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HEALTH RISKS ASSOCIATED WITH FEMALE GENITAL MUTILATION AS EXPRESS BY WOMEN OF CHILDBEARING AGE IN ILORIN SOUTH LGA, KWARA STATE, NIGERIA

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ABSTRACT

Female genital mutilation harms girls and women in many ways and it has no health benefits. Therefore, the study investigated the health risks associated with the female genital mutilation as expressed by women of childbearing age in Ilorin South LGA, Kwara State, Nigeria. The objectives of the study were to determine whether dyspareunia and infertility are health risk associated with female genital mutilation. A descriptive research design of the survey type was adopted for the study. The population of the study comprises women of childbearing age. Two hundred and forty-two respondents were sampled for the study. A validated researcher's developed questionnaire tested for reliability was used for the study. The data collected analyzed using descriptive statistics of chi-square to test the formulated hypotheses at 0.05 level of significance. The findings indicated that dyspareunia and infertility are significant health risks associated with female genital mutilation (Cal. chi-square value > chi-square Table value) at 0.05 alpha level. The study concluded that dyspareunia and infertility are health risk associated with female genital mutilation as express by women of childbearing age in Ilorin South local government area of Kwara State, Nigeria. Evidence generated from the study also suggest implication for the local government authority on the need to conduct enlightenment campaign through mass media on health effects associated with female genital mutilation to enable parents desist from the practice.

Keywords: Health-risk, Associated, Female, Genital-mutilation, women.

INTRODUCTION

Female genital mutilation (FGM) is a procedure performed on women in developing countries and is underreported; it involves cutting or altering the female genitalia. The health consequences of FGM include bacterial and viral infections, obstetrical complications, and psychological problems. Female Circumcision (FC) or Female Genital Mutilation (FGM) describes practices that manipulate, alter, or remove the external genital organs in young girls and women. The procedure is performed using a blade or shard of glass by a religious leader, town elder, or medical professional with limited training. In about 15% of cases, infibulation, the most severe form of FGM, involves the removal of the labia and the suturing together of the vulva; this practice may place the victim's life at risk (Yirga et al. 2012). In contrast to male circumcision, the procedure produces no known health benefits and is not performed for medical reasons. FGM

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is widely recognized as a procedure that violates a person's human rights, as well as increasing their risk for health complications (Donohoe 2006).

Okeke et al. (2012) opined that FGM is recognized worldwide as a fundamental violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against women. It involves a violation of the rights of the children and violation of a person's right to health, security, and physical integrity, the right to be free from torture and cruel, inhuman, or degrading treatment, and the right to life when the procedure results in death. Furthermore, girls usually undergo the practice without their informed consent, depriving them of the opportunity to make an independent decision about their bodies.

World Health Organization (2020) explained that Female Genital Mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injuries to the female genital organs for non-medical reasons. The practise is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. In many settings, health care providers perform FGM due to the belief that the procedure is safer when medicalized. WHO strongly urges health care providers not to perform FGM. FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practise also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

Nigeria, due to its large population, has the highest absolute number of female genital mutilation (FGM) worldwide, accounting for about one-quarter of the estimated 115–130 million circumcised women in the world. FGM is widespread in Nigeria. Some sociocultural determinants have been identified as supporting this avoidable practice. FGM is still deeply entrenched in Nigerian society where critical decision-makers are grandmothers, mothers, women, opinion leaders, men and age groups. FGM is an extreme example of discrimination based on sex. Often used as a way to control women's sexuality, the practice is closely associated with girls' marriageability. Mothers chose to subject their daughters to the practice to protect them from being ostracized, beaten, shunned, or disgraced. FGM was traditionally the specialization of traditional leaders' traditional birth attendants or members of the community known for the trade. There is, however, the phenomenon of "medicalization" which has introduced modern health practitioners and community health workers into the trade. The WHO is strongly against this medicalization and has advised that neither FGM must be institutionalized nor should any form of FGM be performed by any health professional in any setting, including hospitals or the home setting (Okeke et al. 2012)

LITERATURE REVIEW

Female Genital Mutilation (FGM) has no health benefits and it harms girls and women in many ways. The practise involves removing and injuring healthy and normal female genital tissue,

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interfering with the natural functions of girls' and women's bodies. It can lead to immediate health risks, as well as a variety of long-term complications affecting women's physical, mental and sexual health and well-being throughout the life-course. All forms of FGM are associated with increased health risk in the short- and long term. FGM is a harmful practice and is unacceptable from a human rights as well as a public health perspective, regardless of who performs it. Some health care providers perform FGM (medicalization), but WHO is opposed to all forms of FGM and strongly urges health care providers do not to carry out FGM even when their patient or their patient's family requests it (World Health Organization 2021).

Female genital mutilation is classified into 4 major types: Type 1**,** is the partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals), and/or the prepuce/ clitoral hood (the fold of skin surrounding the clitoral glans). Type 2, is the partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva). Type 3, also known as infibulation, is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans (Type I FGM). Type 4, includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area (WHO, 2020).

WHO (2020) pointed out that FGM is mostly carried out on young girls sometime between infancy and adolescence, and occasionally on adult women. More than 3 million girls are estimated to be at risk for FGM annually. More than 200 million girls and women alive today have been subjected to the practice, according to data from 30 countries where population data exist. The practice is mainly concentrated in the Western, Eastern, and North-Eastern regions of Africa, in some countries the Middle East and Asia, as well as among migrants from these areas. FGM is therefore a global concern.

Odukogbe et al. (2017) pointed out that the instruments used in performing FGM have included razor blades, unsterilized sharpened kitchen knives, scissors, glass, sharpened rocks and fingernails. The person who performs the procedure is often called the circumciser or cutter. In most cases, this is an older woman who does it in the house of the girl or woman or circumcision centres. In some communities, it is performed by males, usually barbers because of their skills in handling cutting tools. Unhygienic procedures are commoner among the traditional circumcisers with the report of repeated use of a single instrument in up to 30 girls. In some countries of Africa and Asia such as Egypt, Kenya, Sudan and Indonesia, health professionals often perform the procedures and so it is termed "medicalization" of FGM. Anaesthesia is not used by traditional cutters but medical professionals may use local or general anaesthetic agents. When the procedure is performed by traditional cutters and especially in types II and III, the girl or woman's legs are usually bound together from the hip to the ankle so she remains immobile for approximately 40 days to allow for the formation of scar tissue.

The psychological effects of FGM depend on the type of procedure performed, the experience of the circumciser and the social atmosphere at the time the cutting is performed. The psychosocial consequences include post-traumatic stress disorder (PTSD), anxiety disorders, panic disorders, inhibition, depression and suppression of feeling and thinking and sometimes

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attempted suicide. These effects are due to the psychological trauma of the painful procedure, sense of humiliation and being betrayed by parents, use of physical force by those performing the procedure, negative genital image, lack of sense of ownership of their bodies, devastating sexual life, infertility and vesicovaginal fistulae. Women with type III FGM have a more distressing psychosocial complication about sexual problems and infertility with a documented infertility rate of 30%. The purported infibulated scar that ought to protect from pregnancy out of wedlock and enhance men's sexual pleasure serve as the impediment to conception within marriage and sexual pleasure thus causing an unhealthy sexual relationship and creates the fear that the women may never become mothers while their husbands question their masculinity. These account for 16.3% of divorce and marital discord in a study among circumcised women (Odukogbe et al. 2017).

Tradition and culture are indeed important aspects of any society in helping to mould the views and behavioural patterns of the society; some traditions and cultural beliefs and practices like FGM are harmful and must be abolished. A multidisciplinary approach is needed to tackle this deep-rooted legendary practice of FGM. There is a need for legislation in Nigeria with health education and female emancipation in society. The process of social change in the community with a collective, coordinated agreement to abandon the practice of "community-led action" is therefore essential.

Female genital mutilation is a traditional practice that can have serious health consequences, is of great concern to the world at large. In addition to causing pain and suffering, it is a violation of internationally accepted human rights. All types of female genital mutilation involve the removal of genital parts or damage to the normal functioning of the external female genitalia. The occurrence of physical complications depends on several factors, including the extent of cutting, the skill of the operator, the cleanliness of the tools used and the surrounding area and the physical conditions of the child. Inclusive in the immediate complications of FGM is death which can result from severe bleeding (haemorrhagic shock), pain and trauma (neurogenic shock) or severe and overwhelming infection (septicaemia). The most common long-term complication of all types of female genital mutilation is a Dermoid cyst. It results from the embedding of skin tissue in the scar. The gland which normally lubricates the skin will continue to secrete under the scar and form a cyst or sac full of cheesy material (Olumba 2005).

According to Toubia (1996), forceful intercourse to penetrate tight infibulations is hailed as a sign of masculinity and virility. Apart from the pain and distress that may cause the woman, the negative experience affects some men causing them to become impotent. In Egypt, according to Karim (1994) men have claimed that their excessive alcohol or hashish consumption is because they do not find sex satisfying with their mutilated wives. Husbands often seek extramarital sex with women who are not “circumcised” and describe these women as “complete” and “hot”. Female genital mutilation may be the underlying cause of strained familial relations which manifest themselves as anger, aggression and ultimately divorce.

FGM is practised in more than 28 countries in Africa and a few scattered communities worldwide, its burden is seen in Nigeria, Egypt, Mali, Eritrea, Sudan, Central African Republic, and the northern part of Ghana where it has been an old traditional and cultural practice of various ethnic groups. The highest prevalence rates are found in Somalia and Djibouti where FGM is virtually universal. Female Genital Mutilation is widely practised in Nigeria, and with its

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large population, Nigeria has the highest absolute number of cases of FGM in the world, accounting for about one-quarter of the estimated 115–130 million circumcised women worldwide (UNICEF 2001; Okeke et al. 2012).

Megagfu (1983) investigated the effect of female genital mutilation on the age at first sexual intercourse and the incidence of premarital coitus among young Ibo women in Nigeria. He found no difference in what is termed "levels of promiscuity between "circumcised" (type II) and "uncircumcised" women. He also reported that only 58.8% of the former experience orgasm in contrast to 68.7% of the latter. This study also showed that when the clitoris is removed the labia minora and the breasts take over as the most erotic organs in the body. For men who have to live with the genital mutilation of their wives and sexual partners, the experience can also be unpleasant. The concept of pleasure varies widely between peoples of different backgrounds and cultures, and from individual to individual. In societies where infibulations are the norm, it might be assumed that most men are conditioned to be aroused by a tighter vaginal entrance, by a passive woman or by one who is experiencing pain.

At the grassroots, efforts should be taken to join in the crusade to say "NO" to FGM anywhere it is practised among our people. It is crude, dangerous, wicked and unhealthy. FGM is not required by any religion and there is no scientific evidence that women who have been mutilated are more faithful or better wives than those who have not undergone the procedure. There is no single benefit derived from FGM (Okeke et al. 2012).

Female genital mutilation, also known as female genital cutting, is a deeply rooted cultural practice in more than 28 African countries, parts of the middle east, and pockets of Asia. Annually, an estimated 2 million girls come of age in such areas. Support for the practice in communities is broad-based. Mothers, mothers-in-law, fathers, and religious and community leaders defend the practice based on a girl's future role as wife and mother. Reasons cited for support include its role as a rite of passage into womanhood, marriageability, curbing sexual desire, and protecting virginity. It is not condoned by any major religion but often has socio-religious significance. Despite its cultural entrenchment, a gradual reduction is occurring in many countries, even without targeted interventions. The challenge is to identify successful approaches to accelerate the decline. Therefore, the objectives of the study was to examine whether dyspareunia and infertility are associated heath risks with female genital mutilation as express by women of childbearing age in Ilorin South LGA, Kwara State, Nigeria to provide functional suggestions that will assist in shortening issues cause infection for girls and women in the study area.The research objectives formulated for the study were as follows:

i. Dyspareunia is not significantly a health risk associated with female genital mutilation as express by women of childbearing age in Ilorin South LGA, Kwara State, Nigeria
ii. Infertility is not significantly a health risk associated with female genital mutilation as express by women of childbearing age in Ilorin South LGA, Kwara State, Nigeria.

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THEORETICAL FRAMEWORK

In this study, two theories were applied which include: Social Norms Theory and Theory of Planned Behaviour.

Social Norms Theory

The Social Norms Theory was first used by Perkins and Berkowitz in 1986. Social norms are typically defined as "rules and standards that are understood by members of a group, and that guide or constrain social behaviors without the force of law" and often relate to a perceived social pressure to engage or not engage in specific behaviors. Social norms theory states that our behaviour is influenced by incorrect perceptions of how other members of our social groups think and act. The assumptions of social norms theory lead to a number of questions that can be used to determine the applicability of the theory to other health issues, such as eating disorders, sexual health, and sexual assault, or to bystander behavior. Thus, the following questions assess whether a particular health or social justice behavior issue is amenable to a social norms intervention:

i. What misperceptions exist with respect to the behavior in question?
ii. ii.What is the meaning and function of misperceptions for individuals and groups?
iii. Do the majority of individuals in a group or community hold these misperceptions?
iv. Does the target group function as a group with respect to the behavior in question? (i.e., do the individuals in the group exert an influence on each others' behavior?)
v. ·v. What is the hypothesized effect of these misperceptions?
vi. What changes are predicted if the misperceptions are corrected?
vii. ·vii. What healthy behaviors already exist in the population that should be strengthened or increased?

These questions establish the parameters or conditions for health promotion interventions based on social norms theory. If these questions are not adequately addressed, a social norms intervention may not be appropriate. Social norms theory predicts that interventions which correct these misperceptions by revealing the actual, healthier norm will have a beneficial effect on most individuals, who will either reduce their participation in potentially problematic behavior or be encouraged to engage in protective, healthy behaviors (Alan & Trumansburg, 2002).

The Theory of Planned Behavior (TPB)

The Theory of Planned Behavior (TPB) is a cognitive theory developed by Azjen, I. in 1985. The theory argued that an individual's decision to engage in a specific behavior such as gambling, drug abuse or practice female circumcission can be predicated by their intention to engage in that behavior. 'Intentions are assumed to capture the motivational factors that influence a behavior; they are indications of how hard people are willing to try, of how much of an effort they are planning to exert, in order to perform the behavior. As a general rule, the stronger the intention to engage in a behavior, the more likely should be its performance. TPB is the model most used in

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health psychology. It has been useful in predicting intentions relating to drug abuse, sexual abuse and harmful traditional practices such as female genital mutilation. The three component of the model (Personaal attitudes, Subjective norms and Perceived behavioural control) correlated with the intentions of the community members to engage or disengage in unhealthy behaviour. The theory of planned behaviour stated that perceived behavioural control, together with behavioural intention can be use to predict behavioural achievement (Brookes, 2021 ; Ajzen, 1985).

The two theories used for this study have valuable impacts on health risks associated with female genital mutilation in the study area which occurred due to practice of genital mutilation for young girls in the area as a result of religion or cultural believes of the residents in the study area.

METHODOLOGY

A descriptive research design of the survey type was adopted for the study. The population of the study comprises women of childbearing age. The target population made up of nursing mothers attending routine immunization centres in the Ilorin South local government area of Kwara State, Nigeria. Antoine (2020), Opined that the population include all members from a specified group, all possible outcomes or measurements that are of interest. The exact population will depend on the scope of the study. A sample consists of some observations drawn from the population, so a part of a subset of the population. The sample is the group of elements who participated in the study.

Study Sample

A multi-stage sampling procedure was used for the study. At stage one, cluster sampling technique was used to divide the routine immunization centres existing in the study area into four recognized constitutional districts namely; Balogun Fulani district, Akanbi district, Oke-Ogun district and Okaka district. Stage two, purposive sampling technique was used to select one routine immunization centre that has the highest number of nursing mothers attending routine immunization programme and four routine immunization centres were selected. The selected centres were the University of Ilorin Teaching Hospital (UITH) routine immunization centre, Tanke primary health care centre, Olufadi basic health centre and Magaji Okaka primary health care centre. Stage three, a proportionate sampling technique was used to choose seven per cent of the monthly target population of the selected routine immunization centre. One hundred and seventy-five respondents were selected from UITH, twenty-one respondents selected from Tanke PHC, thirty-seven respondents selected from Olufadi basic health centre and nine respondents were chosen from Magaji Okaka primary health care centre. Stage four, a simple random sampling technique was used to select the number of respondents required from each of the selected routine immunization centres. Two hundred and forty-two respondents selected for the study. The instrument used for the was a researcher-developed questionnaire titled Health Risk Associated with Female Genital Mutilation Questionnaire (HRAFGMQ) which was validated by three experts in a related field and tested for reliability. Daniel (2020) pointed out that a

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questionnaire is a research device or instrument that is made up of a series of questions that are closed-ended or open-ended. The goal is to collect relevant data from respondents which can then be used for a variety of purposes. When you give the respondent the ability to give a longer answer, it can yield more insights because they can elaborate on their thoughts. The test-retest method was used to obtain the reliability of the instrument. Pearson Product Moment Correlation was used to obtain a correlation coefficient result of r = 0.85. The researchers administered the instrument with the help of the three trained research assistants. Inferential statistics of chi-square was used to test the two hypotheses set for the study at 0.05 alpha level using Statistical Package for Social Sciences (SPSS) 25.0 version.

RESEARCH FINDINGS

The results obtained from the two hypotheses used for the study were shown on the tables below:

Hypothesis one: Dyspareunia is not significantly a health risk associated with female genital mutilation as express by women of childbearing age in Ilorin South LGA, Kwara State, Nigeria

Table 1: Dyspareunia as a health risk associated with female genital mutilation

S/N	STATEMENT	SA	A	D	SD	ROW TOTAL	df	CAL. x^2 VAL	TAB. x^2 VAL	Rejection/ Acceptance
1	Women who are subjected to the severe form of FGM experience vaginal laceration During coitus	100 (41.3%)	93 (38.4%)	30 (12.4%)	19 (7.9%)	**242**				
2	FGM lead to swelling of Genital tissue	80 (33.1%)	140 (57.9%)	10 (4.1%)	12 (4.9%)	**242**				
3	FGM lead to the problem of labia agglutination	95 (39.2%)	89 (36.8%)	30 (12.4%)	28 (11.6%)	**242**	**9**	**45.63**	**16.92**	**$H0_1$ rejected**
4	FGM result in the problem of Laceration of the vaginal tract	114 (47.1%)	60 (24.8%)	40 (16.5%)	28 (11.6%)	**242**				
	Column Total	**389**	**382**	**110**	**87**	**968**				

@ 0.05 alpha level; df= degree of freedom, SA= Strongly Agree, A= Agree, D= disagree, SD= Strongly Disagree

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Table 1 shows the result of the tested hypothesis one which stated that dyspareunia is not significantly a health risk associated with female genital mutilation. The hypothesis has a calculated chi-square value of 45.63 which is greater than the tabulated chi-square value of 16.92. This shows that hypothesis one was rejected which implies that dyspareunia is a health risk associated with female genital mutilation as express by women of childbearing age in Ilorin South LGA, Kwara State, Nigeria. The result of this finding supported by the theory propounded by Perkins and Berkowitz which refer to as theory of social norms, the theory argued that risks portraying individuals and families as totally determined by the social-cultural context which can be used to understand how a change in social norms can lead to fundamental change in behaviour. The circumstances make some family practice female genital mutilation without considering its consequences such as bleeding, infections or dyspareunia.

Hypothesis two: Infertility is not significantly a health risk associated with female genital mutilation as express by women of childbearing age in Ilorin South LGA, Kwara State, Nigeria

Table 2: Infertility as a health risk associated with female genital mutilation

S/N	STATEMENT	SA	A	D	SD	ROW TOTAL	df	CAL. x^2 VAL	TAB. x^2 VAL	Rejection/ Acceptance
1	Urinary tract infection is health risk of female genital mutilation	82 (33.8%)	65 (26.9%)	60 (24.8%)	35 (14.5%)	**242**				
2	FGM lead to the problem of chronic pelvic pain	70 (28.9%)	63 (26.1%)	68 (28.1%)	41 (16.9%)	**242**				
3	FGM result to problem of inflammatory disease	95 (39.3%)	76 (31.4%)	41 (16.9%)	30 (12.4%)	**242**	**9**	**32.41**	**16.92**	**$H0_2$ rejected**
4	Women subjected to FGM Experience low libido	78 (32.2%)	83 (34.3%)	35 (14.5%)	46 (19%)	**242**				
	Column Total	**325**	**287**	**204**	**152**	**968**				

@ 0.05 alpha level; df= degree of freedom, SA= Strongly Agree, A= Agree, D= disagree, SD= Strongly Disagree

Table 2 shows the result of the tested hypothesis two which stated that infertility is not significantly a health risk associated with female genital mutilation. The hypothesis has a calculated chi-square value 32.41 is greater than tabulated chi-square value of 16.92. This shows that the hypothesis two was rejected which implies that infertility is a health risk associated with female genital mutilation as express by women of childbearing age in Ilorin South LGA, Kwara State, Nigeria. The conclusion of this finding is in line with the theory propounded by Azjen I

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whicih refer to as theory of planned behaviour. The theory pointed out that the personal attitudes of an individual's plus the subjective norms and behavioural control determine community members' behaviour to engage or disengage on unhealthy practices. In this situation, peoples' attitude, their cultural or religion believes and level of their awareness on health consequences associated with genital mutilation such as bleeding, injury to labia minoral or labia majoral, inflammatory diseases, pelvic disease as well as infertility will determine their willingness or unwillingness to practice genital mutilation.

DISCUSSION

The result of the first hypothesis tested for the study revealed that dyspareunia is a significant health risk associated with female genital mutilation. This finding is in line with Odukogbe et al. (2017) who's opined that one of the cultural and religious reasons for justifying the practice of FGM/C is in the reduction of promiscuity and ensuring virginity before marriage. While attempting to achieve its presumed benefit through reduction in sexual drive and desire it has a negative impact on the overall woman's sexual life. FGM/C deprives women of sexual satisfaction and denies them of their right to sexual health and pleasure to achieve full psychophysical well-being. Circumcised women have reported several sexual problems including reduction in sexual desire, arousal, excitement, orgasm and dyspareunia at varying levels. The level of sexual dissatisfaction among circumcised women depends on the types of circumcision. Women with types II, III and IV are more likely to experience increased sexual dissatisfaction because of lower levels of sexual functioning, decreased arousal, vaginal dryness during intercourse, and orgasm with increased pain and decreased overall satisfaction than those with type I female genital mutilation. The finding also corroborate with the WHO (2021) pointed out that FGM damages anatomic structures that are directly involved in female sexual function and can therefore also have an effect on women's sexual health and well-being. Removal of, or damage to, highly sensitive genital tissue, especially the clitoris, may affect sexual sensitivity and lead to sexual problems, such as decreased sexual desire and pleasure, pain during sex, difficulty during penetration, decreased lubrication during intercourse, and reduced frequency or absence of orgasm (anorgasmia). Scar formation, pain and traumatic memories associated with the procedure can also lead to such problems

The result of the second hypothesis tested for the study showed that infertility is a significant health risk associated with female genital mutilation. This finding agreed with Ferjaoui et al. (2016) pointed out that Female Genital Mutilation (FGM) or excision is an old cultural practice in many African and Asian societies. The most common reason to practice genital mutilation is religious beliefs. This procedure is made by a nonmedical traditional practitioner commonly an old woman. Non sterile instruments are used without any hemostasis. That's why FGM is a common source of complications such as life-threatening hemorrhage, infection, acute and chronic pelvic pain, dysmenorrhoea, sexual dysfunction, obstetrics complications, psychological complication and infertility. Complications may occur immediately or in several years later. Also, the result of the study support the finding of Lars et al. (2005) on 99 infertile women and 180 women who pregnant for the first time were used for control group.

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The group selected during ante-natal care services in Khartoum hospital Sudan. All the participants had undergone female genital mutilation in childhood. The participants included in infertile group were those their infertility was not caused by hormonal factors, previous abdominal surgery or the result of their partner's infertility. The researchers conducted the study examined the genitalia of each women to record the extent of FGM. They also tested the women for sexually transmitted infections that may cause infertility. The incidence of sexually transmitted infections was low in both groups. The result indicated that infertile women had a significant higher risk of having undergone the most extensive form of FGM which involving the labia majoral (female external genitalia) than the control group. The finding shows a strong positive association between the anatomical extents of FGM and primary infertility. The association is not only statistically highly significant, but also highly relevant for preventive work against this ancient practice.

CONCLUSIONS AND RECOMMENDATIONS

Female Genital Mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injuries to the female genital organs for non-medical reasons. The practise is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. Female Genital Mutilation (FGM) has no health benefits and it harms girls and women in many ways. The practice involves removing and injuring healthy and normal female genital tissue, interfering with the natural functions of girls' and women's bodies. It can lead to immediate health risks, as well as a variety of long-term complications affecting women's physical, mental and sexual health and well-being throughout the life-course. FGM is considered a harmful traditional practice because it has no health benefits and is associated with a variety of negative health implications, including bleeding, infection, cyst formation, dyspareuinia (painful sexual intercourse), infertility and issues during childbirth. The findings from the study showed that, dyspareunia and infertility are health risk associated with female genital mutilation in the study area. Swollen of genital tissue and laceration of the vaginal tract were the major predicament which later resulted to problem of dyspareunia among families practice genital mutilation for their young girls and women. Some women experience problem of libido, chronic pelvic pain, urinary tract infections and inflammatory disease as a result of circumcision which later resulted to infertility problem when married. For any notable change to occur in the study area, the local government authority should carry out enlightenment campaign through mass media on health effects associated with genital mutilation to enable parents desist from the practice. The local government authority should formulate law that will regards practice of genital mutilation as an offence to save the life of young girls against health problems involve in the act. The federal government of Nigeria should enact law against practice of female genital mutilation and people caught violating the law should be severely sanctioned according to the law to protect girls against the risk of dyspareuinia and infertility which could be the consequences of female genital mutilation.

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