FEMALE GENITAL MUTILATION : PERCEPTIONS AND BELIEFS IN A NIGERIAN RURAL COMMUNITY

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ABSTRACT

Female genital mutilation (FGM) is a cultural practice prevalent in some parts of the African sub-region and in Nigeria. FGM includes damages done to or inflicted on the female reproductive organ by cutting, tearing or breaking off any part of it. This act predisposes women to ill-health hence must be seen and treated as a major public health hazard, and a social problem.

FGM is customarily supported, and deep-rooted . It also constitutes a violation of the human rights and privacy to which women are entitled. This study investigated the knowledge, beliefs and perceptions of FGM in Iwasi village situated in Ogun State, Nigeria. FGM beliefs, views and knowledge among the Iwasi community dwellers were documented, while strategies for eradicating FGM were also enumerated.

INTRODUCTION

Female genital mutilation (FGM) remains a popular cultural practice in many cultural groups in Africa. Ajayi (1196) describes Female genital mutilations as the partial or total removal of the Female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons. Like most controversial issues, FGM lacks a generally accepted definition. The existence of many discreprancies in the way FGM is described by different authors has been highlighted earlier (Toubia 1995).

There are three main types of FGM. Clitoridectomy : Partial or total removal of the clitoris; Excision : removal of the clitoris and part of the outer lips of the vagina ; and infubilation : removal of all the above and

sealing of the wound leaving only a tiny opening for urination and menstruation (Arkutu 1995, Toubia 1995, Brooks 1996).

Nigeria has the highest number of FGM victims in the world with about 32.8 million (60%) women circumcised as at 1994 (UNICEF 1996, Eferaro 1996). FGM continues to be taken for granted by many people in the southwestern states of Oyo, Ondo, Ekiti, Ogun, Ajayi (1996), and those in the Midwest areas stretching form Edo to Delta states. Also, FGM is widespread in Northern Nigeria (Murphy et al 1981, WHO 1995).

This painful practice may be performed on baby girls, girls nearing puberty, adolescents, and sometimes on grown up women right before or after delivery (Arkutu 1995). The Eritrean position as presented by Brooks (1996), shows that genital mutilation is a routine violence inflicted against girls by age eight with an unsterilized knife. Similarly, Givens (1985) reported that girls are mutilated as early as age four in Mali while in Ghana female circumcision is a very deep rooted cultural practice usually with associated ritualism.

Worldwide, approximately two million girls are mutilated every year. Nigeria, Egypt, Sudan, Somalia, Kenya and Ethiopia reportedly accounted for 75% of all cases. In Djibouti and Somalia however, 98% of the girls are mutilated (UNICEF 1996).

Apart from anxiety and excruciating pain, other consequences of FGM include prolonged bleeding, infections and death (Kiragu 1995, El Saadawi 1998, Hosken 1993). Also victims of FGM often experience prolonged or obstructed labor later in life (Brooks 1996).

Thus, FGM situates in a proper perspective the enormous connection between culture and health. This customary behavior not only greatly endangers the health of women (Toubia 1995) but also threatens Feminity and motherhood in their totality. Mutilation of the Female reproductive organ or any part of it is also a violation of the human rights and privacy which women are entitled to.

Often justified with doubtful and illogical cultural arguments, FGM has medical, psychological and economic implications for females and the

society. It therefore serves as an appropriate subject of socio-medical investigation.

METHODS

THE STUDY VILLAGE, Iwasi, is located in Ijebu East Local Government Area of Ogun State, Nigeria. Indigenes of this village belong to the Yoruba ethnic group with agriculture as their main preoccupation. The population of the village was 120.

The roads leading to Iwasi are untarred from Odolewu the nearest village to the road leading to Epe town and from Owoye on the Benin-Ore Express road. Portable water, health care facilities and educational institutions are lacking in this community. However, it is linked with the national grid (electricity). The selection of the study village, was in part due to the fact that FGM is known to be more prevalent in rural areas and in part based on familiarity with it.

In December 1995, in-depth interviews on FGM were conducted with 30 respondents (15 women and 15 men). The respondents were aged from 30 - 65 years. The importance and contribution of in depth probing in understanding local values and beliefs system have been well demonstrated (Buzzard 1985, Axlinn et al 1991). Participation in the study was strictly on voluntary basis. The study was on a small scale largely due to economic and personal constraint. A copy of the in-depth interview guide is provided in the appendix.

RESULTS

The most striking finding of this study was that respondents described FGM as female circumcision and believed it to be an equivalent of male circumcision. Respondents also identified FGM simply as a cultural obligation and a cleansing rite common in certain parts of Nigeria. Furthermore, a substantial number of the respondents reported that there are female as are male FGM practitioners, thus indicating the nonexistence of gender preference in the occupation.

Interestingly, respondents described the scene of FGM as involving the following : spreading of a white cloth on a table or any platform,

sprinkling palm oil round the white cloth, placing the baby girls on the white cloth, mutilating her reproductive organ(s) and rubbing the mutilated site with sliming secretion from a snail."

Majority of the respondents in the study agreed that FGM practitioners undergo some training. Additionally, the frequency cited consequences of FGM were temporary pain sensation, loss of blood and fatigue. Another finding of this study was that all respondents said they would oppose a request to mutilate their daughters, while female ones married from areas where FGM is greatly practiced (Oyo and Ondo states) said they would welcome such a request whole-heartedly.

A substantial number of the respondents reported mockery, loss of respect and reduced marriage offers as social sanctions imposed against non-circumcised females in cultures where FGM is practiced. Finally, most respondents said the eradication of FGM by government might be problematic because it is deeply embedded in culture while the female ones married from FGM practicing cultures felt the question of eradication was unnecessary.

DISCUSSIONS

Although FGM is not practiced in Iwasi community, indigenes are knowledgeable about it and some female respondents married from other cultures to Iwasi men have unflinching support for it. Proponents of genital mutilation in other studies Hosken (1993), Toubia (1993), contend that it has aesthetic, purifying or hygienic benefits, this is similar to the belief of respondents in this study. However, the main rationale behind FGM, namely the need to control female sexuality can easily be faulted. This reason which was also documented by Artuku (1995) is chauvinistic. Apart from FGM, social control over women's sexuality has taken various other forms such as criminalisation of abortion, forced marriages and demographically driven population control programmes -all with impact on fertility control (Ravindran 1995). According to Artuku (1995), FGM is even performed to enhance the sexual pleasure of men. This thus confirms Klein 's (1995) position that double standards are everywhere and that inequalities between men and women have been institutionalized. Similarly, some respondents reported that mothers who

are likely to resist their daughters' mutilation are sent on errand while the operation is performed.

Further, most of the respondents explained that people who practice FGM believe that the presence of the clitoris causes obstructed labor and foetal mortality. However, medical knowledge antagonizes this assertion, studies by Brooks (1996) Toubia (1995) even associated prolonged labor with female genital mutilation.

Interestingly, FGM practitioners often undergo rudimentary training WHO (1982), nevertheless, their clients are susceptible to enormous risks. In Northern Nigeria and in parts of Africa the traditional practice of cutting the vagina causes fistulae (Murphy et al 1981, Tahzib 1983). These cuts, called 'gishiri' cuts are performed to facilitate childbirth. Women who have fistulae (tears between the vagina and bladder or between the vagina and rectum) leak urine and/or faeces continuously, fistulae victims are usually rejected by their husbands and communities (WHO 1986, Elkins et al 1988, and kwasi 1988). Fistulae corrective surgery is available in Nigeria Tahzib (1983), but the procedure is expensive and with the biting economic depression, it is unlikely that most victims can afford it. Still, fistulae sometimes re-open after childbirth (Evoh and Akinla 1987).

A striking discovery of the study was the belief by a few female respondents (those married from cultures where FGM is practiced) that the use of identical instrument(s) in mutilating daughters ; and in incising their mother's bodies, serves an anesthetic function for such daughters, Ironically many studies (Winsbury 1992 ; WHO 1992), had documented the risk of HIV and other infection through sharing of skin piercing instruments.

This total disregard for aseptic procedures has also been documented among senior Medical Professionals in sterilization camps in India (Ramanathan et al, 1995). These authors observed the use of a single linen bed cover for about 48 sterilization procedures, and the use of the same gloves by surgeons during the course of the day's surgery, in spite of the availability of numerous sterilized others.

Also, the practice of rubbing the mutilated site with sliming secretion from snails which was reported by respondents, is unwholesome and holds risks for infections. Furthermore, a conspicuous but disturbing component of the FGM problem in Nigeria, is the involvement of some orthodox doctors and nurses Toubia (1995); this is mainly for economic reasons. This medicalisation of the procedure has been strongly condemned by WHO (Kiragu 1995). Additionally, international organizations such as the United Nations Children's Fund (UNICEF), have condemned FGM (UNICEF 1994, Kiragu 1995).

Genital mutilation has a context and may be placed firmly within a continuum of global gender oppression that includes from Dawits' (1993) position, the murder of female children, less health care for girls, child marriage and early pregnancy. Researchers working on FGM must have an understanding of this connectedness for their efforts to be effective because FGM is so entrenched in some societies, legislations alone are unlikely to abolish it. For example, even though the operation has been banned in Britain since 1988, it was still performed as late as 1992 (Brooks 1996). In Egypt and Sudan, the practice persists despite the existence of legislations against it (Ladjali and Toubia 1990).

In Nigeria, the local Inter-African committee on Traditional Practices Affecting the Health of Women and Children (IAC) spearheads anti-FGM work. This is by training traditional birth attendants who in turn train their colleagues all over the country. The National Association of Nigerian Nurses and Midwives (NANNM) has also mobilized its members to educate the public through plays and similar performances. Also NANNM, with assistance from the Program for appropriate Technology in Health (PATH), works to keep the attention of the news media Focused on FGM (Guilbert 1993 ; PATH 1991).

RECOMMENDATION

In the light of its findings, the study wishes to recommend as follows :
Women must be empowered through access to critical educational and economic resources. This will in turn be used to influence persons and institutions with divergent views on FGM. The empowerment of women must incorporate the support of men so that they are not antagonistic to the process.

There should be public and grassroots enlightenment campaigns against FGM, with information dissemination on its complications and consequences.

Grassroot communities must be sensitized against FGM in order to correct the misconception that FGM is equivalent to male circumcision. This will also prevent FGM from eroding the culture of communities where this practice does not yet exist.

FGM practitioners must be provided with alternative employment or be trained for effective absorption into such to ensure their support for eradication.

In conclusion, a realistic attempt to eradicate FGM must involve the collaborative efforts of government, non governmental organizations, health providers, FGM practitioners, key figures in rural communities and traditional as well as religious leaders.

In-depth Interview Guide

Title : Female Genital Mutilation : Perceptions and beliefs in a Nigerian Rural Community.

1. What do you understand by Female Genital Mutilation ?
2. What reasons inform the practice of FGM ?
3. By whom and how is FGM done ?
4. Do you Feel FGM practitioners undergo any training ? If yes, how adequate is this ?
5. Are there social/medical consequences of FGM ? If yes mention such consequences ?
6. How would you react to a request to circumcise your daughter ?
7. What are the likely social sanctions against uncircumcised females in communities where FGM is practiced ?
8. How do you feel women in other cultures can avoid FGM ?
9. How can the government help in eradicating the practice of FGM ?

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