FEMALE GENITAL MUTILATION AS A CORRELATE OF INTIMACY OF MARRIED WOMEN IN IBADAN, OYO STATE, NIGERIA

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Abstract
The study examined the relationship between female genital mutilation and intimacy of married women in Ibadan. The descriptive survey research design of the ex-post facto type was employed in carrying out the study. The participants used for the study were 250 married women who had been genitally mutilated. A questionnaire tagged "Female Genital Mutilation and Sexual Intimacy Questionnaire" (FGMSIQ) *was used to collect data for the study. It has a reliability coefficient value of 0.87. The data collected were analyzed using Pearson Product Moment Correlation (PPMC). Three hypotheses were tested at 0.05 level of significance. The study established that there was a significant relationship between female genital mutilation and sexual intimacy of the married women (r= .32, p <.05). The study also showed that there was a significant relationship between female genital mutilation and emotional intimacy of the married women (r= .24, p <.05). Furthermore, the study revealed that there was a significant relationship between female genital mutilation and social intimacy of married women (r= .242, p <.05). Based on the above findings, the study recommended that medical social workers should provide adequate information to the people about the core reasons why female genital mutilation should be stopped and they should give extensive sensitization to men in the community since they are the major decision maker on whether a girl should be circumcised or not. It was also recommended that necessary legal measures should be imposed in the society by the policy makers to ameliorate the practice of female genital mutilation.*

Key Words: *Female Genital Mutilation, Intimacy, Married Women*

Introduction

Female genital mutilation (FGM), also known as female circumcision in Nigeria, is a common practice in many societies in the northern half of sub-Saharan Africa. Nearly universal in a few countries, it is practiced by various groups in at least 25

African countries, in Yemen, and in immigrant African populations in Europe and North America (World Health Organisation, 2016). In a few societies, the procedure is routinely carried out when a girl is a few weeks or a few months old (e.g. Eritrea, Yemen), while in most others, it occurs later in childhood or adolescence. In the case of the latter, female genital mutilation is typically part of a ritual initiation into womanhood that includes a period of seclusion and education about the rights and duties of a wife (United Nations Women Commission, 2015)

There are three main forms offemale genital mutilation. 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, 2015).

Female genital mutilation 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 culture of the world (Hosken, 2016). There are many reasons why female genital mutilation 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, female genital mutilation 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 circumcised are viewed as dirty and are treated badly. There are many superstitious beliefs attached to female genital mutilation, 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. Aesthetic reasons for female genital mutilationare also cited. Some societies view it as enhancing the beauty of female genitalia (Gruenbaum, 2015 and Skaine, 2015). In most cases, as noted by Atere, (2010) the reasons for female genital mutilation contradict one another, and are not grounded on basic biological facts. According to some scholars, customs, religion and sociological reasons are behind the practices of female genital mutilation 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 propounded to justify fundamental motives.

According to UNICEF (2016), female genital mutilation is a human rights issue that affects girls and women worldwide. As such, its elimination is a global concern. In 2012, the United Nations General Assembly (UNGA) adopted a milestone resolution calling on the international community to intensify efforts to end the harmful practice. More recently, in September 2015, the global community agreed to a new set of development goals—the Sustainable Development Goals (SDGs)—which include a target under Goal 5 to eliminate all harmful practices such as child, early and forced marriage as well as FGM, by the year 2030. Both the UNGA (2012) resolution and the SDG (2015) framework signify the political will of the international community and national

partners to work together to accelerate action towards a total, and final, end to FGM in all continents (UNICEF 2016).

The World Health Organisation (2014) Fact Sheet, states that Female genital mutilation has no health benefits and it harms girls and women in many ways. Its immediate complications include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region, injury to nearby genital tissue, and sometimes death (WHO, 2016). Little studies are known about the impact of the psychological effects of FGN on women and their marital or couple relationships. Also, a handful of studies have identified a high frequency of female genital mutilation and intimacy of women with their husbands with women reporting frequent nightmares, chronic irritability, and feelings of incompleteness, fear, inferiority, and suppression (Adejare, 2017), as well as general frustration (UNICEF, 2015). In addition to psychological effects, there are known psychosexual effects. Researchers have found that circumcised women have a number of symptoms that lessen sexual satisfaction, such as vaginal dryness during intercourse, as well as a significant decrease in sexual desire, fewer orgasms, as well as difficulty in achieving an orgasm (Adejare, 2017 and Omigbodun, 2017). These two studies provide elementary support that FGM reduces sexual satisfaction in couples.

With the medical, psychological, and psychosexual effects discussed above, it is appropriate to assume that they impact the couple relationship. For example, when a woman believes that a part of her is missing and that it is irreversible, her self-esteem is decreased and her self-worth is diminished (Yinusa, 2015). Additionally, the pain associated with intercourse, as well as the decreased sexual desire often lead to couples reluctantly engaging in their "duty" of sexual activity together, even though it may be a traumatizing experience psychologically or physically (Tinuoye, 2016). While we might assume that FGM decreases intimacy, sexual satisfaction and marital satisfaction, this assumption has yet to be explored in the context of culture. Therefore, the present study is based on the premise of how female genital mutilation could be eradicated to enhance intimacy (sexual, emotional and social) of married women with their husbands.

Literature Review

Several survey studies have been done on female genital mutilation by various researchers at different settings (WHO, 2016). For instance, Defrawia (2016) investigated psychosexual activity among 250 women randomly selected from patients of maternal and childhood centers in Ismaila using, a structured questionnaire and focused group discussion. The result showed that 80% of those circumcised complained of dysmnorrhea, 48.5% vaginal dryness during intercourse, 45% lack of sexual desire, 28% less frequency of sexual acts per week, 11% inactive during sex, 49% being less pleased with sex, 93% being less organic or reaching orgasm, 25% less frequency of orgasm and 60.5% having difficulty reaching orgasm than the uncircumcised women. Other psychosexual problems such as loss of interest in fore play and dyspareunia did not reach statistical significance. The study suggested that circumcision has a negative impact on a woman's psychosexual life. Megafu, (2002) in his own study on the presumed benefits of female genital circumcision among Ibo tribe of Nigeria, found no significant difference in the promiscuity level between the circumcised

and uncircumcised women. Oyefara (2015) in his study found that female genital mutilation hampered effective and efficient sexual functioning of the women in the study location as circumcised women reported defective sexuality and sexual dysfunctional

Mohammed (2016) investigated the effects of female genital mutilation on the sexual function of married women compared to the non-circumcised women in the Kurdistan province of Iran.The result showed that sexual function in women with female genital mutilation is adversely altered. Raheem (2018) assessed effects of female genital mutilation on couple sexual function in Fayoum governorate, Egypt.The result showed that 157 (30.3%) of women in the study suffered psychological problems and 142 (27.4%) of them suffered marital and social problems related to female genital mutilation practice. Mutilated women had four folds decrease in sexual satisfaction and five folds increase in sexual dysfunction on contrary 57% to 59% decrease in arousal and orgasm. As regards to their husbands' sexual satisfaction, it decreases by around three folds if their wives were mutilated.

Owojuyigbe (2017), found that the disabling consequence of FGM is largely sexual in nature, leading to traumatic experiences and negative beliefs about sex, and requiring a myriad of coping strategies employed by the disabled women, and their spouses, which may have its own implications for marital and sexual bliss.

Ismail, Abbas, Habib, Morsy, Saleh, and Bahloul (2017) carried out a study among 394 healthy sexually active Egyptian women (197 with Female genital mutilation and 197 without Female genital mutilation) and reported that there is a significant association between Female genital mutilation and decline in the female sexual functions.

Abubakar (2004) conducted a cross-sectional study on 210 antenatal patients, assessing their knowledge, attitude and practice of female genital cutting in Amino Kano Teaching Hospital in Northern Nigeria, using focused group discussion and interview guide as instrument. The result revealed that there is a significant association between the incidence of female genital mutilation and sexual intimacy experience by women of reproductive age in rural areas of Northern Nigeria.

Megafu (2002) studied 500 adult females from university undergraduates and females who attended gynaecology outpatient clinic of University of Nigeria Teaching Hospital, Enugu. The result revealed that there is a significant relationship between female genital mutilation and sexual intimacy of women.

Mahmond (2013) revealed a significant association between female genital mutilation and female sexual function among women in Egypt, where reduction of all aspects was obtained namely: desire, arousal, lubrication, orgasm, satisfaction and pain.

Another current area of research into intimate relationships was conducted by Orbuch and Veroff (2002). They monitored newly-wed couples using self-reports over a long period (a longitudinal study). Participants were required to provide extensive reports about the natures and the statuses of their relationships and they reported that there was a strong association between female genital mutilation and emotional intimacy of women residing in rural areas of Ghana.

Berg, Denison, Fretheim (2010) conducted a systematic review of quantitative studies. The study showed that, compared to women without female genital mutilation, women with FGM are more

likely to experience pain during intercourse, reduced sexual satisfaction, and reduced sexual desire, lack of social and emotional intimacy. Onadeko and Adekunke (1995), in their survey of how harmful traditional practices affected women and girls in Nigeria, found that FGM has caused a significant decline in emotional intimacy.

Okoronkwo (2001) found that there was a significant association between women who had experienced female genital mutilation and the level of social intimacy. In a study conducted by Rushwan (2002), he found that a major impact of female genital mutilation is the drastic decline in the social intimacy and interaction women experienced from their spouse in Sudan.

The present study, therefore, aims at investigating the relationship between female genital mutilation and intimacy of married women (sexual, emotional and social) with their spouses. It also aims at addressing the issue of how female genital mutilation could be stopped to enhance intimacy or relationships of married women with their partners.

Hypotheses

HO_1: There is no significant relationship between female genital mutilation and sexual intimacy of married women.

HO_2: There is no significant relationship between female genital mutilation and emotional Intimacy of married women.

$HO_{3:}$ There is no significant relationship between female genital mutilation and social intimacy of married women.

Methodology

The descriptive survey research design of the ex-post facto type was used for this study. This was appropriate because the design enhances easy collection of factual information about the research.The target population of the study is made up of all married women within the study area in which 250 married women who were circumcised in the childhood age were purposively selected as sample for the study.

The research instrument for the study is a single questionnaire tagged 'Female Genital Mutilation and Intimacy Questionnaire' (FGMAIQ). The questionnaire was made up of 46 items divided into three sections A, B, and C respectively. Section A contains 5 items measuring demographic variables of the respondents. Section B contains 14 items measuring the degree of Female Genital Mutilation. The items were drawn from the United States Agency for International Development (USAID)(2013), Female Genital Cutting Module Questionnaire. The scale yielded a cronbach alpha value of 0.71. Section C contains 27 items measuring level of intimacy of the married women (sexual, emotional and social intimacy). The items were drawn from Schaefer and Olson (1981) Intimacy scale. The scale yielded a Cronbach alpha Value of 0.83 for sexual intimacy, 0.73 for emotional intimacy and 0.76 for social intimacy.

Results

Hypothesis one: There is no significant relationship between female genital mutilation and sexual intimacy of married women.

Table 1: PPMC on the relationship between female genital mutilation and sexual intimacy of married women

Variable	Mean	Std. Dev.	N	R	p value	Remark
Female genital mutilation	2.1000	4.4152	250	.320	.000	Sig.
Sexual intimacy	36.8000	3.3018				

*Sig at .05 level

Table 1 showed that there was a significant relationship between female genital mutilation and sexual intimacy of married women (r = .320, N= 250, p <.05). The above result does not give support to the hypothesis. Therefore, the null hypothesis is rejected.

Hypothesis two: There is no significant relationship between female genital mutilation and emotional intimacy of married women.

Table 2: PPMC on the relationship between female genital mutilation and emotional intimacy of married women

Variable	Mean	Std. Dev.	N	r	p value	Remark
Female genital mutilation	36.8000	4.4152	250	.242	.000	Sig.
Emotional intimacy	19.6280	3.7505				

*Sig at .05 level

Table 2 showed that there was a significant relationship between female genital mutilation and emotional intimacy of married women, (r = .242, N= 250, p <.05).

The result does not give support to the hypothesis, hence the null hypothesis is rejected.

Hypothesis three: There is no significant relationship between female genital mutilation and social intimacy of married women.

Table 3: PPMC on the relationship between female genital mutilation and social intimacy of married women

Variable	Mean	Std. Dev.	N	R	p value	Remark
Female genital mutilation	36.8000	4.4152	250	.187	.000	Sig.
Social intimacy	20.1560	3.4958				

Sig at .05 level

Table 3 showed that there was a significant relationship between female genital mutilation and social intimacy of married women (r = .242, N= 250, p <.05). The result does not give support to the hypothesis. Therefore, the null hypothesis is rejected.

Discussion of findings

The result in Table 1 showed that there was a significant relationship between female genital mutilation and sexual

intimacy of the married women. The result is in agreement with the finding of Mustapha (2015), that female genital mutilation has implication on sexual intimacy and pleasure of women in most developing African countries. Also, the result is consistent with the finding of Raheem (2018) that there is a significant association between the incidence of female genital mutilation and sexual intimacy experienced by women of reproductive age in Egypt. Similarly, the result of this study is also in agreement with the finding of Defrawia (2016) that FGM has caused negative impact on sexual intimacy and pleasure of women in low and middle income countries of Africa. Additionally, the result of this study is also in agreement with the finding of Owojuyigbe (2017), that there is a significant relationship between female genital mutilation and sexual intimacy of women.

The result in Table 2 revealed that there was a significant relationship between female genital mutilation and emotional intimacy of the married women. The result corroborates the finding of Berg, Denison, Fretheim (2010) that female genital mutilation had significant impact on emotional intimacy of married women. Similarly, the result is consistent with the finding of Orbuch and Veroff (2002) that there is a strong association between female genital mutilation and emotional intimacy of women residing in rural areas of Ghana. Additionally, the result is consistent with the finding of Onadeko (1995) that FGM has caused a significant decline in the emotional intimacy of couples in Ibadan metropolis.

The result in Table 3 revealed that there was a significant relationship between female genital mutilation and social intimacy of the married women. The result supported the finding of Okoronkwo (2001) that there was a significant association between women who had experienced female genital mutilation and their level of social intimacy. Also, the result is in agreement with the finding of Onadeko and Adekunke (1995) that female genital mutilation had significant impact on the social intimacy of women in rural North of Nigeria.

Findings from the study and those indicated above suggest that FGM has serious negative consequences for women, at adulthood or when they get married. It is imperative, therefore, that all hands must be on deck to eradicate the harmful practice to enhance the intimacy or relationships of the married women with their spouses.

Implication of the findings

Findings from the study have many useful implications. Firstly, the findings will help community members to be aware of the demerits of FGM practice, thereby changing their attitude towards stopping the practice. Findings from the study will also help healthcare providers to have an in-depth knowledge of the importance of discontinuing FGM practice, document their evidence based findings as a result of FGM practice on its effect on women during labour and delivery. The findings will also help academia in the field of social work, nursing, social sciences and medicine to have increased knowledge about female genital mutilation (FGM) for the benefit of teaching and research.

The findings from the study will contribute to the body of knowledge in the area of physical, emotional, social and reproductive health of women. The findings from the study will also help government make policies and sensitization programmes that will help put an end to FGM practice in the country.

Conclusion

Female Genital Mutilation does not only have negative effects on the sexual life of the married women but also on their emotional and social intimacy with their spouses which can result to marital dispute between them.It can also create more social problems in the society. Therefore, `it can be summarily concluded that when female genital mutilation is vehemently discouraged, an end will be put to it in the society and many female children will be free from the anguish associated with the practice. Also, many married women will enjoy sexual intimacy and sexual satisfaction with their spouses.

Recommendations

Based on the outcomes of this study, the following recommendations were made: All health care workers should give adequate information to the people about the core reasons why FGM should be stopped. For instance, the medical social workers and community health nurses should embark on extensive sensitization and give adequate information to women and men on the negative effect of female genital mutilation, such as pain, excessive bleeding, shock, sepsis, scars and so on.

The health care-givers should involve the community leaders in the dissemination of demerits of FGM on health and psychosocial well-being of women and girls of reproductive age. They should also engage the religious leaders in providing consistent education on the demerits of FGM to their members, especially parents so as to stop this harmful practice among them.

The educational sector should include FGM in the school curriculum of the students so that the awareness of FGM can revolve round the society, and also to educate the students about the implications of the practice and encourage prevention at early stage.

Furthermore, the social worker, policy makers and government agencies should provide policy services that address the elimination of FGM in the country and strict legal actions or punishment should be placed on anyone violating the rules.

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