DETERMINANTS AND HEALTH CONSEQUENCES OF FEMALE GENITAL MUTILATION (FGM) AMONG CHILDBEARING MOTHERS (CBMS) IN UZO-UWANI LOCAL GOVERNMENT AREA OF ENUGU STATE.

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Abstract

The thrust of the study was to investigate the determinants and health consequences of female genital mutilation (FGM) among childbearing mothers (CBMs) in Uzo-Uwani LGA of Enugu State. Specifically, the study identified four objectives with four corresponding research questions formulated to guide the study. The study adopted the descriptive survey research design. A multi-stage sampling technique of balloting without replacement was used to select 390 CBMs in Uzo-Uwani LGA of Enugu State. Data were collected using questionnaire. Data collected were analyzed using percentages to answer the four research questions. Results showed that educational factors were determinants (52.5%) of FGM; socio-cultural factors were determinants (58.9%) of FGM; .religious factors were not determinants (39.4%) of FGM and CBMs 204 (54.5%) appreciate the health consequences of FGM. Based on the findings, the investigator recommended among other things that all health educators and other health professionals

to counteract through health education programmes all socio-cultural practices associated with FGM and advocacy meetings to solicit the support of political, religious and community leaders in the elimination of FGM.

Key words: *Determinants, health consequences & female genital mutilation*

Introduction

Female genital mutilation (FGM) also called female circumcision or female genital cutting is defined as all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (WHO, 2004). According to Attama (2005), FGM encompasses a number of traditional operations that involve surgical removal or cutting away parts of the female genitalia, whether for cultural or any other non-therapeutic reason. The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending to childbirths.

Obionu (2006) stated that female circumcision is called FGM because of its harmful, physical, psychological and human rights consequences. He further asserted that where female circumcision is performed, it is often done during infancy, childhood or adolescence. FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. FGM also violates a person's right to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

FGM according to Myles (2009) is classified into four major types namely

(1) Clitoridectomy; partial or total removal of the clitoris (a small, and erectile part of the female genitalia) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris). (2) Excision: partial or total removal of the clitoris and the labia minora with or without excision of the labia majora (the labia are the lips that surround the vagina).

(3) Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and

repositioning the inner, or outer labia, with or without removal of the clitoris, and (4) others: all other harmful procedures to female genitalia for non-medical purposes, example, pricking, piercing, incising, scraping and cauterizing the genital area.

FGM has no health benefit, and it harms girls and women in many ways (Ojo, 2004). According to her, it involves removing and damaging healthy and normal genital tissue and interferes with the natural functions of girls' and women's bodies. Immediate complications according to her can include severe pain, shock, haemorrhage, tetanus or sepsis, urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term health consequences as suggested by Ojo can include: recurrent bladder and urinary infections; cysts; infertility; an increased risk of child-birth complications and newborn deaths, and the need for later surgeries.

World Health Organization (WHO), United Nations Children Fund (UNICEF) and the United Nations Population Fund (UNFPA) (1997) issued a joint statement against the practice of FGM. United Nations UN (2008) issued another statement to support increase advocacy for the abandonment of FGM. The report further highlights the increased recognition of the human rights and legal dimensions of the problem and provides current data on the frequency and scope of FGM. Its report also summarizes research why FGM continues, how to stop it and its damaging effects on the health of women, girls and newborn babies. Since 1997, great efforts have been made to counteract FGM, through research, work within communities and changes in public policy: The report presented progress at both international and local levels which includes: wider international involvement to stop FGM; the development of international monitoring bodies and resolution that condemn the practice; revised legal frameworks and growing political support to end FGM, and in some countries, decreasing practice of FGM, and an increasing number of women and men in practicing communities who declare their support to end FGM. The report also indicated that research shows that, if practicing communities themselves decide to abandon FGM, the practice can be eliminated very rapidly

According to WHO (2008), the World Health Assembly passed a resolution on the elimination of FGM, emphasizing the need for concerted action in all sectors – health, education, finance, justice and women's affairs. The report revealed the WHO efforts to eliminate FGM focus on:

advocacy, research and guidance for health systems. Advocacy involves developing publication and advocacy tools for international, regional and local efforts to end FGM within a generation. On research activities, there is need to generate knowledge about the causes and consequences of the practice, how to eliminate the practice. On the other hand, guidance to health systems call for developing training materials and guideline for health professionals to help them treat and counsel women who have undergone procedures. According to the report, WHO is particularly concerned about the increasing trend for medically trained personnel to perform FGM and strongly urges health professionals not to perform such procedures. FGM Act was introduced in UK in 2003 and came into effect in March 2004. The Act makes it illegal to practice FGM in the UK; makes it illegal to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in that country; makes it illegal to aid, abet, counsel or procure the carrying out of FGM abroad, and has a penalty of up to 14 years in prison and/*or* a fine.

UNICEF (2008) stated that majority of cases of FGM are carried out in 28 countries of Africa. In some countries, (e.g. Egypt, Ethiopia, Somalia and Sudan), prevalence rates can be high as 98 per cent. In other countries such as Nigeria, Kenya, Togo and Senegal prevalence rates vary between 20 and 50 per cent. The prevalence rates are associated with some factors or determinants and they vary from the community to community and from country to country.

Hornby (2010) described determinants as a thing that decides whether or how something happen. In the present context, they are factors that bring about FGM. Such factors according to Lucas and Gills (2003) are education, religion and socio-cultural. They further stated that Nigeria being a developing country where majority of the people live below the poverty line, such factors appear to play significant roles for the increase practice of FGM.

According to Mausksch (1981), knowledge is essential to determine both the extent and quality of information that persons have about a particular issue or behaviour before a change can be effectively initiated. Knowledge, according to Okun (1996) is a means towards practice. Manoncout (1996) asserted that education is one of the most frequently used instruments to measure family and individual behavioural status. Bulent and Jannet (1995) stated that better educated young women were more likely not to be

practicing FGM than the less educated counterparts. They however explained that knowledge plays a vital role in the practice of FGM. Edward (1992) asserted that ignorance associated with lack of knowledge of the harmful effects of FGM would make one reject the gospel against the practice of FGM. According to Edward, inadequate knowledge of the harmful effects of FGM influences its practice among people of different classes or group. However, Olise (2007) contended that knowledge or level of education has no significant role in the practice of FGM. According to him, cultural factors and religious belief are major factors influencing the practice of FGM. He maintained that attitude influences practice, therefore individuals or group of people behave the way they want to, simply because of the conviction deep rooted in their socio-cultural beliefs, values and norms.

Religion, according to Olukoye (1988), is a powerful factor controlling the live and attitude of the people who believe in it. It controls not only the practice of FGM but also their political ambition, type of food eaten, types of dress to put on and so on. As there are many religious groups, there are different opinions on FGM which also affect the degree of its practice. Even within the same religious groups, there are individual opinions which depend on the level of commitment and conviction of the person. Though no religious scripts prescribe the practice, practitioners often believe the practice has religious support (WHO, 2005). Religious leaders according to the report take varying positions with regard to FGM; some promote it, some consider it irrelevant to religion, and others contribute to its elimination. Local structure of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice. In a study conducted by Thomas and Maluccio (1995), to determine the effect of religion on the practice of FGM in the Columbia, it was reported that 89.8 percent Roman Catholic women rejected the practice of FGM while 72.4 per cent of traditional religion worshippers accepted the practice of FGM.

Taylor (1971) explained culture as that complex whole which include knowledge; beliefs; acts; morals; laws; customs and any other capabilities and habits acquired by one as a member of the society. According to Ottaway (1980), culture is the configuration of learned behaviours whose components are shared and transmitted by members of a particular society. Hobson (1975) asserted that socio-cultural factors affect the acceptance/adoption and practice of any

health programmes in any given society. According to him, every tribe or ethnic group has some customs and traditions guiding their day to day activities and the people hold strongly to them. He added that since these people hold tenaciously to their traditional beliefs and practices, it will be very difficult for them to accept any other thing outside those views they hold.

In most Igbo societies, according to Ogbalu (1978), the primary support for many years has been the practice of virginity through FGM. He stated that the causes of FGM include a mix of socio-cultural factors within the families and communities. Where FGM is a social convention, the social pressure to conform to what others do and have been doing is a strong motivation to perpetrate the practice. FGM is often considered in many Igbo cultures a necessary part of raising a girl properly, and a way to prepare her adulthood and marriage FGM is often motivated by beliefs about what is considered proper sexual behaviour, linking procedures to premarital virginity and marital fidelity. FGM is in many communities of Igbo community believed to reduce a woman's libido, and thereby is further believe to help her resist 'illicit' sexual acts. Ogbalu further stated that when a vaginal opening is covered or narrowed (type three FGM), the fear of pain of opening it, and the fear that this will be found out, is expected to further discourage 'illicit' sexual intercourse among women with this type of FGM. He concluded by the assertion that FGM is associated with socio-cultural ideals of femininity and modesty, which include the notion that girls are 'clean' and 'beautiful' after removal of body part that are considered 'male' or 'unclean'. This removal is usually associated with some health consequences/ implication.

The consequences of FGM according to Olise (2007) include: severe pain and shock; infection; urine retension; injury to adjacent tissues, and immediate fatal haemorrhage while long-term consequences are extensive damage of the external reproductive system, vaginal and pelvic infection; cyst and neuromas; increased risk of vesico vaginal fistula; complications in pregnancy and childbirth; psychological damage; sexual dysfunction and difficulty in menstruation. According to him, in addition to these health consequences, there are considerable psycho-sexual, psychological and social consequences of FGM. He further stated that the roots of FGM are complex and- numerous and it has not been exactly possible to determine when or where the tradition of FGM originated. The justification given for the practice is multiple and reflects

the ideological and historical situation of the societies in which it has developed. He maintained that the ignorance associated with lack of knowledge of health consequences of FGM is deep rooted in socio-cultural values of the people. These health consequences according to him have jeopardized the fate of many young girls with resultant reproductive health problems.

These reasons cited generally relate to tradition, power inequalities and the ensuring compliance of women to the dictates of their communities. Such reasons as custom and tradition; religion; in the mistaken belief that it is a religious requirement; preservation of virginity; social acceptance especially for marriage, hygiene and cleanliness, increasing sexual pleasure for the male; family honour; a sense of belonging to the group and conversely the fear of social exclusion, and enhancing fertility. These socio-cultural factors are strong determinants that may promote FGM in many parts of our Igbo society.

However, there is neither evaluative study nor basic surveys in literature that focused on determinants and health consequences of FGM among CBMs in Uzo-Uwani LGA. Uzo-Uwani LGA is one of the seventeen LGA's in Enugu State. It is predominantly rural with socio-cultural and poor socio-economic characteristics. WHO (2008) estimated that over 92 million girls from ten years of age and above in Africa have undergone FGM. Uzo-Uwani LGA may not be an exception. This is the gap this study is poised to fill. In the bid to accomplish this task, four principal study questions were posed, thus,

I. What are the educational determinants of FGM in Uzo-Uwani LGA?
2. What are the socio-cultural determinants of FGM in Uzo-Uwani LGA?
3. What are the religious determinants of FGM in Uzo-Uwani LGA?
4. What are the health consequences of FGM in Uzo-Uwani LGA?

Methods

The descriptive survey research design was adopted for the present study. This method was used because it permits the description of the situation in the natural setting (Nworgu, 2006). The population for the study consisted of all CBMs in Uzo-Uwani LGA. The multi-stage sampling technique was adopted and using simple random sampling technique of balloting without replacement, a sample size of 390 CBMs were selected. The sample size was adjudged representative of the population based on Nwanna (1996) principle which stipulated that if the population is in few thousands 10 per cent of such

population may be used as a sample size.

The instrument used for data collection was the questionnaire. The face and content validity of the instrument was established through the judgment of three experts drawn from the University of Nigeria, Nsukka. The investigator and his four research assistants administered the questionnaire to the selected CBMs on the appropriate immunization and infant welfare clinic days. The copies of the administered questionnaire were collected on the spot with a return rate of 95.9 per cent with 374 copies of the questionnaire returned.

Data collected were examined to ensure completeness of information and response. The responses were coded, put into frequency tables, and percentages. Igbokwe's (2008) criterion for describing determinants of non-acceptance of family planning practices was adopted to ascertain determinants of FGM practices. In order to achieve this, a score, of less than 50 per cent was considered "not a determinant" (NAD) and a score of above 50 per cent was considered determinant (D) of FGM practice. The result was presented in Tables and each table was followed by a brief interpretation of its content.

Results

Table 1

Educational Determinants of FGM (N = 374)

Educational determinants	f	%	Decision
Lack of awareness of the consequences of FGM Practices	228	60.9	D
Inadequate Knowledge of reproductive health	218	58.3	D
Inadequate knowledge of the concept of virginity	37	36.6	NAD
Inadequate knowledge of the concept of safe motherhood	198	52.9	D
Inadequate knowledge of the concept of fertility	201	53.7	D
Overall		52.5	D

Table 1 shows that educational factors are determinants of FGM by CBMs as evidenced by the overall score (52.5%) which is more than 50 per cent criterion score.

Table 2

Socio-Cultural Determinants of FGM (N = 374

Socio-cultural determinants	F	%	Decision
FGM reduces sexual urge	224	59.9	D
FGM promotes virginity	23.2	62.0	D
FGM enhances fertility	201	5.37	D
Belief that FGM controls fertility	192	51.3	D
FGM promotes socio-cultural heritage	252	67.4	D
Overall		58.9	D

Table 2 reveals that socio-cultural factors are determinants of FGM by CBMs as evidenced by the overall score (58.9%) which is more than 50 per cent criterion score.

Table 3

Religious Determinants of FGM (N = 374)

Religious determinants	f	%	Decision
Your priest or pastor encourages FGM practice	106	28.3	NAD
Belief that FGM is moral and should be practiced	214	57.2	D
Belief that FGM is from God	102	27.2	NAD
Belief that FGM promotes chastity	193	51.6	D
Belief that FGM promotes Christianity	122	32.6	NAD
Overall		39.4	NAD

Table 3 indicates that religious factors were not determinants of FGM as evidenced by the overall score (39.4%) which is less than 50 per cent criterion score.

Table 4

Health Consequences of FGM (N = 374)

Health implications	f	%
Lack of sexual satisfaction	48	12.8
Poor sexual and marital relationship	56	14.9
Lack of femininity and modesty in womanhood	34	9.3
Sever pain, shock, infection, urine retention and increased risk of vesico-vaginal fistula	204	54.5
Delay marriage and increases infertility	32	8.5
Total	374	100

Table 4 shows that CBMs 204 (54.5%) appreciates the health consequences of FGM. However, other items in the table were very insignificant in causing any health problem.

Discussion

The study focused on the determinants and health consequences associated with FGM practices among CBMs in Uzo-Uwani LGA of Enugu State. The discussion was organized under the following sub-headings

1. Educational determinants of FGM
2. Socio-cultural determinants of FGM
3. Religious determinants of FGM, and
4. Health consequences of FGM

Educational Determinants

The findings in Table 1 showed that educational factors were determinants of FGM in the area of study. The result was expected considering the location of the study which is predominantly rural with poor socio-cultural characteristics of the CBMs. The finding supports the view of many literature assertions. Mausksch (1981) stated that knowledge is essential to determine both the extent and quality of information that a person has about a particular issue or behaviour before a change can be effectively initiated. Bulent and Jannet (1995) asserted that better educated CBMs were more likely not to be practicing FGM than the less educated counterparts. They however, explained that knowledge plays a vital role in the practice of FGM. Knowledge is a means towards practice (Okun, 1996). The implication of Okun's assertion is that one cannot indulge in any health behaviour without having basic knowledge of such health issue. Thus, lack of

knowledge played a significant role among CBMs in the practice of FGM in the area of study.

Socio-cultural Determinants

Consistent with expectation, the result in Table 2 reveals that socio-cultural factors are determinants (58.9%) of FGM in the area of study. The result was not unexpected considering the poor socio-cultural characteristics of the people. Furthermore, the area of the study is predominantly rural with poor socio-economic features resultant outdated, non-health profit oriented behaviours. This finding was in line with the assertion of Ogbalu (1978) who stated that the primary support for many years has been the practice of virginity through FGM. He contended that the practice of FGM include a mix of socio-cultural factors within families and communities. According to him, where FGM is a social convention, the social pressure to conform to what others do and have been doing is a strong motivation to perpetrate the practice. He further stated that FGM is often considered in many Igbo cultures a necessary part of raising a girl properly, and a way to prepare her for adulthood and marriage. Similarly, UNICEF (2008) reported that majority of the cases of FGM are carried out in many countries of Africa. The report further stated that the prevalence rates are associated with socio-cultural factors and they vary from community to community and from country to country. According to the report, FGM is often motivated by beliefs about what is considered proper sexual behaviour, linking procedures to premarital virginity and marital fidelity which are deep rooted in some socio-cultural practices.

Religious Determinants

The results in Table 3 indicated that religious factors were not determinant (39.4%) of FGM in Uzo-Uwani LGA. This finding was surprising considering the fact that many FGM practitioners often believe the practice has some religious support. However, according to WHO (2005) religious leaders take varying positions with regard to FGM; some promote it, some consider it irrelevant to religion, and .others contribute to its elimination. The 'result was' in agreement with Thomas and Maluccio (1995) who reported that 89.8 per cent of Roman Catholic women rejected FGM in Columbia. This could be perhaps why religious factors were not determinant as majority of the dwellers in Uzo-Uwani LGA are Roman Catholic worshippers. It could be in the realization of the above assertion that,

Olukoye (1988) had earlier stated that no religious scripts prescribe the practice of FGM. According to him, as there are many religious groups, there are different opinions on FGM which also affect the degree of its practice. Even within the same religious group, he added there are individual opinions which depend on the level of commitment and conviction of the person.

Health Consequences of FGM practice

The findings in Table 4 showed that CBMs 204 (54.5%) appreciate the health consequences of FGM. The result was unexpected considering the poor educational, socio-cultural and socio-economic characteristics of the people in the area of study. The result was in line with the assertion of Olise (2007) who stated that the health consequences of FGM are deep rooted in socio-cultural values of the people. He maintained that the health consequences of FGM have jeopardized the fate of many young girls with resultant reproductive health problems. He further stated that in addition to these health consequences, there are considerable psycho-sexual, psychological damage, sexual dysfunction and difficulty in menstruation.

Conclusion

Based on the findings and discussions, the following conclusions were made:

1. Educational factors were determinants of FGM.
2. Socio-cultural factors were determinants of FGM.
3. Religious factors were not determinants of FGM.
4. CBMs 204 (54.5%) appreciate the health consequences of FGM

Recommendations

Based on the findings and conclusions, the following recommendations were made.

1. Advocacy meeting to solicit the support of political, religious, and community leaders in the elimination of FGM.
2. Since FGM is deeply rooted in culture, CBMs should be informed and educated that the female external genitalia are designed for some specific purposes and not nature's mistake.
3. Both men and women should be enlightened through health education on the numerous dangers of FGM.
4. Both state and local government should make laws against FGM practice and such legislation demonstrate the government's commitment to the elimination of FGM.

5. Provision of alternatives to FGM where communities may still perform initiation ceremonies without performing the mutilations and during such occasions, gift may be exchanged and the values of good moral behaviours reinforced.

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