LEVEL OF KNOWLEDGE AND PRACTICE OF FEMALE GENITAL MUTILATION (FGM) AMONG LITERATE WOMEN THAT ATTENDED HEALTH CENTRES IN EZEAGU LOCAL GOVERNMENT AREA IN ENUGU STATE

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Abstract

This study investigated the level of knowledge and practice of Female Genital Mutilation (FGM) among literate women that attended Health Centres in Ezeagu Local Government Area in Enugu State. A cross-sectional survey research design was used for the study. Four research questions guided the study. The population consisted of 255 literate women that attended the six health centres at the time of the study. A sample of 255 literate women that attended the Health Centres at the period of study (April to June 2012) responded to the questionnaire. They formed the sample size because the population was manageable. A 25-item questionnaire was constructed by the researcher. Face validation of the instrument was obtained through the judgement of three experts in Health and Physical Education. A reliability index of .86 was obtained through the outcome of a pre-test using Kuder-Rechardson formular (K-R 2020). Out of the 255 copies of the questionnaire administered, 250 usable ones were used for the study. Frequency table and simple percentage were used to answer the research questions. The study revealed that the respondents possessed average level of knowledge on the Types of FGM, high level of knowledge on the Reasons for practicing and Health consequences of FGM, and very high knowledge on the measures for eradication of FGM. The study recommended among others that educational efforts geared towards the girl-child, women and men should be directed at eliminating the practice of FGM.

Introduction

Female Genital Mutilation (FGM) also called female circumcision (FC) or female genital cutting (FGC) is a traditional practice that started in Africa over 2000 years ago and in many parts of the world. It may be termed a traditional practice since it is believed culturally that a girl will not become a woman without this practice. In most cultures a woman cannot marry without Female Genital Mutilation. FGM is a cultural identity practice (http://wolvessdeams.tripod.com/fmg.html). Olakekam (2007) stated that it is a traditional practice of subjecting females to either partial or total genital cutting of the external reproductive organs. FGM is widely performed and generally recognised all over the world. The practice is performed on girls and women by the members of their families in the belief that what they are doing is good and necessary for the child as well as the family (Nnachi, 2007). FGM is

mostly performed at the early ages of the girl when they have no opinion of their own and when the pain and the trauma will be less felt. Female Genital Mutilation (FGM) is a procedure that involves partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (World Health Organization, 2010). World Health Organization (WHO) estimates that 100-140 million women and girls around the world have experienced the procedure. WHO (2007) conducted a survey on 28,373 women who gave birth between 2001 – 2003 at 28 hospitals in Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan. It was discovered that three quarter of the women had genital mutilation of varying degrees. Manhara (2004) revealed that FGM is still broadly practised among ethnic and religious groups in Nigeria. It is practised by most ethnic groups, particularly in the southern part of the country (Ajayi, 1997). In most rural communities where female genital cutting is practised, the exercise is usually performed by traditional birth attendants or other traditional health practitioners (Olakekan, 2007). The practice is mostly performed by people that have no form of medical training (htt://www.upenn/pennpress/book/doc/4221). They perform the surgery without anaesthetics and with unsterilized crude instruments like broken glass, a tin lid, razor blades, knives, scissors or any other sharp object (http://wolvessdeams.tripod.com/fmg.htm)l. They have no knowledge of the use of medico-surgical instruments.

Female Genital Mutilation has been classified into four types by WHO (1995): Type I, Partial or total removal of the clitoris (clitoridectomy); Type II, Excision: Partial or total removal of the clitoris and the labia minora with or without excision of the labia majora; Type III (Infibulation) narrowing 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 the removal of clitoris; Type IV other. All other harmful procedures to the female genitalia for no-medical purposes e.g. pricking, piecing, incising, scraping and cauterizing the genital area.

Mandara (2004) stated that 34 percent of women are found to have some type of FGM. Type I and Type II procedures were most common. In Africa 85% of FGM cases consist of clitoridectomy Type I and Type II (http://wolvessdeams.tripod.com/fmg.html) Female genital mutilation has continued, according to Olakekan (2007). The reasons behind this practice, he stated, include attempt to prevent immoral sexual behaviour in the girls (prevention of promiscuity), prepare her for marriage (marriagebility), ensure cleanliness (hygiene), prevent labia hypertrophy, improve fertility, give more pleasure to the man/husband (by tightening the vagina). It is a form of traditional practice (Ada, 2012), for aesthetic or cosmetic purposes (Omorodion, 1989). Most often, women cite custom and tradition as a main cause for their support of the practice (Yoder, Abderahim and Zhuzhuni, 2004). In the cases of infibulations, Gruenbaum (2006) stated that it is to achieve smoothness which is considered to be beautiful.

FGM which is always performed by older woman with instruments that are not sterilized, in a poor sanitary condition and without anaesthesia is often very painful and has both short and long term health consequences on the girl-child and women. The harmful effects of FGM have been identified by many researchers to include short or long term health consequences.

Muniz (2008) contended that the most common short-term health consequences of FGM are haemorrhaging, severe pain, infection, shock, keloids scars, tetanus, and

potential death. Long-term health consequences include urine and menstral blood retention, urinary tract and pelvic infections, infertility, dysmenorrhea, dermiod cysts, obstetrical bleeding, tearing and fistulae. Olakekan (2007) stated that most of the adolescents who undergo the practice experience such side effects as surgical shock, bleeding, infection, tetanus, complication during labour and delivery, as well as the frequent need for episiotomy. He maintained that nationally and internationally, government and non-governmental organizations, professionals, religious and community leaders have become worried about this rather brutal practice. It is a worrisome practice that defies efforts by WHO and other agencies to eliminate. It is still practised by some ethnic groups in Nigeria. According to Hosken (1993), the only way to stop female circumcision in Africa is change on the village level. This change should be targeted to both men and women to bring about changes in values and attitudes. He further stated that no one has ever really tried to reach African men who make all the decisions in each family about the truth regarding FGM.

These changes require the involvement of women themselves, men, religious leaders, community leaders and the youth. We also have to accept the reality that change will not come without the full or committed participation of men be they politicians, religious and community leaders or future husbands (Moges, 2012). FGM is an abuse and violation of human right. The practice should be eliminated as suggested by WHO (1979) through education, increasing awareness through information and communication, teaching medical professionals to guarantee optimum prevention and care for women with FGM and empowerment of women. Demographic Health Survey (2003) data indicated a very high support for the abandonment of the practice in Nigeria; 66% of women aged 15-49 who have heard of FGM believed the practice should be discontinued compared to 21% of women who said the practice should be continued. It is on the above premise that the study was carried out to investigate the Female Genital Mutilation (FGM) knowledge and practice among literate women that attended the health centres in Ezeagu Local Government Area in Enugu state from April – June, 2012.

The purpose of the study was to investigate the female genital mutilation knowledge among literate women that attended the health centres in Ezeagu Local Government Area. Specifically, the study aimed at finding out the level of knowledge and practice possessed by literate women regarding the following (a) Types of FGM. (b) Reasons for practising FGM. (c) Health consequences of FGM. (d) Measures for eradication of FGM.

Research Questions.

The following research questions guided the study:

1. What are the levels of knowledge possessed by literate women regarding types of Female Genital Mutilation?
2. What are the levels for knowledge possessed by literate women regarding reasons for Female Genital Mutilation?
3. What are the levels of knowledge possessed by literate women regarding the health consequences for Female Genital Mutilation?
4. What are the levels of knowledge possessed by literate women regarding the measures for eradicating Female Genital Mutilation?

Methods

The cross-sectional survey research design was adopted for the study. The population comprised of 255 literate women that attended the six Health centres in Ezeagu Local Government Area from April to June 2012. The entire population was used for the study because the sample size was manageable. No sampling was done. Those women that can read and write were regarded as literate in this study.

The instrument used was 25-item questionnaire structured by the researcher to elicit information from the respondents titled; level of knowledge and practice of female Genital Mutilation among women attending Health Centres (KPFGMQ). The KPFGMQ was subjected to three experts in health education in Enugu State University of Science and Technology for validation. Their criticisms, advice and suggestions were used in modifying the instrument that was used for data collection.

To determine the reliability of the instrument 20 copies of the questionnaire were administered on women who attended Ebe Health Centre in Udi Local Government Area. To ascertain the reliability Kuder-Rechardson formular 20 (K-D 20) was employed.

The internal consistency of the instrument yielded a reliability coefficient of .86 which shows a high reliability. The instrument was therefore considered reliable for use in the present study based on Ogbazi and Okpala (1994) criterion of .60 or higher for good instruments.

Data collection was through administration of the questionnaire to the women on clinic days, using two trained research assistants. On each day completed copies of the questionnaire were collected by the researcher and the assistants. The 255 copies of the questionnaire were cross-checked for correction and completeness of response. Five copies of the questionnaire had incomplete responses and were discarded and 250 copies were correctly filled showing 98% return rate.

Data from responses of women were analyzed using descriptive statistics of frequency counts and percentages that provided answers for the research questions. The criterion for deciding the level of knowledge by Ashur (1977) was adopted. In this regard, scores less than 20 percent indicates very low level of knowledge, 21-39 percent low level of knowledge, 40 – 59 percent average level of knowledge, 60-79 high level of knowledge and 80 percent and above very high level of knowledge.

Results

Table 1: Level of knowledge possessed by literate women regarding types of Female Genital Mutilation. N= 250

S/N	TYPES	F	%	Dec
1	Type I is partial or total removal of the clitoris (Clitoridectomy).	220	88	VHLK
2	Type II is excision: Partial or total removal of the clitoris and the labia minora with or without excision of the labia majora.	180	72	HLK
3	Type III is infibulations 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 the removal of the clitoris.	95	38	VLLK
4	Type IV is others. All other harmful procedures of the female Genitalia for non-medical purpose e.g. pricking, piercing, incising, scraping and cauterizing the genital area.	90	36	VLLK
	Mean level of knowledge		58.5	ALK

The results in Table I show that the respondents 220 (88%) and 180 (72%) possessed very high level of knowledge on items 1 and 2 (Type I and Type II) respectively. The table indicated very low level of knowledge possessed by the respondents on items 3 with percentage score of 95 (38%) while item 4 also indicated very low level of knowledge with percentage score of 90 (36%). The table further revealed that literate women possessed an average mean (58.5%) knowledge on the types of FGM.

Table 2: Level of knowledge possessed by women on the reason for practising Female Genital Mutilation. N=225

S/N	REASONS	F	%	Dec
5	Custom and tradition	230	92	VHLK
6	Purification	40	16	VLLK
7	Hygiene (Unclean to hand food)	195	78	HLK
8	Aesthetic reason	160	64	HLK
9	Protection of Virginity	210	84	VHLK
10	Prevention of Promiscuity	220	88	VHLK
11	Reduce a woman's desire for sex.	200	80	VHLK
	Mean level of knowledge		77.71	ALK

Results in Table 2 show that the respondents possessed very high level of knowledge regarding reasons for practicing FGM on items 1, 9, 10 and 11 with percentage scores of 230 (92%), 210 (84%), 220 (88%) and 200 (80%) respectively. The table indicated that the respondents possessed high level of knowledge on items 7 and 8 with percentage scores of 195 (78%) and 160 (64%) and very low level of knowledge on item 6 with percentage score of 40 (16%). The table also revealed that the respondents possessed (77.71%) high level of knowledge.

Table 3: Level of knowledge possessed by women on the Health Consequences of Female Genital Mutilation. N=250

S/N	HEALTH CONSEQUENCES	F	%	Dec
12	Infection	195	78	HLK
13	Retention of urine	180	72	HLK
14	Painful and prolonged labour	224	89.6	VHLK
15	Frequent need for episiotomy	45	18	VLLK
16	Fistulae formation- VVF	220	88	VHLK
17	Forming of scar tissue and Keloids	50	20	VLLK
18	Loss of normal sexual functions	200	80	VHLK
19	haemorrhages (excessive bleeding)	220	88	VHLK
20	Shock	65	24	VLLK
	Mean level of knowledge		61.96	ALK

Data in Table 3 show that the respondents possessed very high level knowledge on items 14, 16, 18 and 19 with percentage scores of 224 (89.6%), 220 (88%), 200 (80%) and 220 (88%) respectively. The table revealed that the respondents possessed 195 (78%) on item 12 and 180 (72%) on item 13 indicating high level of knowledge on the health consequences of FGM. The table also indicated that the respondents possessed very low level of knowledge on items 15, 17 and item 20 with percentage scores of 45 (18%), 50 (20%) and 65 (24%). On the whole, the mean knowledge possessed by literate women regarding the health consequences of FGM was 61.96% indicating a high level of knowledge of the health consequences of FGM.

Table 4: Level of knowledge possessed by women regarding the measures for eradication of female Genital Mutilation. N=250

S/N	MEASURES	F	%	Dec
21	By creating awareness on the ill effects of Female Genital Mutilation.	220	88	VHLK
22	Health education for men and women on the dangers of	230	92	VHLK
23	Female Genital Mutilation. Education of girl child and women.	240	96	VHLK
24	Government to pass a decree forbidding FGM.	160	64	HLK
25	Educating the general public on the health consequences of FGM.	180	72	HLK
	Mean level of knowledge		82.4	ALK

Results in table 4 show that literate women had very high level of knowledge regarding the measures for eradication of FGM with mean knowledge of (82.4%). The table also revealed that literate women possessed very high level of knowledge on items 21, 22 and 23 with percentage scores of 220 (88%), 230 (92%) and 240 (96%). The table further indicated high level of knowledge on items 24 and 25 with percentage scores of 160 (64%) and 180 (72%) respectively.

Discussion

The results from research question one revealed that literate women that attended health centres in Ezeagu local Government Area possessed average level of knowledge (58.5%) on the types of FGM. The finding of the study is in line with Mandara (2004) who stated that Type I and Type II procedures were the most common FGM practised in Africa. The respondents themselves may have heard or undergone any of these two procedures.

Regarding the reasons for practising FGM the results research question two show that the respondents possessed high level of knowledge (77.71%). The data collected showed that the respondents were knowledgeable on all items except for purification as a reason for FGM. This supports Omorodion (1989), Olakekan (2007) and Ada's (2012) assertion that FGM are practiced for aesthetic or cosmetic purposes, to prevent promiscuity, marriageability, cleanliness, hypotrophy of the labia and is a form of traditional purpose. There are some who practice FGM for purification but in most cases it is for religious reasons.

The respondents possessed high level of knowledge of the health consequences of FGM. This was reflected from the high level of knowledge of (61.96%). However, the

respondents indicated very low level of knowledge (18%), (20%) and (24%) on frequent need of episiotomy, forming scare tissue and keliods and shock. This may be because some of these health consequences have long term effect and the practice is performed on the child during infancy. WHO (2003) stated that the surgery is mostly performed without anaesthetics and with unsterilized instruments. It is presumed that since the respondents are knowledge able on the health consequences of FGM, there will now be a final stop to this ugly and brutal practice.

Results from research question four revealed that the respondents possessed very high level of knowledge (82.4%) regarding the measures for eradication of FGM. The finding was not surprising because most of the respondents are knowledgeable on the health consequences FGM. The result is in agreement with Toubia (1993) who stated that no ethical defence can be made for preserving a cultural practice that damages women's health and interferes with their sexuality. He further stated that it is only a matter of time before all forms of female circumcision in children will be made illegal in western countries and eventually in Africa. Also in line with the findings of World Health Organization (2012) who passed a resolution on the elimination of FGM, emphasizing the need for concerted action in all sector of health, education, finance, justice and women's affairs will eventually stop the practice. They emphasized research for generating knowledge about the causes and consequences of the practice and how to eliminate it, raising awareness and promoting dialogue, integrating the abandonment of FGM/C into government programmes and national legislation, coordinating activities, developing training materials and guidelines for health professionals to help them treat and counsel women who have undergone the procedure. http://www.who.int/mediacentre/factsheets/fs241.

Conclusion

Based on the findings and discussion, the following conclusions were;

The finding shows that the respondents possessed high and average level of knowledge on the types, reasons, health consequences and measures for elimination of FGM. However, their knowledge if strengthened will help to improve all the effort geared towards elimination of female genital mutilation in any community which is essential for the achievement of millennium Development Goals.

Recommendations

In view of the above finding these recommendations were made:

1. National and international groups should be involved in stopping the practice of FGM through adequate monitoring and campaign.
2. Educational efforts geared towards girl-child, women and men should be directed at eliminating the practice of FGM in Nigeria and beyond.
3. Educational seminars and workshops directed towards enlightening/awareness campaign to the parents, guardians, families, community members, women groups, youths (boy and girls) on the health consequences of FGM should be organised by the government and non-governmental organizations.
4. Government should enact law prohibiting the practice of FGM in every community at national, state and local levels.

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