Original Research Article

Assessing Female Genital Mutilation Practice in South-Western Nigeria

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ABSTRACT

Background: With always dwindling resources in mitigating against various negative effects of female genital mutilation among girls/women in Nigeria, identifying factors that encourage the practice is highly imperative.
Aim: This research assesses the effects of some socio-cultural and economic factors on the practice among states in the South-West of Nigeria.
Method: Data were collected across states in the South-West using a structured questionnaire relating to various earlier similar surveys on similar research.
Results: It was found that the age, resident, wealth status, and educational background of respondents are significant factors in the uptake of FGM. The odds of knowledge is highest in Osun state while it is lowest in Ogun state. The highest percentage of respondents who had their daughters' circumcised used the help of traditional practitioners while removal of the clitoris is the most prevalent form of mutilations among residents in states in the South-West.

Keywords: Female Genital Mutilation, Knowledge, Method, Practice

1. INTRODUCTION

Female Genital Mutilation (FGM) is an old practice that reflects human rights abuse with the potential for medical complications [1]. This has triggered various efforts that are aimed at the eradication of FGM at community, national, and international levels. The practice however remains endemic in about 29 countries in Africa, Asia, and the Middle East. Advocacy in form of information about the necessary treatments and education and counselling of women that are mutilated had been identified as pertinent [2]. The creation of awareness and education as essential instruments towards attitudinal change towards the eradication of the practice was identified by [3]. Many socio-cultural beliefs of indigenes had been attributed to the practice.

As defined by [4], Female Genital Mutilation (FGM) (also called Female Genital Cutting, FGC) comprises "all procedures involving partial or total removal of the external part of the female genitalia or a form of injury to the female genital organs outside medical necessities. It is a form of gender-based violence and hence has been documented as a harmful practice and a defilement of the human rights of girls and women. In about 29 countries in Africa where FGM is practiced, over 200 million girls/women who are alive today have had FGM [5]. Although the practice has obscured origins, it has been in practice for over two millennia [6]. Historical and anthropological research found the history of FGM in traditional group and community cultures that have patriarchal structures. [6] reported that the practice was traced to the 5th century BC in Egypt by some anthropologists, where the infibulation was known as '*Pharaonic Circumcision*'. Others believed that the practice existed among herders in Equatorial Africa as armour against rape for young female herders [7]. The idea is motivated

by convictions concerning what is viewed as suitable sexual conduct for certain communities with the belief that it protects and saves virginity and conjugal honesty and forestalls indiscrimination.

FGM is always traumatic with immediate complications including tetanus or sepsis, urine retention, severe pain, shock, haemorrhage and injury to proximate genital tissue of urethra, vagina, rectum and perineum [8]. Its long-term consequences include recurrent bladder and urinary tract infections, cysts, infertility, an increased risk of newborn deaths and childbirth complications including fistula, and the need for later surgeries [8].

Table 1: Classifications of FGM

Type I (Sunna)	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Note also that the term 'excision' is sometimes used as a general term covering all types of FGM.
Type III (Infibulation/Pharaonic)	Narrowing of the vaginal orifice with the creation of a covering seal by cutting and positioning the labia minora and/or the labia majora, with or without excision of the clitoris infibulation.
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation.

Source: WHO, 2008

According to [8] FGM is grouped into four classes (table 1). The classes are based on the extent of amputation of the tissues [9-11]. Both types I and II belong to a group called *clitoridectomy* (reduction operation) and type III belongs to *infibulation* (covering operation). Other harmful procedures distinct to Nigeria include *angurya* (scraping of tissue surrounding the opening of the vagina) and *gishiri* (cutting of the vagina). Some also introduce herbs or corrosive substances to narrow the vagina. To allow for sexual intercourse and convenient childbirth, a woman with type III needs to be cut open later [4]. In most cases, the practice is often done in the first month after birth [12]. Types I and II are predominantly found in Southern parts of Nigeria with high prevalence in Akwa Ibom, Cross River, Delta, Anambra, Imo, Ondo, Osun, and Rivers states. Type III is common among the Igbos (in Imo and Delta states) while Type IV is generally practiced among Hausas in Northern states of Nigeria [13].

Justifications for FGM are numerous. These include purification; tradition and custom; the increased sexual pleasure of husband; enhancing fertility; hygiene; aesthetic reasons and protection of virginity and prevention of promiscuity. Traditionally, FGM is a specialization of traditional healers and birth attendants. The practice is widespread in Nigeria with the identification of some sociocultural determinants as supporting it. FGM is still deeply in the Nigerian society where serious resolution makers are mothers and grandmothers [14].

Efforts to abolish FGM in Nigeria have not been largely fruitful. A multidisciplinary methodology is needed to tackle this deep-rooted legendary practice [15]. Many national and multinational organizations are involved in the fight to curb FGM in Nigeria. Intensification of education of the general public at all levels has been prioritized [16].

Among regions in the country, the South-West has a prevalence of more than 50% for FGM which is the second-highest in the country [17]. Therefore, this research is focused on identifying some sociocultural factors that encourage the practice with intention of identifying

significant areas to channel enlightenment and education about the risk involved in FGM among states in the South-West of Nigeria.

Nigeria is divided into six geo-political zones with 36 states and the Federal Capital Territory. Large variation in the prevalence across the zones has been documented from women in reproductive ages (15-49 years) [17]. From about 50% in South-East to close to 3% in North-East Zone; Osun State in South-West has close to 80% while Katsina State in North-West has only 0.1% [17]. South-West Nigeria consists of predominantly *Yorubas* who make up about 21% of the entire population of the country. The region has a prevalence of FGM 54.5% [17] which is the second-highest in the country. Type I and type II infibulations are mostly practiced in the region [18].

Nigeria's government has responded to the call for the elimination of FGM in diverse ways. One of these is the passage of federal legislation, the *Violence against Persons (Prohibition) Act 2015*, banning Female Genital Mutilation (FGM) and other forms of Gender-Based Violence (GBV) [19]. In 2003, the country along with other African states adopted the Maputo Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, ensuring that survivors of Gender-based Violence (GBV) and of gross human rights violations can obtain redress before a domestic or regional court such as the Court of Economic Community of West Africa States (ECOWAS) [20]. Although the practice of FGM prevalence in Nigeria is actually not the highest in the region sub-Saharan Africa countries, at 24.8% among women aged 15 to 49 [17], this rate is globally significant with some 20 million women and girls who have been cut or are at risk of being cut [17].

2. METHODOLOGY

Research Instrument: By reviewing recent and relevant literature, the research utilizes a semi-structured questionnaire on FGM practice. The questionnaires are administered to respondents in selected localities across states in the South-West geopolitical zone.

Respondent Selection Procedure: 18 local governments (each from the 18 senatorial districts among states in South-West Nigeria) are randomly selected. In each selected local government, questionnaires are evenly distributed in urban and rural environments as much as possible. Only women in the productive stage (15-49 years) are selected as final respondents.

Data analysis cleaning is done using Microsoft Excel while the analysis is performed using IBM SPSS ®23

3. RESULTS

The descriptive statistics for the responses obtained are shown in table 2. The age group of respondents is approximately equally distributed except for those aged 45-49 with only 9.0% of total respondents. Being the most populous state in the region, Lagos state has the highest responses with 29.9% while Ekiti state has the least with only 9.8% respondents.

The wealth index for each respondent is measured by the presence of some basic essentials (like television, radio, access to the internet, household income, etc.) in respective households. 75% of the respondents are categorized as being wealthy while only 10.5% are categorized as *poor*. Almost three-quarters (72.6%) of respondents reside in urban environments while 67.1% are Christians. A higher percentage of respondents are literate and most of higher levels of literacy.

Table 2: Socio-demographic background of respondents

Characteristics	**Frequency (Percentage)**
Age Group	
15-19	467 (17.5%)
20-24	374 (14.0%)
25-29	415 (15.5%)
30-34	419 (15.7%)
35-39	429 (16.1%)
40-44	326 (12.2%)
45-49	241 (9.0%)
State	
Oyo	311 (11.6%)
Osun	408 (15.3%)
Ekiti	261 (9.8%)
Ondo	431 (16.1%)
Lagos	799 (29.9)
Ogun	461 (17.3)
Wealth Index	
Poor	280 (10.5%)
Middle	389 (14.6%)
Rich	2002 (75.0%)
Residence	
Urban	1940 (72.6%)
Rural	731 (27.4%)
Religion	
Christian	1793 (67.1%)
Islam	875 (32.8%)
Other	3 (0.1%)
Educational Level	
No Education	190 (7.1%)
Primary	414 (15.5%)
Secondary	1520 (56.9%)
Post-Secondary	547 (20.5%)
Literacy Level	
Low	1133 (42.4%)
High	1538 (57.6%)

Source: 2021 Survey

Responses on knowledge of female genital mutilation are presented in table 3. Overall, 68.9% of total respondents have prior knowledge of FGM practice. With a consistent increase in percentage knowledge as age increases, age is a significant factor in knowledge about FGM among respondents. The least percentage of knowledge is observed for those aged 15-19 years (46.5%) while those aged 40-44 have the highest percentage knowledge level of 80.1%. respondents from Osun state has the highest knowledge percentage (87.5%) among the six states in the region, followed by Ekiti (78.9%) and Lagos (78.2%) states in that order while Ogun state has the least with only 37.7%.

Respondents in the *rich* category of the wealth index have the highest percentage of knowledge of FGM with 70.1% while those in the *poor* category have the least (63.6%). Urban residents have a significantly higher percentage of knowledge (72.6%) in comparison with those from rural set up with 59.1%. table 3 also shows that religion is not a significant factor in knowledge about FGM, although the Muslims have a slightly higher percentage of

knowledge. Educational level is a significant factor in the knowledge of FGM. The highest percentage knowledge level is observed for those with a higher level of education.

Table 3: Socio-demographic characteristics of respondents on Ever Heard of FGM

Characteristics	***Ever Heard of Female Genital Mutilation***		***Chi-Square***
	No	***Yes***	
	831 (31.1%)	***1840 (68.9%)***	***P-value (α=0.05)***
Age Group			
15-19	250 (53.5%)	217 (46.5%)	
20-24	125 (33.4%)	249 (66.6%)	
25-29	129 (31.1%)	286 (68.9%)	*0.000**
30-34	105 (25.1%)	314 (74.9%)	
35-39	103 (24.0%)	326 (76.0%)	
40-44	65 (19.9%)	261 (80.1%)	
45-49	54 (22.4%)	187 (77.6%)	
State			
Oyo	112 (36.0%)	199 (64.0%)	
Osun	51 (12.5%)	357 (87.5%)	
Ekiti	55 (21.1%)	206 (78.9%)	*0.000**
Ondo	152 (35.3%)	279 (64.7%)	
Lagos	174 (21.8%)	625 (78.2%)	
Ogun	287 (62.3%)	174 (37.7%)	
Wealth Index			
Poor	102 (36.4%)	178 (63.6%)	*0.042**
Middle	131 (33.7%)	258 (66.3%)	
Rich	598 (29.2%)	1404 (70.1%)	
Residence			
Urban	532 (27.4%)	1408 (72.6%)	*0.000**
Rural	299 (40.9%)	432 (59.1%)	
Religion			
Christian	574 (32.0%)	1219 (68.0%)	*0.351*
Islam	256 (29.3%)	619 (70.7%)	
Other	1 (33.3%)	2 (66.7%)	
Educational Level			
No Education	61 (32.1%)	129 (67.9%)	
Primary	142 (34.3%)	272 (65.7%)	*0.000**
Secondary	509 (33.5%)	1011 (66.5%)	
Post-Secondary	119 (21.8%)	428 (78.2%)	
Literacy Level			
Low	334 (29.5%)	799 (70.5%)	*0.118*
High	497 (32.3%)	1041 (67.7%)	

Source: 2021 Survey * *Significant factors at α = 0.05*

Using knowledge about FGM as a binary Yes/No response variable, table 4 shows the result of binary logistic regression of the knowledge about FGM on the examined socio-demographic variables.

Among the age groups, the odds of knowledge is highest among those aged 40-44 years. This is more than double for those in 15-24 years and slightly above the odds for those ages 45-49 years. The odds of knowledge is more than 16 times among respondents from Osun state in comparison to those from the reference state (Ogun state). This is also more than double the next high odds observed from Ekiti and Lagos states.

The odds of knowledge is highest among respondents in the *rich* category of wealth index while it is the lowest among those in the *poor* category. Those residing in the urban areas have a slightly higher odds of knowledge than those residing in rural environments. As noted earlier from table 3, religion is also found to be an insignificant factor in the knowledge about FGM. Although table 4 shows that the respondents in the *"other"* category of religion have higher odds, this is largely due to the low responses obtained for the option as noted in table 3.

Education is a significant factor in the knowledge of FGM. The odds of knowledge is highest among those with post-secondary education while it is least among those with primary education. Literacy level has no significant effect on the knowledge about FGM although those with a "*low*" level of literacy have slightly higher odds.

Table 4: Binary Logistic of Knowledge of Female Circumcision on some factors

Factor	P-value	Odds Ratio (OR)	95% C.I. for OR
Age	0.000		
15-19	0.000	0.175	(0.118, 0.261)
20-24	0.000	0.481	(0.319,0.725)
25-29	0.005	0.558	(0.372, 0.836)
30-34	0.105	0.712	(0.473, 1.073)
35-39	0.192	0.764	(0.510, 1.145)
40-44	0.772	1.066	(0.690, 1.648)
45-49 (reference category)		1.000	
State	0.000		
Oyo	0.000	2.604	(1.869, 3.628)
Osun	0.000	16.069	(10.908, 23.672)
Ekiti	0.000	7.512	(5.079, 11.111)
Ondo	0.000	3.952	(2.890, 5.404)
Lagos	0.000	6.073	(4.554, 8.100)
Ogun (reference category)		1.000	
Wealth Index	0.008		
Poor		0.571	(0.401, 0.813)
Middle	0.002	0.861	(0.639, 1.160)
Rich (reference category)	0.324	1.000	
Place of residence			
Urban	0.239	1.157	(0.908, 1.474)
Rural (reference category)		1.000	
Religion	0.137		
Christian	0.336	0.224	(0.011, 4.724)
Islam	0.400	0.270	(0.013, 5.698)
Other (reference category)		1.000	
Education Status	0.009		
No Education	0.141	0.699	(0.434, 1.126)
Primary	0.002	0.545	(0.369, 0.805)
Secondary	0.003	0.654	(0.495, 0.865)
Post-Secondary (reference category)		1.000	
Literacy Level			
Low	0.284	1.141	(0.896, 1.453)
High *(reference category)*		1.000	
Constant	0.259	5.865	

Source: 2021 Survey **Significant factors at α = 0.05*

Table 5: Forms of Genital Mutilation for respondents

	Yes (%)	No (%)
Flesh removed from the genital area	221 (70.2)	94 (29.8)
Genital area nicked without removing any flesh	37 (35.6)	67 (64.4)
Genital area sewn closed	11 (3.3)	319 (96.7)

Source: 2021 Survey

Among techniques of genital mutilations, table 5 reveals that "*removal of flesh from the genital area*" is the most common form. Also, tale 6 shows that the mutilations are mostly done by traditional "*circumciser*"

Table 6: Person who performed circumcision

	Frequency (%)
Doctor	14 (2.7)
Trained nurse/midwife	36 (6.9)
Traditional "circumciser"	432 (83.1)
Traditional birth attendant	33 (6.3)
Other traditional	5 (1.0)
Total	520 (100.0)

Source: 2021 Survey

Among respondents who have daughters that had gone through genital mutilation, table 7 shows that the prevailing methods are the "*removal of the clitoris*" and *gishiri*.

Table 7: Forms of Genital Mutilation for respondents' daughter

	Yes (%)	No (%)
Removal of clitoris	109 (35.5)	198 (64.5)
Infibulation	29 (9.3)	282 (90.7)
Angurya	32 (10.6)	271 (89.4)
Gishiri	91 (28.1)	233 (71.9)

Source: 2021 Survey

4. DISCUSSION

FGM constitutes a prerequisite for inheritance in some practicing societies which serve as a social stratification mechanism whereby circumcised females are perceived to be in higher status [21]. Some evidence indicates that disadvantaged socioeconomic position (usually measured by education and wealth index) compels some women to admit the practice [22]. Some cultures believe that FGM reduced a woman's libido, hence assisting women in preventing adulterous sexual actions.

In this research, the age of respondents is found to be a significant factor in the knowledge of FGM with an increase in knowledge as age increases. The odds of knowledge about FGM is highest among respondents between ages 40-44 while it is lowest among the youngest groups (15-19). Those in the age group 40-45 years are five times more knowledgeable about FGM in comparison to those between age groups 15-19 years. This finding is also supported by [23]1. This may be unconnected with the fact that older people may not wish to be parted with cultural norms associated with FGM practice.

The percentage of knowledge is highest in Osun state followed by both Lagos and Ekiti states while respondents in Ogun state have the least knowledge. The odds of knowledge

about FGM is more than sixteen times in comparison to that of Ogun state and more than twice of the closest state (Ekiti).
The wealth of respondents is found to have a significant effect on the knowledge about FGM. Rich people exhibit more knowledge than other categories. The odds of knowledge about FGM among the *rich* is almost twice those from the *poor* category of the wealth index. Literature [24] has shown that affluent women have strong decision-making power on harmful traditional practices like FGM on themselves and their daughters because of their wealthy status.

Knowledge is higher in urban centers than in rural. Urban residents have higher odds of knowledge than those from rural settings. Rural areas have stronger community ties and traditions with more influential social norms. Although FGM is more likely to occur in rural areas where livelihood is more archaic with its attending challenges, statistics from the Nigeria Demographic Health Survey [17] showed that over 32% of women in reproductive ages who are living in urban areas have undergone FGM while only 19.3% of women living in rural areas have had FGM. This implies that prevalence by current place of residence may not be a reliable factor but rather the place of residence as at when the FGM was done [17].
The religion of respondents is found to be non-significant in the knowledge about FGM, although practitioners of Islam have a slightly higher knowledge percentage.

The educational status of the respondents plays a significant role in the knowledge about FGM. Those who are more educated are found to be more knowledgeable about FGM. Those with *Post-Secondary* education have about twice the odds of knowledge in comparison with those who only have *Primary School* education. Similar findings had been reported [25-27]. Educated women are more exposed and have convincing reasons not to abide by societal-cultural norms that may be harmful to their health. In a similar study among the Chadian populace [23], the educational status of respondents, religion and wealth index were all found to be significant in the practice of FGM. Also, [28] reported that the educational status of mothers, residence area and wealth status are all significant factors on the uptake of FGN among different countries in Africa.
Among forms of genital mutilations, the removal of flesh from the genital area is ranked highest mostly carried out by *Traditional "circumcisers"*. The WHO is strongly against this traditional “circumciser” and 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 in the home setting [14]. The traditional "circumciser" procedure has no health benefits for girls and women where the adverse consequences of FGM are shocked from pain and haemorrhage, infection, acute urinary retention which could harm the victim's urethra or anus during the process, causing the extent of the operation to be dictated in many cases by chance, acquired gynatresia resulting in hematocolpos, chronic pelvic infection, sexual difficulties with anorgasmia, and vulval adhesions [29].

5. CONCLUSION

In states where FGM is prevalent, interventions should focus on lobbying and instructional tactics such as focus group talks, peer teaching, and mentor-mentee programmes at both the national and community levels. Other programmes including women capacity-building such as entrepreneurial training, media advocacy and community dialogue could also help in addressing the FGM public health challenge [30]. Both Governmental and non-governmental organizations must implement policies that would improve dialogue and media advocacy to turn the tide against the practice of FGM among states in South-West Nigeria.

COMPETING INTERESTS DISCLAIMER:

Authors have declared that no competing interests exist. The products used for this research are commonly and predominantly use products in our area of research and country. There is absolutely no conflict of interest between the authors and producers of the products because we do not intend to use these products as an avenue for any litigation but for the advancement of knowledge. Also, the research was not funded by the producing company rather it was funded by personal efforts of the authors.

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