

ORIGINAL RESEARCH ARTICLE

Perception and Practice of Female Genital Cutting in a Rural Community in Southern Nigeria

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Abstract

This study was carried out to determine the awareness and practice of FGC in a rural community in southern Nigeria. A cross sectional study was carried out among Ayadehe women in Itu, LGA Akwa Ibom State, Nigeria using a semi-structured interviewer administered questionnaire. Information obtained was analysed using SPSS version 17. A total of 218 respondents participated in the study. Majority, 215 (98.6%) were aware of the practice of FGC. Type 2 FGC was the commonest type reported by 71.2% of respondents. Prevalence of FGC was 92.7%. A total of 69.8% were circumcised at 6-12 years. Health complications experienced included excruciating pains, (36.6%), severe bleeding, (15.8%), and painful urination, (26.7%). Up to 53.5% were circumcised by traditional birth attendants. The belief that FGM should be discontinued increased with educational level. The practice of FGC was high in this community. Increased female education, community involvement and legislation are needed to reduce this practice (*Afr J Reprod Health 2012; 16[4]: 132-139*).

Résumé

Cette étude a été réalisée afin de déterminer la prise de conscience et la pratique de l'excision dans une communauté rurale au sud du Nigéria. Une étude transversale a été réalisée auprès des femmes d'Ayadehe, dans l'Administration locale d'Itu dans l'état d'Akwa Ibom, au Nigéria à l'aide d'un questionnaire semi-structuré administré par l'intervieweur. Les informations recueillies ont été analysées en utilisant la version SPSS 17. Au total, 218 interviewés ont participé à l'étude. La majorité, 215 (98,6%) étaient au courant de la pratique de l'excision. L'excision de Type 2 était le type le plus fréquent qui a été signalé par 71,2% des interviewés. La prévalence de l'excision est de 92,7%. Au total, 69,8% étaient circoncis à l'âge de 6-12 ans. Les complications de santé éprouvées comprennent des douleurs atroces, (36,6%), les hémorragies graves, (15,8%), et une miction douloureuse, (26,7%). Jusqu'à 53,5% étaient excisées par des accoucheuses traditionnelles. La croyance que la MGF doit être arrêtée s'accroît avec le niveau d'éducation. La pratique de l'excision a été élevée dans cette communauté. Pour réduire cette pratique, il faut une accélération dans l'éducation de la femme, la participation de la communauté et la législation (*Afr J Reprod Health 2012; 16[4]: 132-139*).

Keywords: Perception, practice, female education, female genital cutting, traditional birth attendants

Introduction

The World Health Organization defines female genital cutting (FGC) as “all procedures which involve partial or total removal of the external female genital organs, whether for cultural or any other non-therapeutic reasons”¹. The agency has classified FGC into four typologies, type I (excision of the prepuce, with or without excision of part or all of the clitoris); type II (excision of the clitoris with partial or total excision of the labia minora); type III (excision of part or all of

the external genitalia and stitching/narrowing of the vaginal opening- infibulation) and type IV (a set of unclassified procedures). The term female genital mutilation (FGM) highlights the severity and irreversibility of the practice. It is a prevalent practice in most parts of the world, especially in the sub-Saharan Africa where the practice is associated with non sterile techniques and multiple complications ranging from hematological, urologic, hemodynamic, infections and psychosocial morbidities². Globally 130 million girls and women are genitally mutilated while 2 million are at risk yearly, with the operation being

forced on 6000 girls on a daily basis³. In Africa, FGC is practiced in more than 28 African countries and 90% of the global estimates are from this continent^{1, 3}. In Nigeria, the reported prevalence of FGC ranges between 23.3% and 88%⁴⁻⁸. The highest rates of more than 90% were found in Djibouti, Eritrea, Mali and Somalia^{9, 10}.

The operations are mostly performed by non-medical practitioners in unhygienic environments, usually without anaesthesia^{11, 12}. It is performed on girls whose ages range from 3 days to puberty or sometimes delayed till pregnancy or 2 months after delivery^{10, 11}. In Nigeria, 82% of those operated had it done at the age of 0-12 months⁴. It is difficult to determine the number of women who die from FGC related complications largely because of the highly secretive nature of the practice¹⁰. In Nigeria, the 2008 National Demographic and Health Survey reported a national prevalence of 30% and zonal prevalence of 53.4% in the south west and 34.2% in the south-south zone. The reported prevalence in Akwa Ibom State was 15.2%, with type 2 mostly in practice⁴.

Various reasons have been advanced to justify female genital cutting. A study carried out in a semi-urban town in Rivers State, Nigeria revealed that 58.2% of 600 respondents observed that it reduced libido, 39.5% said it promoted culture while 20% reported that it prevented overgrowth of the clitoris¹⁰. Immediate health consequences reported in a study included intense pain, hemorrhage, tetanus, retention of urine, injury to surrounding tissues¹³. More recently concern has also risen about possible transmission of human immune deficiency virus due to the use of the same instrument in multiple operations. Also due to damage to the female genital organs, sexual intercourse can result in laceration of tissues which greatly increase the risk of transmission¹⁴.

A study carried out in the present study area in 1990 among circumcised women reported infection rate of as high as 89.2%¹⁵. In view of the fact that the last study done in this area was about 20 years ago and considering the grave consequences of FGC, this study set out to determine the current prevalence of the practice with the intention of making the findings available to policy makers in order to assist in curbing the practice.

Method

Study Area

There are 5 clans in Itu LGA. Ayadehe clan is located in the south eastern part of Itu local government area in Akwa Ibom State, southern Nigeria. It is bounded on the north and east by Oku Iboku, on the west by Ikot Offiong and on the south by Odukpani in Cross River State. It is made up of 3 villages. It has an estimated population of 4000¹⁶. It has one primary and one secondary school. It also has a recently established health post. The inhabitants are mainly Christians. The predominant language spoken in the area is Ibibio. Majority of the inhabitants engage in trading or fishing.

Study Population

This consisted of all women aged 18 years and above in the 3 villages that make up Ayadehe clan.

Study Design

This was a descriptive cross sectional study carried out among the eligible women in Ayadehe.

Sampling Size

The sampling size was derived using the formula: $n = z^2 pq / d^2$

Where n= minimum sample size; z= (1.96), which is 95% confidence limit

p= prevalence of FGC in Akwa Ibom State= 15.2%⁴, q= 1-q

d= acceptable margin of error = 0.05

Minimum sample size (+10% attrition) =218

Sampling Method

This study was carried using a multi-stage method. The stages were as follows:

Stage 1: selection of LGA: There are 31 LGAs in Akwa Ibom State. Itu LGA was selected by simple random sampling method.

Stage 2: selection of clan: One clan was selected from the 5 clans in Itu local government area by simple random sampling method.

Stage 3: selection of village: All the 3 villages in Ayadehe clan participated in the study.

Stage 4: selection of women: A list of women who were 18 years and above was obtained from the women leader in each of the 3 villages in Ayadehe clan. This gave a total of 1400 women, from where 218 women were selected by simple random sampling method using a table of random numbers.

Instrument of Data Collection

This was an interviewer administered semi-structured questionnaire. Information obtained included socio-demographic characteristics, knowledge, perception and practice of FGC and also the health problems associated with the practice if any. The questionnaire was pre-tested among 30 women in Uyo local government area.

Data collection procedure

Five research assistants who were community health officers in training were recruited into the study. They had a two-day training session on the content of the questionnaire so that they could effectively guide the respondents while administering the research instrument. The investigator and the trained research assistants administered the questionnaires to the participants in their houses where respondents' privacy was maintained. Data was collected for a period of three weeks.

Data management/Analysis

The data obtained was edited and collated manually, entered into the computer and analysed using Statistical Package for the Social Sciences (SPSS) version 17. Frequencies were generated and the Chi-square test was used to compare different proportions and test associations.

Ethical Considerations

Permission to carry out the study was obtained from the clan head. The purpose, content and significance of the study were explained to the subjects. Written informed consent was obtained

from respondents and they were told that participation was voluntary and they would not suffer any consequences if they chose not to participate.

Result

Most of the respondents, 138 (63.3%) were above 30 years of age. More than half, 129 (59.2%) were married, while 45 (20.6%) were single. A total of 83 (38.1%) had no formal education, 79 (36.2%) had primary and 49 (22.5%) secondary education. One hundred and twenty one (55.5%) were farmers, while civil servants constituted the least group of 7 (3.2%). (Table 1)

Table 1: Socio demographic characteristics of respondents

Variable (N=218)	Frequency n (%)
Age (yrs)	
<20	41 (18.8)
21-30	39 (17.9)
31-40	68 (31.2)
>40	70 (32.1)
Marital Status	
Single	45 (20.6)
Married	129 (59.2)
Divorced	16 (7.3)
Widowed	28 (12.8)
Educational Level	
No Formal Education	83 (38.1)
Primary Education	79 (36.2)
Secondary Education	49 (22.5)
Tertiary Education	7 (3.2)
Occupation	
Civil Servant	7 (3.2)
Farmer	121 (55.5)
Trader	41 (18.8)
Student	47 (21.6)
Others	2 (0.9)

Majority, 215 (98.6%) of the respondents were aware of the practice of FGC. Among 215 women who responded, 157 (73.02%) received information about FGC from family members. Only 13 (6%) knew about FGC through health workers and 12 (5.6%) from the media. Among the (215) respondents that were aware of FGC, type 2 was the commonest reported, 153 (70.2%), while 17 (7.9%) reported type 1 and 45 (20.9%)

could not classify it. Up to 136 (62.4%) of the respondents knew about possible complications of FGC. The commonest complication mentioned by 80 (36.7%) of the respondents was bleeding. A total of 90 (41.3%) of the respondents opined that FGC was a good practice while 128 (58.7%) felt it was a bad practice. A total of 70 (32.1%) felt the practice should be continued (Table 2). Maintenance of tradition was the commonest reason given by 45 (64.3%) of the respondents, while 12 (17.1%) said the practice prevented the overgrowth of the clitoris and 6 (8.6%) gave no response.

Table 2: Knowledge and Attitude towards FGC

Variable (N=218)	Frequency n (%)
Awareness of FGC	
Yes	215 (98.6)
No	3 (1.4)
Knowledge of complications	
Yes	136 (62.4)
No	82(37.6)
Perception of FGC	
Good	90 (41.3)
Bad	128 (58.7)
Continue FGC	
Yes	70 (32.1)
No	144 (66.1)
No Response	4 (1.8)

Majority of the respondents, 202 (92.7%), were circumcised. The most common age at circumcision was 6-12 years, 141 (69.8%), while 47 (23.3%) carried it out at 13-18 years. The health complications commonly associated with the procedure included excruciating pains, 74 (36.6%), severe bleeding, 32 (15.8%), and painful urination, 54 (26.7%). Up to 35 (17.3%) experienced all the symptoms mentioned above. Only 7 (3.5%) reported having no symptoms at all. (Table 3) Out of the 202 who were circumcised, 108 (53.5%) of them had the procedure carried out by traditional birth attendants, 93 (46.0%) by native doctors and only 1 (0.5%) by a nurse. A total of 201 (99.5%) of the respondents carried out the procedure at home and the instrument used in all cases was razor blade.

Table 3: Practice of FGC among respondents

Variable (N=218)	Frequency n (%)
Practice of FGC	
Yes	202 (92.7)
No	16 (7.3)
N=202 n (%)	
Age of FGC (yrs)	
<6	11 (5.4)
6-12	141 (69.8)
13-18	47 (23.3)
>18	3 (1.5)
Complications experienced	
Severe pains	74 (36.6)
Serious bleeding	32 (15.8)
Painful urination	54 (26.7)
All of the above	35 (17.3)
None	7 (3.5)

There was a significant association between age and perception of FGC (Table 4). Majority of the respondents aged <20 years, 31(75.61%), felt that FGC was a bad tradition, while up to 37 (52.9%) of those >40 years felt it was a good tradition. There was also a significant association between educational level and perception about FGC. The perception that it was a bad practice increased with educational level from 40.9% among those with no formal education to 75% among respondents with secondary/tertiary education.

Age and education were also significantly associated with opinion about continuation of FGC ($p<0.05$) (Table 5). While 35 (87.5%) of the respondents aged <20 years did not agree that the practice should be continued, 26 (38.2%) of those >40 years opined that the practice should be continued. Also, the opinion that FGC should not be continued increased from 51.85% among those with no formal education to 83.33% among respondents with secondary/tertiary education.

Discussion

Female genital cutting is still being actively practiced in several communities in Nigeria. The fact that about two thirds of the respondents in this study were above 30 years and over a third of them had no formal education suggests that the attitude of this group was more likely to be influenced by old traditional beliefs compared to

Table 4: Association between respondents' socio demographic variables and perception of FGC

Characteristic	Perception of FGC N=218		Statistics χ^2	p-value
	Good N=90 n (%)	Bad N=128 n (%)		
Age				
<20	10 (24.39)	31(75.61)	9.21	0.03
21-30	14 (35.90)	25 (64.10)		
31-40	29 (42.65)	39 (67.35)		
>40	37 (52.86)	33 (47.14)		
Educational level				
No Formal	49 (59.04)	34 (40.94)	18.56	0.00
Primary	27 (34.18)	52 (65.82)		
Secondary/Tertiary	14 (25.0)	42 (75.0)		
Marital Status				
Single	11 (24.44)	34 (75.56)	6.9	0.07
Married	58 (44.96)	71(55.04)		
Divorced	7 (43.75)	9 (56.25)		
Widowed	14 (50.00)	14 (50.00)		

Table 5: Association between respondents' socio demographic variables and continuing with FGC

Characteristic	Continue FGC N=214		Statistics χ^2	p-value
	Yes N=70 n (%)	No N=144 n (%)		
Educational level				
No Formal	39 (48.15)	42 (51.85)	15.93	0.000
Primary	22 (27.85)	57 (72.15)		
Secondary/Tertiary	9 (16.67)	45 (83.33)		
Age				
<20	5 (12.5)	35 (87.5)	9.35	0.02
21-30	13 (34.21)	25 (65.79)		
31-40	26 (38.24)	42 (61.76)		
>40	26 (38.24)	42 (61.76)		
Marital Status				
Single	4 (9.1)	40 (90.9)	14.45	0.002
Married	48 (37.5)	80 (62.5)		
Divorced	6 (42.85)	8 (57.15)		
Widowed	12 (42.86)	16 (57.14)		

those of the younger age group. Similar age distribution was reported in the 2008 National Demographic and Health Survey (NDHS) report in Nigeria⁴. A study conducted in Aminu Kanu Teaching Hospital, Kano, Nigeria however had different age distribution as 80% of the

respondents were below 30 years and almost a third had tertiary education⁵. Such enlightened people were less likely to be susceptible to much traditional influence. Majority of the women in the present study were aware of the practice of FGC and almost three quarters heard from family

members. This was not surprising as they were the perpetrators of the practice. Similar level of awareness was reported in the Kano study where 91.4% of the respondents admitted being aware of FGC. However, up to 40.5% of the respondents in that study heard about FGC from the media compared to only about 5% in the present study. Information from the media was likely to be more factual than from the family members. It was therefore not surprising that only 16.2% of the respondents in that study felt that the practice should be continued compared to about double that proportion in the present study⁵. Lower level of awareness was reported among Nigerian women in the 2008 NDHS as only 61% of those aged 15-45 years had heard of FGM. Over three quarters of the respondents in the present study reported that the commonest type of FGC practiced in the area was type 2. This was similar to findings of the 2008 NDHS⁴.

Nine out of every ten respondents in this study were circumcised and it was carried out mostly between 6-12 years of age. Similar findings were reported in a study in another rural Nigerian community where about nine tenth of the respondents were circumcised.⁶ Some other studies reported lower prevalence of 23-45%^{4, 5, 7, 8}. In three studies in Nigeria, 82%, 40.8% and 60.3% respectively of those circumcised, had it done at the age of 0-12 months⁴⁻⁶. Some studies in Nigeria have however shown that the average age at which FGC was performed was 6.9 ± 2.9 years, with 4% of women having the procedure performed in pregnancy^{17, 18}. In a study carried out among Egyptian girls, the prevalence of FGC was 50.3% among girls 10-18 years. The average age at which the procedure of FGC was performed was 10.1 ± 2.3 years¹⁹. At such ages, the girls had no say in what was done to them as their opinions would normally not be sought. The Reproductive Health Rights views the practice as a violent act against girls causing them serious lifetime problems²⁰.

In the present study, all respondents except one had the procedure carried out in the rural environment by traditional practitioners. This exposed them to various types of hazards especially with the use of crude instruments in unsanitary environments. The various complications reported in this study were therefore

not surprising. This finding differed from that reported in a study in Port Harcourt, Nigeria, where over a third of the operators were medical doctors¹⁰. Also, more than two thirds of the circumcisers reported in the Egyptian study were health workers¹⁹. The complications recorded were expectedly less as only 1.5% of girls reported that they suffered severe bleeding compared to 15.8% in the present study.

Almost three quarters of the respondents reported type 2 as the most common type. Similar findings were reported in other studies in Nigeria^{4, 6}. This differed from findings in a study among 1836 women attending family planning and antenatal clinics at three hospitals in Edo State, South-south Nigeria where 71% of the women had type 1, while 24% had type 2 genital cutting. This procedure is usually carried out without any form of anaesthesia in most rural communities. In this study, over a third of the respondents reported experiencing agonizing pains. This level of pain can sometimes leave lasting psychological impact on the victims. In a study to assess the psychological impact of female genital mutilation on 23 circumcised Senegalese women in Dakar, the circumcised women showed a significantly higher prevalence of post traumatic stress disorder (PTSD) (30.4%) and other psychiatric syndromes (47.9%) than the uncircumcised women. PTSD was accompanied by memory problems²¹. The fact that more than a quarter of the respondents in this study also reported having painful urination was not surprising taking into consideration the unhygienic state of the environments where the procedures were carried out. Similar findings were reported in other studies where the cut women were found to be significantly more likely than the uncut women to report having different forms of vaginal infections^{8, 14, 22}. In some studies, the rate of complications ranged between 13% and 69%^{21, 23}.

Up to nine respondents in this study reported of people who died from FGC in their community. This really highlights the need to stop this practice by all means. A country like Australia has a law which makes FGC a criminal offence²⁴. The desire to maintain the culture of the community was the commonest reason given by the majority of those who wanted the practice continued. In the 2008

NDHS in Nigeria, 32.6% of the women who participated in the survey felt it was a good tradition and part of their culture⁴. Culture and tradition therefore seem to play leading roles in fuelling the continuation of the practice. The cultural pressures, particularly on mothers to circumcise their daughters remain a major consideration in the perpetuation of the practice. This suggests the need of involving the key opinion leaders within the community in the campaign against the practice. In some cases, women are indoctrinated to believe that the practice results in increased sexual pleasure for men. However, a study carried out on males' preference for circumcised women in northern Ghana reported that only illiterates and those with only primary school education are more likely to prefer circumcised women²⁵.

In this study, it was observed that support for the practice of FGC decreased with increasing education. In a study in Kano where up to a third of the women had tertiary education, almost three quarters wanted the practice discontinued. Female education is therefore likely to assist in the reduction of the practice. In another study carried out among 182 nurses, only 2.8% supported FGC and only 4.4% of the respondents said they would have their daughters circumcised⁷. Factors found to be statistically significantly associated with the practice of FGC in this study were age and educational status of respondents. Similar findings were reported in other studies^{5, 6}.

Conclusion

The practice of FGC is an unnecessary, life-threatening procedure that damages not only the women's physical, mental, body image and general well being but also their sexuality. This practice is still highly prevalent in the studied community. To guarantee the integrity of women, serious efforts must be taken to ensure that the practice is discontinued and that interventions that aim to do so are successful. Legislation, female literacy and empowerment and provision of alternative vocation for excisors are recommended ways of stopping the practice.

Contribution of Authors

The second author conceived, designed the study and collected the data under the supervision of the first author. The first author analysed the collected data and prepared the entire manuscript. Both authors approved the manuscript.

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