

The Epidemiology of Female Genital Mutilation in Nigeria - A Twelve Year Review

*Epundu UU¹, Ilika AL¹, Ibeh CC¹, Nwabueze AS¹, Emelumadu OF¹, Nnebue CC²

ABSTRACT

Background: About 140 million women worldwide have suffered genital mutilation. The practice is common in several African countries including Nigeria. This paper reviews the prevalence, distribution, causes, consequences and strategies for elimination and proffers solutions to aid elimination of this practice.

Methods: Relevant literature pertaining to female genital mutilation in Nigeria were obtained from journals, textbooks, selected documents and internet search of databases using Pubmed, Google scholar and African Journals Online. Cross referencing was used to identify additional articles. The study period was from 2004 to 2016.

Results: Female genital mutilation is a common practice in several parts of the country, especially the Southern geopolitical zones. Nationally representative surveys reported a gradual decline in the prevalence. The practice has several negative health and economic consequences. Culture and tradition are important factors fuelling its persistence.

Conclusion: Female genital mutilation is a crime against womanhood, posing a great health and financial burden to individuals, families and the society. Although its prevalence is on the decline in many parts of Nigeria, more sustained and coordinated efforts of stakeholders at all levels are needed to fast-track the elimination of this practice in Nigeria.

Keywords: Female genital mutilation, circumcision, cutting, Nigeria.

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INTRODUCTION

Female genital mutilation (FGM) otherwise known as female genital cutting or female circumcision, is defined as “all procedures that involve the partial or total removal of the external female genitalia, or any other injury to the female genital organs for non-medical reasons”.¹ In other words, it is any procedure that causes injury to the female genitals without medical indication. This contrasts with male circumcision, a relatively low-risk procedure which has scientifically proven health benefits.^{1,2} Although of uncertain origin, FGM is known to have been practised in ancient times in African and European continents in countries such as Egypt, Ethiopia and Greece.^{3,4} Twentieth century obstetricians in America were also reported to have performed FGM as treatment for clitoral enlargement, hysteria, lesbianism and erotomania.⁵

The World Health Organization (WHO),¹ classifies FGM into four broad types, based on the anatomical extent of the procedure:

Type I (Clitoridectomy): This refers to the partial or total removal of the clitoris and/or the prepuce (the fold of skin covering the clitoris). This is also referred to as ‘Sunna’.

Type II (Excision): Removal (in part or whole) of the clitoris and labia minora. The labia majora may or may not be removed.

Type III (Infibulation): Here, the vaginal orifice is narrowed, and a covering seal created by cutting and repositioning the labia minora and/or the labia majora. The clitoris may also be removed. It is sometimes referred to as ‘Pharaonic’.

¹ Department of Community Medicine, Nnamdi Azikiwe University Teaching Hospital, Nnewi, Nigeria

² Department of HIV Care, Nnamdi Azikiwe University Teaching Hospital, Nnewi, Nigeria

*Corresponding author. Email: epunduuuzo@gmail.com

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Type IV (Others): Any other harmful procedure performed on the female genitalia for non-medical purposes, for example: pricking, piercing and incision of the clitoris and/or labia, stretching and/or cutting of the vagina ('gishiri'), scraping of tissue surrounding the vaginal opening ('angurya') and cauterization. It also includes the introduction of corrosive substances into the vagina to cause bleeding or to tighten or narrow the vagina.

Global estimates show that about 140 million girls and women have been circumcised, with as many as 3 million girls at risk of undergoing FGM every year.² In Africa, FGM is practised in twenty-eight countries, with some of the highest prevalence rates in West African countries such as Sierra Leone, Gambia, Burkina Faso and Mauritania.^{6,7} Children between the ages 0 and 15 years are most at risk.⁸ It is estimated that in Africa alone, 91.5 million females aged 10 years and above have been mutilated.⁷ Certain societies mutilate their girls as infants while others do so during childhood, often as a rite of passage to adulthood or during marriage.⁹⁻¹² In some other cultures, FGM is performed on pregnant women or on corpses of dead women.¹³ As at 2013, Nigeria, with a population of over 69 million women,¹⁴ had a national prevalence of 25%.⁹ Majority (82.0%) of these mutilations occurred before the age of five years,¹⁵ a period when these children can neither give informed consent nor understand why they are being cut.

This study discusses the trends, causes, consequences and elimination efforts with regards to female genital mutilation in Nigeria and outlines recommendations for curbing the practice.

Prevalence and distribution of FGM in Nigeria

The practice of FGM in Nigeria is widespread and varies from one geopolitical zone, state and ethnic group to another. The highest prevalence of FGM is reported from the Southern geopolitical zones of

the country, among the Yoruba and Igbo ethnic groups.^{15, 16} Although the commonest types practiced in Nigeria are types I and II,^{10, 17-19} the other types of FGM (types III and IV) are also carried out, particularly in the northern parts of the country.^{15,16}

According to the 2013 National Demographic and Health Survey (NDHS),¹⁵ Nigeria has a national prevalence of 25%, an improvement from the 30% reported in the preceding 2008 survey.²⁰ The Multiple Indicator Cluster Surveys (MICS)^{16,21,22} also show a gradual decline from 26% reported in 2007 and 27% in 2011, to 18% as reported in 2016. While there are difficulties in the direct comparison of data across surveys due to differences in the methodology applied during the data collection processes, these results still remain valid clues to the fact that positive change is taking place. This decline is further evidenced by the fact that girls 15-19 years of age are less likely to have undergone FGM than older women.^{15, 16, 20-22}

The reasons for the reduction in prevalence may not be unconnected to the global push for the elimination of FGM, noted to have begun in the late 1990s^{23, 24} These efforts were driven by several international debates on the topic occurring about the time, notably the Convention on the Elimination of all forms of Discrimination against Women in 1979, World Conference on Human Rights in 1993, International Conference on Population and Development in 1994 and the World Conference on Women in 1995.^{23,24}

Table 1 shows the socio-demographic variations in the prevalence of FGM in Nigeria, as reported in NDHS and the MICS. The ethnic differences in prevalence may explain why FGM is more prevalent in the urban than the rural areas, among women of higher educational status and higher wealth quintiles. The people of Yoruba and Igbo ethnicities among whom the prevalence of FGM is higher live in the Southern parts of Nigeria, which is more

urbanized than Northern Nigeria; and a higher proportion of these women have also received some formal education compared to their northern counterparts.^{15, 20, 22} The distribution of wealth quintiles in Nigeria is also skewed, with a higher proportion of the population in southern Nigeria belonging to higher wealth quintiles than those in the Northern geopolitical zones.¹⁵ It is also possible to explain the rural-urban distribution of FGM by the massive rural-urban drift taking place in most parts of the country. This is likely to shift the proportion of circumcised women in favour of the urban/ semi-urban than the rural areas.

Studies done by independent researchers^{10, 11, 18, 25, 26} to ascertain the FGM prevalence in different parts of the country have yielded various conflicting results. Studies carried out among women attending antenatal clinics in Jos and among women living in a rural community in Kwara State (North Central geopolitical zone) have reported a prevalence of 31.3% and 88% respectively.^{10, 27} Another done using data from 420 women of reproductive age (15-49 years) in the six states of the South Western zone observed a prevalence of 75% and 71% for mothers and daughters respectively.²⁵ A study by Johnson and Okon in Akwa Ibom State, South-South Nigeria reported a prevalence of 92% among women in a rural community.¹⁸ Hospital-based studies in the South East have reported prevalence rates ranging from 60.4% in 2005 to 42.1% in 2010 among expectant mothers.^{26, 28} On the other hand, Garba et al and Abubakar et al respectively reported a prevalence of 23.3% in 2004 and 13% in 2012 among different groups of respondents attending hospital clinics in Kano.^{11, 29} The differences in the selection of study subjects across these independent, peer-reviewed studies and the smaller study sample sizes involved pose a challenge in the comparison of results emanating from these studies both with each other

and with the results from national surveys in this review.

Data obtained during nationally representative surveys over the period of review^{15, 16, 20-22} also show that there was very little change in the attitude towards the practice of FGM among reproductive age Nigerian women, despite awareness of the practice. This does not bode well for the country's elimination efforts.

WHY FGM IN NIGERIA?

Several reasons have been advanced for FGM, many of which border on tradition and culture.^{11, 19, 30, 31} Other reasons include ensuring better marriage prospects for the women,^{31, 32} protection of their virginity,^{11, 12} preventing promiscuity by reducing a woman's sexual desire and increasing her faithfulness to her husband,^{27,32} promoting cleanliness as well as increased sexual satisfaction for husbands.^{11,31} Some others have the belief that women who have undergone FGM are more fertile and have an easier time giving birth as it improves their ability to tolerate the pain of childbirth.^{33, 34} Research has shown that social factors such as peer pressure, societal acceptance and parental pressure borne out of fear of ostracism and family shame contribute to the perpetuation of FGM.^{32, 35}

MEDICAL FGM

Also known as medicalization of FGM, this term is used to describe the practice of FGM by health care providers, whether in the private, public or home setting.³⁶ While most of the practice of FGM is perpetuated by traditionalists (circumcisers, barbers, birth attendants), the involvement of medical professionals has also been noted.^{11, 30} In 2011, 17% of all FGM in Nigeria was carried out by medical personnel,³⁷ especially nurses /midwives.^{15,20,11} The perception of FGM as being harmless, 'good' or less risky when performed by

professionals have been put forward as reasons for the practice of medical FGM.^{30,36} Medical FGM has come under severe criticism by the WHO,³⁶

as the involvement of medical professionals may serve to justify the practice, as well as contravene fundamental medical ethics.

Table I: Prevalence of FGM among Nigerian women of reproductive age (15-49 years) according to socio-demographic characteristics, 2007, 2008, 2011, 2013, 2016.

Variable	Prevalence (%)			
	2013 NDHS	MICS 2007	MICS 2011	MICS 2016
Age group (years)				
15-19	15.3	19.6	18.7	12.3
20-24	21.7	22.0	21.5	15.4
25-29	22.9	24.6	26.1	16.9
30-34	27.4	26.7	29.7	20.1
35-39	30.4	29.7	31.5	21.3
40-44	33.0	31.2	34.9	24.4
45-49	35.8	40.3	38.0	27.6
Ethnicity				
Yoruba	54.5	NA	NA	45.4
Igbo	45.2	NA	NA	29.2
Hausa	19.4	NA	NA	13.9
Geopolitical zone				
North-Central	9.9	14.0	13.8	8.6
North-East	2.9	2.0	3.5	1.4
North-West	20.7	2.8	11.9	19.3
South-East	49.0	52.7	46.8	32.5
South-South	25.8	39.5	36.4	23.3
South-West	47.5	51.3	48.4	41.1
Wealth quintile				
Lowest	16.5	7.3	12.2	9.9
Second	20.3	16.7	20.8	14.6
Middle	23.5	25.1	29.3	19.0
Fourth	30.6	40.2	38.9	22.9
Highest	31.0	35.6	30.8	23.3
Place of residence				
Rural	19.3	20.7	23.8	15.6
Urban	32.3	36.7	32.6	23.4
Educational status				
None	17.2	9.5	14.5	11.6
Primary	30.7	38.2	34.8	24.3
Secondary	28.8			20.2
Above secondary	29.1	37.4	32.2	21.5

NA- Data unavailable

Sources: NDHS 2013, MICS 2007, 2011, 2016

HEALTH BURDEN OF FEMALE GENITAL MUTILATION

The severity of complications due to FGM depends on the extent of anatomical involvement, with type III the most severe and may be physical or psychological in nature.

Physical health effects

The physical health effects may be divided into immediate, late effects and obstetric complications.

Immediate effects- These include pain and haemorrhage, wound infection, difficulty and pain in passing urine and even death.^{18, 19, 38} These are often underreported and usually documented only when the victims seek hospital care.

Late effects- They include but are not limited to infertility, chronic pelvic pain, painful menstruation, cyst formation and vesico-vaginal fistule.³⁹⁻⁴¹ These women often experience difficulty and pain during sexual intercourse with the consequence of having a poor quality of sexual life. The possibility of transmission of the Human Immunodeficiency Virus has also been documented.^{38, 42, 43}

Obstetric risks/complications: Victims of FGM frequently experience prolonged labour during childbirth and post-partum haemorrhage, and hence are at risk for caesarean births and obstetric fistulae.²⁹ Babies born to these women are also at risk of neonatal asphyxia and /or death.⁴⁰

Psychological health effects

FGM is often a very traumatic experience for victims. Traditional circumcisers typically use crude implements with questionable levels of sterility such as knives, razor blades, scissors and shards of broken glass.^{8,9} There have been reports of inhumane treatment such as being held down and cut without any form of anaesthesia and having the legs and thighs of the circumcised bound for a long time to ensure proper healing of the wound.⁹ Self-esteem issues sometimes manifested by a 'feeling of incompleteness' have also been documented.²⁸

FINANCIAL BURDEN OF FEMALE GENITAL MUTILATION

The financial burden posed by FGM is huge, as medical costs, especially that related to management of the complications weigh heavily on families and health care systems. A study in South East Nigeria⁴⁴ estimated the cost of managing the post mutilation complications per girl child in a pediatric clinic to be about US \$120; a huge amount for Nigerian families considering that many live on less than the national minimum wage of 18,000 naira (US \$50). In a study to estimate the obstetric cost of FGM in some countries including Nigeria, it was shown that the number of years of life lost per incident case of FGM in 15-45 year-old women increases progressively from type 1 to 111.⁴⁵

FGM had been considered a deterrent to the achievement of the recently concluded Millennium Development Goals 2, 3, 4, 5, 6.^{35, 36} If left unchecked it may still be a limiting factor to the achievement of the Sustainable Development Goals 3, 5, 16.

THE GLOBAL AND NIGERIAN RESPONSE

In 2008, the 61st World Health Assembly called upon member states to institute actions aimed at preventing and eliminating FGM, as well as provide support for victims.⁴⁶ The WHO is working with professional organizations as well as the United Nations (UN) system to achieve this goal. Several UN agencies, notably the United Nations Childrens Fund (UNICEF) and the United Nations Population Fund (UNFPA), have been in the forefront of the fight against FGM. In conjunction with UNICEF and the United Nations Educational Scientific and Cultural Organization (UNESCO), the WHO in 2010 launched a global "de-medicalization campaign" strategy; aimed at coordinating the efforts of policy makers in government, parliamentarians, international agencies, professional bodies, associations, community leaders, religious leaders and Non-Governmental Organizations in the fight

against medical FGM.³⁶ In 2007, the UNFPA and UNICEF together launched the 'Accelerating Change'; a partnership which is the main tool of the United Nations against FGM.⁴⁷ This collaboration has recorded tremendous progress in fast-tracking the elimination of FGM across several African countries using cultural and rights sensitive strategies. Other UN agencies have issued joint statements geared towards the elimination of FGM.²

Other landmark achievements by the UN are the adoption of the 6th day of February each year as the International Day for Zero Tolerance for FGM in 2012, and the resolution to 'Intensify global efforts for the elimination of FGM in 2014'.^{48, 49} Other professional bodies such as the Federation of International Obstetrics and Gynecology (FIGO), Medical Women International Association, International Council of Nurses, World Medical Association are also partners in this fight, especially with regard to Medical FGM.^{36, 50}

At the 47th World Health Assembly more than two decades ago, Nigeria resolved to eliminate FGM. This was further reinforced in 2012, when the country joined other African nations to sponsor the Anti-FGM Resolution at the 69th session of the UN General Assembly.⁴⁹ In 2013, the National Policy and Plan of Action for the Elimination of FGM in Nigeria was also formulated and approved.¹³ The Nigerian government has also sponsored the conduct of various surveys on FGM, and a federal law against FGM was passed in May 2015. Several Nigerian states such as Edo, Ogun, Cross-River, Osun, Bayelsa and Rivers have also outlawed the practice. National ministries, departments and agencies involved in the anti-FGM war include the Federal Ministries of Women Affairs and Social Development, Information and Communication, Justice, Health, as well as the National Human Rights Commission.

CONCLUSION

Female genital mutilation is a practice deeply rooted in the Nigerian society, especially in the Southern geopolitical zones of the country. The Northern zones of the country paradoxically have an abundance of the severe forms of FGM being practised. It is an act that violates womanhood, with negative, far-reaching health, social and economic implications. Despite the reported reduction in prevalence in the country, a lot more needs to be done to fast-track its elimination, particularly in the area of attitudinal change towards the discontinuation of the practice. Being a practice deeply rooted in culture, change may be slow; but with concerted and well-directed efforts it will surely come.

RECOMMENDATIONS

Eliminating FGM requires a sustainable, community-targeted approach, involving all relevant sectors of the economy such as women affairs, finance, justice, health; and relevant organizations such as religious, health professionals, women groups, professional bodies, policy makers and Non Governmental Organizations. The involvement of the various women's and religious groups cannot be overemphasized; especially as such groups have shown to be very effective agents of cultural change in the grassroots as evidenced by a study on widowhood practices in Nigeria.⁵¹ Sustainability is an essential component of any such approach since the process of culture-change is a gradual one.

Other recommendations include:

Increased and sustained support of the government, key policy/decision makers, general public, developmental partners, media and healthcare workers towards curbing the practice.

Fostering education and empowerment of girls and women. The Universal Basic Education programme of the Nigerian government is an initiative that will yield great dividends in this regard, considering that

studies have shown that educated and financially empowered women are less likely to subject their daughters to such a harmful practice^{15, 22, 25} and therefore may be more likely to withstand external and internal family influencers.

Cultural and religious-sensitive awareness, health education and public dialogue with relevant stakeholders in the communities on the harmful effects of FGM, with emphasis on the rights of women and the illegality of the practice. This will help to foster attitudinal change and encourage discontinuation.

The institution and enforcement of appropriate ethical guidelines for medical professionals by the relevant professional organizations.

Legal action where and when necessary. This provides an official platform for other activities against FGM and serves as a discouragement to circumcisers and families fearing prosecution.

Provision of medical, psychological and social support to the victims of FGM.

More research into the perception and practice of FGM in Nigeria. This will provide necessary data to monitor trends as well as ensure that resources are appropriately channelled to areas where they are needed.

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