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Female genital mutilation as sexual disability: perceptions of women and their spouses in Akure, Ondo State, Nigeria

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Abstract: *Disability encompasses the limitations on an individual's basic physical activities, and the consequent social oppressions such individual faces in society. In this regard, the limitation on the use of some parts of the genitals in a patriarchal system is considered a form of disability. This paper describes the perceptions of and the coping mechanisms employed by affected couples dealing with the consequences of female genital mutilation (FGM) as a form of sexual disability. Cultural Libertarianism was employed as a theoretical framework. The paper presents the results of a descriptive cross-sectional study conducted in Akure, Ondo State, Nigeria, with 10 male and 12 female respondents purposively selected through a snowball sampling for in-depth interviews. The findings present the justifications provided for the practice of FGM, and victims' perceptions of how it affects their sexual relations. Furthermore, it highlights coping strategies employed by affected women and their spouses. The study shows 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. DOI: 10.1080/09688080.2017.1331685*

Keywords: sexual disability, reproductive health, female genital mutilation, coping strategies, Nigeria

Introduction

Impairment is often used to make reference to a condition that to a large extent limits the basic physical activities of an individual, such as limitations in movement, sight, reaching, hearing and more. A measurable impairment that interferes with a person's ability to make use of body parts constitutes the definition of such terms as disability and impairment. Crisp¹ distinguishes one from the other, noting that a person with physical or intellectual limitations is said to be impaired, whilst a disability means being unable to function in the same way as most people in that particular area. One area where the full extent of disability has not been fully explored, despite extensive research on the discourse, is in the realm of sex and sexuality. Questions have been raised time and time again about coping strategies adopted in dealing with the sexual consequences of disability,²⁻⁵ and the desirability as well as frequency of

sexual activities of those defined as disabled as a result of their loss of limbs, non-fully developed minds, or other body parts. However, that one area that is often left out of the definition of disability is the loss of certain parts of the reproductive organs. This is particularly important given Thomas's⁶ contention that a thorough analysis of disablement must examine the impact of "impairment effects" on the lives of the people living with disabilities. Oliver⁷ noted that social oppression plays a crucial role in the definition of impairment as disability, thus providing that the social oppression of women who have undergone female genital mutilation (FGM) in patriarchal societies takes the loss of some sex organs from the realm of impairment into the realm of disability. The resulting limitation on, or the inability to use some parts of the genitals should be considered a form of disability. As well as the physical one defined by the medical model of disability, the social model reveals a sexual disability as it views FGM from

an angle of oppression and discrimination, which violates the rights of the girls and women affected, and has a myriad of sexual and reproductive health implications.⁸

FGM has been defined as “all procedures involving partial or total removal of the external female genitalia or any injury to them for socio-cultural and non-therapeutic reasons”.⁹ Also known as female circumcision or female genital cutting, the continued practice of these demeaning acts has in recent times received the attention of international organisations. For instance, the United Nations General Assembly passed resolutions, first in 2012: 67/146, and again in 2014: 69/150, intensifying global efforts for the elimination of FGM, and affirming that it constitutes a serious threat to the health of women and girls including their psychological, sexual and reproductive health.¹⁰ These resolutions note that the victims of this harmful practice face immediate consequences, and possibly long-term effects, including the loss of sexual functioning.^{11–13} Muteshi et al⁸ discussed the physical and medical harms brought about by FGM to include severe pain, bleeding, shock, difficulty in passing urine and faeces, chronic pain and susceptibility to infections, particularly sexually transmitted infections (STIs). Other complications include obstetrical problems such as prolonged and/or obstructed labour, perineal tears and post-partum haemorrhage, which could lead to maternal and foetal/neo-natal death. These complications could in turn affect sexual functioning whilst inhibiting sexual pleasure and the ability to commit emotionally and mentally to relationships, and lead to imbalances in marriage and adult life.^{14,15}

According to the Nigeria Demographic and Health Survey,¹⁶ the estimated prevalence of FGM in women in Nigeria aged 15–49 is 24.8%, despite the fact that the act is a criminalised offence.^{17,18} UNICEF¹⁰ aptly notes that the “more than twenty million” affected Nigerian girls and women represent a massive 10% of the global total. The concentration of affected women in Nigeria, and the need to understand the sexual consequences of the practice from the viewpoint of affected couples prompted this study. Coping with these sexual consequences is a major issue, given the sexual disability caused by FGM.¹⁹

The widespread existence of the practice in patriarchal societies, particularly African cultures around the world, persists due to a number of reasons, ranging from cultural to religious and

individual reasons, and is supported by impunity by domestic laws.²⁰ Hejil²¹ and Abdel-Azim²² note that within such societies where this practice is predominant, circumcising the girl-child is thought to help in reducing her libido, keeping her uninterested in exploring sex and her own sexuality, and consequently preserving her virginity till she gets married.^{15,23} Other scholars^{24–26} assert that the practice, which transcends religious affiliations, tribe, or educational attainment, is a part of patriarchal societal norms that is handed down from one generation to another and any attempt to discontinue the practice will be met with societal pressure and the risk of isolation.⁸ Abdel-Azim²² further explained that sexual excitement of the female is sought to be blocked by partially or totally removing the clitoris, or other parts of the female genitalia, an impairment which this paper posits more often than not has implications for the sexual satisfaction of not just the disabled person, but also for her spouse.

This paper documents the views of women who have been subject to this harmful practice, often in childhood.²⁷ It further explores how issues revolving around sexuality and sexual experiences of the “disabled” are negotiated within the framework of marriage in Southwest Nigeria. This is crucial particularly in light of the fact that virginity, despite modern trends and a changing morality, is still revered in many parts of patriarchal Nigeria and Africa.²⁸ Furthermore, Hughes and Patterson²⁹ note that the relationship existent between the disabled and their bodies extends beyond the field of medicine, into psychosocial and cultural effects, policies and remedies.

From the foregoing, how women cope with the sexual disability foisted on them by FGM, is a crucial part of this study. The process of coping with various forms of disabilities has become an emerging area of study in recent years,⁴ with quite a number of studies focusing on the various strategies adopted by individuals in coping with diverse disabilities. There is no universally accepted conceptualisation of coping strategies. Albeit, findings from previous studies on the subject have tried to demonstrate gender differences in coping strategies³ pointing out that women report more daily stress and depression, and greater use of coping via social support and emotional venting^{2,5} whereas males turned to humour, or hobbies such as sports. Gender differences in coping could thus be interpreted as evidence for gendered socialisation of emotions, and construction of

realities. As such, women who have undergone FGM, like other people with various forms of disabilities, evolve various strategies with which they cope with this disability. Their spouses are also part of this study, as they have to cope with the effects of the sexual disabilities of their wives, and this also may take diverse forms.

The general objective of this study is thus to describe the perceptions of, and the coping mechanisms employed by affected couples dealing with sexual disability resulting from FGM.

Theoretical framework

A Cultural Libertarianism view of patriarchy

The theoretical framework applied to this study is the Cultural Libertarianism framework. Feminists in this view argue that in patriarchal systems, women are not only systemically unrepresented or underrepresented, they also have freedom, economically or otherwise, to the extent that men willingly give it to them through cultural practices.³⁰ Bem³¹ wrote that in patriarchal societies, the woman is defined as different from and inferior to the man. She further asserted that some feminists incorporate Marxist notions into this argument by asserting that men have defined women as private property. Rubin,³² in what is termed “the sex/gender system”, noted that kinship relations are at the basis of patriarchal societies with women internalising the appropriate societal norms. In this system, members of society are socialised to regard women as objects suited to fulfil the needs of their masculine partners, that is, women’s sexuality exists to please men.³³ Thus, whether a woman desires sex is often irrelevant, while men’s needs and experiences are important, with coitus being defined by male pleasure and orgasm. The sexual satisfaction of the man often comes with the price of pain for the woman, with “bridal innocence” (virginity) at marriage and spousal faithfulness thereafter also considered as very important. Practices such as FGM, foot-binding, wife inheritance and breast ironing represent the inequalities manifest in the patriarchal society at different time epochs and in different places. These practices, although often illegal, and at times disabling, are mostly met on women and girls, often by other women, not for their own benefits, but in pursuance of male pleasure,³⁴ hence giving them legitimacy and social acceptance in these male-centred societies despite global concerns.^{35,36}

Method

The study adopted a descriptive cross-sectional research design, and a qualitative methodology employing the use of semi-structured in-depth interviews which focused on areas such as the socio-cultural justification for FGM; the perception of their situations as disabling or otherwise; coping mechanisms adopted by both the victims and their spouses to deal with the consequences of this sexual disability as a result of FGM. The interviews were conducted by the researchers in either English or Yoruba (the dominant language in the region) depending on the respondents’ level of education and grasp of the language. Furthermore, these interviews, consisting of 10 married women whose spouses were accessed for interviews as well as two women whose spouses were unavailable, were conducted separately for each individual.

Area of study

The South East and South West Zones of Nigeria according to DHS¹⁶ are deemed to have the highest prevalence of FGM in the nation (49% and 47.5%, respectively). Of particular interest within this study is Ondo State in the Yoruba-speaking South Western part of Nigeria, due to the fact that it is home to the Abiye Initiative (Safe Motherhood Programme) which focuses on the reproductive health of women and health issues of young children.^{37,38} The State also serves as host to many activities of the Inter-African Committee on Traditional Practices (IAC) particularly with regards to FGM.^{39,40} Despite the above strides, it must be noted that the State still has a 45% prevalence of circumcised women.¹⁶ The area of study is Akure town, an urban centre and the capital of Ondo state, thus contributing to the 32.3% of Nigerian women between ages 15 and 49 who have undergone FGM, and live in urban areas.

Sample selection

Twenty-two participants for the study were purposively selected, using snowball sampling, and included married women who had been subject to FGM, and their spouses. Marital status and prior mutilation of the female genitalia were considered as inclusion criteria for the women. Willingness to take part in the study was the only inclusion criterion for the spouses. The age range, which was also an inclusion criteria, of female respondents was 28–50, due to the need

to allow for notions of sexual satisfaction, coping, childbearing, marital experience and a depth of spousal relations among others. Married women below the age of 28 were excluded for the reasons above-mentioned, as were married women above 50 years of age, as there was the need to interview women within the child-bearing age.

Data collection and analysis

Primary data were collected in June and July 2016 using semi-structured in-depth interviews, which were conducted in the respondent's preferred language (Yoruba or English) and on average lasted for 1 h and 15 min per session. Interviews were recorded and notes were taken by research assistants, and later translated into English language by interpreters. Male researchers interviewed male respondents and female researchers interviewed female respondents to allow for respondent experiences to be freely expressed. Collected data were verified by the researchers, as well as interpreters and analysed using Atlas.ti version 7.5.7, and correlating basic themes were identified using open coding in the same software.

Instrument

The interview-guide focused on a number of issues, including how a couple's perception of their sexuality could affect their sexual relations; how culture shapes a couple's sexual relations; socio-cultural justifications for FGM; the extent to which FGM can influence sexual relations between spouses; and how spouses cope with the sexual and physical challenges prompted by FGM.

Ethical considerations

Written informed consent was sought from all respondents. Anonymity and confidentiality of data were ensured by identifying the respondents with codes only, and keeping identifying markers out of the data, as well as restricting access to the data set to the researchers. Approval for the study was granted by the Ethics Committee of the Department of Sociology (University of Ibadan).

Results

The socio-demographic characteristics of the respondents are presented in Table 1. The modal age of female respondents was 30–39, while for male respondents, the age group with the highest

Table 1. Socio-demographic characteristics of respondents.

Variables	Frequency (22)	
	Male (10)	Female (12)
<i>Age</i>		
20–29	0 (0%)	1 (8.3%)
30–39	3 (30%)	6 (50%)
40–49	6 (60%)	4 (33.4%)
50–59	1 (10%)	1 (8.3%)
<i>Religion</i>		
Christianity	10 (100%)	10 (83.3%)
Islam	0 (0%)	2 (16.7%)
<i>Educational level</i>		
Primary education	0 (0%)	3 (25%)
Secondary education	1 (10%)	2 (16.7%)
Tertiary education	9 (90%)	7 (58.3%)
<i>Occupation</i>		
Civil servant	5 (50%)	2 (16.7%)
Public servant	2 (20%)	5 (41.6%)
Private employment	2 (20%)	1 (8.3%)
Trading	0 (0%)	4 (33.4%)
Artisan	1 (10%)	0 (0%)
<i>Membership of local community</i>		
Non-indigenes	1 (10%)	0 (0%)
Indigenes	9 (90%)	12 (100%)

frequency was 40–49. The absolute majority was Christians and indigenes of Akure; with the level of education of the majority being tertiary.

The socio-cultural justifications for the continued practice of FGM as given by respondents are presented on Table 2. The reasons highlighted by the majority of the respondents are: the need to curb promiscuity among young women before and after marriage, as well as the need to continue

Table 2. Reasons for FGM.		
	Socio-cultural justification for FGM	Respondents frequency (%)
(1)	To keep up with traditional practices	Male: 10 (100%)
		Female: 12 (100%)
		Total: 22 (100%)
(2)	To curb promiscuity	Male: 10 (100%)
		Female: 12 (100%)
		Total: 22 (100%)
(3)	To avoid being ostracised	Male: 7 (70%)
		Female: 11 (91.7)
		Total: 18 (81.8%)
(4)	To prevent child death	Male: 8/10 (80%)
		Female: 5/12 (41.7%)
		Total: 13 (59.1%)
(5)	To prevent infertility	Male: 1 (10%)
		Female: 0 (0%)
		Total: 1 (4.55%)

with traditional customs and rites. These were views expressed by a number of respondents, some of which are provided below.

“It is believed that if the female is not circumcised, she will have a strong urge for sex. The sexual drive is located in the clitoris and that is why it is cut off. It is to curb promiscuity by reducing the libido.” (Male, 41)

“When I asked my mother why she did it for me, she said she did not know, that it is something that has always been done. I can say it is just tradition.” (Female, 40)

“In the olden days, it was compulsory for circumcision to be done for both male and female. It is something we met, our forefathers used to do it and it was handed down to us.” (Female, 40)

Others reasons included: avoidance of neo-natal mortality, avoiding ostracism for failing to observe

traditional practices and the fear of infertility. Interviewees’ responses included:

“It is done to stop promiscuity. Also, when a woman wants to give birth, if she is not circumcised the baby’s head may break. This is according to Yoruba tradition.” (Female, 45)

“A girl who was not circumcised was kind of ostracised, she was seen as a promiscuous lady or one who had promiscuous tendencies.” (Female, 50)

“According to what I heard from my mother, any woman who is not circumcised cannot give birth. So, it is done to prevent infertility.” (Male, 39)

The female respondents were questioned on how they perceived FGM in relation to their sexual satisfaction in marriage. Many of them described the amount of “pain” or “pleasure” they derived from intercourse. Two of the 12 women interviewed had mixed feelings about the way they viewed its influence, citing that sometimes, they experienced some degree of pain, and at other times, they enjoyed sex:

“Women who are circumcised do not get aroused easily. The man will enjoy the sex, but the woman may not. She could enjoy it at times and at other times, especially when she feels pains, she would not.” (Female, 37)

Two other respondents stated that they were mostly satisfied during sex, although this notion was held due to a lack of sexual experience prior to marriage.

“I do not know how female circumcision influences sexual satisfaction for a woman and I do not think it affects the man. Maybe I enjoy sex because I had no sexual experience before.” (Female, 32)

Sixty-six per cent (eight persons) of the female respondents, however, held negative views about sexual intercourse, stating concerns relating to pain, frigidity and dissatisfaction. One of the respondents stated that the resultant sexual dissatisfaction was not limited to the wife alone, but also affected the husband.

“Female circumcision causes frigidity and sexual dissatisfaction for both the husband and wife, I am talking from personal experience and experiences shared with me as a counsellor.” (Female, 50)

The majority (nine) of the spouses, however, noted that there was a marked difference between their sexual experiences with women with or

Table 3. Coping among victims and their spouses.

No.	Coping among spouses of victims	Frequency among male spouses
(1)	Stimulating other parts of the body	4 (40%)
(2)	Applying sexual “experience”	3 (30%)
(3)	Trying and Re-trying	4 (40%)
(4)	Communication and Counselling	2 (20%)
(5)	Seeking sexual satisfaction outside the marriage	7 (70%)
No.	Coping among victims	Frequency among women
(1)	Seeking knowledge	4 (33.3%)
(2)	Not expecting more than what one gets	4 (33.3%)
(3)	Seeking solace in one’s children	6 (50%)
(4)	Giving in	9 (75%)

without FGM, with their wives often complaining during sex, unwilling to engage in different sexual positions, and seemingly less desiring of sex to the extent of just lying down passively and entirely motionless during intercourse, than some of their other partners who had not gone through the practice. However, seven affirmed that they had extramarital sex frequently with different partners, while two male respondents noted that they had sexual relations with women, who had not been subjected to FGM, prior to their marriages. When questioned further on whether they still had sex with their wives and why, all seven stated that they still did, but at varying frequency, and for various reasons which included not depriving the wife of her marital right and a sense of entitlement whenever another option is not available. Only one male respondent claimed that he had no sexual experience before marriage, and had since his marriage remained faithful to his wife. This

respondent, however, pointed out that he could not definitely attribute his wife’s occasional rejection of his sexual advances, and complaints of pains after sex, to FGM, because his mother as well as his sisters also had gone through the same practice, and he had never heard any complaints about it affecting their sex lives either from his father or from his in-laws, thus he often believed that she (his wife) was just being too lazy.

Spouses of the victims of FGM were then asked about the coping strategies adopted to deal with the ensuing sexual challenges. The spouses mentioned different techniques they had adopted to ensure sexual satisfaction for both themselves and their wives. The majority (seven) of the respondents confessed to seeking sexual satisfaction outside the marriage from other women;

“Religion influences my sexual relations, Solomon in the Bible had so many wives and concubines which is why I have girlfriends to satisfy me.” (Male, 41)

“My wife knows I have girlfriends, she only begs me day and night not to impregnate any of them. She begs me morning, afternoon and night.” (Male, 37)

Some respondents were open to communicating and seeking psychological help alongside their spouses. Other coping strategies adopted include attempts at stimulating other erogenous body parts, the application of sexual experience and continuous trial and retrial efforts (Table 3). Some of the responses given were:

“Cutting the clitoris makes a woman less sexually aroused, some other sensitive parts of the body have to be stimulated to get her aroused.” (Male, 38)

“It is good, but not perfect; but that shows that the remaining job lies in my hand, if I was not an experienced person, I would have given up. But because of my experience, I know how to handle circumcised women.” (Male, 41)

“Sexual satisfaction means enjoyment of sex, especially when it is mutual but most of the time I get to my peak before my wife and then I have to rest for a while before trying again, so that she can attain her own satisfaction.” (Male, 41)

“There should be open communication about sex. There should be sexual counselling sessions for the couples; Yes, I am more sensitive to my partner’s needs than she is to mine.” (Male, 41)

The coping strategies employed by women who have undergone this harmful practice include

giving in to their husbands' sexual demands; tending to their children; seeking knowledge and having low expectations prior to intercourse with their spouses. Giving in to the demands of their spouses was the most employed coping strategy among the women, with 9 out of 12 women stating that they often do this to avoid trouble in the home. The responses below are some of the statements made by the women interviewed:

"From what was happening around me, I had some kind of fear especially in regards to sex. Growing up in a local area, there were people who always came to my house for dispute settlement, my dad being the community head, and most of the issues were sex related, how the woman wasn't giving herself to her husband etc. This made me take steps to avoid such in marriage, I read books on sexual relationship in marriage. And these books gave me a different perspective on marriage and sex and also gave me positive expectations." (Female, 40)

"I had no sexual expectations because I was told that sex was wrong and so I never imagined it." (Female, 45)

"It seems more of a slave-master relationship, it seen as though the woman is the slave and the man is the master ... her husband could cheat, she usually took solace in her children if she had any. Men are more licentious." (Male, 40)

"Clerics tell us not to be involved in any extra-marital sexual practices, that is, in marriage to stay faithful. I have never denied my husband sex, whenever he needs it and I always oblige, even when I am feeling pains." (Female, 32)

Discussion

In every society within which FGM is widely practiced, men and women usually support it without question, with condemnation, harassment and ostracism as a punishment for dissent. This manifestation of gender inequality is perpetuated by the social, economic and political structures within such societies. As observed in this study, such socio-cultural justifications given for the continued practice of this mutilation range from the need to keep up the traditional practices of forebears, to reducing promiscuity, and false beliefs that it prevents infertility and infant mortality.⁴¹ These findings support the National Demographic Health Survey report⁴² which noted that the supposed benefits of FGM among practising communities

were, among others, social approval and acceptance, preservation of virginity, better marriage prospects, and more sexual pleasure for the husband. Alaba²⁸ further made an allusion to this in his work on understanding Yoruba sexuality, stating that great importance had always been attached to virginity. It is often believed that the practice ensures and preserves a girl's or woman's virginity. In such patriarchal settings, it is thought to ensure marital fidelity,^{15,23} with an expectation that men will marry only women who have undergone the practice, due to a notion that the practice enhances men's sexual pleasure, with many seeing it as essential to ensure proper marriages as well as a means of fulfilling local ideals of womanhood and femininity;⁸ an idea that further reinforces the patriarchal nature of such practices, wherein the voices and sexuality of the female victims (many of whom were children at the time of the circumcision), were tailored to meet the specifications of the male-centered society. This is supported by evidence from Okunade et al²⁷ who noted that most FGM victims who participated in their study, as well as other studies, had been circumcised during their childhood and early puberty, underscoring the importance of the need for relevant government agencies to protect girls and young women in this regard.

Findings also point out that majority of the female victims of the practice experience sexual dissatisfaction, pain and frigidity within their marriages as a direct consequence of FGM, resulting in feelings of lack of sexual fulfilment, and inability to measure up to other women who have not been subjected to the practice. Furthermore, the removal of or damage to the clitoris and other sensitive genital tissues, may not only affect sexual sensitivity and the quality of sexual life, but bring multiple sexual problems, not least decreased sexual pleasure and chronic pain during sex, which can be due to trapped or unprotected nerve endings. Also, bleeding as a result of friction may occur during sex from scars increasing the risk of STI transmission, not least HIV, increasing the sexually disabled's vulnerability to health challenges, complications and infections.^{11,12}

In addition, studies^{14,15} have shown an increased likelihood of fear of sexual intercourse, post-traumatic stress disorder, anxiety, depression and memory loss, as pain during sex may become the foundations of psychologically traumatic episodes which may affect the victim's outlook on sex, and eventually marriage. Muteshi et al⁸ note

that eating and sleeping disorders have been attributed to FGM. This raises the question of how affected women and their spouses cope with the sexual frigidity, dissatisfaction and pain which result from FGM. Negativity towards sex as noted among the women who were interviewed in this study, and unsatisfactory sexual intercourse due to their wives' complaints of pain, and reluctance to participate actively, highlighted by spouses, create a major problem experienced by couples as a result of the impairment caused by the crude practice of FGM.

In general, when a person with a disability is unable to cope, negative perceptions about such person may be held by others in the forms of stereotypes, derogatory labels and depersonalisation, and may manifest in the portrayal of such a person as helpless, suffering and deserving of sympathy.^{43,44} One such instance is observed in this study, wherein the spouse due to the fact that he is yet to hear his mother or his sisters complain about their own sexual issues, labels his wife "lazy". Discussing one's challenges with others is often regarded as complaint and a sign of one's inability to cope. At other times, disabled persons are discriminated against. As noted in the preceding section, the victims of FGM are often thought to be portrayed in a negative light when they are unable to cope with the negative and disabling effects of the practice. Karhu⁴⁵ pointed out that such women reported a lack of sexual desire, which often led to divorce because their husbands saw them as unfit partners. The psychological trauma and issues of painful intercourse which are attendant problems when mentioned to others may paint the disabled as helpless and suffering, and create a situation where the disabled may be shamed into silence.

This study noted that women more often sought emotive-repression by denying their expectations, or indirect emotional support by leaning on their children as means of coping. Others however surrender to their disability by giving in to their husbands whenever sex was required of them.

On the other hand, their spouses sometimes deal with sexual dissatisfaction by seeking more sexually gratifying relations outside the home which may have further damning consequences for the marriage, while others attempt to find means by which to ensure their "disabled" wives can attain a degree of sexual satisfaction.

In some patriarchal communities, wherein the practice of FGM is rampant, the sexual desires of women are not considered important, with sexual

desires and the initiation of sexual relations being considered the property of the man; and male sexual satisfaction and pleasures being used as the major criteria for judging to what extent marital sexual life is satisfying for both partners.³⁴ Bartoi and Kinders¹⁹ pointed out that circumcised women may not be able to recognise sexual satisfaction. Coping strategies for dealing with the issues arising as a result of FGM, however, helps construct the notion of sexual satisfaction which becomes peculiar to individuals and defines their experiences. Findings from the study show that both men and women alike place a high importance on sex, although with differential opinions on what can and should be sexually satisfying, with the majority of the women believing that giving in to the sexual demands of their spouses should buy them some "peace", while the majority of the men were dissatisfied with the sexual relations with their sexually disabled wives, and believed their problems could only be solved by seeking sexual satisfaction elsewhere. Although some of the findings of this study are in tandem with Lightfoot-Klein's⁴⁶ position that men often tried to arouse their partners who had gone through FGM through several other means, the study however confirms that the patriarchal beliefs and values defining sex and sexual satisfaction by male satisfaction alone still exist as shown above. In addition, the continued use of coping strategies to deal with FGM, such as surrendering among women, and extra-marital affairs among men, accentuate that, beyond the denial of a woman's rights to a healthy sexual life, this harmful practice passes on her a verdict of disability in her sexual life.⁴⁷

Conclusion

FGM is an archaic practice which not only perpetuates gender inequality within the societies wherein it is practiced, but also brings about disabling consequences among its victims. The disabling consequence of FGM that this paper focuses on is sexual in nature, is justified with a variety of cultural reasons, and, as this study notes, is traumatic and has grievous implications for marital and sexual bliss. Coping thus becomes a very important aspect of sex life among affected couples, with couples adopting a number of strategies often detrimental (and often reinforcing patriarchal inequality) to the affected women and to spousal relations, in dealing with the challenges brought about by the disability. Muteshi et al⁸ point out

that isolated acts such as training health personnel or educating female students produced no effects in knowledge or beliefs/attitudes about FGM, as against the effect of multifaceted community activities which increased knowledge about, and affected prevalence of, FGM. Altogether, there is a need to attack this disabling cultural practice at all levels, including: the criminalisation of the practice, providing psychosocial and medical support for its victims, and involving traditional and religious leaders in anti-FGM initiatives.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Appendix 1

INTERVIEW GUIDE FOR MARRIED WOMEN WHO HAD GONE THROUGH FGM

SECTION A

Background

Socio-Demographic characteristics: Age, Religion, Ethnicity, Occupation, Educational Level, Age/Status at FGM

SECTION B

Determine the extent to which FGM can influence Sexual relations.

1. How long have you been married?
2. How can you describe your sexual relations (intercourse) with your spouse? Probe for:
 - i. importance of sex in respondent's marriage,
 - ii. reasons for having sex, iii. Who wields control of sexual matters in marriage? Probe for: who often initiates sex? How often do you have sex? Are you always sexually responsive? How often do you feel sexual desire or interest? How often do you feel sexually aroused? Have you ever experienced orgasm? If yes, how often do you reach orgasm? Will you say you have a healthy sexual life? Probe further for (i) understanding of sexual satisfaction, (ii) sexual satisfaction
3. Knowledge and perception of FGM. Probe for – sociocultural reasons for FGM, forms of FGM, individual dispositions towards FGM, hazards and perceived benefits of FGM. Probe for: notion of FGM as sexually disabling.
4. How does FGM affect sexual intercourse with your spouse? Probe for: feelings about and the awareness of the effects of FGM on sexual intercourse, how it affects male and female sexual satisfaction. Do you experience pain during sex?

Section C

Determine coping strategies employed

1. Should there be open communication about sexual needs in marriage? Probe for: (i) her sexual expectations (ii) partner's sensitivity to her sexual needs.

2. What is your view on women having the right to demand sex and refusing her husband sex?
3. How do you cope with the effects of FGM on your sexual life? Probe for multiple coping strategies used. Probe for the effects these have on her relations with her spouse.

Appendix 2

INTERVIEW GUIDE FOR SPOUSES OF MARRIED WOMEN WHO HAD GONE THROUGH FGM

SECTION A

Background

Socio-Demographic characteristics: Age, Religion, Ethnicity, Occupation, Educational Level

Section B

Importance of Sexual relations in Marriage

1. How long have you been married?
2. How important is sex in marriage? Probe for: (i) reasons for sex in marriage. (ii) is sex equally important to both spouses (iii) should sex be equally enjoyed (iv) Who wields control of sexual matters in marriage? (v) who often initiates sex. (vi) do women have the right to demand sex (vii) does a wife have the right to refuse her husband sex?
3. Should there be open communication about sexual needs in marriage? Probe for: (i) sensitivity to partner's sexual needs. (ii) sexual expectations
4. Describe your cultural beliefs and practices regarding sexual intercourse. 2. What is the role of each spouse in sexual relations? Probe for: (i) who decides when it is right to have sex. (ii) Whose obligation is it to ensure satisfaction?

Section C

Determine the extent to which FGM can influence Sexual relations.

1. Knowledge and perception of FGM. Probe for (i) sociocultural reasons for FGM, (ii) forms of FGM, (iii) individual dispositions towards FGM, (iv) hazards and perceived benefits of FGM (v)

- notion of FGM as sexually disabling, (vi) differences in sexual experiences with women who had gone through FGM and those who had not.
2. Describe your sexual satisfaction with your spouse. Probe for: (i) positive or negative views of the impact of FGM on sexual relations (ii) is respondent always sexually satisfied (iii) is respondent's spouse always satisfied (iv) how he attempts to ensure that his spouse is sexually satisfied (v) how he attempts to ensure his own sexual satisfaction (vi) Do these have any implication(s) for the (sexual) relations between him and his spouse?

Résumé

Le handicap englobe les limitations des activités physiques essentielles d'un individu, et les oppressions sociales conséquentes que cet individu affronte en société. À cet égard, la possibilité limitée ou l'incapacité d'utiliser certaines parties des organes génitaux dans un système patriarcal est considérée comme une forme de handicap. L'objectif de cet article est de décrire les impressions et les mécanismes d'adaptation utilisés par les couples qui font face aux conséquences de la mutilation sexuelle féminine comme forme de handicap sexuel. Le cadre théorique utilisé est le libertarisme culturel. L'article expose les résultats d'une étude transversale descriptive menée à Akure, État d'Ondo, Nigéria, avec 10 répondants masculins et 12 féminins sélectionnés à dessein au moyen d'un échantillonnage boule de neige pour des entretiens approfondis. Les conclusions présentent les justifications fournies pour la pratique de la mutilation sexuelle féminine et montrent comment les victimes pensent qu'elle influe sur leurs relations sexuelles. De plus, l'article décrit les stratégies d'adaptation utilisées par les femmes concernées et leur conjoint. L'étude révèle que la conséquence invalidante de la mutilation sexuelle féminine est largement sexuelle de nature. Elle aboutit à des expériences traumatiques et des croyances négatives sur le sexe, et exige de multiples stratégies d'adaptation employées par les femmes handicapées et leur conjoint qui peuvent avoir leurs propres répercussions sur le bonheur sexuel et conjugal.

Resumen

La discapacidad abarca limitaciones en las actividades físicas básicas de una persona y las opresiones sociales consecuentes que enfrenta esa persona en la sociedad. A este respecto, la limitación o incapacidad para usar algunas partes de los genitales en un sistema patriarcal, es considerada como una forma de discapacidad. El objetivo de este artículo es describir las percepciones de las parejas afectadas, y los mecanismos empleados por éstas para lidiar con las consecuencias de la Mutilación Genital Femenina como una forma de discapacidad sexual. El Libertarismo Cultural fue empleado como marco teórico. Este artículo presenta los resultados de un estudio transversal descriptivo realizado en Akure, en el Estado de Ondo, en Nigeria con 10 hombres y 12 mujeres encuestados, quienes fueron seleccionados intencionalmente por muestreo de bola de nieve para entrevistas a profundidad. Los hallazgos presentan las justificaciones proporcionadas para la práctica de Mutilación Genital Femenina, y las percepciones de las víctimas de cómo ésta afecta sus relaciones sexuales. Además, se presentan las estrategias de afrontamiento empleadas por las mujeres afectadas y sus cónyuges. El estudio muestra que la consecuencia incapacitante de la Mutilación Genital Femenina es principalmente de carácter sexual, lo cual produce experiencias traumáticas y creencias negativas sobre las relaciones sexuales y requiere un sinnúmero de estrategias de afrontamiento empleadas por las mujeres discapacitadas y sus cónyuges, lo cual podría tener sus propias implicaciones para la felicidad conyugal y la dicha sexual.