

# Assessment of Female Genital Cutting Practice and Its Drivers among Women of Reproductive Age in a Rural Community in South-West Nigeria

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## Abstract

**Background:** Worldwide, Female Genital Mutilation/Cutting (FGM/C) has been practiced for generations. This study examined the practice of FGM/C and identified factors influencing its continuity in Osu, a rural community in Osun State, Nigeria. **Methods:** This study employed a mixed method cross-sectional design. The quantitative aspect involved interview of 294 women using a semi-structured questionnaire while the qualitative aspect entailed 16 in-depth interviews using an in-depth interview guide to seek information from selected spouses of the respondent, women leaders, religious leaders and health workers. The study took place between January and June 2023. The quantitative data were subjected to descriptive and inferential statistics while the qualitative data were analyzed using thematic content analysis. **Results:** Ninety four percent of the women had poor knowledge of the health risks associated with FGM/C practice. About three-third (76.5%) had undergone FGM/C while 77.2% intend to continue FGM/C practice on their daughters. The predictors of continuing FGM/C practice include being married (AOR 2.03, 95% CI 1.12 - 3.65,  $p = 0.019$ ), none/primary education (AOR 10.02, 95% CI 2.88 - 34.88,  $p = 0.0001$ ), lower income (AOR 3.17, 95% CI 1.54 - 6.55,  $p = 0.002$ ) and having undergone FGM/C (AOR 14.65, 95% CI 5.31 - 40.37,  $p = 0.0001$ ). In-depth interviews revealed that the factors sustaining FGM/C in the community include curbing promiscuity, religious rites, community customs and traditions. **Conclusion:** Socio-cultural factors continue to sustain FGM/C practice in the community.

It is necessary to target married women and other community leaders in the campaign against FGM/C practice.

## Keywords

Factors, Female Genital Cutting, Opinion Leaders, Women

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## 1. Introduction

Female Genital Mutilation/Cutting (FGM/C) is a practice that is deeply rooted in traditional beliefs and societal influence, which propagates the continuity of the practice. This practice harm women's physical and emotional health throughout their lives with no known health benefits but is associated with psychological and physiological problems [1]. The World Health Organization (2014) estimated that additional 5 - 15 babies die per 1000 deliveries as a result of FGM/C practice [1].

In Nigeria, about 20 million girls and women have undergone FGM/C with the global estimate being 100 - 140 million girls that have undergone the procedure and at least 2 - 3 million girls a year at risk of undergoing one of the forms of FGM/C procedure [2]-[4]. The practice exists to various degrees throughout Nigeria, and it is sustained through migration and cultural diffusion. The age at which FGM/C procedure is executed varies and it dependent on the prevailing custom of the practicing community. FGM/C is performed anytime from the neonatal period to late adulthood, and it is also linked with rites of passage of girls to adulthood [2] [3]. The major exception is when women in certain ethnic groups undergo FGM/C during the birth of their first child, because of the belief that it is critical that a baby should not touch its mother's clitoris [5]. Many girls are cut as infants (16% of girls aged 0 - 14 undergo FGM/C before their first birthday), while most women (82%) aged 15 - 49 who have had FGM/C stated that they were cut before the age of five [6].

In Nigeria, FGM/C has been recognized as a harmful and brutal practice that has a detrimental impact on the health and the human rights of women and girls. It is deeply rooted in socio-cultural beliefs and a social norm that requires a long-term approach to be changed [6]. In the light of this, a federal law on Violence Against Persons Prohibition Act (VAPP) was passed banning FGM/C and other harmful traditional practices, and each of the 36 states was given the liberty to pass similar legislation prohibiting the practice [7]. Despite the mass media publicity against the practice of FGM/C and the enactment of law against the practice, Osun State accounts for the highest prevalence of the practice in the southwestern part of the country [8]. This study assessed the socio-cultural factors that have sustained the practice of FGM/C over the years in Osu, a rural community in Osun State, Nigeria.

## 2. Method

### 2.1. Study Design

This study used a mixed-methods cross-sectional design.

## 2.2. Setting

This study was carried out in Osu town, the headquarters of Atakumosa West Local Government Area (LGA), Osun State between January and June 2023. Osu town had a projected population of 15,256 [9].

## 2.3. Study Population

The study population for the quantitative aspect consisted of reproductive aged women within the age 15 - 49 years old, while the qualitative aspect included their spouses, women leaders, religious leaders and health workers. Consenting women age 15 - 49 years old, their spouses, women leaders, religious leaders and health workers were included while Eligible respondents that were ill or not available during the study period were excluded from the study.

## 2.4. Sampling Strategy

The minimum sample size of 294 was calculated using an appropriate statistical formula for descriptive health studies ( $n = Z^2pq/d^2$ ) with 76% as reported by the UNFPA/UNICEF Joint Programme on FGM/C practice in 2015 and non-response/attrition rate taken into consideration Sixteen spouses and opinion leaders were used for the qualitative aspect of the study. The multistage sampling technique was used to recruit participants into the quantitative aspect. Stage 1: The two Enumeration Areas (EA) in Osu Town *i.e.* Osu Ward I and Osu Ward III respectively constituted the first stage of sampling units. Stage 2: Eighteen streets were selected using simple random sampling procedure (balloting procedure) as follows: 10 streets out of the 21 streets in Osu Ward I and 8 streets out of the 17 streets in Osu Ward III respectively. Stage 3: Fifteen houses were selected from each street using systematic sampling technique with the first house selected by simple random sampling (balloting). Fifteen houses were selected from each chosen street at an interval of 2 houses. Stage 4: One eligible consenting respondent was selected from each house selected for the study. For the qualitative aspect, purposive sampling technique was used to select 16 respondents made up of 4 spouses, 4 women leaders, 4 religious leaders and 4 health workers. This number was deemed sufficient for thematic saturation.

## 2.5. Data Collection

### 2.5.1. Quantitative Data

A semi-structured interview was administered for the study. This validated questionnaire was adapted from previous studies [10]-[12]. It was pre-tested among targeted population outside of the study location. The questionnaire collected information on socio-demographic characteristics, knowledge, attitude and intention to continue FGM/C practice.

### 2.5.2. Qualitative Data

The in-depth interview (IDI) complemented the questionnaire survey. The IDI guide use questions that assessed the knowledge and attitude of these opinion

leaders towards FGM/C practice in the study area. The research instruments were written in English then translated to Yoruba, the indigenous language, to ease communication and back translated to English to ensure content validity. All the proceedings in the session were audio-taped with the consent of the respondents. Data were collected by the authors assisted by two trained research assistants through the study period.

## 2.6. Data Analysis

Quantitative data were entered into a computer, cleaned and analysis performed using SPSS version 20 (SPSS Inc., Chicago, IL, U.S.A.). Simple descriptive and inferential statistics were performed and the results presented in tables. A binary logistic regression model was used to examine the association between continuing FGM/C practice (main outcome variable) and selected variables which included socio-demographic variables and having undergone FGM/C (explanatory variables). Results were expressed as odds ratios (ORs) and 95% confidence intervals (CIs). Tests were considered significant for a p-value < 0.05. Qualitative analysis: Rapid review of the field notes were done initially to identify major patterns and preliminary themes. Subsequently, all interviews were transcribed verbatim and those not conducted in English language was translated by a paid translator. All transcripts were proofread for accuracy. Earlier identified and new emerging themes and subthemes were through coding methods to enhance transparency and rigor. The emerging themes and sub-themes were applied to the transcripts using thematic content analysis.

## 2.7. Ethical Consideration

Ethical approval was obtained from the Research and Ethics Committee of the Institute of Public Health, Obafemi Awolowo University, Ile-Ife. Written consent was sought and obtained from the respondents with assurance of confidentiality before going ahead with the interview. Confidentiality of collected data was maintained throughout the study.

## 3. Results

Questionnaire with completed data from 294 women was analyzed. Their mean age was 27.0 (7.6) years. Most women (54.4%) were married, 166 (56.5%) were Christian while 128 (43.5%) were Muslims. Over 77% of the respondents had lived in the study area for 11 years or more. Almost all the respondents had formal education with 125 (42.5%) having secondary education (**Table 1**) Majority (98%) have heard about FGM/C practice with their sources of information being their parents (55.2%) and community elders (35.8%). Over 93% stated FGM/C was practiced during infancy in the community currently by midwives (69.4%) and auxiliary nurses (23.6%). Type 1 FGM/C (Cloridectomy) was the only type known and practiced by the respondents. Most have undergone FGM/C (76.2%) and had it done to their daughters (85.7%). Reasons encouraging practice include religion (98.6%) and curbing promiscuity (74.7%). Only 32.3% were aware of health

problems due to FGM/C practice with wound infection (91.4%) the most indicated. Majority (69.1%) said the victim feel regretful after been cut while (26.7%) feels stigmatized. Despite this, 80.6% intend to circumcise their daughter in future (**Table 2**). The statistically significant variables associated with continuing FGM/C practice include being married (85.6% vs. 74.6%), none/primary education (96.4% vs. 75.2% vs. 72.9%), lower income (83.5 vs. 61.5%) and having undergone FGM/C (97.4% vs. 20.3%) (**Table 3**). The predictors of continuing FGM/C practice include being married (AOR 2.03, 95% CI 1.12 - 3.65,  $p = 0.019$ ), none/primary education (AOR 10.02, 95% CI 2.88 - 34.88,  $p = 0.0001$ ), lower income (AOR 3.17, 95% CI 1.54 - 6.55,  $p = 0.002$ ) and having undergone FGM/C (AOR 14.65, 95% CI 5.31 - 40.37,  $p = 0.0001$ ) (**Table 4**). This suggests that marital status may play a crucial role in the decision to perpetuate FGM/C practices.

**Table 1.** Socio-demographic characteristics of respondents.

Variables	Frequency (n = 294)	Percentage (%)
Age (in years)		
15 - 24	130	44.2
25 - 34	108	36.7
≥35	56	19.1
Marital Status		
Married	117	39.8
Single	160	54.4
Divorce	16	5.4
widow	1	0.4
Level of education		
None	18	6.1
Primary	66	22.5
Secondary	125	42.5
Tertiary	85	28.9
Occupation		
None	38	12.9
Farming	61	20.8
Civil servant	83	28.2
Trading	83	28.2
Artisan	29	10.0
None	38	12.9
Religion		
Islam	128	43.5
Christianity	166	56.5
Duration of residence (in years)		
5 - 10	67	22.8
≥11	227	77.2
Income/day (USD)		
<1	255	86.7
≥1	39	13.3

**Table 2.** Knowledge, attitude and FGM/C practice among respondents.

Variable	Frequency (N = 294)	%
Heard of FGM/C		
Yes	288	98.0
No	6	2.0
*Source of information (n = 288)		
Parents	159	55.2
Community elders	103	35.8
Religious bodies	28	9.7
Mass media	8	2.8
*Stage when FGM/C is practiced (n = 284)		
During infancy	265	93.3
During early childhood	20	7.0
Marriage rite	9	3.2
Type of FGM/C practiced		
Type 1 (surgical removal of clitoris)	288	100
*Reasons encouraging practice (n = 288)		
Religion	284	98.6
To curb promiscuity	215	74.7
Tradition/cultural requirement	93	32.3
Promote girl child health	69	24.0
Aware of health problems of FGM/C (n = 288)		
Yes	93	32.3
No	195	67.7
Health problems caused by FGM/C (n = 93)		
Infection	85	91.4
Bleeding	6	6.5
Damage to the urinary tract	2	2.1
*Societal benefits of FGM/C (n = 288)		
Religious acceptance	125	43.4
Better marriage prospects	122	42.4
Sociocultural acceptance	92	31.9
None	23	8.0
Undergone FGM/C (n = 294)		
Yes	224	76.2
No	70	23.8

**Continued**

FGM/C done for daughters (n = 154)			
Yes	132	85.7	
No	22	14.3	
How FGM/C victims feel (n = 288)			
Regretful	199	69.1	
Stigmatized	77	26.7	
Okay	12	4.2	
*Community members performing FGM/C (n = 288)			
Midwives	200	69.4	
Auxiliary nurses	68	23.6	
Traditional Birth Attendants	36	12.5	
Elderly women	11	3.8	
Intention to continue FGM/C (n = 294)			
Yes	237	80.6	
No	57	19.4	

\*Multiple response.

**Table 3.** Association between selected variables and continuing FGM/C practice among respondents.

Variable	Intention to continue FGM/C practice		X <sup>2</sup> ; p-value
	Yes (%)	No (%)	
Age group (years)			
15 - 24	98 (75.4)	32 (24.6)	4.485; 0.108
25 - 34	90 (83.3)	18 (16.7)	
≥35	49 (87.5)	7 (12.5)	
Marital status			
Not married	100 (74.6)	34 (25.4)	5.644; 0.018
Married	137 (85.6)	23 (14.4)	
Level of education			
None/primary	81 (96.4)	3 (3.6)	18.988; 0.0001
Secondary	94 (75.2)	31 (24.8)	
Tertiary	62 (72.9)	23 (27.1)	
Income/day (US\$)			
<1	213 (83.5)	42 (16.5)	10.467; 0.001
≥1	24 (61.5)	15 (38.5)	
Undergone FGM/C			
Yes	224 (97.4)	6 (2.6)	190.328; 0.0001
No	13 (20.3)	51 (79.7)	

**Table 4.** Logistic regression analysis on variables predicting continuing FGM/C practice among respondents.

Variable	AOR	95% CI	p-value
<b>Marital status</b>			
Not married (Ref.)	1		
Married	2.03	1.12 - 3.65	0.019
<b>Level of education</b>			
None/primary	10.02	2.88 - 34.88	0.0001
Secondary	1.13	0.60 - 2.11	0.731
Tertiary (Ref.)	1		
<b>Income/day (US\$)</b>			
<1	3.17	1.54 - 6.55	0.002
≥1 (Ref.)	1		
<b>Undergone FGM/C</b>			
Yes	14.65	5.31 - 40.37	0.0001

### Qualitative

The 16 participants interviewed were 4 women leaders with over 20 years' experience; 4 religious' leaders - 2 Christians and 2 Muslim leaders; 3 were indigenes. Other informants included 4 spouses and 4 female health practitioners. Their age ranged 35 - 71 years. Majority were farmers (31.2%), civil servants (31.2%), traders 25.1% and had primary education (43.8%). Most were indigenes (87.5%) and monogamous (75%). All speak Yoruba fluently. Knowledge and Attitudes towards FGM/C practice Participants confirms FGM/C as an age long practice, persisting in the community and recently performed mostly in the hospitals with few people having it done in their homes. A key informant stated: *"If a female child is born, what we inherited from our forefathers is to have her cut."* (IDI/Community Women leader/Female/64 years)

### Reasons for Female Genital Mutilation/Cutting

FGM/C is more revered than male circumcision due to perceived high sexual sensitivity and promiscuity when not done. This carries a lot of negative effects and stigma. The statement below aptly corroborates this: *"...if a woman is not circumcised, she will feel like having sex every time more than a dog but when that part is cut, her sexual urge is much less. Even as you are like this (referring to the female researcher) if you are not circumcised, you will have problems with males."* (IDI/Spouse/Male/49 years)

### Benefits attributed to FGM/C practice

Another participant said: *"It is done to make the girl clean as a religious rite. It prevents waywardness in girls, avoid teenage pregnancy and satisfy the community tradition. It gives the girls good prospects for marriage in the future and prevent difficulty during child labour."* (IDI/Pastor/Male/49years) Further affirming psychologically that they hold to FGM/C practice with great value, A participant

said: *“If a man discovered that his wife was not cut after marriage, he definitely would have it done so that she will keep to him or she would naturally be hot to have more than one man to meet up with her sexual urge.”* (IDI/Muslim faithful/Male/52 years)

#### **Health issues around FGM/C practice**

All participants belief that FGM/C has no known health consequences on the girls. This ignorance poses a major threat to its eradication in the community. *“The practice is not dangerous (with an affirmative facial expression), it is safe as God approved including the gods of the land that has handed over the practice to our elders by our forefathers.”* (IDI/Spouse/Male/61 years) The healthcare workers supported the practice shying away from the fact that it has dangerous health implications. According to one of them: *“Although it has recently been raised that FGM/C practice should be banned in our communities but those making laws against the practice have neglected the benefits derived from cutting a woman. Although as a nurse, I should obey the law but the tradition that works on morals should be observed to prevent promiscuity in girls who by chance were not cut.”* (IDI/PHC Nurse/47years) When asked if there are scientific evidence that girls not cut were more promiscuous, none could provide any such evidence. A nurse said: *“Although I cannot point to one paper supporting cutting girls but it’s our culture. If you don’t cut it in the hospital, they will go to quacks which will endanger their life and could lead to serious damage or death.”* (IDI/PHC Nurse/58 years)

The common procedure practiced in the community is the Type I (Clitorectomy). This establishes the medicalization FGM/C practice in this community. *“It is the apex of the clitoris that is cut off, and this is done in order to reduce unlawful sexual urge in girls as they grow to puberty. As a health worker, the instruments we use to carry out this procedure include mackintosh, scissors, cotton wool, normal saline, and penicillin ointment to prevent infection.”* (IDI/PHC Matron/Female/51 years) There was no known natural/biologic role of the part being cut off. *“It doesn’t have any use; it is disposed by burying it in the ground. This was the practice in the past and in recent times, mothers still bury it and some flush it away in the soak away.”* (IDI/Auxiliary nurse/female/37 years)

#### **Religious Beliefs and Female Genital Mutilation/Cutting**

The FGM/C practice has existed long before Christianity and Islamic religion became the order of the day and is just part of the Yoruba belief system. A participant said: *“...if we notice very well, Christians, Muslims and Traditional worshippers all circumcise their children whether male or female.”* (IDI/Spouse/male/56 years) A religious leader said: *“...the practice has no root in my religion. Female Genital Mutilation/Cutting is a Yoruba tradition that has nothing to do with my religion.”* (IDI/C.A.C Pastor/Male/53 years) These statements showed diverging views that while some respondents use religion to perpetuate the practice, others saw no relationship. Suggestions to mitigate FGM/C practice by participants. The suggested ways to mitigate FGM/C practice in the community include increase community sensitization on the risks of FGM/C practice,

intensified advocacy targeting religious and opinion leaders on the dangers of FGM/C practice, education and enforcement of legislation to stop the health workers from medicalization of FGM/C practice.

#### **4. Discussion**

This study assessed the factors sustaining FGM/C practice among reproductive aged women in a rural setting in Osun State, southwest Nigeria. It reported that most respondents were aware of FGM/C practice in the community. This finding has been reported in previous studies in Nigeria [10]-[13]. Despite most respondents being aware of FGM/C, they lack proper understanding of the types of FGM/C procedures with its accompanied health complications. The respondents' commonest source of information on FGM/C practice was from their parents. This finding has previously been reported [14]. For instance, a study conducted in North Western, Nigeria, indicated that no respondent gave mass media as their source of information on FGM/C [15]. Various studies have shown the relevance of the mass media in information provision to the public [11]-[15]. This lack of media publicity will continue to encourage negative traditional beliefs hindering FGM/C eradication. This study shows some healthcare workers justifying FGM/C practice despite being aware it's against the law. Also, it was reported that the procedure is being done in the hospital, with the only type done being type 1. FGM/C medicalization has been reported in several studies [16]. For instance, a study on FGM/C medicalization conducted in 4 referral hospitals in Bayelsa State demonstrated its continued support by Public Health Workers [17]. Though, these health workers engagement in FGM/C practice reduces quackery, it undermines the fact that FGM/C remains a discriminatory act of violence that denies women and girls their right to the attainable standard of health and physical integrity [17]. This study shows that the women strongly support the practice implying that they are the perpetrators of FGM/C in this community. They seemed to be the influential social group in the community promoting its continuity. Also, there is evidence that most community leaders interviewed supported the practice. Thus, implying that an intervention should target these women and the community leaders to eradicate the practice. This study reported diverging views on the role of religion in continuity of FGM/C practice in the community. However, there seems to be more support among the respondents for religion as a reason for FGM/C continuity. Also, the ignorance of its health implications as reported in this study poses a major threat to FGM/C eradication. This further reinforced the suggested ways to mitigate FGM/C continuity in the community. This study by its being limited to a rural based community hence its findings might not be generalizable outside the study area. However, the study provides useful information that can influence the policy on eradication of FGM/C.

#### **5. Conclusion**

FGM/C is an act that is formed by the people through experiences and interaction

created by existing myths and cultural perceptions within the confines of their environment. It is therefore necessary for Governments, policy makers and health program manager provide more specific and actionable policy recommendations for FGM/C eradication, addressing the identified socio-cultural drivers and the role of healthcare workers.

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## Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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