Perception of Women on Female Genital Mutilations and implications for health communications in Lagos State, Nigeria

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Abstract. Female Genital cutting is a culture-rooted practice common mainly in developing countries, Middle East, South East and Asia .FGC involves cutting mildly or severely the female genital organs especially two weeks before the adulthood. Type 1 and Type 11 are common in different parts of the world. Type 11 is highest in Egypt and Sudan, while Type I is common in Nigeria. However, the health problems associated with the practice informed the need to find out the perception of women about FGC and examine the most effective communication strategies to fight against it. The sample size for the study was one hundred and fifty –five respondents that were selected through Multi-stage sampling techniques. The major findings show that generally, women have negative perception about FGC, but there is still the belief among the elderly women that FGC checks promiscuity and that it is a noble practice. Communication strategies recommended for appropriate checking of the practice in traditional rural communities in Nigeria are group and interpersonal communication techniques coupled with multi-media and participatory approaches. However, educative programmes that enhance self-learning are viewed as being more effective than mass-media based communication and campaign strategies.

Keywords: perception, women, female genital cuttings, ethnic groups, Lagos State, Nigeria

1 INRODUCTION

Female genital cutting (FGC) also controversially known as female circumcision or female genital mutilation (FGM) is any procedure involving the partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons (Women's Health U.S. DHHS, 2009). There are three main forms of FGC. The minor form is the Type 1 in which the clitoris is completely or partially removed. Type I is commonly referred to as 'Clitoridectomy'. Type II involves partial or total removal of the clitoris and the labia minora with or without excision of the labia majora. This is referred to as excision. The Type III is the most severe form (infibulation) where all the external genitalia are removed and the vaginal opening is stitched nearly closed, only a small opening is left for urine and menstrual blood(Green, 2005).

FGC is practiced throughout the world with the practice concentrated most heavily in Asia and Africa. Amnesty International (2006) estimated that over 130 million women worldwide have been affected by some form FGCs. It is common in most West African countries - Nigeria, Senegal, Ghana etc. In North Africa, Egypt has the highest prevalence worldwide.

Mali, Ethiopia, Tanzania, Uganda and Cargo are countries m East and Central Africa practicing FGC. In the Middle East, FGC is practiced in Northern Saudi-Arabia, South Jordan, Kurdistan, and Syria. Very few ethnic groups practice FGC in South America. In South East Asia, FGC is practiced to a lesser degree in Indonesia, Malaysia, Pakistan, and India. Immigrants from African extraction practice FGC in the West-Australia, New Zealand, Canada, and United States of America and in Europe.

The prevalence of FGC in Nigeria is about 25 percent. The classifications FGC into types do not reflect the complexity of real life situations. Each type includes different degrees of severity depending on the amount of tissue excised, which is in part affected by a host of factors ranging from level of expertise of the practitioners to the movements of subject during the operation. Nevertheless, all of them have short- term and long-term physical consequences ranging from loss of blood, to serious problems in pregnancy and childbirth (WHO, 1996. UNICEF,1996). In view of these issues about FGC raised from global literature and the health concerns, that has informed the researchers to sample the perception of women about FGC in Nigeria and proffer appropriate communication strategies to fight against it.

The aim of this paper therefore is to

1- Examine whether women perceive FGC as a good practice or an undesirable one
2- Compare the perception of married and single women about FGC.
3- Ascertain whether tribe of the women have any relationship with their perception about FGC.
4- Highlight the implication for health communication

2 Brief Literature Review and Theoretical Framework

Female circumcision is as old as the human race. Infact, some authors saw the practice as a component of the African culture in the same way as it is in the other group of the world (Hosken, 1982). There are many reasons why FGC is practiced. Those who support it believe that it will empower their daughters, ensure the girls get married, and protect the family's good name. In some ethnic groups, FGC is performed to show a girl's growth into womanhood. Some do it in order to prevent or reduce promiscuity, keep the girl's virginity by limiting her sexual behaviour (including masturbation and sexual self- abuse). In some groups, women who are not cut are viewed as dirty and are treated badly. There are many superstitious beliefs attached to FGC, such as: the clitoris will continue to grow as a girl gets older and so it must be removed. That the external genitalia are unclean and can actually cause the death of an infant during delivery and that it is a cure for psychological disease (IAC,1995) .Aesthetic reasons for FGC are also cited. Some societies view it as enhancing the beauty of female genitalia (Gruenbaum, 2001 and Skaine,2005). In most cases, as noted by Atere, et al, (2000) the reasons for FGC contradict one another, and are not grounded on basic biological facts. According to the scholars, Customs, religion and sociological reasons are behind the practices of FGC in our communities. The sense of duty by society to control sexual excesses of girls and women is one reason. Religion and cultural reasons are the propounded to justify fundamental motives.

Furthermore, FGC can cause a range of health problems both in short term and long term. All types of FGC have one form of physical consequences and complications or the other. The kinds of problems develop depend upon the degrees of the cutting, the cleanliness of the tools used and the health status of the girl or woman receiving the cutting. It should be noted that FGC is performed on infant girls and women of all ages. Most often, it is done before a girl reaches puberty - 2 weeks to 16 years. Sometimes, it is done just before marriage or during a woman's fast pregnancy. The average age at which a girl undergoes FGC is decreasing in recent times in some African countries. In most African countries, mainly traditional

practitioners who may use scissors, razor blade, or knives perform FGC in unclean conditions. Short-term problems include a, Bleeding that can lead to death if it is severe. b, Infection enter the wound and develop into an abscess, c , Pains which could be severe during urination. d, Physical or psychological traumatisation particularly when forced upon an unwilling grown up girl(Adebajo,1999)

Long-term health problems do occur especially with women with the most severe forms of FGC - type 111. They include a, Psychological and emotional stress. b,Problems with getting pregnant or labour c,Increased risk of sexually transmitted infections including HIV. d,Problems with urinating and menstrual bleeding (Braun, 2005)

Fortunately, in Nigeria the prevalence rate is 25 percent and the less severe form of FGC - Type I is the most popular. This form does not cause severe health problems. Modernity has drastically reduced the occurrence of FGC in most communities in Nigeria over the last 30 years. Young ladies between the ages of 18-30 years in the metropolis have hardly heard about FGC. FGC prevails more in null communities with strong tradition.

2.1 Theoretical Framework

In this context, it is useful to look at Durkheim's functionalist theory and Weberian Social Action Theory. The mention of function of the society as a moral entity brings in the collective values and the order of priorities that the members of the society agree to use to substantive elements of functionalism. In substituting reality for symbols, he brings the society's functions and cohesion down to earth to ascertain the social function of FGM.

FGC is notorious for its psychological and health consequences. This provides a test case of functional analysis, being something that is widely regarded as unnecessary and socially harmful. Durkheim reveals that ritualistic ceremonies having a number of social functions vary with the nature of the particular ceremony being performed. Durkheim classified four functions of moral entity as follows: Disciplinary function; preparatory function; cohesive function and revitalizing function.

In Weberian Social Action model, it is believed and argued that all human action is directed by meaning and in order to understand and explain an action, the meanings, and motives that underlay it must be evaluated and appreciated in the first instance (Haralambos, 1990). Weberian social action theory identified three types of distinguished actions based on meaning through which they could be understood. These are: a, Effective, b, Traditional and c, Rational actions respectively. Each of the identified types of action is pointed out to provide a particular motive for obedience that result into a particular form of organization.

In view of this theoretical model, it shows the importance of how society influences the subjects, and meaning attached to FGC. Thus, individual behaviour that is related to the choice and commitment to practice of FGC, the perception of FGC as functional to the individual and society are undoubtedly determined and moulded within the context of their societal norms and values acquired through socialization.

Two null hypothesis were stated

1. There is no significant difference in the perception of women about FGC based on marital status.
2. Ethnic background of women will not significantly affect their responses about FGC

3 Research Methods

Survey research designed was adopted in this study. The population consists of women resident in Lagos State. The state, being the former capital of Nigeria, inhabits most major ethnic groups in Nigeria. One hundred and fifty five (155) women were sampled using the

multistage sampling technique to arrive at the total sample population. Married and single women about twenty-five years and above were deliberately selected. Knowledge of and/or experience on FGC was used as criteria to select the respondents. Questionnaires containing ten-item statements with a liked-scale response of Strongly Agree (SA), Agree (A), Disagreed (DA) and Strongly Disagreed (SDA) were used to elicit response from the women. Bio-data collected included marital status, age and tribe. Positive statements about the virtue of FGC were raised. Negative deleterious effect of FGC was also stated. For purpose of numerical analysis, the responses of positive and negative statements were coded as follows:

Figure 1

SA	A	DA	SDA
4	3	2	1
1	2	3	14

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The mean responses of each respondent on all 10 statements and all 155 respondents on each statement were computed. In addition mean responses of the respondents by ethnicity and marital status were calculated. Mean response 2.50 was judged as the cut-off point. Thus mean responses above 2.50 is seen as having positive perception about FGC while those below 2.50 constitute negative perception. Frequency counts of Agree, Disagree on each statement was made, and percentage calculated. T-test was the statistical tool used to compare the mean responses of respondents based on marital status. While Analysis of Variance (ANOVA) established whether there was any statistical difference in the mean responses based on ethnicity.

4 Data Analysis

Table l: Distribution of Personal Characteristics of Respondents

Characteristics	**Frequ**	**%**	**Mean/Modee**
M			M Mode
(1) Married	86	55.5	M Married
2 Single	69	44.5	
Age			M Mean
(1) 25-30	30	19.35	
(2) 31-35	69	44.52	34.5
(3) 36-40	12	7.74	
(4) 41-45	23	14.84	
(5)46-50	15	9.68	
6 50 & above	6	3.87	
Tribe			M
North Hausa-	17	11.0	
Igbo- South-	27	17.4	
Yoruba- South		71.6	Y

55.5 percent of the respondents were married while 44.5 percent of them were single. I l percent are Hausa, 17.4 percent Ibo while the majority of 71.6 percent were Yoruba.

Table 2: Perception of the Respondents about each Statement on FGC

	Statement	N=_155 X	A (%)	DA (%)
1.	FGC helps vent sexual immorality	2.30	66 42.6	89 57.4
2.	HIV can be transmitted through FGC.	1.37	14 90.3	15(9.7)
3.	FGC is a painful and barbaric act.	1.44	131(84.5)	24 15.5
4.	FGC can hinder maximum sexual pleasures.	2.07	97 62.6	58 37.4
5.	Cultural FGC is a noble idea.	2.42	75 48.5	W51.6)
6.	FGC can cause emotional trauma.	1.75	111 71.6	28.4
7.	Ladies who undergo FGC are not likely to enjoy sex.	2.17	92(59.4)	63(40.6)
8.	FGC can transmit life-threatening infections.	1.69	114 73.5	41 26.5
9.	FGC does not have any effect on sexual pleasures.	2.38	71(45.8)	84(54.2)
10.	FGC should be encouraged in Nigeria.	1.65	36(23.2)	119(76.8)

All the mean responses for all ten statements about FGC are below the cut-off point of 2.50. This implies that the women, no matter the ethnic affiliation or marital status perceive FGC negatively. Analysis of the responses for each item is quite revealing. Though 76.8 percent of the women disagree that FGC be encouraged in Nigeria, with only 23.2 percent agreeing, many seem to support the idea that FGC is a noble idea culturally (48.4% agree while 51.6% disagree). In addition, 42.6 percent agrees that FGC help to prevent immorality while 57.2 percent disagree (mean response 2.30). Another issue that has close response between those who agree and those who disagree is the statement that FGC does not have any negative effect on sexual pleasures (45.8% agrees, 54.2% disagrees). Issues that border on the effect on sexual behaviour attracted more variance among the women. FGC is likely to hinder maximum sexual pleasures attracted 62.6 percent agreement and 37.4 percent disagreement. Secondly, "girls who were cut are not likely to enjoy sex" received 59.4 percent agreement and 40.6 percent disagreement. But issues on the health problems of FGC drew a unanimous agreement. For instance "HIV can be transmitted through FGC" - 90.3 percent agree while only 9.7 disagree. FGC is a painful and barbaric act - 84.5 percent agree and 16.5 percent disagree. FGC can transmit life-threatening infections - 73.5 percent agrees and 16.5 percent disagrees. FGC can cause emotional trauma - 71.6 agrees and 28.4 percent disagrees

Table 3: Mean Response Based on Marital Status: T-Test Table

Variable	x response	Standard Deviation	Statistical Tool		
Marital n			t-calc	t-tab	Decision
Married (86)	2.01	1.86	1.04	2.89	No statistical difference. Accept null hypothesis
Single 69	1.85	1.45			

t-calc of 1.04 is less than t-tab of 2.89. Hence the decision is that there is no statistical difference between the responses of the married and single ladies. The null hypothesis is therefore accepted.

Table 4: Comparative Mean Response Based on Ethnicity of the Respondents: ANOVA table.

Source of variance	Sum of squares	df	Variance estimate	F.calc	Ftab at 0.05	Decision
Between group	1.81	2	1.27			Accept Ho
Within group	15.86	155	16.7			
				0.14	2.68	
Total						

Ftab at V I = 2, V2 =155 at alpha 0.05 is 2.68

Since F-calculated of 0.14 is less than F-tabulated of 2.68, the null hypothesis is accepted. This means that there is no statistical difference in the mean response of Hausas - 1.835, lbo - 1.804 and Yoruba - 2.05.

4.1 Implication for Health Communication

Cultural practices constitute a strong factor in aiding or impeding health messages to communities and groups with great passion and adherence to such practices. Immunisation of children against the five killer diseases, Malaria campaign, HIV/AIDS programmes, breast cancer early detection campaign are few examples of health issues in the front burner. Female Genital Cutting (FGC) does not seem to be a serious health issue in Nigeria. Yet the prevalence of FGC in Nigeria is 25 percent (Msuya, et al, 2002). Though modernity is fast eroding the practice, a number of communities in the north, south west and south east still stick to it. People living in rural communities are mainly involved in it.

These groups hold the practice of FGC in high esteem. In view of the fact that health problems associated with FGC has not been brought to the fore, these ruralites continue the practice. There is no law banning FGC in Nigeria Agencies fighting against FGC are mainly NGOs sponsored by International Oganisations from the Western world. Though February 6th of every year has been declared by United Nations as a day of campaign against FGC, the media in Nigeria does not seem excited about it.

4.2 Appropriate Communication Strategies

Little faith is placed on the mass media - Radio, TV and Print, to fight the practice of FGC effectively in Nigeria Theories and models from the West particularly USA and the United Nations agencies such as UNDP, UNICEF, WHO etc do not seem to work effectively in a sustainable manner in most developing countries. ACADA model, P-process, social marketing, diffusion of innovation model and behaviour change communication are some of the models arrogantly bandied around and pushed to African countries by their "expert communication consultants" (Czaplicki 2008, Akinfeleye, 2008 & Amnesty International, 2006).

However, the developing world is offering alternative strategies.

1) Edutainment and participatory approach based o n horizontal communication mainly through interpersonal and group channels using multi-media technique.

2) Participatory video approach coupled with the rural video tele-centre strategy is believed to be able to fast-track positive behaviour change of FGC practitioners in rural communities in Nigeria.

3) Community mobilization through various group meetings, testimony of people/group with FGC experience, opinion leaders, inter community meeting etc. are reliable and sustainable strategies. These involve sharing of ideas, experience and technology at the community level.

4) Self-learning through watching video clips, listening to audiotapes and continuous education programmes with high frequency over long periods.

5) Folk media - through theatre groups, songs dances, drama, puppetry etc are long lasting communication strategies that could be employed in fighting against FGC (Yahaya 2006). These strategies are rooted in sound socio-psychological and communication theories among which are Bandura's social learning theory, social cognitive (learning) theory and health belief model. (Davies & Dart, 2005).

Key and emerging issues raised under the health strand at the first world congress on communication for development held in Italy in 2006 include the following:

- Culture is part of people's realities and can both an enabling factor for and a barrier to communication. Either way, it must be engaged from the beginning. People are more ready to change cultural practices or adapt them than many assume when they think of culture as static or traditional.

- Participation is not just about who is being heard but also about supportive spaces where people can develop a sense of their own priorities and set the agenda. They need to be given the capacity to express themselves on their own ways, on their own terms.

- Community monitoring is needed to hold authorities to account - an important part of building capacity that empowers communities.

- New technologies (internet, cell phone etc) are important, but there will always be a need for face and interpersonal communication. (Chitinis, 2006)

These significant issues and recommendations which emerged from the health strand of the congress goes to buttress the assertion by Davies and Dart (2005) that indigenous communication strategies highlighted above are more effective than models forced down "our throats" by the West with their financial muscle. These alternative strategies are sustainable and can yield positive behaviour change in culture-rooted practices like FGC.

5 Conclusion

FGC is culture-based practice that cuts across all religions and tribes in Nigeria except the Fulanis. There are convincing arguments for and against FGC as seen from literature reviewed. One fat remains, uncut women are not disadvantaged in any way. On the contrary, women that go through FGC particularly the type III stand the risk of health problems. Some include I-IIV infection, delivery complications, emotional trauma and difficulty in reaching orgasm. The type I which involves partial or complete removal of the clitoris only, do not seem to pose any health problems.

The belief is still strong in Nigerian rural communities that uncut women tend to be promiscuous. Promiscuity is a state of the mind founded on upbringing and the social environment. Many uncut women many as "virgins".

Communication strategies appropriate is not campaigns which are "flash in the pan", not mass media-based strategies via radio/TV jingles, talk shows or newspapers and magazines. The conclusion drawn from the mass of literature reviewed posit that sustainable and effective communication strategies that could fast track eradication of FGC in Nigeria and other developing countries are group and interpersonal horizontal communication using multi-media and participatory approach that involve all stakeholders. These may include varying categories of health workers, policy makers, traditional rulers and the end-users of the messages designed by communication experts.

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