced not only by Muslims but also by Christians and Jews [3,9]. FGM is not only a violation of the human right of women and girls, but is also a major health problem, with numerous physical and psychological consequences. Female circumcision has caused a lot of havoc by rendering most women infertile in their life time because of ascending infection following circumcision. Some get Vesico-Vaginal Fistula (VVF), an abnormal fistulous tract extending between the bladder and the vagina that allows the continuous involuntary discharge of urine into the vagina vault. FGM has increased the incidence of death among married women that practice it.

Indeed, studies have documented various gynaecological and sexual health implications associated with female genital cutting [17]. These relate mainly to the more severe form of female genital cutting (infibulations), in which there is severe narrowing and scarring of the vaginal introituses. There are many reports about the high incidence of severe dyspareunia, penetration problems, marital disharmony, dysmenorrhoea and various psychological problems in association with type III female genital cutting on the sexual and reproductive health of women [18,19].

Available evidence suggest that type I and II female genital cutting are more common in Nigeria, and other West African countries [20]. Therefore, little is known about the direction of these effects, especially for women with mild and moderate types of female genital mutilation.

The present study was designed to investigate the attitude and perception of impact of female genital mutilation on health and sexual drive among married women in Ebenebe, Awka North LGA of Anambra State. The study is considered significant if it is able to highlight the truth and myth of desiring female genital mutilation. Consequently, the study will be viable to health practitioners, policy makers, the female folks as well as researchers generally. For the health practitioners, the problem associated with female genital mutilation in the cause of their medical practice will be reduced to the barest minimum. For policy makers, law making bodies will find the result of this study extremely important in drawing up policies and programmes relating to female genital mutilation in terms of abolition, awareness campaign and possible sensitization of the female folks. The female folks will no doubt be exposed to the hazards and health implications of female genital mutilation.

Materials and Methods

This study employed a descriptive study survey which describes the pattern of female genital mutilation among married women in Ebenebe, Awka North Local Government Area, of Anambra State Southeast Nigeria. The studied area comprises of 8 villages (Obuno, Uwani, Umuaba, Okpuno, Amagu, Umuji, Umuogbuefie and Ogolubo). The established health facilities located in four villages are health center in Umuji and Obuno, health maternity home in Amagu and Okpuno, then traditional birth attendants are found in many homes respectively. The population for the study consists of married women from 15 years and above who were living in Ebenebe town as at the time of the study. The study was conducted on 250 married women who gave their consent and they were interviewed with the use of well designed questionnaire. The random sampling methods were adopted in collecting data from the various villages in Ebenebe community. The questionnaire was designed to cover demographic data, attitude, health of the women, and perception of impact of female genital mutilation among married women in Ebenebe community. The questionnaire was administered to people of Ebenebe community on face-face basis and some of them were guided to complete the questionnaires especially those that were not

Table 1a: Socio demographic characteristics of the respondents.

	Frequency					
Item	Obuno	Uwani	Umuaba	Amagu	Umuji	Total
Age (Years)						
15 – 25	0	0	1	2	6	9 (3.6%)
26 – 35	1	2	4	6	4	17 (6.8%)
36 – 45	27	21	25	22	21	116 (46.4%)
46 – 55	13	19	12	11	13	68 (27.2%)
56 – 65	9	8	5	6	6	34 (13.6%)
66 >	0	0	3	3	0	6 (2.4%)
						X^2 = 221.41 (p<0.001)
Marital status						
Single	0	0	0	0	4	4(1.6%)
Married	44	33	36	34	35	182(73%)
Widowed	5	17	12	16	7	57(23.8%)
Divorced	1	0	2	0	3	6(24%)
						X^2 = 336.14 (p<0.001)
Religion						
Christianity	50	39	44	47	43	223(89.2%)
Islam	0	0	0	0	3	3(1.2%)
ATR	0	11	6	3	4	24(9.6%)
						X^2 = 353.77 (p<0.001)

properly educated. The validity of the instrument was reviewed by experts in reproductive health and health educator to ascertain that the contents of the questionnaire achieved the study objective. The reliability of the instrument was approved after a pilot test with 10% of the study population to minimize error due to data collection. The completed questionnaires were sorted out and put in tables that had frequencies and percentages. The generated data were plotted into charts, also analyzed using descriptive statistics and chi-square statistics.

Results

The results of this study, "attitude and perception on the impact of female genital mutilation on health and sexual drive among married women in Ebenebe, Awka North Local Government Area of Anambra State", are presented in the Tables and Charts below. In this study, five communities of Ebenebe were studied. The following socio-demographic characteristics were considered in this study. The age ranges were presented in (Table 1a & 1b) where 36-45 years accounted for the highest number of respondents with 116 (46.4%), while the least number of respondents was 6 (2.4%) for 66 years and above. A chi-square statistical test gave a value of 221.41 with a p-value of 0.001 which was very highly significant at p<0.001. The marital status of the respondents recorded least among single women with 4 (2.2%), divorced was 6 (2.4%), widowed 57 (22.9%) while married women had the highest 182 (73.1%) responses. A chi-square analysis of the marital status gave a value of 336.14 with a p-value of <0.001 which was significant at p<0.001 confidence level. Christianity accounted for the highest number of respondents with 223 (89.2%) followed by African Traditional Religion (ATR) with 24 (9.6%) and Islam had

Table 1b: Shows the educational level and occupational status of the women frequency.

	Frequency					
Item	Obuno	Uwani	Umuaba	Amagu	Umuji	Total
Educational level						
Non formal	1	6	6	3	7	23(9.2%)
Primary	4	7	8	12	6	37(14.8%)
Secondary	40	24	25	25	28	142(56.8%)
Tertiary	5	13	11	10	9	48(19.2%)
						X^2 = 139.86 (p<0.001)
Occupation						
House wife	5	4	6	5	19	39(15.6%)
Artisans	13	11	12	13	8	57(22.8%)
Civil servants	5	10	4	5	7	31(12.4%)
Public servants	5	6	6	5	4	25(10.0%)
Business	20	15	18	20	12	85(34.0%)
Retired Civil Servants	2	4	4	2	0	12(4.8%)
						X^2 = 81.72 (p<0.001)

3 (1.2%). The chi-square value was 353.77 with a p-value of <0.001. Majority of them had secondary education 142 (56.8%) followed by tertiary education 48 (19.2%), primary 37 (14.8%) and non-formal education recorded 23 (9.2%). The chi-square statistics gave a value of 139.86 with a p-value of <0.001. In terms of occupations, business had the highest number of respondents with 85 (34.1%), followed by the artisans 57 (22.9%), next was housewife 39 (15.7%), the least response came from retired civil servants with 12 (4.8%). The chi-square test showed a significant difference with 81.72 at p<0.001.

Table 2 presented the attitude of women towards female circumcision; 201 (80.4%) heard of female circumcision while 49 (19.6%) have not heard of it. A chi-square gave statistical significant of 92.42 at p<0.001. The source of information of the respondents was highest with 173 (86.5%) from those who got their information from their family (immediate and extended), 11 (5.5%) got theirs from peer groups while 16 (8%) got theirs from their own personal experience. A chi-square statistical test gave a value of 254.59 with a p-value of 0.001 which was very significant at p<0.001 probability limit. On the same note, 189 (94.03%) of the interviewed women were aware of the practice of female circumcision in their community while 12 (5.97%) were not aware of the practice in their community. Therefore, it showed a statistical significant with 155.87 at p<0.001. Majority 102 (51.52%) of the women reported that FGM practice usually carried out at native home, maternity home has 92 (46.46%), and hospital has 4 (2.02%). It showed a statistical significant of 174.98 at p<0.001.

Table 3 showed the knowledge of women on female circumcision; 71 (35.68%) reported that female circumcision was done by grandmothers, 26 (13.06%) said native doctors, 6 (3.02%) said doctors and nurses and the highest was recorded on 96 (48.24%) Traditional Birth Attendants (TBA). The statistical test value (101.88) was significant at p<0.001.

The women were interviewed on the type of female circumcision practiced in their community; majority 190 (95%) reported no idea

Table 2: Attitude of the respondents towards FGM.

	Frequency					
Item	Obuno	Uwani	Umuaba	Amagu	Umuji	Total
Have you heard of female circumcision?						
Yes	46	37	44	38	36	201(80.4%)
No	4	13	6	12	14	49(19.6%)
						X^2 = 92.42 (p<0.001)
If yes, the source of information						
School	0	0	0	0	0	0
Family	46	29	35	33	30	173(86.5%)
Peers	0	2	7	2	0	11(5.5%)
Personal experience	0	5	2	3	6	16(8%)
						X^2 = 254.59 (p<0.001)
Is it practiced in your community?						
Yes	46	30	42	35	36	189(94.03%)
No	0	7	2	3	0	12(5.97%)
						X^2 = 155.87 (p<0.001)
If yes, where do they normally stay to carry out the practice?						
Maternity home	26	16	20	17	13	92(46.46%)
Hospitals	0	3	0	1	0	4(2.02%)
Native home	20	18	22	22	20	102(51.52%)
						X^2 = 174.98 (p<0.001)

while the least was on type II with 2 (1%) and it showed statistical difference of 704.2 at p<0.001. The period where the circumcision is being carried out on the born female child within the chosen communities were recorded as follows; at birth had the peak with 166 (83.83%), followed by adolescent with 27 (13.64%), 3 (1.52%) said that its one month after and 2 (1.01%) said it's a week after birth with statistical value of 373.68 at p<0.001.

The (Table 4) depicted the health implications of FGM; 176 (89.34%) were aware of the health implications of female circumcision while 21 (10.66%) said no idea of health implications. A chi-square statistical test gave a value of 121.95 with a p-value of 0.001 which was significant at p<0.001. Large number of women report health implications as infection 157 (31.03%) followed by haemorrahage/bleeding 127 (25.09%) while the least was on keloid formation with 9 (1.78%) of all the responses and it has a statistical difference of 168.8 at p<0.001.

Table 5 presented perception of respondents towards FGM; 145 (73.98%) said that they were circumcised while 51 (26.02%) said that they were not circumcised. It gave a significant value of 168.8 at p<0.001. Also, (65.12%) got their consent from their parents while the least was 8 (4.65%) that got theirs by themselves and it has significant value of 158.28 at p<0.001. Majority 134 (30.45%) of the respondents gave their reason for practicing female circumcision as to fulfill cultural demands while the least percentage (0.90%) of the respondents gave reason as to satisfy peers influence and it has significant value of 296.97 at p<0.001. The perceived practice within the studied community stated that 135 (68.18%) had bad practice,

Table 3: Knowledge of respondents towards FGM.

	Frequency					
Item	Obuno	Uwani	Umuaba	Amagu	Umuji	Total
Who normally does the practice?						
Grand mother	20	15	12	14	10	71(35.68%)
Native doctors	6	3	7	5	5	26(13.06%)
Doctors and Nurses	2	0	0	1	3	6(3.02%)
Traditional Birth Attendants	18	19	23	18	18	96(48.24%)
						X^2 = 101.88 (p<0.001)
Type of female circumcision practice in the community						
Type I - Partial or total excision of the clitoris	1	2	2	2	1	8(4%)
Type II - The excision of the clitoris and the labia minora				2		2(1%)
Type III - The excision of the clitoris, Labia minora, labia majora with stitching and narrowing of the introitus	0	0	0	0	0	0
Type IV - The unclassified type and refers to the mutilation performed on the external genital such as piercing and massaging of any part of the external genitalia	0	0	0	0	0	0
No idea	46	35	40	34	35	190(95%)
						X^2 = 704.2 (p<0.001)
Normal age for circumcision in your community?						
At birth	43	30	40	30	23	166(83.83%)
A week after	0	0	0	2	0	2(1.01%)
One month after	0	0	9	3	0	3(1.52%)
Adolescent	3	7	2	3	12	27(13.64%)
						X^2 = 373.68 (p<0.001)

Table 4: Health implication of FGM on Women.

Item	Frequency					
	Obuno	Uwani	Umuaba	Amagu	Umuji	Total
Any health implication						
Yes	42	31	36	35	32	176(89.34%)
No	4	6	6	3	2	21(10.66%)
						X² = 121.95 (p<0.001)
Observed health implications						
Shock	24	12	23	19	15	93(18.38%)
Haemorrhage/ bleeding	38	15	28	33	13	127(25.09%)
Urinary/Renal problem	17	9	13	17	14	70(13.83%)
Infection	39	21	32	39	26	157(31.03%)
Scaring and keloid formation	2	2	2	2	1	9(1.78%)
Dyspaenuria	6	23	12	8	1	50(9.88%)
						X² = 168.8 (p<0.001)

followed by 54 (27.27%) with a fair practice and 9 (4.55%) reported good practice. A chi-square statistical test gave a value of 123.55 with a p-value of 0.001 which was significant at p<0.001. From the sample respondents; 146 (73.37%) said the practice should be abolished, followed by 29 (14.57%) said they don't know and lastly 24 (12.06%) said that the practice should be allowed to continue and it was significant (143.71) at p<0.001. The measures taken to abolish female circumcision in the studied community had the highest responses on health education with 119 (26.86%), while the least measure was on research for designing effective reforms with 21 (4.74%). It gave a significant value of 132.53 at p<0.001.

Discussion

The general findings of the study titled attitude and perception on the impact of female genital mutilation on health and sexual drive among married women in Ebenebe, Awka North L.G.A., Anambra State". The responses from the interviewed women were high between the age ranges of 36-45 years which is not a common practiced age of the studied women. FGM is mostly carried out on girls between the ages of 0 and 15 years. However, occasionally, adult and married women are also subjected to the procedure. Though, the age at which female genital mutilation in this study was not ascertained but performed FGM in different places varies with local traditions and circumstances and now decreasing in some countries [2]. The highest responses were found among business women which indicated that majority of dwellers are not employed and may be attributed to the fact that it is a rural community. Among the interviewed women, greater number of them got their information through their family (immediate and extended) which was also linked to the rural community.

However, majority of women were aware of the practice type of female circumcision and most of practice was done in the native homes either by grandmother, native doctors or Traditional Birth Attendants (TBA) and more common by TBAs. The idea of their practice was not far from WHO [1] repot, that most women in

Table 5: Perception of respondents towards FGM.

Item	Frequency					
	Obuno	Uwani	Umuaba	Amagu	Umuji	Total
Have been circumcised						
Yes	37	29	35	27	17	145(73.98%)
No	9	8	7	11	16	51(26.02%)
						X² = (p<0.001)
Consented for circumcision						
From Parents	27	17	26	20	22	112(65.12%)
By Self	0	6	0	0	2	8(4.65%)
From Guardian	4	14	3	7	9	37(25.51%)
Husband	0	0	0	0	0	0
No idea	6	0	6	0	3	15(8.72%)
						X² = 158.28 (p<0.001)
Reasons for practicing Female circumcision						
To reduce promiscuity among ladies	29	17	28	24	23	121(27.5%)
To fulfill cultural demands	36	14	34	21	29	134(30.45%)
To satisfy peer's influence	1	0	0	1	2	4(0.90%)
To fulfill spouse demand	3	0	4	3	5	15(3.41%)
To initiate into womanhood	25	20	14	23	24	106(24.09%)
To be able to deliver the baby	0	0	0	0	0	0
To prevent the death of the baby	8	15	11	7	4	45(10.23%)
To satisfy sexual demands	1	0	3	2	9	15(3.41%)
						X² = 296.97 (p<0.001)
Perceive practice of female circumcision						
Good practice	22	22	3	0	2	9(4.55%)
Fair practice	16	12	7	6	13	54(27.27%)
Bad practice	28	23	32	32	20	135(68.18%)
						X² = 123.55 (p<0.001)
Practice should be abolished or allowed to continue						
It should be abolished	27	27	34	30	28	146(73.37%)
It should be allowed	7	5	5	4	3	24(12.06%)
Don't know	12	5	3	4	5	29(14.57%)
						X² = 143.71 (p<0.001)
Measures taken to abolish female circumcision						
Legislative change and advocacy	22	22	21	22	17	104(23.48%)
Health education campaign	27	27	26	27	12	119(26.86%)

Media education	26	26	24	21	14	111(25.06%)
Working with healthcare provider	3	9	2	3	6	23(5.19%)
Advocacy campaign by women	15	13	15	15	7	65(14.67%)
Research for designing effective reforms	4	1	4	4	8	21(4.74%)
						X^2 = 132.53 (p<0.001)

rural area believe that doctors and nurses are not as reliable as to local practitioners because FGM is done for cultural, religious, non-therapeutic, and not medical purposes.

This study indicated that some women have had health implications due to female circumcision where most of them reported infections that lead to complications in urinary system such as bleeding from the vulva because it is richly supplied with blood, keloid formation, and shock; some said dyspaeuria (painful intercourse). This is usually because of the tightness and fragility of the cervix that can result in regular tear during intercourse. According to Hosken [21] reports that infection is common among females that undergone circumcision.

Large number of the studied women were circumcised at different age but is mostly done at birth and they gave their reason as to reduce promiscuity among ladies, fulfill cultural demands, satisfy peers influence, fulfill spouse demand, initiate into womanhood, be able to deliver the baby, prevent the death of the baby and to satisfy sexual demands etc which was in line with the article published by WHO [1].

From the responses of the people, it showed that female circumcision was perceived as a bad practice among women. Although, few people saw it as a fair practice because it's their culture. This study showed that greater number of people wanted female circumcision to be abolished. It was recorded according to Kaso [22] that "harmful practices such as female genital mutilation not only constrain the capacity of children and women to live a healthy and productive life but also undermine their human right". This group of respondents said that measures like legislative change and advocacy, health education campaign, media education, working with healthcare provider, advocacy campaign and research for designing effective reforms should be put in place to ensure female circumcision is abolished in their community.

Conclusion

From the findings in this study it was discovered that majority of the women have knowledge of FGM, perceived that it is a bad practice because of its health implications. It shows that the attitude of married women would significantly influence the practice of FGM.

Recommendations

In the light of this study, the following recommendations were given; relevant to Government organizations in Anambra State should engage in health education campaign, legislative change and advocacy, health education campaign, media education and working with healthcare provider which should be put in place to ensure female circumcision is abolished in the community.

Government should help in drawing up policies and programs relating to FGM in terms of abolition, awareness campaign and possible sensitization of the female folks.

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