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Prevalence and Challenges of Female Genital Mutilation (FGM) in Edo State, Nigeria

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ABSTRACT: This paper presents the results of study conducted on women in Edo state, Nigeria. It probes into the nature, determinant and prevalence of domestic violence against women in the area of Female Genital Mutilation. Data were collected through in-depth interviews, case studies and survey. A sample size of three hundred and seventy-seven was selected for the survey. The result indicate that although prevalence of FGM is not very high in the state, however the practice is still commonly done and the women are not in position to decide in most cases on whether to have FGM done or not. To contain the prevalence of FGM the use of formal and informal channels of education to re-orientate the populace is strongly suggested. This will help to ensure attitudinal and cultural change towards FGM. In addition, there is need for policies that will genuinely protect women against FGM.

KEYWORDS: Women, Daughter, Violence, Health risk and Female Genital Mutilation (FGM).

INTRODUCTION

Female Genital Mutilation (FGM) is practiced commonly in Sub-Saharan and North East Africa Countries Bettina S and Hernlund Y (2000) Abiodun A et al (2011). It involves the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons with the goals of inhibiting a woman's sexual feelings Nwakeze N, (2006) Bettina S and Hernlund Y (2000). Most often the mutilation is performed before puberty, often on girls between the age of four and eight, but recently it is increasingly performed on nurslings who are only a couple of days, weeks or months old. The procedure is irreversible and the effect last a life time. FGM is practiced as a cultural ritual by ethnic groups. Nnorom C, (2000). It is typically carried out with or without anesthesia by a circumciser using knife or razor. The practice involves one or more of several procedures which vary according to ethnic group. Some cut a tip of the clitoris while some cut all the outer part leaving a small hole for urine and menstrual blood and the vagina is open up for intercourse and childbirth. FGM has no health benefit while the health effects depend on the procedure. It has immediate and late complication. Immediate complications include fatal bleeding, acute urinary retention, wound infection, tetanus, re-current infection and death (Oduro et al 2006, Onuh et al 2006). Late complications could include inability to get pregnant; complications during child birth include the need to have caesarian section and transmission of HIV if instruments are not sterile or reused (Ibekwe Perpetus C et al **(**2012), WHO (2006). It is not known how many girls or women have died from the procedure, few records are kept. Complication may not be recognized and fatalities are rarely reported.

In Nigeria like many other countries FGM is forbidden by law. However, the fact that this act is outlawed in most countries, the law is poorly enforced. There has been an international effort to eradicate this act. Law and campaigns against the practice have not been successful in eliminating the practice (Kolawole A & Anke Van. K (2011). Despite the awareness and campaign, the prevalence of this act is still on the high side. For instance in Egypt the prevalence is 91%, Sierra Leone has 88%, Burkina Faso recorded 76%, Chad 44%, Cote divoire had 38%, Nigeria 27%, Central Africa Republic 24%, Benin 13% Ghana 4% and Cameroou1% (UNICEF 2013). About 125million girls and women in Africa have undergone FGM. The practice is an ethnic maker rooted in gender inequality, ideas about purity, modesty and aesthetics and attempts to control women's sexuality. It is support by both women and men in countries that practice it, particularly by women who see it as a source of honour and authority and an essential part of raising a daughter well.

There has been much work on the practice, spatial distribution of FGM and its origin (Kandala etal 2006, Freymeyer R & Johnson B, 2007 and Nnorom C, 2000, Oduro et al 2006) but little attention is paid on the fact that the act is violation against women and many did not see it in that light except when the complication is fatal and result into death. It is against this that this study examines the violence done to women in the name of FGM with the objective of eradicating it.

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Violence against women is the most pervasive and the least recognized human right abuse in the world. Aderinto etal (2006). The specific act that constitutes this crime according to the United Nations Declaration of violence Against Women include: sexual abuse of female children, battering, marital rape, female genital mutilation and other traditional practices harmful to women. Nigeria, with population of over 140 million NPC 2006, where about half of the population is women, hence issues concerning domestic violence against women like FGM should not be ignore. Female Genital Mutilation (FGM) is a global problem (WHO, 2006, Population Council, 2004, UNICEF 2013). It remains common in many parts of the developing world. It is endemic in Africa, particularly sub-Saharan Africa. Carr D, (1997) (e.g. Niger, Mali, Ethiopia, Chad, Kenya, Nigeria, etc.), Southeast Asia (e.g. Bangladesh, Nepal, Pakistan, Indonesia, India, Myanmar, Cambodia, etc.) and the Middle East (e.g. The Philippines, Iraq, etc.).

It is mostly common among the rural poor and populations under stress. Bettina S and Hernlund Y, 2000, (P.I., 2006). According to Population Council (2004), a third of the more than 330 million girls and young women who currently lives in developing countries were victim. It's one of the most political areas of women's health. Worldwide it's estimated that well over 120 million women have been subjected to it. Supporters of the practice say it's an important part of cultural and religious life, and some compare it to the practice of male circumcision that is more widely accepted in the Western world, but opponents say that not only is it potentially life-threatening, it's also an extreme form of oppression of women.

There are limited literatures available for policy strategies; however the international community has recognized the human rights implications of FGM. Agencies such as UNICEF and WHO have played major roles to end this menace unfortunately the effort have not yield desire results. The practice has been outlawed but has not been fully enforced for example in Nigeria government recognized FGM as harmful practice to be eliminated but no specific federal law is yet in place to ensure strict compliance Kandala et al (2006). Although the 1999 constitution shun any act of torture or inhuman treatment or violence against any person, some state have passed law against this practice they include: Ondo, Ekiti, Edo, Cross River and Bayelsa states. In most cases the person convicted under the law is liable to a fine or imprisonment. For instance, Edo state banned this practice in 1999 and convict are subject to fine or imprisonment of only six months. It is important to note here that the government law is necessary but not sufficient to eradicating FGM.

In Nigeria, FGM is endemic in the southern part, especially in the southeast and southwest geo-political zones with over 45 per cent of it occurrence. In all these endemic areas, rural girls and women are particularly affected as they continue to bear the health risks, social and economic costs FGM and forced marriage, non-consensual sex and early pregnancies. FGM is globally recognized as a blatant violation of Fundamental Human Rights.

MATERIAL AND METHODS

This study address the following questions: what is the relationship between socio-cultural factors and FGM? To what extent does the perception of FGM seen as violence against women? How far has it affected the psychosocial and physical emotional of individuals and communities in Edo state. What is the most effective strategy for curbing FGM in Nigeria? In the quest for a comprehensive understanding, these questions influenced the study methodology.

Both qualitative and quantitative techniques were used in gathering data for the study. Survey, in-depth interviews and case studies were triangulated to explore issues relevant to the subject. The process of data collection begins with the designing of in-depth interview guide for pretest to facilitate questionnaire design. A total of 10 women of different age groups who had undergone FGM were interviewed. The data generated through this technique were rich in information. To ensure representativeness, respondents for interview were selected from specific study location within the state. Although most of the in-depth interview preceded the survey, some were conducted alongside questionnaire distribution.

A sample size of 400 respondents was anticipated for the study but a total of 377 questionnaires were fully completed and returned. The questionnaire comprises items that covered topics on socio-demographic characteristics, sexual attitudes and psychological and emotional attitude toward FGM. Beginning with the purposive selection of local governments to represent urban and rural settlement in the study area. Then the respondents in the chosen location were identified and a random selection of these groups was made. The simple random sampling was also used in the choice of individual

respondents for the study. Case study was adopted at the tangential level as a result of the serendipity of the in-depth interviews. The life stories of 4 respondents who had been victims of FGM were elicited. Qualitative data were analyzed using manual content analysis. Quantitative data generated through questionnaire were analyzed. A descriptive analysis of data was done using univariate frequency distributions

RESULTS

DEMOGRAPHY CHARACTERISTICS OF RESPONDENTS

The study adopted a sample size which tilted heavily in favour of women hence 77.1% of the respondents were women. However because it was necessary to obtain the views of men on such topic, a sample size of 22.9% of men was selected. (Table 1) Since the study focused on adult girls and women who had undergone FGM or have understanding of the meaning, the majority of the respondents were between the ages of thirty and fifty. The lowest age recorded was twenty-four while one respondent claimed to have attained the age of 69 years. Almost all the respondents (92.4%) belong to the Christian faith. This was expected because Christianity is the dominant faith in Edo state where the study was conducted (Segynola 2000). Respondents that were Muslims constituted 4.8% while the remaining 2.8 belonged to various traditional religions.

Table 1 Socio-Demographic Characteristic of Respondents

VARIABLE	CATEGORY	FREQ	%
Sex	Male	87	22.9
	Female	290	77.1
Age	Below 30	54	13.5
	30 – 34	67	17.5
	35 – 39	77	20.6
	40 – 44	81	21.7
	45 – 49	60	15.5
	50 – 54	21	7.8
	55^{+}	17	3.7
Religion	Christianity	346	92.4
	Islam	18	4.8
	Traditional	17	2.8
Marital status	Single	50	6.9
	Married	327	87.1
	Divorced	13	3.4
	Widowed	10	2.5
No of Children	0	13	4.0
	1-4	239	70.2
	5-9	82	24.2
	10+	5	1.6
Level of education	None	1	0.4
	Primary/Secondary	22	6.1
	Polytechnic	134	36.3
	University	198	54.0
	Others	12	3.2
Place of Residence	Urban area	245	65.0
	Rural area	132	35.0

Source: Author Field work 2013.

On marital classification, 87% of all the respondents are married, 2% are separated from their spouse, 1.3% are divorce 2.5% lose their partner due to death (widowed and 6.9% are single. Most respondents (70.2%) have between one and four children, while 24.2% have between five and nine children, those that have above ten children constitute 1.6% of the sample population while the remaining 4.0% do not have any child. The educational level of respondents was high with 90.3% of

them having attained tertiary education, only 6.1% of them did not go beyond secondary school while the remaining 3.2% have other forms of education.

The place of residence was also examined. About 65% live in the urban area while the remaining 35% are in the rural area. Ethnic group composition in Edo state is diverse. About 80%of the respondents indicated they belong to one of the following groups Igbo, Isoko, Esan, and Benin which are the dominant groups in the state. Other groups represented are Yoruba, Hausa, Idoma, Ogoni, Ijaw and Itsekiri. There was evidence of intra and inter-ethnic group marriage among the respondents. By implication, intra-ethnic marriage could encourage FGM if is acceptable by both couple.

PREVALENCE OF FGM

FGM varies from country to country, tribes, religion, and from one state and cultural setting to another and no continent in the world has been exempted. (Odoi A, 2005) In most parts of Nigeria, it is carried out at a very young age (minors) and there is no possibility of the individual's consent. (Hathout H, 1963) Type I and Type II are more widespread and less harmful compared to Type III and Type IV. In Nigeria, there is greater prevalence of Type I excision in the south, with extreme forms of FGM prevalent in the North. Nigeria, due to its large population, has the highest absolute number of female genital mutilation (FGM) worldwide (UNICEF 2001), accounting for about one-quarter of the estimated 115–130 million circumcised women in the world of the six largest ethnic groups, the Yoruba, Hausa, Fulani, Ibo, Ijaw, and Kanuri, only the Fulani do not practice any form. (International women's Issues Report on FGM 2010)In Nigeria, FGM has the highest prevalence in the south-south (77%) (among adult women), followed by the south east (68%) and south west (65%), but practiced on a smaller scale in the north, paradoxically tending to in a more extreme form.(UNICEF 2001, Adegoke P. 2005).

Table 2 Knowledge and Prevalence of FGM

Zones	Percentage of Women who heard of FGM	Percentage of Women Circumcised	Types of Circumcision Type1 Type2 Type 3 %
North Central	36.0	9.6	1.2 64.6 2.5
North East	40.1	1.3	- - -
North West	25.1	0.4	- - -
South East	87.7	40.8	0.3 12.2 2.7
South South	82.5	34.7	3.0 66.0 7.5
South West	85.7	56.9	2.2 36.3 1.3

Source: Nigeria Demographic and Health Survey: 2003

The Demographic Health Survey of Nigeria (2003) found a prevalence of FGM of 61% among Yoruba, 45% among Ibo and 1.5% among Hausa-Fulani tribes (Table 2), thus making it a greater problem in Southern Nigeria. (Kolawole &Anke 2012). Nigeria has a population of 150 million people with the women population forming 52%. (Adegoke P.2005). The national prevalence rate of FGM is 41% among adult women. Prevalence rates are still on the high side. However, 37% of circumcised women do not want FGM to continue. (UNICEF 2001) 61% of women who do not want FGM said it was a bad harmful tradition and 22% said it was against religion. Other reasons cited were medical complications (22%), painful personal experience (10%), and the view that FGM is against the dignity of women (10%). (UNICEF 2001) However, there is still considerable support for the practice in areas where it is deeply rooted in local tradition. (UNICEF 2001)

NATURE AND DETERMINANT OF FGM IN NIGERIA

FGM practiced in Nigeria is classified into four types (WHO, 2007, Kolawole A &Anke 2010) as follows. Type I: It involves the removal of the prepuce or the hood of the clitoris and all or part of the clitoris. In Nigeria, this usually involves excision of only a part of the clitoris. Type II is the removal of the clitoris along with partial or total excision of the labia minora. Type I and Type II are more widespread compared to Type III. Type III is the most severe form of FGM. It involves the removal of the clitoris, the labia minora and adjacent medial part of the labia majora and the stitching of the vaginal orifice, leaving an opening of the size of a pin head to allow for menstrual flow or urine. FGM is still deeply entrenched in the Nigerian society where critical decision makers are grandmothers, mothers, women, opinion leaders, men and age groups. (WHO, 2003) Mothers chose to subject their daughters to the practice to protect them from being ostracized, beaten, shunned, or disgraced (Yoder P, & Khan S. 2007; UNICEF. 2003) FGM is regarded as a tribal traditional practice (our custom is a good tradition and has to be protected), as a superstitious belief practiced for preservation of chastity and purification, family

honor, hygiene, esthetic reasons, protection of virginity and prevention of promiscuity, modification of socio sexual attitudes (countering failure of a woman to attain orgasm), increasing sexual pleasure of husband, enhancing fertility and increasing matrimonial opportunities. Other reasons are to prevent mother and child from dying during childbirth and for legal reasons (one cannot inherit property if not circumcised). Based on secondary data from published literatures, the determinant and reason for FGM are summarize below:

Cultural Determinants: Cultural factor is the major determinant of FGM. It also influences lifestyle and behavior. Many people continue FGM because it is part of the societal norms handed down by their mothers and grandmothers and any attempt to discontinue the practice is met with societal pressure and risk of isolation (Babatunde, 1998, Rahman 2000, Mohammed 2000) They see it as a way for identification with the cultural heritage, initiation of girls into womanhood, social integration and maintenance of social cohesion and social acceptance.

Psychosexual Determinant: One of the reasons for FGM is to ensure respectability of a woman, thus enhancing her chances of marriage and getting a better 'bride price' (Rahman, 2000; Myers, 1985; Chege, 2001; Caldwell, 1997). This is more important in Southern Nigeria where FGM is linked with preservation of virginity, to attenuate sexual desire in the female, maintain chastity and virginity before marriage and fidelity during marriage, and increase male sexual pleasure.

Hygiene and Aesthetics: Among some societies, the external female genitals are considered unclean and unsightly, and so are removed to promote hygiene and provide aesthetic appeal (Kolawole A &Anke Van 2010). Moreover, the uncircumcised clitoris is said to emit a bad odour, itch or cause pelvic infection (Chege, 2001, Anuforo, 2004). The female external genitals are believed to be unsightly hence the cosmetic surgery. Therefore, FGM is thought to purify a woman both physically and spiritually so that children born to her are considered pure and legitimate.

Religious: Unlike male circumcision, the Bible and Korah did not mention FGM (Mohammed, 2000; Rahman, 2000). Female genital mutilation is practiced in a number of communities, under the mistaken belief that it is demanded by certain religions. However, since it aims to curb female "hyper sexuality" support is implied especially in Islam (Walker, 1996).

Others: FGM is common in rural areas of Sub-Saharan Africa and underdeveloped countries, (WHO, 2006; Dorkenoo, 1994). Since poverty, illiteracy and low social status are rife in these areas, these people are more likely to follow traditions (Anuforo, 2004; Adeokun, 2006; Myers 1985). Also it is believe to enhance fertility and promote child survival, better marriage prospects and helps delivery of babies

Attitude towards FGM

To determine the extent of FGM in the study area and the attitude towards it, a number of questions were asked. First respondents were asked if they had undergone FGM. About 58.9% of those living in the rural area (Table 2) claimed to have undergone it which is on the side. While those living in urban area account for the remaining 33.2% by implication, then prevalence of FGM is still high in the rural area compare to the urban area. Respondents were also asked to indicate their approval or disapproval of the practice. Majority of the respondents indicated that they will object to the act if they were to decide. Most mothers who had undergone it vow never to allow their daughters experience it. Why those whose daughter had gone through it claim they are not in position to decide.

Table 2: Prevalence of FGM among Mother and Daughter with reference to place of residence and educational status

	Mum Circumcised	**Daughter Circumcised**
	Yes No	**Yes No**
Place of residence		
Urban	**72 (33.2%) 145 (66.8%)**	**52 (21.8%) 186 (78.2%)**
Rural	**43 (58.9%) 30 (41.1%)**	**35 (48.0%) 38 (52%)**
Mother Education		
None	**68 (59.1%) 47(40.9%)**	**45 (39.8%) 68 (60.2%)**
Some Education	**57 (51.8%) 118 (48.2%)**	**28 (16.9%) 138 (83.1%)**

Source : Author Field work 2013.

Women had living children of whom some daughters had undergone FGM. In the urban area, 21.8% (Table 2) had daughters that had been circumcised, while those whose daughters were not circumcised are 78.2%. However in the rural areas 48.0% has daughters that were circumcised while the remaining 52% were not. Education, awareness and enlighten are

also factors that determine the prevalence and attitude towards FGM. Among women that have undergone FGM preliminary results shows that they live in rural areas and are with no education (Table 2)

The following case studies summarize the experience of women who had undergone FGM. This was gotten from in-depth interview.

Case one

This woman is a 28years old mother and a student. According to her*: I was 6years old when it happen. All I know was I was playing outside, I also remember a lot of relatives and family friends were at the house and a lot of food and sweets were cooked. The nightmare started when my friend told me "you will be a big girl now all you have to do is to be brave and don't cry" I didn't understand when she explain what was going to happen to me, all I wanted was a way to escape. I ran so fast trying to hide I was caught and dragged to the table. I was key down I fought as much as I could but I was overpowered and cut. As I got older I have realize the damage FGM has caused me physically and mentally. The mental scar I carried till today. After my little girl was born I knew as a mother I couldn't let that happen to her.*

Case two

The day of my circumcision was extremely appalling and traumatizing, feeling of intense fear, helplessness horror and severe pain. It all started when my aunt called me. My younger sister followed but was told to wait outside, when I got there I notice the circumcisers cleaning his small knife while he asked me to climb the table. I ran towards my aunt. They grabbed hold of my legs trying to pull them apart my aunt stuffed a big cloth in my mouth so l wouldn't scream so loud. When he was done I felt so ashamed that those men saw my private part and actually touched it and hurt me.

When it was my sister turn she was not too lucky, I heard her scream, I never heard such scream in my life even today when I shut my eye I can hear her screaming. She later died as a result of complication from the incident.

Case three

I still suffer from intrusive re-experience of the circumcision I undergone. It was perform on me unexpectedly and without any preliminary explanation. My Dad took me to the circumciser, well that is what people called them if l had to give them title it would be children butcher. He and two other elderly women pull me to the table, I started calling my Dad he had left "behave you silly girl it doesn't hurt" that was his word. I was overpowered ant cut. I suffered complications there after I remember I bled for several days.

Case 4

This woman is married with three daughters but never wanted to allow her daughters to undergone FGM but she is not in position to decide.

Circumcision was done to me when I was very young according to my parents I was 3months old can't remember what pain l went through. When l was pregnant of my first daughter we have been told of the health risk of FGM at anti-natal clinic and I made up my mind not to allow my daughter to be cut. But I yield to pressure from my in-law as they insist that circumcision is the family culture. I saw my daughter went through the pain and complications. She almost died and I fought my husband for not standing by me when I said no. So when the others daughters were born we decide not to perform circumcision on them.

DISCUSSIONS

The main objective of this paper was to examine the prevalence of domestic violence against women in the area of genital mutilation in Edo state. Ethnic and cultural factors are the reasons for its prevalence; however other factors are also contributing to it prevalence. Despite the effort of government and various groups at combating it, the prevalence is still high as the laws biding it are not properly enforced. Education, awareness and enlighten are also important factors that can reduce it prevalence. The attitude of most women towards it also reveal that they are not in support of the practice but at times they are not in position to decide Nwakeze, N (2006). Over the past years an increasing number of studies have documented that FGM practice affect the wellbeing of women and children including high risk of HIV/AIDS and death in severe cases.

CONCLUSION AND RECOMMENDATIONS

Today violence against women has become a major topic Reichert, (1990). The problems of violence in this regard are universal and differ only in scope from one society to other UNFPA, (1999). It occurs in broad context of gender-based discrimination, with regard to access to education, resources and decision-making power in private and public life. This research drew insight from the views of women and men and especially victims of FGM in order to have clear understanding of the factors that contribute to the menace. The results of the study shows that most women that are victims of FGM would have objected to it if they are to decide and the act is rooted in cultural believe and have no health benefit.

In order to effectively contain the menace of FGM, formal education should be used to eliminate the social and cultural believe attached to FGM. Combatting FGM should be part of school curriculum. Teaching materials should be developed to informal methods of education should be encouraged. Education campaign, consisting of posters, leaflets (at health centers, schools and religious centers can be effective. The mass media can also be used to enhance more balance of the campaign. Furthermore, local authorities such as village leaders, elders, should be engaged in programmes that would help discourage FGM. These groups can intervene to relieve the prevalence of FGM to an extent. Very important laws and policies aimed at eliminating FGM should be enforced.

Female Genital Mutilation is violence against women and has no health benefit. It will not be eradicated until there is fundamental change in some norms and believe and enforcement of laws and policies where necessary.

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