Life-Threatening Cultural Practices That Are Health Risk: The Dilemma Of Female Genital Mutilation

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Abstract
This study was concerned with life-threatening cultural practices that are health risk: the dilemma of female genital mutilation. It was carried out in Oron and Uruan Local Government Areas of Akwa Ibom State, Nigeria. A total of 460 literate adults (230 males and 230 females were randomly selected from a stratified socio-cultural population. A validated likert format questionnaire was used for data collection. A test retest reliability coefficient of 0.79 was obtained. The descriptive analysis was used for the frequency distribution. The results showed that female genital mutilation was practiced in the Local Government Areas through traditional methods. This practice continued because of the culture and tradition of the people which encouraged the practice.

Introduction

All socialites have norms of care and behaviour based on age, life stage, gender and social class. These norms often referred to as cultural practices may be beneficial or harmless, but some may be harmful (Olumba 2005). Those cultural practices relating to female children, relations between women and men, and marriage and sexuality often have a harmful effect on women and girls. To many people the phrase" female circumcision" or "female genital mutilation" brings to mind an exalted cultural practice which needs to be protected from contamination of western medicine. To others, it is an exotic repugnant, debarring and cruel practice. It is therefore not surprising that this practice rather than being remote and extinct, is in fact being continued in over 40 countries of the world and affect 74 million women (Mclean, 1985).

One deeply rooted cultural practice that has severe health consequences for girls and women is female genital mutilation (FGM) some times called female circumcision. Female genital mutilation comprises all the procedures involving practical or total removal of the external genitalia or other injury to the female genitalia organs whether for cultural or other non therapeutic reasons. In cultures where it is an accepted norm, female genital mutilation is usually performed by traditional practitioners generally elderly women in the community specially designated for this task or traditional birth attendants who use crude instruments and without anaesthesia. In some countries, health professionals-trained midwives and

physicians increasingly perform female genital mutilation. It is a practice in which culture of the area determines the age at which the surgery is performed. Hosken (1978) as quoted by Agwubike and Edeoghon (1997) observed that in Ethopia, female infants are circumcised within the first few days of life. In Sudan, Greunbaum (1982) found that the age of surgery is 12 years while in some other parts of Africa, surgery is performed as part of puberty rites. Though female circumcision is widely practiced among Moslem populations, Shaw (1985) noted that there is no direct edict in the religions which demand female circumcision.

However, among the Oron and Uruan people of Akwa Ibom State of Nigeria, female genital mutilation has persisted despite the rigorous campaign against it by modern health care providers. Female genital mutilation involves a variety of procedures with degrees of severity as imputed by Olafimihan (1993) who identified three basic ways of female genital mutilation and a fourth by Post (1995). The simplest from of the practice called Clitoridectomy involves the cutting of the clitoris, the second procedure (excision) involves the removal of the entire clitoris and the adjacent parts of the labia minora. The third and the most extensive of the procedures is called infibulations. Infibulations involves the surgical removal of the whole clitoris, all of the labia minora and parts of the labia majora. The remainder of both sides of the labia majora are joined by the use of sutures to form a wall over the vagina while a small opening is maintained for the flow of urine and menses by the insertion of a small match stick or rod until healing takes place. The fourth type of female genital mutilation encompasses a variety of procedures, most of which are self explanatory. Post (1995) described two procedures, angurya cuts (ie, the scraping of the tissue around the vagina opening) and gishiri cuts (ie., posterior or backward cuts from the vaginal outlet to relieve obstructed labour). They often result in vesicovaginal Fistulae (VVF) and damage to the sphincter. The procedures described above are irreversible and its effects last a lifetime (WHO, 1998).

Some complications associated with such surgery include tetanus, shock, sepsis, haemmorrhage, retention of urine and later retention of menstrual flow as observed by (Shaw 1985). Agwubike & Edeogho (1997) noted that for many of the infibulated women, the scar must be practically opened to allow sexual penetration at the time of marriage. It also often results in laceration, infections, bleeding, painful intercourse, anterior episiotomy, child birth in infibulated women, Keloid formation, fistulas of varying types, cytoceles, rectocele, dysmenorrhea, pelvic inflammatory diseases and infertility as opined by Aziz (1980). Mental health complication such as frigidity, dysp-areunia and anxiety are common are after effects of female circumcision.

These complication not withstanding, the practice continues for a variety of reasons because it is erroneously believed that female circumcision controls a woman's sexuality, prevents her from being sexually promiscuous and preserves the honour and integrity of her male relatives. In some areas, it is a common belief that

unless the clitoris is cut, it will grow, become ugly and impede intercourse, and may even injure new born babies during delivery.

In order to address this ugly practice and probably curb the excesses of this conflicting belief and practice, a research such as the present one is imminent. Incidentally, neither evaluative studies nor basic surveys to the best of the knowledge of the researcher exist in literature that cover Akwa Ibom State, Nigeria. The present study was set out to fill this gap. In bid to accomplish this task, some principal study questions were formulated thus: which is the type of health personnel used to perform female genital mutilation; health problem; behavior change; and reason for perpetuating the act.

Methods

Respondents

A total of 460 literate adults, comprising of 230 males and 230 females randomly selected from a strata of socio-cultural backgrounds in Oron and Uruan Local Government Area of Akwa Ibom State formed the respondents for the study. The choice of the two local government areas was because these are areas where the act persist most. The age range was 20-60 years. The choice of range is consistent with Badri (1984) that ages of respondents do not influence their attitude toward female circumcision.

Instrumentations and Analysis

The instrument for data collection was a validated likert format questionnaire self constructed and used to elicit information from the respondents. The reliability of the questionnaire was obtained through a test-retest which yielded a co-efficient of 0.79. The questionnaire was divided into two sections: A and B, section A dealt with bio-data of the respondents while section B focused on the life threatening cultural practices that are risky health-female genital mutilation. The five-point likert scale format of strongly Agree (SA), Agree (A) Undecided (UD), Disagree (D) and Strongly Disagree (SD). The SA and A responses formed the positive responses, the undecided stood for neutral, the D and SD responses formed the negative responses and the responses were weighted accordingly. The data were descriptively treated by using relative frequency distribution as indicated in labels 1-4.

Results

Table I: Choice of Health Personnel used to Perform (FGM n=460

Type of Health Personnel	Responses			
	Positive	**Neutral**	**Negative**	**Total**
Surgeon	34(7.4)	6(1.3)	12(2.6)	52(11.3)
Nurse	32(7.0)	4(.9)	14(3.0)	50(10.9)
Herbalist	56(12.2)	16(3.5)	30(6.5)	102(22.2)
Traditional Midwife	116(36.1)	18(3.9)	34(2.6)	208(47.4)
Others	20(4.3)	6(1.3)	12(22.2)	38(8.3)
Total	308(67.0)	50(10.9)	102(22.2)	460(100)

( ) percentages

Data in table I show that 308 (67.0) of the respondents accepted the existences of female genital mutilation in Oron and Uruan Local Government Area irrespectively of the types of health personnel that carried out the surgery 48.3% of the respondents admitted the high patronage given to trado- medical personnel (36.1% traditional midwives and 12.2% herbalists) in performing female genital mutilation in the areas. The respondents attested to the fact that orthodox surgeons (7.4%) and traned nurses (7.0%) were responsible for carrying out the mutilation. The 10.9% that could not testify to the specific personnel that performed the surgery revealed the level of some peoples ignorance with regard to health care providers in the Local Government Areas. These findings confirmed the practice of female genital mutilation but also laid credence to the importance of trado-medical health care or services provided in the area.

Table 2: Health Problems Associated With Fgm

Type of Health Problem			Responses	
	Positive	**Neutral**	**Negative**	**Total**
Medical or health	48(10.4)	10(2.2)	24(5.2)	82(17.8)
Psycho-social	38(8.3)	3(1.30	14(3.0)	58(12.6)
Gynecological/ Obstetric	62(13/5)	14(3.0)	16(7.0)	108(23.5)
Reduction in Sexual Desire/ Promiscuity.	62(13.5)	26(5.7)	124(27.0)	212(46.1)
Total	210(45.7)	56(12.2)	194(42.2)	460(100)

( ) Percentages

Data in table 2 shows that (45.5%) indicated that the respondents were aware that female genital mutilation is associated with varied problems. 10.4% of the respondents affirmed that medical or health problems results from such a practice while 13% each positively responded to psycholosocial and gynaecological or obstetric problems as part of the consequences. The fact that 27% refuted the

assumption that female genital mutilation reduces sexual desire or promiscuity suggest the high knowledge of the respondents towards the falsity of such a belief.

Table 3: How to influence behaviour change toward FGM

Influence Methods	Responses			
	Positive	**Neutral**	**Negative**	**Total**
Adequate Publicity	50(10.7)	10(2.2)	8(1.7)	68(14.8)
Adequate Health Education	78(17.)	20(4.3)	34(7.4)	132(28.7)
High literacy Standard	2(.4)	2(.4)	10(2.2)	14(3.0)
Change in Cultural values and Practices	120(26.1)	36(7.8)	28(6.1)	184(40.0)
Change in Religions Inclination	4(.9)	2(.4)	14(3.0)	20(4.3)
Functional Prohibitive, law or Legal ban	10(2.2)	6(1.3)	26(5.7)	42(9.1)
Total	246(57.4)	76(16.5)	120(26.1)	460(100)

(   ) Percentages

Data in table 3 shows that 246 (57.5%) of the respondents were aware of the possibility of positively influencing behaviour change toward female genital mutilation. It also indicates that it's the peoples view that the practice should be reduced or rejected entirely if there was a change in cultural values and practices as indicated by (26.1%) through health education (10.7%) and adequate publicity (10.9%) as to its consequences. Other less determinants in the rejection of the dehumanizing practice included religious beliefs (.9%), legal ban (2.2%) and high literacy standards (.4%).

Table 4: Why perpetuate FGM

Reasons	Responses			
	Positive	**Neutral**	**Negative**	**Total**
Aesthetic or Cosmetic	36(7.8)	20(4.3)	26(5.7)	82(17.8)
Socio-culture	154(33.51)	12(7.0)	18(3.9)	204(44.3)
Religious	4(.9)	28(6.1)	10(2.2)	42(9.1)
Health or medical	6(1.3)	0(0)	52(11.3)	58(12.6)
Legal or political	6(1.3)	2(.4)	16(3.5)	24(5.2)
Ethical	36(7.8)	8(1.7)	6(1.3)	50(10.9)
Total	242(52.6)	90(19.5)	128(27.9)	460(100)

Percentages

Table 4 indicates that 242 (52.6) of the respondents admitted that the perpetuation of female genital mutilation in the areas understudy was as a result of reasons such as socio-cultural practices (33.5%) as the main force. Religion (.9%), political or legal (1.3%) and health or medical (1.3%) were not powerful.

Discussion

The present study indicates the fact that female genital mutilation continues to exist in Oron and Uruan Local Government Area of Akwa Ibom State, Nigeria and is being performed mostly by traditional midwives and some medical personnel. The implication therefore is that trado-medical health care is given prominence. This agrees with the findings of Badri (1984) Agwubike and Edeoghon (1997), Olumba (2005) at an earlier finding in a study carried out at Ibadan Oyo State, Esan community-Edo State on female genital mutilation which revealed that female genital mutilation is still widely practiced and favoured by some proportion of Nigerians.

The present findings indicate the respondents great knowledge of the consequences of female genital mutilation is in agreement with Agwubike and Edeoghon and Olumba (2005) but at variance with Olafimihan's (1993) claim that the consequences are generally unknown by the practitioners or the consumers, except to health professionals and health workers involved in maternity care in the area where these operations are practiced. In his further submission Olafimuhan (1993) asserted that neither the adults who continue today to perform these operations, nor the young upon whom these operations are performed, are aware of the health damage involved and the psychological trauma that these operations cause. Some complications include haemorrhage, El Daeer (1982), anaemia, Fleischer (1975), injury to the urethra, the vagina, the perineum or the rectum (Sami 1986). This agrees with Hosten (1979) conjecture that tradition is always the reason given anywhere in Africa for practicing female genital mutilation on children, who most often are subjected to these operations by force.

The result also show that the people recognize the need for change in their attitude and practices. This does not keep them in dark or skeptical about the outcome of their behaviour. Until people understand and appreciate that they themselves are solely to blame for the continuation of their practice of female circumcision in the community, and really want to stop it, the practice will continue (Agwubike & Edeoghon 1997). If this life –threatening cultural practices must be stopped, it should be viewed as a public health problem. The rejection of the practice can be assured if there is a change in cultural values and practices as well as adequate health education and publicity. From the results, people regard legal ban, change in religious inclination, and high literacy standard as less influential factors to guarantee people's change of attitudes and to practices of female circumcision. Legal ban, therefore is not a good strategy for behavioural change.

Conclusion and Recommendations

It must be recognized that women are frequently preoccupied with ensuring their own and their families survival and may not see female genital mutilation as an immediate priority. The elimination of female genital mutilation is also a step toward the achievement of gender equity, equality and women's empowerment (Olumba 2005).

Seeing it as part of a broader effort to improve womens status and health including their sexual and reproductive health, may give it wider appeal. Efforts toward elimination of the practice should also be included in the programmes for adolescent and child health, family planning and safe motherhood.

Organization and individuals have attempted community-based activities aimed at eliminating female genital mutilation. While there is not a great body of successful experience, those involved in action against female genital mutilation have agreed to the overall approaches to be taken in line with the resolution of the United National General assembly (1979) as follows:

1. Adoption of clear national policies for the abolition of female genital mutilation including where appropriate, the enactment of legislation to prohibit it.
2. Establishment of interagency teams that bring together representation of relevant government ministries, non-governmental organization and associations to ensure action to eliminate female genital mutilation.
3. Support for research into all aspects of female genital mutilation, including incidence, prevalence, the main reasons why it continues to be practiced and health consequences, as well as operation research on interventions for eliminating it.
4. Organization of strong community outreach and family life education, village and religious education programme that involves religious leaders and address the main reasons for continuing the practice.
5. Use of consistent messages and all available channels to communicate information to all sections of the public (mass media, popular music, drama and crafts, group discussion sessions) as well as one to one counselling have been successfully used to target women and men, old and young, community leaders and family members.

The components of such an education programme should be relevant to the culture and environment of the people.

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