Persistence of Female Genital Mutilation in Rural Communities: Example from Igbo-Eze North Local Government Area of Enugu State, Nigeria

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Abstract

The study evaluated the influence of residence, religion and education on the practice of Female Genital Mutilation (FGM) and the effect of the practice on the reproductive health of women. Igbo-Eze North was chosen for the study because it is one of the rural communities in Nigeria that still have active cultural practices. A cross-sectional survey research design was adopted for the study. A cluster and simple random sampling techniques were used to select 183 respondents. Structured questionnaire was adopted as the instrument for data collection. The Statistical package for Social Sciences (SPSS) was used to analyze the data collected and chi square was used to test the hypotheses. The study found a significant relationship between place of residence and the practice of Female Genital Mutilation. It also revealed a significant relationship between religious affiliation and practice of FGM. The study equally indicated a significant relationship between level of education and the practice of FGM. The study recommends that sensitization should be intensified in rural communities to eradicate the practice of Female Genital Mutilation.

Keywords: Female Genital Mutilation, Reproductive Health, Cultural Practices, Tradition

Introduction

A scary practice as it is, Female Genital Mutilation is mostly practiced in African countries like Nigeria. According to WHO (2008), female genital mutilation is a process that involves partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or non-medical reasons. Abolfortouh, Catania, Hindin, Say & Abdulcadir (2015) noted that FGM typically is carried out without anesthesia, by a traditional circumciser using knife or razor. Girls who undergo this procedure vary from weeks after birth to puberty. Nwamarah (2015) noted that, globally, FGM is considered a harmful traditional practice that has both social and health effect on girls and women. Undoubtedly, according to Abdulcadir, Catana, Hindin, Petignat & Say (2016), mutilation of female genitals, could come in various forms and contributes to the problems of maternal health, where it is practiced. Okeke, Anyaechi & Ezenyeaku (2012) found out that subjection of girls and women to obscure traditional practices is an unhealthy practice inflicted on girls and women worldwide.

The pains encountered in this practice supersede whatever intention it is set to achieve. This practice has continued to persist despite the numerous effects on the girl-child and women. It seems the merriment aspect of it is considered essential. Hence, Ofor & Ofole (2015) noted that FGM in West African countries also has a close nexus with the maturity ceremonies and celebrations which familiarize the girls with their responsibilities of future women in the society. According to Joseph (2003), these ceremonies are cherished in West Africa, and are usually accompanied with celebrations, coupled with drinking, dancing, singing and cooking of special dishes.

Complications accompanying FGM practice, as reported by Kimonge (2011) in a study carried out in Kenya, include wound infection, uncontrolled bleeding and fever. Furthermore, psychological consequences such as horror, anxiety posttraumatic stress disorders and depression are short term complications. Long term complications include dysmenorrheal, which is also known as painful period, or cramps during menstruation; dyspareunia known as difficult or painful sexual intercourse; recurrent vaginal and urinary tract infection, infertility, cysts, abscesses, keloid formation and sexual dysfunction. Moir (1967) found, in a study carried out on

FGM in northern part of Nigeria that about 10% of maternal morbidity seen at a particular hospital in Zaria was linked to FGM. A town in Kaduna State was directly attributed to the traditional practices of female circumcision with a further 30% following a combination of genital cutting with obstructed labour. WHO (2006) reports that FGM may be responsible for as many as 15% of fistula cases in some parts of Africa.

A study conducted by WHO (2012) on FGM, using population African countries in which the practiced has been documented, suggests that 100-140 million girls and women worldwide are living with the consequences of FGM. In Kenya, according to UNICEF (2013) reports, in spite of the law prohibiting FGM, the practice still prevails. Ezenyeaku, Okeke, Chigbu & Ikeako (2011) found that the practice is still pronounced in Enugu Ezike, a rural part of Enugu State, despite the attempts of governmental and non-governmental organizations to stop the practice

There are traditions that have gone into extinction in Nigeria, for instance killing of albino twins. Yet, FGM is still prevalent, despite its health and social consequences. According to Ejiofoma (2006), most people have heard of the "tradition" done against the girl-child; over 200 million girls and women have undergone the unfortunate experience, with majority of them living in 30 countries, including Nigeria.

To actually appreciate the magnitude of the situation, it will be instructive to consider some data as presented by World Health Organization. An estimated 100 million girls are at risk for cutting each year on the Africa continent alone (WHO 2008). The Foundation for Women's Health, Research and Development (2002) estimates that there are 86,000 first generation immigrant and refugee women and girls in UK who have undergone FGM in their countries of origin, with more than 7000 girls at risk. Similarly, the International Federation of Red Cross and Red Crescent Societies reported in 2006 that, in Cameroon, FGM is carried out in a barbarous manner by traditional midwives with no medical training, without anesthetic and with rudimentary instrument. It can give rise to serious complications, sometimes resulting in death. According to official estimates carried out by WHO (2008), Cameroon currently has a population of 17 million, 52 percent of them are women. The United Nations figure suggests that around 20 percent of these women are victim of FGM an experience that can occur at various ages of birth, during adolescence, just before marriage or even after first child.

How the public perceive an act will go a long way in determining how they act towards it. Moreover, the opinion of the public is important because it helps to identify ways through which practices that are detrimental to the health of women can be eradicated. Since this practice is commonly associated with women, it is necessary to investigate the views of women of child bearing age concerning the implications of this practice for female reproductive health. This is the crux of this study. It will also identify what the public perceive to be the implication of FGM and tried to identify ways of discouraging the practice of FGM.

Statement of Problem

Female Genital Mutilation (FGM) is one of the dangerous cultural practices that have defied attempts at eradication in many communities in Nigeria. Despite the numerous negative consequences of the practice, many rural communities in the country have held FGM tenaciously as an indispensible aspect of their culture. The reasons for the refusal of many rural communities to discard this harmful practice are not clear. It has become imperative to find out the rural residents' perception of the practice and factors that aid the survival of the practice, amidst its various adverse consequences.

Objectives of the Study

The study aimed to determine:

1. The influence of place of residence on Female Genital Mutilation
2. The relationship between level of education and Female Genital Mutilation
3. The relationship between religious affiliation and Female Genital Mutilation

Literature Review

UNICEF (2013) reports that the practice of Female Genital Mutilation still persists in Kenya, despite the existence of laws prohibiting it. Kaplan, Hechavarria & Bonhoure (2013) examined knowledge and attitudes of healthcare professionals working in rural in Gambia to FGM. The study made use of survey research method, using a sample of 468 healthcare professionals, including all nurses and midwives. The study found that a significant proportion (42.5%) of Gambian healthcare professionals embraced the continuation of FGM. In fact, 47.2% of them intend to subject their own daughters to it. Their knowledge, attitudes and practices were shaped by sex and ethnic identity.

Bogale et al (2014), in a study carried out in Bale zone, a rural zone of Oromia regional state located south east of Ethiopia, using a cross sectional survey, found that 486 (78.5%) of women had undergone some forms of FGM. Ibrahim et al (2013) in their perception study conducted in Bayelsa State, Nigeria found that 84.1% of the female population leaving in that area believed that all forms of FGM are harmful, while 4.3% of them believed that it was a good practice; 4.3% of the respondents seemed to encourage the practices while 80.6% of them were of the opinion that the practice should be criminalized. Only 1.4% of the respondents stated that they could have their children circumcised. From all indications, people have negative perception on FGM as health implications, physical injuries; emotional trauma that accompany the practice remain indelible in the lives of those affected

Theoretical Framework

The study was anchored Feminist theory. The theory was propounded by Deegan (1988) who investigated the experiences of women in the society and found that gender inequality has led to marginalization and discrimination. Feminism can be used to describe a political, cultural and economic movement aimed at establishing equal right and legal protection for women. There are key women writers on feminist theory, Jone Johnson Lewis (2018); Andrea Dworkin (1946-2005) a radical feminist whose early activism including working against the Vietnam War; Crsytal Eastman (1881-1928) was a socialist feminist who worked for women's rights, civil liberties and peace amongst others. Feminist theory can help to explain FGM and its health implications in Enugu-Igbo-Eze North. Barbara (2008) rightly stated that one of the most important activities of feminists is the eradication of FGM as a harmful practice, promoting women's empowerment and integration in all societies. Authors and feminists have not kept mute on this tropical issue as volumes have been written in attempts to view FGM through the lens of feminism. According to Easton (2006), FGM is an expression of patriarchal control over women and believe that the practice can only end with eradication of patriarchy system. Women, particularly in developing societies like Enugu-Ezike, are faced with constant challenges to maintain tradition in the face of fast changing social conditions due to globalization and cultural change that is evident in Enugu-Ezike. Feminist theory will give them a voice for a change of practices that pose threat to their lives.

Area of Study

The area of this study is Enugu Ezike. It is a well known community because it is the land of fertile palms; it has one of the highest concentrations of palms trees in Nigeria. The people are predominantly traders and farmers. It also boasts of many soothsayers, traditional medicine men and herbalist. Enugu-Ezike, is located in Igbo-Eze North Local Government Area of Enugu State, Nigeria.

The area is characterized by high lands and some dry valleys. Enugu Ezike has two seasons: wet and dry seasons. It is made up of 36 villages, not including the newly created political autonomous communities namely Umuida, Ogrute, Uumuopu, Uda, Aji, Amufie, Inyi, Uroshi, Umuagama, Amachalla, Ugbaike, Umuogbo Ulo, Olido, Okpo, UmuogbAgu, Imufu, Amaja, Inyi, Igbele, Isugwu, Ekposhi, Ikpuiga, Ufodo, Ezillo, Okata, Igogoro, Ikpamodo, OwereEze, Umachi, Amube, Ogbodu, and Aguibeje.

Enugu Ezike people claim that they are descendent of Enugu Ezike Oba, who married two wives that gave birth to four sons who make up Enugu Ezike. The two wives were Ayigwa, who bore him the first son, Ezzodo and the third son, Essodo, while Osegbe gave birth to the second son Itodo and the fourth and last born, Ozzi.

Enugu Ezike has common boundaries with Benue and Kogi States of Nigeria. On the North is Ette, an Igbo speaking community in Igbo Eze North Local Government Area. On the East is Ofante and Idoma while the North West flank are Amaka and Akpanya communities of Benue state. To the south West is Ibagwa while to the South West is AlorAgu, Unadu and Itchi. To the South East of Enugu-Ezike are ObolloAfor, Iheaka and Ovoko. Enugu Ezike is renowned for her palm wine tapping, traditional medicine and African Traditionl Religion

Data and Method

This study adopted a cross-sectional survey research design. Babbie (2010) described cross-sectional research design as a research design that enables one to collect data on certain variables in the population at a particular point in time. Survey is proven to be the best method for studies of attitudinal and behavioral trends. It enables a researcher to measure the responses of a sample on a particular topic (Sills, 1988). Surveys are very useful in the measurement of public opinions, attitudes and orientations which are dominant among large population at a time. Questionnaire was used as a major instrument for data collection.

Table 1: Demographic Characteristic of Respondents

Characteristics	Frequency (N)	Percentage (100)
Sex	45	24.6
Female	138	75.4
Total	183	100.0
Marriage		
Single	82	48.8
Married	40	21.9
Separated	24	13.1
Divorced	16	8.7
Widower	21	11.5
Total	183	100.0
Residence		
Urban	85	46.4
Rural	98	53.6
Total	183	100.0
Religion		
Christianity	164	89.6
Islam	11	6.0
African traditional religion8		4.4
Total	183	100.

Test of Hypotheses

Hypothesis One

H_1: Females who reside in rural areas are more likely to be circumcised than those in the urban areas.

H_0: There is no significant relationship between place of residence and likelihood of circumcision

Significance Level: A significance level (α) of 0.05 was used in testing this hypothesis.

Table 2 Cross Tabulation of Place of Residence and ever Experienced Circumcision

Place of residence	Ever experienced circumcision		Total
	Yes	No	
Urban	13 (15.3%)	72(8.7)	85(100.0)
Rural	42(42.9%)	56(57.1%)	98(100.0%)
Total	55(30.1%)	128(69.9%)	183(100.0%)

χ2=(N=183), 16.450; df=1, p<.000, critical value=3.841

In testing hypothesis two, place of residence was cross-tabulated with ever experienced circumcision. The result in Table 2 shows that 15.3% of those who reside in urban areas have experienced circumcision and 84.7% have not experienced circumcision. On the other hand 42.9% of those who reside in the rural areas have experienced circumcision while 57.1% have not experienced circumcision.

However, given the computed $\chi 2 = 16.450$ and critical $\chi 2 = 3.841$; df = 1, the test shows that there is significant relationship (P<0.000) between place of residence and over experienced circumcision. As a result of this, the alternate hypothesis which states that: Females who reside in rural areas are more likely to be circumcised than those in the urban areas hereby upheld. Therefore the null hypothesis which states that there is no significant relationship between place of residence and likelihood for circumcision is hereby rejected.

Hypothesis Two

H_1: Christian women are less likely to experience circumcision than women from other religions.

H_0: There is no significant relationship between religion and likelihood of circumcision.

Significance Level: A significance level (α) of 0.05 was used in testing this hypothesis.

Table 3 Cross tabulation of religion and ever experienced circumcision

Religion	Ever experienced circumcision		Total
	Yes	**No**	
Christian	41(25.0%)	123(75.0%)	164(100.0)
Other religions	14(73.7%)	5(26.3%)	19(100.0%)
Total	55(30.1%)	128(69.9%)	183(100.0%)

X2= (N=183), 19.198; df=1, p<.000, critical value=3.841

In testing hypothesis two, religious affiliation was cross-tabulated with ever experienced circumcision. Respondents were, therefore, grouped into two categories – those whose religious affiliations are Islam or ATR were re-coded as "other religions", while all those that indicated that their religious affiliation was Christianity were coded as "Christians." The result in Table 3 above shows that 25.0% of those who are Christians have experienced circumcision and 75.0% have not experienced circumcision. On the other hand 73.7% of those in other religions have experienced circumcision while 26.3% have not experienced circumcision.

However, given the computer $\chi 2 = 19.198$ and critical $\chi 2 = 3.841$; df = 1, the test shows there is significant relationship (P<0.000) between religion and circumcision. As a result of this, the hypothesis which states that: Christian women are less likely to experience circumcision than women from other religions is accepted. Therefore, the null hypothesis which states that there is no significant relationship between religion and likelihood for circumcision is rejected.

Hypothesis Three

H_1: More educated women are more likely to regard female circumcision as having no cultural benefits than less educated women.

H_0*:* There is no significant relationship between level of education and cultural benefits of female circumcision.

Significant level: A significant level (α) of 0.05 was used in testing this hypothesis.

Table 4 Cross tabulation of level of education and cultural benefit

Level of education	Does female circumcision has anyCultural benefit		
	Yes	No	**Total**
Less educated	99(67.8%)	47(32.2)	146(100.0)
More educated	11(29.7%)	26(70.3%)	37(100.0%)
Total	110(60.1%)	73(39.9%)	183(100.0%)

$\chi 2$= (N=183), 19.198; df=1, p<.000, critical value=3.841

In testing hypothesis three, level of education was cross-tabulated with female circumcision having cultural benefits. Respondents were, therefore, grouped into two categories – those who have no formal education, who have primary education and secondary education were coded as "less educated", while all those that indicated that they had tertiary education were coded as "more educated." The result in Table 4 shows that 67.8% of those who were less educated believed that female circumcision has cultural benefits and 32.2% do not believe that female circumcision has cultural benefits. Meanwhile, 29.7% of those who were more educated believed that female circumcision has cultural benefits and 70.3% did not agree that female circumcision has cultural benefits.

However, given the computed $\chi 2$ =17.850 and critical $\chi 2$ = 3.841; df = 1, the test shows there is significant relationship (P<0.000) between level of education and female circumcision having cultural benefits. As a result of this, the hypothesis which states that: more educated women are more likely to regard female circumcision as having no cultural benefits than less educated women is accepted. Therefore, the null hypothesis which states that there is no significant relationship between level of education and female circumcision having nor cultural benefits is hereby rejected.

Summary of Research Findings

Enugu Ezike people believe that those living in rural areas are more vulnerable to be circumcised than those living in urban areas. Therefore, there is a significant relationship between place of residence and experience of circumcision. It was found that a majority of Enugu Ezike people affirmed that the reason female circumcision was practiced in their community was to prevent women from being promiscuous. According to the findings, a majority were of the view that educated women have less regard for the practice of female circumcision than non-educated women. Therefore, there is a significant relationship between the level of education and practice of FGM. It was also found that a majority of the respondents affirmed that people from other religions are more vulnerable to the practice of FGM, compares to Christians. Therefore, there is a significant relationship between religion and experience of female circumcision.

Discussion of the Findings

The Enugu Ezike people practice Female Genital Mutilation (FGM) or Female Circumcision (FC) from time immemorial. The age at which some societies carry out this practice differs considerably from one place to another.

From the research findings, it can be deduced that, most significantly, the quest to ensure that women are not promiscuous and also cultural beliefs of Enugu-Ezike people can be underlined as reasons for continuous support for female genital mutilation among them and many communities in Africa today. Momoh (2005) states some of the factors of cultural beliefs, such as customs, cultural hierarchies and religious beliefs. The practice affects mostly girls and woman of all ages. It can be noted that in a bid to ensure fidelity, some women embrace the practice, especially in societies where infidelity brings shame to the individual's family and this can be linked to cultural belief.

Some people practice female genital mutilation for religious reasons. The research finding revealed that especially Muslims practice mutilation to show their commitment to Islam. However, some of the African traditional religion, seventh day Adventist Pentecostal and Lutherans seem to practice the Female Genital Mutilation for other reason not based in the bible, but are against the practice. Female genital is more common in Muslim communities, Mustafa (2001). The study further revealed that those residing in rural area are more vulnerable to FGM practice. This could be as a result of non-exposure to knowledge and health issues surrounding such practices. Educated women from the findings show that they have less regard to the practice and do not believe it has cultural benefits than non-educated women. This aligns with UNICEF (2013) that despite the law prohibiting FGM, the practice still prevails. Enugu-Ezike people still agree that FGM has cultural value.

Conclusion

The result confirms that the practice of FGM is still prevalence in Enugu-ezike. Sensitization campaigns in the communities that practice FGM, Enugu-ezike, inclusive may be positive in eradication of FGM. It will boost the knowledge of FGM and the health challenges associated with it among the rural dwellers and the non-educated among them. For practical relevance, issues dealing with culture are so sensitive. Knowledge on cultural and traditional beliefs should be wrapped up in such a way that a solution to this dreadful practice is minimized to the barest minimum or eradicated.

Recommendations

Awareness programmes to women, mostly in the rural areas, are essential in eradicating the practice of FGM. This is because education of women will give way to greater access to knowledge to speak for themselves.

Secondly, in-depth knowledge of the culture, tradition and beliefs of the affected group devoid of preconceived sentiments is paramount to effective ways of reorienting such group or society. Women should be educationally empowered. This would enable them challenge those discriminatory cultural practices which have held them captive and finally Government should harness effort to eradicate FGM practice among the entire cultural group in Nigeria.

Human rights and other non-governmental organizations should continue to demonstrate their commitment to the elimination FGM by enforcing laws prohibiting such practice to free women from immeasurable trauma. When empowerment is thorough, those with such knowledge will educate others through campaign believing that through women leadership positions that they can be part of the decision making process especially on the protection of rig hts of women and the extinction of marginalization and discriminatory behaviors against women.

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