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Original Article

Knowledge, Perception and Determinants of Female Genital Mutilation Among Women In Benin City, Nigeria

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Abstract *- Female Genital Mutilation (FGM, remains not only a harmful cultural practice but a major contributing factor to violence against the female gender, and the practice is increasing despite the numerous advocacies on the phenomenon. The age at which this practice is carried out differs, from a few days after birth to early teens, to adulthood just before marriage, and in some communities, at first pregnancy. The study's objectives are to assess the knowledge, perception and determinants of female genital mutilation among women in Benin City, Nigeria. This is a descriptive cross-sectional study with a structured questionnaire as the instrument for data collection with a reliability of 0.796 involving 220 respondents. IBM SPSS version 22 package was used for data analysis. The findings revealed that the mean age of the participants was 42.48 ± 12.928years. 88(40.0%) of the respondents demonstrated high knowledge of FGM. The mean age of FGM practice was 18.09 ± 2.091years. FGM practice among the women includes a condition for marriage 51(92.7%), rite into womanhood 44(80.0), cultural norms 40(72.7%), and having mothers that had also undergone FGM 46(83.6%). 176(80.0%) demonstrated a negative perception towards FGM. There is a low level of knowledge, and a high negative perception of FGM Stakeholders should be involved to eradicate the practice.*

Keywords *- Knowledge, Perception, Determinants, Female genital mutilation.*

1. Introduction

The World Health Organization (WHO) and the United Nations (UN) defined FGM as any partial or total removal of the external female genitalia or any other injury of the female genital organs for non-medical reasons[1]. FGM is recognized as an international public health problem because of its adverse impact on women's physical and psychosocial well-being and the violation of their sexual and reproductive health rights[2].

More than 200 million girls and women alive today have been cut in 30 countries in Africa, the Middle East and Asia where FGM is concentrated [3]. Reports have indicated that if FGM practices continue at recent levels, 68 million girls will be cut between 2015 and 2030 in 25 countries where FGM is carried out[4].

In Africa, more than 101 million girls aged 10 years and above have undergone FGM, and an estimated 3 million girls have their genital cut annually as the practice is a well-known African culture [3]. The practice of FGM is high in Nigeria, with one-quarter of the global estimates occurring in the country, and it cuts across all socio-cultural and geo-political zones in the country [5]. The current Nigerian prevalence of FGM among women of reproductive age stood at 20 percent and 19 percent among daughters less than 14 years of age, with the highest prevalence among adult women (35%) found in the South East, followed by South West (30%) and lowest in the North East (6%) region of the country [6, 4], and a practice whose origin and significance is shrouded in secrecy[7]. The recent report indicated that the practice is on the increase in Nigerians, particularly within the age group of 0-14 years, from 16.9 percent in 2013 to 19.2 percent in 2018 and concluded that it is worrisome [8,9].

Female genital mutilation harms women and the girl child and violates women's fundamental human rights. Studies indicate that FGM is slowing down; however, the practice is widespread in Nigeria despite efforts towards its complete eradication [10]. The practice violates a person's rights to health, security and physical integrity, freedom from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death [5]. The practice can lead to chronic pain, infections, keloids, fibrosis, primary infertility, increased delivery complications, psychological sequele, trauma, and sexual life of victims [11, 12, 13.] Continuing [12] reported that although the practice has been prohibited by law in Benin City and its environs, the

practice still persists. Consequently, this study is aimed at assessing the knowledge, perception and determinants of female genital mutilation among women in Benin City, Nigeria.

2. Material and Methods

This study adopted a descriptive cross-sectional design carried out on patients at the General Practice Clinic (GPC) of the University of Benin Teaching Hospital, Benin City, Nigeria, from June 2021 to March 2022. The study involved 220 adult women who were ≥ 18 years of age

2.1. Study Design

This study adopted the descriptive cross-sectional study design

2.2. Study Location

This study was carried out in the general practice clinic at the university of Benin teaching hospital, Benin City, Nigeria

2.3. Study Duration

June 2021 to March 2022.

2.4. Sample Size

220 patients.

2.5. Sample Size Calculation

The target population was 400, and an accidental sampling approach was used to recruit the participants. The studied sample was calculated from the study population using the Taro Yamane formula [14]**.** The Yamane formula is given as; $n = N / (1 + N(e)^2)$ where n = sample size: N= the population size: e = level of error margin (0.05): at a confidence interval of 95% and the sample size of 220 was obtained for the study.

2.6. Subject & Selection Method

The study sample was selected among patients visiting the general practice clinic with various ailments**.**

2.6.1. Inclusion Criteria

- Female gender
- Aged 18 years and above
- Willingness to participate in the study
- Women present during the period of data collection

2.6.2. Exclusion Criteria

- Male gender
- Women very ill to participate

2.7. Procedure Methodology

An application for ethical clearance was made to the University of Benin Teaching Hospital, Benin City, Nigeria, ethical committee and approval with protocol number: ADM/E. 22/A/VOL.VII/14831102 was obtained. Finally, individual informed consent was also obtained from each respondent prior to questionnaire administration. At the end of the exercise, all the questionnaires (220) were retrieved**.**

Data for this study were collected using a structured questionnaire. The questionnaire consisted of five sections: Section A contained both closed and open-ended questions, which dealt with sociodemographic characteristics of the respondent, such as age, marital status, religious affiliation, academic qualification, type of job, family setting and the number of children. Section B elicited a response to questions on knowledge of FGM and its associated risk factors. Section C asked questions on the perception of FGM practice. Section D elicited a response to questions on the prevalence towards the practice of FGM, while section E elicited a response to questions on determinants of FGM practice.

Data was collected from Monday to Friday for two weeks until the desired sample size was obtained. The structured questionnaire allowed the researchers to ask the same question in the same way, sequence, and order to different people, thus enabling the researchers to reach more respondents with divergent opinions simultaneously. The research instrument was pretested to 22 women (representing 10% of the sample size) attending a similar out-patient clinic at a tertiary hospital (Edo Specialist Hospital) in Benin City, Nigeria, using the split-half method and the data obtained was computed in IBM SPSS version 22 to estimate the reliability of the test instruments using Cronbach's alpha reliability. A reliability coefficient of 0.796 was obtained, considered significant for the instrument used for the study.

2.8. Statistical Analysis

The raw data retrieved were coded and imputed into the computer for easy analysis using IBM SPSS version 22.0. Data were presented in words, frequency distribution tables, and mean and standard deviation.

3. Results

3.1. Section A: Sociodemographic Characteristics of Respondents

The study revealed, as shown in table 1, that majority of the respondents, 112(50.9%), were in the age bracket of 38-47 years (mean age /SD (3.48 ± 12.928). The majority of 200(90.9%) were Christian, while 14(6.4%) and 6(2.7%) practiced Islam and Africa Traditional Religion (ATR), respectively. Those married were more 146(66.4%) followed by those who were single 56(25.5%), widowed 16(7.3%), and divorced 2(0.9%). Those with tertiary 104(47.2%) were more, 86(39.1%) secondary level of education, primary 12(5.5%) while 18(8.2%) had no formal education. Business holders were more 102(46.4%) followed by civil servants 86(39.1%), artisans 21(9.5%) and unskilled labourers 11(5.0%). Many 90(40.9%) have 3-4children, 68(30.9%) have more than 4children, 51(23.2%) have 1-2children while 11(5.0%) had no child yet.

Table 1. Showing social-demographic characteristics of the respondents (n = 220)

Variable	Tenets	Frequency	Percent
Age	18-27	20	9.1
	28-37	25	11.4
	38-47	112	50.9
	>47	63	28.6
Religion affiliation	Christianity	200	90.9
	Islam	14	6.4
	ATR	6	2.7
Marital status	Single	56	25.5
	Married	146	66.4
	Divorced	2	0.9
	Widowed	16	7.3
Academic Qualification	Primary	12	5.5
	Secondary	86	39.1
	Tertiary	104	47.2
	None	18	8.2
Profession	Civil Servant	86	39.1
	Business	102	46.4
	Artisan	21	9.5
	Unskilled labourer	11	5.0
Family Monthly Estimated Income	<N50, 000	55	25.0
	N50, 000 – N100, 000	98	44.5
	> N100, 000	67	30.5
Number of Children	1-2	51	23.2
	3-4	90	40.9
	More	68	30.9
	None	11	5.0

3.2. Section B: Knowledge and risk factors for FGM

Table 2 revealed that almost all the respondents 216(98.2%) have heard of female genital mutilation (FGM), 156(70.9%) agree that Female Genital Mutilation (FGM) is a partial or total removal of the external female genitalia for non-medical reasons, 162(73.6%) affirms that FGM is sometimes called "female circumcision, only 102(46.4%) agrees that there are four major types of FGM. 155(70.5%) affirms that FGM has no health benefits, 116(52.7%) agreed that women with type 3 FGM are at greatest risk for a more prolonged second stage of labor, episiotomy, or cesarean section, 136(61.8%) also agrees that FGM is recognized internationally as a violation of the human rights of girls and women. In comparison, 145(65.9%) affirm that FGM practice is prohibited in Edo State.

Table 2. Showing knowledge of FGM and its associated risk factors among the respondents (n = 220)

S/N	Items	Response	
		Yes (%)	No (%)
1	Heard of female genital mutilation or cutting (FGM/C)	216(98.2)	4(1.8)
2	Female Genital Mutilation (FGM) is a partial or total removal of the external female genitalia for non-medical reasons	156(70.9)	64(29.1)
3	FGM/C is sometimes called "female circumcision	162(73.6)	58(26.4)
4	There are four major types of FGM/C	102(46.4)	118(53.6)
5	The partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora, is considered type 2 FGM/C	122(55.5)	98(44.5)
6	The narrowing of the vaginal opening through the creation of a covering seal by cutting and repositioning the labia minora, or labia majora, refers to type 3 FGM/C	124(56.4)	96(43.6)
7	FGM/C has no health benefits	155(70.5)	65(29.5)
8	Women with type 3 FGM/C are at greatest risk for a longer second stage of labor, episiotomy, or cesarean section	116(52.7)	104(47.3)
9	FGM/C is recognized internationally as a violation of the human rights of girls and women	136(61.8)	84(38.2)
10	FGM/C practice is prohibited in Edo State	145(65.9)	75(34.1)

Mean knowledge score = 64.6%

Table 3. Showing perception towards the practice of FGM among the respondents (n = 220)

S/N	Description	Responses					Mean	SD
		SA (%)	A (%)	U (%)	D (%)	SD (%)		
1.	The practice of FGM/C should Continue	35 (15.9)	35 (15.9)	28 (12.7)	62 (28.2)	60 (27.3)	3.35	1.434
2.	FGM/C reduces promiscuity in Women	22 (10.0)	53 (24.1)	86 (39.1)	33 (15.0)	26 (11.8)	2.95*	1.125
3.	Women who did FGM/C are more responsible in their marriages	23 (10.5)	43 (19.5)	26 (11.8)	69 (31.4)	59 (26.8)	3.45	1.345
4.	My culture place a high value of FGM/C, which my family and I must uphold	32 (14.5)	48 (21.8)	36 (16.4)	55 (25.0)	49 (22.3)	3.19	1.384
5.	My religion place a high value on FGM/C, which my family and I must uphold	20 (9.1)	19 (8.6)	13 (5.9)	77 (35.0)	91 (41.4)	3.50	1.531
	Grand mean						**3.29**	**1.364**

Mean cut-off = 3.0

Table 4. Showing the prevalence of FGM practice among the respondents (n = 220)

S/N	Items	Response	
		Yes (%)	No (%)
1	FGM practice	55(25.0)	165(75.0)
2	Age at FGM practice **(n = 55)**		
	• <18years	17(30.9)	38(69.1)
	• 18-22years	26(47.3)	29(52.7)
	• 23-27years	7(12.7)	48(87.3)
	• >27years	5(9.1)	50(90.9)
	• Mean ± SD = 18.09 ± 2.091		
3	Any of your daughter(s) do FGM	35(15.9)	185(84.1)

3.3. Section C: Perception of FGM among respondents

Table 3 shows that the general perception of the respondents towards the practice of FGM is good, with a grand mean > 3.0

3.4. Section D: Prevalence of FGM practice among women in Benin City

Table 4 shows that 55(25.0%) had experienced FGM, out of which (30.9%) had it at the age < 18 years, (47.3.%) had it within the age of 18-22years, (12.7%) had it within the age of 23-27years while (9.1%) had it at age >27years age. FGM practice among the respondents was (18.09 ± 2.091years). 35(15.9) of the respondents have daughters that have undergone t

3.5. Section E: Determinants (reasons) for FGM

On determinants of FGM, as presented in table 5 shows that the common reasons for FGM practice among the respondents include a condition for marriage 51(92.7%), rite into womanhood 44(80.0), cultural norms 40(72.7%), virginity preservation 4(7.3), womanhood Hygiene/purification 2(3.6%), and religious duty 4(7.3). with respect to place of residence prior to procedure (FGM/C), 30(54.5%) were residing in an urban environment while 25(45.5%) were residing in rural environment. 45(81.8%) voluntarily consented to undergo the procedure. Only 24(43.6%) had adequate knowledge of FGM before the procedure. On the position of the female child in the family, the table revealed that 33(60.0%) were the first female child in their family, 14(25.5%) were in the middle, and 8(14.5%) were the last female child in their family. For the highest education level prior to the procedure, 20(36.4%) had primary education, 15(27.3%) had secondary, 8(14.5%) had tertiary, while 12(21.8%) had no formal education. 25(45.5%) were from monogamous family setting while 30(54.5%) were from polygamous family setting. 46(83.6%) have mothers that had also undergone FGM.

Table 5. Showing the determinants of FGM practice among the respondents (n = 55)

S/N	Items	Response	
		Yes(%)	No(%)
1	Reasons for FGM/C practice**		
	• Virginity preservation	4(7.3)	51(92.7)
	• Womanhood Hygiene/purification	2(3.6)	53(96.4)
	• Rite into womanhood	44(80.0)	11(20.0)
	• Condition for marriage	51(92.7)	4(7.3)
	• Religious duty	4(7.3)	51(92.7)

	• Cultural norms	40(72.7)	15(27.3)
2	Place of residence prior to the procedure		
	• Urban	30(54.5)	25(45.5)
	• Rural	25(45.5)	30(54.5)
3	Voluntary consent to the procedure	45(81.8)	10(18.2)
4	Adequate knowledge of FGM/C prior to the procedure	24(43.6)	31(56.4)
5	Position in the family		
	• First	33(60.0)	22(40.0)
	• Middle	14(25.5)	41(74.5)
	• Last	8(14.5)	47(85.5)
6	Highest education level prior to the procedure		
	• Primary	20(36.4)	35(63.6)
	• Secondary	15(27.3)	40(72.7)
	• Tertiary	8(14.5)	47(85.5)
	• None	12(21.8)	43(78.2)
7	Parental family setting		
	• Monogamous	25(45.5)	30(54.5)
	• Polygamous	30(54.5)	25(45.5)
8	Maternal FGM practice	46(83.6)	9(16.4)

4. Discussion

The mean age (42.48 ± 12.928) of participants is incomparable to (30.3 ± 4.8)[12] among pregnant women attending antenatal clinics in selected health facilities in Benin City, Edo State. The age difference could be related to the scope of the study. For instance, while the above study was limited to women aged 20-49 years, the present study covers adult women with no upper age limits (from 18 years and above). However, both studies share the similarity of predominance in Christianity, married status, and tertiary academic qualification. The consistency of these findings in both studies conducted in Benin City is not surprising. Christianity is the most practiced religion by inhabitants of Benin City. Therefore, it is expected that studies conducted in such an environment should record more respondents of the Christian faith. Secondly, being a study conducted among adults, it is expected that the majority should be married. Finally, Benin is one major city in south-south Nigeria with several higher academic institutions, and as such, the predominance of tertiary academic qualification among respondents in the study is not unusual.

Only (40.0%) of the respondents in the present study demonstrated good knowledge of FGM. This finding is inconsistent with the (62.9%) level of good knowledge reported from rural Egypt [27]. The difference may be due to the variability of participants in both studies. Unlike the present study, which involved only female participants, Egypt's study was done among male and female participants. The level of awareness and accurate definition of FGM recorded in the present study are comparable to [12]. However, the proportion (61.8%) of the participants who are familiar with the risk of pregnancy/delivery complications associated with FGM is at variance with (20.7%) reported in the Egypt report. Awareness of FGM as illegal practice (65.9%) is higher than (49.0%) [12]. The prevalence of FGM among the participants (table 4) was (25.0%) of which (15.9%) have had their daughters circumcised. This finding is consistent with [16] but lower compared to (96%) for participants and ((49%) for participants' daughters [17]. Over two-thirds (80.0%) of respondents expressed a negative perception of FGM, as many disagreed with the continuation of the practice and that it has no religious significance. This finding reflects the national finding where (67.0%) of women objected to the continuation of FGM practice while (78.0%) stated that FGM has no religious obligation [5]. However, many of the respondents opined that FGM reduces promiscuity in women [18]

The current prevalence rate is also lower than Edo State's (35.5%) current prevalence rate [6]. The lower prevalence in this study could be attributed to the growing body of evidence reporting the negative health consequences associated with FGM coupled with a high awareness of the FGM prohibition in Nigeria and Edo state, mainly where the law on FGM is enforced [19]. However, it is higher compared to (7.14%) [20]. The mean age at FGM among respondents was (18.09 ± 2.091years) which is high compared to (11.5 ± 2.3year) [18]. The most familiar reasons for FGM practice (table 5) among respondents include a condition for marriage, rite into womanhood, and cultural norms, which has been acknowledged [3,] with over half (54.5%) of the FGM cases being carried out among urban dwellers. This finding is consistent with the survey report, which stated that urban women are more likely than rural women to have experienced FGM [18]. Similar findings were reported from Ethiopia [16 and 22,] respectively. In a meta-analytic study [23,] the geographical variation in odd for FGM practice (with higher

older among urban dwellers) was also reported. The higher prevalence of FGM in the urban setting may be due to social convention (social norm), the social pressure to conform to what others do and have been doing, and the fear of being rejected by the community. Only (43.6%) of the circumcised participants had adequate knowledge of FGM prior to the procedure, while (18.2%) of them were subjected to the procedure without their voluntary consent. Culture is a strong force, especially in the African context, that often pays less attention to women or girl child opinions. Cultural norms are one the main reasons the FGM was performed on them could account for the proportion of non-voluntary consent in this study as the circumcision of victims is forceful [24]**.** FGM was higher among the first girl child in the family and polygamous family setting. FGM is a common practice and has been transferred from generation to generation in communities where the practice is prevalent [25, 26.] It was also higher among those having mothers that had undergone the FGM, which is consistent [12] but decreases with higher education qualifications [18, 22].

5. Conclusion

FGM is a cultural practice with no health benefit, is associated with significant consequences, and is a common practice among women in Benin City, Nigeria. There is good knowledge of the phenomenon and a high negative perception towards the continual practice of FGM among women in Benin City, Nigeria. Efforts by government and non-governmental groups and other stakeholders, including men, religious and community leaders, should be sustained to eradicate this practice.

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