

Full Length Research Paper

Prevalence and Awareness of Female Genital Mutilation in Southeast Nigeria: A Survey

Ibekwe Perpetus C.*, Onoh Robinson C, Onyebuchi Azubike K., Ezeonu Paul O.
and Ibekwe Rosemary O.

Department of Obstetrics and Gynaecology, Federal Medical Centre, Abakaliki, Ebonyi State.

Accepted 9 April, 2024

Female genital mutilation (FGM) has been recognised as a major reproductive health problem and a dehumanising practice that has resisted change especially in developing countries. The study reviews the current knowledge and practice of FGM in Southeast Nigeria. This is a questionnaire based descriptive study involving women of reproductive age in Abakaliki, South east Nigeria. A semi-structured questionnaire was distributed to 320 women by simple random sampling. Information sought included the socio-demographic characteristics, and personal information on FGM with regards to knowledge and practice. Two hundred and sixty (81.3%) were appropriate for analysis. The mean age of the respondents was 28.6 years \pm 5.4 SD. Most had formal education, with tertiary education contributing 60.8%. A high percentage was aware of FGM, and the problem associated with it was 91 and 72%, respectively. Half of the respondents (49.6%) were genitally mutilated while almost the same number (47.7%) affirmed that FGM is still practised today. Eighty – two percent do not support FGM but were not doing anything about it and 36% were not aware of any problem associated with FGM. The prevalence rate of FGM of 50% is high. Though most did not support the practice, nothing has been done to change the practice. Serious advocacy, government support and legislation are needed to curb this serious health problem as significant proportions are still not aware of the problems of FGM.

Key words: Female genital mutilation, prevalence rate, knowledge, practice, Abakaliki, Southeast Nigeria.

INTRODUCTION

The practice of Female Genital Mutilation (FGM) is regrettably persistent in many parts of the world. This occurs commonly in developing countries where it is firmly anchored on culture and tradition, not minding many decades of campaign and legislation against the practice (Onuh et al., 2006; WHO, 2008). Female genital mutilation comprises any procedure involving partial or total removal of the external female genitalia or other injury to the female genital organs for cultural, religious or other non-therapeutic reason (WHO, 2008; WHO, 1996). The World Health Organization (WHO) estimates that between 100 and 140 million girls and women worldwide are presently living with female genital mutilation and every year about three million girls are at risk (WHO, 2008). In Africa, it is estimated that about 92 million girls

from 10 years of age and above have undergone female genital mutilation (WHO, 2010). FGM is practised in one form or the other in 28 African Countries including Nigeria. It is also practised in a few countries on the Arab Peninsula, among minority community in Asia, and among migrants from these areas who have settled in Europe, Australia and North America (WHO, 2010; Toubia, 1994). In Nigeria, the prevalence of female genital mutilation averages 50% but ranges from 0% in parts of Kogi, Fulani and Ogun States to 100% in Benue and Kebbi States (Onuh et al., 2006; Toubia, 1994). With an overall national prevalence of 50%, Nigeria has the highest absolute number of genitally mutilated women throughout the world (Okonofua, 1998).

Female genital mutilation is classified into four major types (WHO, 1996). The most common type of the female genital mutilation is type 2 which account for up to 80% of all cases while the most extreme form which is type 3 constitutes about 15% of the total procedures

*Corresponding author. E-mail: drogoperps@yahoo.com.

(WHO, 1996; Oduro et al., 2006). Types 1 and 4 of FGM constitute the remaining 5%. The consequences vary according to the type of FGM and severity of the procedure (Onuh et al., 2006; Oduro et al., 2006).

The practice of FGM has diverse repercussions on the physical, psychological, sexual and reproductive health of women, severely deteriorating their current and future quality of life (Oduro et al., 2006; Larsen, 2002). The immediate complications include: severe pain, shock, haemorrhage, urinary complications, injury to adjacent tissue and even death (Onuh et al., 2006; Oduro et al., 2006; Larsen, 2002). The long term complications include: urinary incontinence, painful sexual intercourse, sexual dysfunction, fistula formation, infertility, menstrual dysfunctions, and difficulty with child birth (Akpuaka, 1998; Okonofua et al., 2002; Oguguo and Egwuatu, 1982). The physical and psychological sequelae of female genital mutilation have been well highlighted in many literatures (Onuh et al., 2006; Oduro et al., 2006; Badejo, 1983; Klouman et al., 2005; ACHPR, 2003; Ibekwe, 2004). Recently, there has been serious concern on the increased rate of transmission of Human Immunodeficiency Virus (HIV) following this practice (WHO, 1996; Klouman et al., 2005). The practice is also a violation of the human rights of the women and girl child. FGM categorically violates the right to health, security and physical integrity, freedom from torture and cruelty, inhuman or degrading treatment and the right to life when the procedure results in death. It constitutes an extreme form of violation, intimidation and discrimination.

Despite its numerous complications, this harmful practice has continued unabated, notwithstanding that Nigeria ratified the Maputo Protocols and was one of the countries that sponsored a resolution at the 46th World Health Assembly calling for the eradication of female genital mutilation in all nation (Klouman et al., 2005; ACHPR, 2003; Idowu, 2008).

In Ebonyi State, South-East Nigeria, FGM is viewed differently from their wide indigenous cultural inclinations and traditional beliefs. This study surveys the current opinion of women of reproductive age in the capital city of Ebonyi State, Abakaliki, South-East Nigeria on their knowledge and practice of FGM.

METHODOLOGY

The study was carried out in the Obstetrics and Gynaecology Department of the Federal Medical Centre, Abakaliki, Ebonyi State, Southeast Nigeria. Women who attended antenatal and postnatal care were recruited for the study between June to September 2010.

The hospital is located in Abakaliki the Capital city of Ebonyi State and receives referrals from all parts of the State and neighbouring States of Benue, Enugu, Cross River and Abia. Ebonyi State created in 1996 from the old Abakaliki division of Enugu State and old Afikpo division of former Abia State has 13 Local Government Areas (LGA's), one urban, one semi-urban and the rest rural. It has estimated population of about 4.3 million and occupies a land mark of 5935 km. About 75% of the population dwell in the rural areas with farming as their major occupation.

The study was conducted using a semi structured questionnaire which was administered using simple random sampling. The questionnaire was pretested, and validated by a pilot study. Written consent was obtained from the respondents before the study. The questionnaires were administered by trained nurses and doctors over a period of four months. Information sought included the socio-demographic characteristics, personal information on FGM with regard to the respondents' knowledge on the past and current practice of FGM and their suggestions on the best way to deal with the problem.

A total of 320 questionnaires were given out to the highly motivated respondents (antenatal and postnatal women) at the clinics, of which 260 were fit for analysis.

Data collation and analysis were done using Epi-Info 2007 Statistical Analysis Software package (CDC-Atlanta USA).

The study was certified by the Ethics and Research committee of the hospital. There was no conflict of interest.

RESULTS

Of the 320 questionnaires distributed, 260 (81.25%) were appropriately filled and returned for analysis.

Table 1 shows the socio-demographic characteristics of the respondents. The mean age of the respondents was 28.6 ± 5.4 years with range of 15 to 40 years. Majority of the respondents (61.5%) were in the age bracket of 20 to 29 years. 90% (294) of them were married while 10% (26) were not married. The literacy level was quite high in this study. About 60.8% had tertiary education while 3.8% had no formal education. Majority were civil servants (41.2%) by occupation. Regarding parity, 126 (48.5) were para 14, nulliparae 117 (45%), while 16 (6.2%) were grandmultiparae.

Table 2 shows the degree of awareness, attitude, and practice of FGM by respondents. Greater percentage (90.5%) was aware of FGM. Similarly, a significant percentage (71.5%) was aware that FGM is being discouraged. On the other hand, 166 (63.8%) were aware of the side effects or problems associated with FGM, 94 (36.2%) did not know of any side effects or problems associated with FGM. Forty-six (17.7%) of the respondents supported FGM, while 214 (82.3) did not support FGM.

Approximating half of the respondents (49.6%) were circumcised at various stages of their life giving a prevalence rate of 49.6%. On the current practice of FGM, 136 (53.3%) asserted that FGM is not currently practiced while 124 (47.7%) opined that FGM is still being currently practised. Majority 231(88.80%) of the respondents would not want their wife circumcised if they were to assume the responsibility of being a man, while a lower percentage 29 (11.20%) will still advocate that their wife should be circumcised if made a man.

Table 3 shows reasons for persistent practice of FGM among those who affirmed that FGM is still practiced currently. Out of the 260 respondents analysed, 124 (47.7%) affirmed that FGM is still practised currently. However, there were 145 reasons for the persistent practice of FGM. This was because multiple entries were

Table 1. Sociodemographic characteristics of respondents.

Variables	No (260)	% (100)	C/I
Age (years)			
10–29	5	1.9	0.6 – 4.4
20–29	160	61.5	55.3 – 67.5
30–39	88	33.8	28.1 – 39.9
≥ 40	7	2.9	1.1–5
Marital status			
Single	26	10	7.2 – 15.5
Married	234	90	85.6 – 93.1
Separated	Nil	Nil	Nil
Widowed	Nil	Nil	Nil
Education status			
No formal education	10	3.8	1.9 – 7.0
Primary	11	4.2	2.1 – 7.0
Secondary	81	31.2	25.6 – 37.2
Tertiary	158	60.8	54.5 – 66.7
Occupation			
Trader	30	11.5	7.9 – 16.1
Civil Servant	107	41.2	35.1 – 47.4
Student	47	18.2	13.6 – 23.3
Corper	3	1.2	0.2 – 3.3
Applicant	4	1.2	0.4 – 3.9
Other*	69	26.5	2.1 – 32.3
Parity			
None	117	45	38.8 – 51.3
1 – 4	126	48.5	42.2 – 54.7
≥ 5	16	6.2	3.6 – 9.8

* Represent farmers, seamstress, hairdressing and fashion designers.

Table 2. Degree of awareness, attitude and practice of FGM.

Variables	N (260)	% (100)	C/I
Are you aware of FGM			
Yes	235	90.5	86.1 – 93.7
No	25	9.5	6.3 – 13.9
Are you aware that FGM is being discouraged			
Yes	186	71.5	65.6 – 76.9
No	74	28.5	23.1 – 34.4
Are you aware of any side effect or problem associated with FGM			
Yes	166	63.8	57.7 – 69.7
No	94	36.2	30.3 – 42.3
Do you support FGM			
Yes	46	17.7	13.3 – 22.9

Table 2. Contd.

No	214	82.3	77.1 – 86.7
Were you circumcised			
Yes	129	49.6	43.4 – 55.9
No	131	50.4	44.1 – 56.6
Is FGM still currently practiced			
Yes	124	47.7	41.5 – 54.0
No	136	52.3	46.6 – 38.5
If you are a man, will you want your wife circumcised			
Yes	29	11.20	7.6 – 15.6
No	231	88.80	84.4 – 95

Table 3. Reasons for persistence of the practice of FGM among the 124.

Variables	No (145)**	% (100)	C/I
Culture	32	22.07	9.1 – 17.7
Tradition	22	15.17	4.1 – 14.9
Ignorance	25	17.24	6.3 – 13.9
Reduced sexual desire	6	4.14	0.9 – 5.0
Lack of awareness	2	1.38	0.1 – 2.8
Easy vaginal delivery	1	0.69	0.0 – 2.1
Do not know	57	39.31	46.0 – 58.5

Table 4a. Reasons adduced for supporting the practice.

Reasons	No (64)**	%
Increased female hygiene	9	14.06
Reduced sexual desire	14	21.88
Safe delivery	5	7.81
Risk to baby (could kill baby)	5	7.81
Tradition/Culture	21	32.81
Do not know	10	15.63

allowed. Majority 57 (30.30%) did not know the reason for the persistence of FGM. Culture, ignorance and tradition were significant reason for the practice of FGM with proportion of 32 (22.07%), 25 (17.27%) and 22 (15.17%), respectively. Other reasons for the persistence of FGM were reduce sexual desire - 6 (4.14%), lack of awareness - 2 (1.38) and easy vaginal delivering -1 (0.69%).

Table 4a shows reasons adduced for supporting FGM. Tradition and culture 32.81% were the main reasons given for supporting FGM. This was followed by 21.88% who affirmed that it will reduce sexual desires. Other reasons given for supporting FGM include increased female hygiene -14.06%, safe delivery - 7.81% among others. A significant percentage (15.63%) of the respondents did not know the reason but they still supported

FGM.

Table 4b shows reasons adduced by the respondent for not supporting FGM. Out of the 260 respondents analyzed, 214 (82.3%) did not support FGM but the adduced reason given for not supporting FGM, were 277. This was because multiple entries were allowed. Majority 20.22% did not support the practices because it could lead to difficulty labour and delivery. Others were bleeding - 18.05%, religious reasons - 12.64%, barbaric (uncivilized) - 10.47%, reduced sexual satisfaction - 8.30%, culture and tradition - 7.22%, painful coitus - 5.42%, infection - 4.70%, death - 3.97%, fistula formation e.g VVF - 2.89%, genital scarification - 2.17%, HIV/AIDS - 1.81%. Small percentage of the respondents (2.17%) did not know the reason for not supporting FGM.

Table 4b. Reason adduced for not supporting the practice of FGM.

Reason	No (277)**	%
Difficult labour/delivery	56	20.22
Bleeding	50	18.05
Not biblical	35	12.64
Barbaric (uncivilized)	29	10.47
Culture/tradition	20	7.22
Painful coitus	15	5.42
Infection	13	4.70
Death	11	3.97
Fistula formation (v v f)	8	2.89
Genital scarification/keloid	6	2.17
HIV/AIDS transmission	5	1.81
Do not know	6	2.1

Table 5. Knowledge of side effects of FGM.

Reason	No (216)**	% (100)
Difficult labour/delivery	68	31.48
Bleeding	48	22.22
Infection	28	12.96
Painful coitus	15	6.94
Reduced sexual satisfaction	16	7.41
Fistula formation (v v f)	12	5.56
Risk to baby	9	4.17
HIV/AIDS transmission	8	3.70
Death	12	5.56

Table 5 illustrates the knowledge of side effects of FGM among those who are aware of side effects or problems associated with FGM. Of the 260 respondents analyzed, 166 (63.8%) were aware of side effects or problems associated with FGM. Difficult labour and delivery 31.48% were the main problem noted to be associated with FGM. Others were: bleeding (22.22%), infection (12.96%), reduced sexual satisfaction (7.41%), and painful coitus (6.94%). The remaining reasons in descending orders include death - 5.56%, fistula formation - 5.56%, risk to baby - 4.17% and HIV/AIDS - 3.70%.

Table 6 illustrates how best to prevent the practice of FGM. Majority (31.25%) of the respondents did not know how best to prevent the practice of FGM. Increasing literacy level (20.40%) was given as the best way to prevent practice of FGM. Others include awareness campaign (19.08%), mass media (10.53%), health education (7.24%), capital punishment (5.92%), Government intervention (3.29%) and advocacy (2.30%).

In this study, 218 (83.8%) of the respondents expressed their desire to ban FGM if they are in position of authority whereas 42 (16.4%) will still advocate for it if placed in a position of authority.

Table 6. How best to prevent the practice of FGM.

Variables	n (304)**	% (100)
Public enlightenment	62	20.40
Awareness campaign	58	19.08
Mass media	32	10.53
Health education	22	7.24
Capital punishment	18	5.92
Government intervention	10	3.29
Advocacy	7	2.30
Do not know	95	31.25

** Multiple answers allowed.

DISCUSSION

Female genital mutilation remains an unending public health problem in many societies and cultural groups despite the concerted efforts and laws forbidding the practice. The prevalence rate of 49.6% in this study laid credence to this. This figure is approximately equal to the national average of 50% but higher than the 37% in the South-south (Briggs, 2002). The implication of this finding is that the prevalence rate of female genital mutilation is rather on the increase. This figure is also higher than other regional findings in Nigeria of 48% South-West, 16% North-Central, 3% North-West and 2% North-East (Briggs, 2002).

The socio-demographic analysis indicates that the mean age of the female respondents was 28 ± 5.4 years.

Surprisingly, a higher number of respondents attained tertiary education (62%), a factor that ideally would have reduced the prevalence rate. However, it was not possible to ascertain the educational status of their parents as the circumcision was done in infancy in almost all the respondents.

A higher percentage of the respondents were aware of female genital mutilation and the problem associated with it (91 and 72%, respectively) and yet 48% affirmed that FGM is still currently practiced. This has been sustained by various reasons which included: culture, tradition, ignorance, misconception (reduced sexual desire, easy vaginal delivery) among others. This is in conformity with the findings in Somalia where FGM connote symbol of female womanhood and an instrument for the control of female promiscuity/sexuality (Ntiri, 1993). Okonofua et al. (2002) in a cross sectional study, affirmed that FGM has nothing to do with attenuating sexual feeling or desire and that it may predispose women to adverse sexual outcomes. This study also corroborates with the findings by Meyers et al. (1985), Caldwell et al. (1997) and Osifo and Eubuomwan, (2009) which supports that FGM is shrouded on culture and tradition.

Eighty-two percent of the respondents do not support FGM yet 50% of them were circumcised. Thus, it may be assumed that most FGM would not have been performed

if they were given options of making a choice by themselves. Most of the reasons adduced for supporting FGM sounded absurd but they reflect the level of ignorance, unenlightenment and myth (most of which are enshrined in the culture and tradition), that are still prevalent in our society. These reasons were also noted in previous studies (Osifo and Eubomwan, 2009; Anuforo et al., 2004; Odimegwu et al., 2001; Oyeledum et al., 1997; WHO, 2000; Ragheb et al., 1978). Haemor-rhage, infection, difficult labour have been noted as major problems associated with FGM in other studies (Osifo and Eubomwan, 2009; Oyeledum et al., 1997; Yount and Abraham, 2007).

Despite the national, international, governmental and non-governmental organisations (NGOs) efforts to eliminate this practice, it has persisted in many communities today. The practice remains highly prevalent in 28 countries across Africa and the Middle East. Public enlightenment, awareness campaign, mass media, health education and advocacy on the negative health implications of FGM are suggested as best ways of eliminating the practice.

Some respondents in this study suggested capital punishment and Government intervention as best ways of curbing the practice. In Nigeria, there is no Federal Law against FGM unlike in France, Canada, Belgium, Ghana, Sweden and United Kingdom among others. In late 1999, the advocacy efforts of the Edo State government in Nigeria government resulted in the successful passage of state legislation making FGM punishable by fine and/or 6 months imprisonment. Capital punishment (prosecution) has been adopted by four out of the 28 Countries where FGM is prevalent (Onuh et al., 2006).

In Conclusion, there is great awareness on FGM and the side effects/problems are well known. However, the practice is still persistent in Abakaliki South-East Nigeria, sustained perhaps by culture, tradition and misconceptions. Serious advocacy is vital to stop the menace of this problem. The society and the nation should look for strategies to curb the practice of FGM. These may include education of the girl child, woman empowerment, and legislation against FGM. All government, non-governmental organisation (NGOs), supporters of reproductive health issues are called upon to initiate authentic programmes that will end this menace of reproductive ill-health.

REFERENCES

- African Commission on Human and People's Right (n.d.) (ACHPR) Protocol to the African Charter on Human and Peoples' Rights on the Rights of women in Africa. Adopted by the 2nd ordinary session of the Assembly of the Union on 11th July, 2003. Maputo <www.Achpr.org/English/info/woem-en.Intml. 30 January 2011.
- Akpuaka FC (1998). Vulva adhesions following female Circumcision in Nigeria. *Postgrad. Doct. Afr.*, 13(4): 98-99.
- Anuforo PO, Oyedele L, Paequiano DF (2004). Comparative study of marriage, beliefs and practices of female Circumcision among three Nigerian tribes in the United States and Nigeria. *J. Transcut. Nurs.*, 15: 103-113.
- Badejo OA (1983). Complications of female Circumcision. The life experience. *Nig. Med. Pract.*, 5(3): 103-105.
- Briggs LA (2002). Male and Female viewpoints on female Circumcision in Ekpeye Rivers State, Nigeria. *Afr. J. Reprod. Health*, 6(3): 44-52.
- Caldwell JC, Orubuloye IO, Caldwell P (1997). Male and female circumcision in Africa from a regional to a specific Nigerian examination. *Soc. Sci. Med.*, 44(8): 1181-1193.
- Ibekwe PC (2004). Physical and Psychological sequele of female genital mutilation: A case report. *Niger. J. Med.*, 13(3): 293-294.
- Idowu AA (2008). Effect of Female Genital Mutilation on Human rights of Women and Female Children: The Nigerian Situation, 8: 13-26.
- Klouman E, Manongi R, Klepp KI (2005). Self-reported and observed female genital Cutting in rural Tanzania: associated demographic factors, HIV and Sexually Transmitted infections. *Trop. Med. Intl. Health*, 10(1): 105-115.
- Larsen U, Okonofua FE (2002). Female Circumcision and Obstetrics Complications. *Intl. J. Gynaecol. Obstet.*, 77: 522-326.
- Meyers RA, Omorodion FI, Isealumhe AE, Akenzua GI (1985). Circumcision: its nature and practice among some ethnic groups in Southern Nigeria. *Soc Sci Med.*, 21(5): 581-588.
- Ntiri DW (1993). Circumcision and health among rural women of Southern Somalia as part of a family life survey. *Health Care women Inter.*, 14 (3): 215-226.
- Odimegwu CO, Ojo M, Okemgbo CN (2001). Tradition and health: the predicament of Female and adolescent among the Igbo. *J. Cult. Sci.*, 3(1): 284-300.
- Oduro AR, Ansah P, Hodgson A, Afful TM, Baiden F, Adonge P, Adonge P (2006). Trends in the prevalence of Female Genital Mutilation and its effect on deliver Outcome in the Kassena – Nankana District of Northern Ghana. *Ghana Med. J.*, 40(3): 87-92.
- Oguguo NEN, Egwuatu VE (1982). Female Circumcision. Management of Urinary Complications. *J. Trop. Paed.*, 28: 248-252.
- Okonofua FE (1998). female genital mutilation: The shame of our nation. *Women's Health forum*, 3: 1-2.
- Okonofua FE, Larsen U, Oronsaye F, Snow RC, Slanger TE (2002). The association between female genital cutting and correlatives of sexual and gynecological morbidity in Edo State, Nigeria. *Br. J. Obstet. Gynaecol.*, 109: 1089-1096.
- Onuh SO, Igbarese GO, Umeora OIJ, Okogbenin SA, Ofoide VO, Agariki EP (2006). Female genital mutilation: Knowledge, Attitude and Practice Among Nurses. *J. Natl. Medscape*, 98(3): 409-414.
- Osifo DO, Eubomwan I (2009). Female genital mutilation among Edo People: The Complications and pattern of presentation at a paediatric Surgery Unit, Benin City. *Afr. J. Reprod. Health*, 13(1): 17-25.
- Oyeledum BO, Oyediran MA, Wolter S (1997). Assessment of knowledge attitude to and practice of Female genital mutilation among women in Eti –Osa Local Government Area of Lagos State in Nigeria. *Curare*, 20(2): 243-246.
- Ragheb SS, Smith E, Meklemer SA (1978). Study of knowledge and attitude of nurses in Alexandria towards female Circumcision. *Bull. High Inst. Public Health*, 8(1): 293-306.
- Toubia N (1994). Female genital mutilation and the responsibility of health professionals. *Int. J. Gynecol. Obstet.*, 46 (27): 127-135.
- World Health Organization (WHO) (2000). Female genital mutilation. WHO, Fact sheet, p. 241.
- World Health Organization (2008). Eliminating Female genital mutilation: an interagency Statement. World Health Organization. WHO:
- World Health Organization (1996). Female genital mutilation: Report of a WHO Technical working Group, Geneva.
- World Health Organization (2010). Female genital mutilation: WHO media Centre. Fact sheet No. 241. World Health Organization WHO.
- Yount KM, Abraham BK (2007). Female genital Cutting and HIV/AIDS among Kenyan women. *Stud. Fam. Plan.*, 38: 73-88.