

Original Article

Exploring the Persistence of Female Genital Mutilation: Primary Healthcare providers experience and their Perspective on Elimination.

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Abstract

Background: Female genital mutilation/cutting (FGM/C) remains widespread in Nigeria. With an estimated 19.9 million survivors, Nigeria accounts for the third highest number of women and girls who have undergone FGM worldwide. This study, therefore, aimed at identifying the factors that sustain the practice despite its illegality. Primary healthcare providers' experience and their perspectives on the elimination of FGM/C.

Methodology: This study used a descriptive qualitative design based on grounded theory. We used purposive sampling to identify and recruit primary health care providers. In-depth interviews and focus group discussions were conducted, and qualitative analysis was undertaken to develop a conceptual framework for understanding both the roots and the drivers of FGM.

Results: Historical traditions and religious rites preserve FGM and ensure its continuity, and older women and peers are a source of support for the practice through the pressure they exert. The easy movement of circumcisers across communities helps to perpetuate the practice, as does the belief that FGM will reduce promiscuity. Data collected between October and December 2023 were transcribed verbatim and thematically analyzed. Three themes exploring healthcare providers' perspectives on elimination of FGM/C were identified, namely understanding laws against FGM/C; perspectives on culturally sensitive education; and exploring public awareness raising activities in Nigeria.

Conclusion: Female Genital Mutilation continues to persist despite its illegality because of social pressure on women/girls to conform to social norms, peer acceptance, fear of criticism, and religious reasons. Implementing interventions targeting schools, religious leaders, older men, women, and strengthening Violence Against Persons (Prohibition) Act (VAPP) will help eradicate the practice.

Keyword: Explore, Cutting, Female, Genital, Mutilation, Persistence

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Background

According to the WHO (2020), approximately 200 million women and girls in the world today have undergone FGM/C, and every year, 3 million girls are at risk of this harmful practice. It is also estimated that if nothing is done to change the current rate, about 4.6 million girls will be at risk of FGM/C each year by 2030. [1]. Female Genital Mutilation (FGM) is deeply ingrained in many African societies. The practice occurs in 28 African countries with varying prevalence within and across countries [2].

FGM is a practice whose origin and significance are shrouded in secrecy, uncertainty, and confusion. [3] The origin of FGM is fraught with controversy, either as an initiation ceremony of young girls into womanhood or to ensure virginity and curb promiscuity, or to protect female modesty and chastity. [4] The ritual has been so widespread that it could not have risen from a single origin. [3,5,6]

Historical antecedents and social research revealed that FGM was practiced by the Phoenicians, Hittites, and ancient Egyptians. England and the United States used FGM to treat hysteria, lesbianism, masturbation, and other female deviances in the 1940s and 1950s [7,8]. Some studies reported that traditions and social norms pressure girls to undergo circumcision: women who are not circumcised often experience ridicule from peers and rivals [9, 10]. In some communities, the practice is tied to traditional religion [10] and in others, it is associated with Islam [11,12]. In some societies, circumcised girls receive mentorship to prepare them for marriage and meaningful lives.

Though FGM is practiced in many countries in Africa and a few scattered communities worldwide, its burden is seen in Nigeria, Egypt, Mali, Eritrea, Sudan, the Central African Republic, and the northern part of Ghana, where it has been an old traditional and cultural practice of various ethnic groups. [9,13]

FGM is widely practiced in Nigeria, and with its large population, Nigeria has the highest absolute number of cases of FGM in the world, accounting for about one-quarter of the estimated 115-130 million circumcised women worldwide. [9] 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 be in a more extreme form. [9,14] Nigeria has a population of 150 million people, with the female population forming 52%. [14]

In Nigeria, subjection of girls and women to obscure traditional practices is legendary. [9] FGM is an unhealthy traditional practice inflicted on girls and women worldwide. FGM is widely recognized as a violation of human rights, which is deeply rooted in cultural beliefs and perceptions over decades and generations, with no easy task for change. About 20 million women and girls in Nigeria have undergone FGM/Cutting, and this represents 10% of the global total.

The prevalence of FGM in Nigeria was 41 per cent in 2001 and 27 per cent in 2013, with variations across the regions and the highest in the southern part of the country [6]. The 2013 Nigerian National Demographic and Health Survey-NDHS however, reported that 25 percent of Nigerian women are circumcised, with Ebonyi State having the highest percentage in southeastern Nigeria [15]

Despite being declared illegal in the Ebonyi State Violence Against Persons Prohibition Law of 2018, the burden of FGM is high; communities like Afikpo, Izzi, Ohaukwu, and Ebonyi still bear the brunt of this violation [16]

Several intervention strategies have been employed in different settings globally to promote abandonment of FGM/C, including education about health risks, training Health Care Practitioners (HCPs) as change agents, community empowerment, legal measures, and alternative rites of passage (ARP), with varying success [17]. Health risk approaches have been found to inadvertently contribute to the demand for medicalization and the potential transition toward less severe forms of FGM/C, while the introduction of legal measures has prompted the practice to be driven "underground" [17]. Medicalization has become increasingly common, with estimates suggesting that 52 million FGM/C affected girls and women (1 in 4

of all FGM/C survivors) have been cut by HCPs (18). A study determining the trends of medicalization, based on self-reported data, found rates were highest in Sudan (67%), Egypt (42%), Guinea (15%), Kenya (15%), and Nigeria (15%) [19]. In Ebonyi, there is also anecdotal evidence to suggest that some HCPs hold pro-FGM/C views, despite the FGM/C Act 2011 prohibiting it. The prevalence of FGM in Ebonyi State in the last Nigeria Demographic and Health Survey-NDHS was 74.2% [20]

However, primary healthcare providers' understanding of FGM/C is yet to be explored, and their perception of the adequacy of these laws in the elimination of FGM/C is absent in the research literature. Guidelines about the elimination of FGM/C emphasize that laws against the practice need to be complemented by culturally sensitive education and public awareness-raising activities.

To date, in Nigeria, primary healthcare providers' perception, which complements FGM/C elimination have not been explored. The aim of this study was to address these gaps in the research literature.

Materials and Methods

Design

A qualitative study design with a phenomenological approach was chosen. It involved individual interviews with 20 primary healthcare providers. The interviews were analysed using thematic analysis informed by phenomenological assumptions, which suggest that it is important to understand the phenomenon from the viewpoint of the participants [21].

Study Setting

The study was conducted in Abakaliki, Ebonyi State metropolis. Ebonyi State is one of five states in the Southeast geopolitical zone of Nigeria, created in 1996 with an estimated population of 4.3 million, and has a land mass approximated at 5,932 square kilometers. [22] The state has boundaries in the North with Benue State, East with Cross River State, South with Abia State, and West with Enugu State. About 75% of the population dwells in rural areas with farming as their major occupation [22]

Participants

A total of 20 participants were included in the study. For the selection of the participants, a purposeful sampling strategy was used, which implies identifying and selecting individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest [21]. Using a purposive sampling approach, the 20-participants for this study were recruited from Primary health care centers in Ebonyi State. To participate in the study, participants needed to satisfy the inclusion criteria of (1) working in a primary healthcare setting, (2) being 18 years or over, and (3) providing healthcare or services to women. Of the 20 participants recruited, fourteen women had undergone FGM. Therefore, we sought to learn from participants' knowledge about female genital mutilation (FGM), perception of the level of awareness of female genital circumcision in Ebonyi State, the legal position of FGM/C in Ebonyi State, and how and why FGM is still practiced in Ebonyi State despite its illegality.

Data Collection

Data were collected through face-to-face open-ended semi-structured interviews and focus group discussions. First, a few questions exploring the sociodemographic characteristics of the sample were undertaken. The following general questions included women's experiences on FGM, its consequences, and why FGM is still practiced in Ebonyi State despite its illegality.

The focus group was conducted to stimulate the interaction between the participants and to explore the discourse in a certain social context, capturing the social experience and the different opinions and contractions. The focus group was open, non-directive, and flexible, and offered the participants the freedom to answer or not the questions posed to them. For the implementation of the focus group, a second person was required to act as moderator.

Ethical Considerations

All participants received oral and written information about the purpose of the study. voluntary participation, guaranteed confidentiality, and the right to discontinue at any time without any adverse effects. All interviews were coded prior to their transcription to guarantee the confidentiality of the participants. Ethical approval was obtained from Ebonyi State Ministry of Health Ethical Committee with reference number EB/EBOSACA/ES/R/003.

Data Analysis

Data analysis was conducted according to the phenomenological approach [21] and took place concurrently with data collection. The first step was data immersion; interview transcripts and field notes were thoroughly read to obtain a sense of the whole described by the participants. All interviews were transcribed verbatim, protecting all the participants' identities using code numbers. The second step involved dividing narrative data into concepts, which required the extraction of individual meaning units or conceptualizations. This was possible by re-reading the transcripts again, breaking down the whole through analysis into common elements. Together two authors independently analyzed the narratives and interviews, both as a whole and for meaning. The third step consisted of organizing, analyzing, and transforming the language of the participants into a conceptual perspective of the experience, relative to the phenomenon of interest. This step saw the emergence of themes, and the authors worked collaboratively to discuss the emerging themes and resolve any differences. In the final step, themes and sub-themes were combined into a final general description that reflected the lived experience of participants. All researchers agreed on the final thematic structure.

Report

From the 20 experiences collected, 14 women had undergone FGM, and all are mothers. The mean age was 40 years. All the participants were health workers.

Two main themes were derived from narrative data: (a) FGM consequences, (b) How to end FGM. From these, several sub-themes emerged, which are described below (Table 2). Representative quotations from the participants are used to verify and validate the findings.

Table 1. Themes and subthemes emerging from the data.

Theme	Sub-themes
Reason for FGM persistence	Culture Prevent promiscuity To please men To improve fertility Medicalisation
Consequences of FGM	Obstetric consequences Sexual complications Psychological and social consequences Infection
FGM Abandonment	Education and awareness Speaking up Improving prevention Penalization Strengthen VAPP act Community involvement

Reasons for FGM persistence -In this category, the following subthemes were derived:

"culture", "promiscuity", "Peer pleasure", "to Prevent infertility", and "Medicalisation". The most frequently mentioned were " culture and promiscuity." They believe it will reduce sexual desires, increase female hygiene, and promote safe delivery.

Table 2: Reasons for FGM persistence.

Reasons for FGM persistence	Quotes from participants
Culture	I did it because it's an indication that I am a matured girl; Its one of our cultural practices done for young girls at an early age. These are periods during which FGM can be done "Ibe Ugwu umu school'-FGM done before starting school. "Ibe Ugwu umu agbogo-FGM done as a teenager. "Ibe Ugwu umu nwanyi-FGM done as a mature woman. It is a taboo not to circumcise a girl child.
Prevent promiscuity	It's done to prevent girls from indulging in sexual practices before marriage.
To please man	It makes the vagina beautiful for men, as it increases female hygiene
Peer pressure	I did it because all my friends have done it, and they were calling me 'akpapi' (girl that still has a clitoris) "The cutting makes girls grow well."
Improve fertility	They said that without FGM, I would not get pregnant, and if I become pregnant, I will not have a safe delivery.
Medicalisation of FGM	A nurse did FGM for me. She gave me an injection kept in her house for a week while dressing the wound

Consequences of FGM

In this category, the following subthemes were derived: "obstetric consequences", "pain", "sexual complications", and "psychological and social consequences".

Obstetric Consequences

The most frequently mentioned were prolonged labour, postpartum haemorrhage, and perineal tears. pain, caesarean delivery, and the risk of infection. (Table 5). Of the fifteen women who had undergone FGM and had been mothers, 46% had prolonged labour.

Table 3. Obstetric and gynecological consequences of FGM.

Obstetrics/Gynecological complications	Quotes from participants
Postpartum Hemorrhage	I lost a lot of blood after delivery. I was transfused blood after delivery.
Prolonged Labour	I had delayed labor because of a scar. I had a delay in cervical dilation during Labour. I had difficulty during delivery. My body is too tight, and delivery was difficult.
Perineal tear	I had a bilateral episiotomy during labour.
Infection	I had an infection in the vagina.
Pain	Had severe pain during delivery

Sexual Complications

Regarding the consequences on sexuality, dyspareunia, the decrease or absence of erotic desire, the decrease in the quality of sexual relations, and anorgasmia were mainly mentioned:

Table 4: Sexual Complications of FGM/C

Sexual Complication	Quotes from participants
Dyspareunia	I experience pain during sex. I cry due to pain during sexual intercourse.
Deficit in sexual desire	Sexual depression, I do not have an urge for sex.
Anorgasmia	I have difficulty reaching orgasm.

Psychological and Social Consequences

Regarding psychological consequences, we can find verbatim accounts of clear components of psychosocial affectation, such as loss of self-esteem, feelings of humiliation, and fear of social rejection and dishonor of the family.

"I was forced because my mother was ignorant."

Proposed plans for the abandonment of FGM/C

Under this main theme, the subthemes "education, awareness", "speaking up, "improving prevention", and "penalization" were derived.

Table 5: Proposed plans for abandonment of FGM/C

Education	Educating women on the need to avoid FGM during ANC, immunization, and post-natal services. Frequent health education on the dangers of FGM.
Awareness	Developing jingles and songs to discourage FGM. Organizing public campaign, e.g., Road walks on FGM. School sensitization on the dangers of FGM, Engaging town announcers
Advocates (Health professionals)	Health workers shall be advocates and agents of change for female genital mutilation. Acknowledging and performing their roles as anti-FGM crusader in various facilities. Condemning the practice of FGM and never to take part in it.
Enforcement of the VAPP Act	To report any case of known FGM to the appropriate authority. Strengthen the task force on FGM Understanding of Ebonyi state laws against FGM/C.
Community engagement	Liaising with the community leaders and champions to preach against FGM in communities and to identify the perpetrators. To discourage young men from believing that girls must be circumcised before marriage. Identify and engage Traditional birth attendants in the campaign against FGM.
Integration	FGM should be included in the curriculum of both primary and secondary schools Integrating anti FGM campaign into health services

Discussion

The participating health workers had clear ideas about how FGM can be prevented within their communities. There was an overwhelming feeling that the current VAPP Act, the effort of the government in raising FGM Focal persons and community involvement, will be sufficient to tackle FGM if effectively implemented. Participants felt that there had been low awareness of the dangers of FGM/C and the VAPP Act in the communities. They believed that community-led solutions were the most effective way to tackle FGM. For an effective abandonment strategy, campaigns against FGM should be included in the curriculum of both primary and secondary schools and integrated into health services. In many communities. FGM is

a cultural requirement for girls who go into adulthood to acquire a certain social position and belong to a group. FGM is an important brand of social identity and not conforming to this can lead to social consequences, such as bullying, ridicule, social stigma, exclusion from the adult community, community events and social support, discrimination by peers, social rejection, loss of social status, increased isolation due to lack of marital capacity and family shame, as well as exclusion of the whole family from the social acceptance and welfare system of the community, as demonstrated by participants [23,24].

The participants in this study being health workers, emphasized the need for education about FGM, its harmful effects, and the implications of the legislation. The prevalence of FGM is high in Ebonyi state, and the media is key in providing people with information. There are no education initiatives run in schools to help prevent FGM.

The study found considerable poor implementation of the VAPP act, as many participants felt that perpetrators of FGM were never arrested by law enforcement agencies nor prosecuted. Furthermore, there were concerns about significant peer pressure in driving the continuity of FGM in communities. Participants highlighted that the medicalization of FGM will drive the practice underground and undermine the efforts towards abandonment.

Also noted that communities themselves are the key to tackling FGM effectively was an important finding. Participants were clear that the initiatives aimed at tackling FGM should come from within the communities.

The campaign against FGM should be included in the curriculum of both primary and secondary schools, and Integrate anti FGM campaign into health services.

Limitations of this study

This work focused on the prevention of FGM among health workers in specific communities. Therefore, the findings cannot be generalized to other affected communities in other states in Nigeria.

Conclusions

FGM is a public health issue that continues to adversely affect communities in Nigeria. The initiatives aimed at tackling FGM should come from within the communities, as well as strengthening the VAPP Act. Also, campaigns against FGM should be included in the curriculum of both primary and secondary schools and integrated into health services.

(1) the conception and design of the study, or acquisition of data, or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content,

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