

Exploring the practice and attitude of circumcisers in the eradication of female genital mutilation/cutting

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Abstract

Background: Female Genital Mutilation/Cutting (FGM/C) remains a form of violence against women despite efforts aimed at its eradication.

Objectives: To explore the practice and attitude of circumcisers towards eradication of FGM/C.

Methods: A descriptive (pilot) study involving local circumcisers in Kwara State, Nigeria using interviewer-administered questionnaire; analysis was done using SPSS version 21.0 and $p < 0.05$ was significant.

Results: There are 57 circumcisers including 36(63.2%) males, 49(86%) acquire the skill for circumcision as a family tradition, 3(5.3%) practice circumcision as sole occupation and 49(79%) derive higher average monthly income from other sources. Forty-two (73.7%) have a dedicated knife used for multiple clients, 44(77.2%) clean the instrument before use, 17(29.8%) wear protective gloves, 55(96.5%) apply substances to the wound mostly iodine 15(26.3%) and shea butter 11(19.3%) while 27(47.4%) have encountered complications previously. Among circumcisers, 44(77.2%) believe FGM/C prevent sexual promiscuity while 26(45.6%) think it is for culture/tradition. Thirty (52.6%) are aware of government activities to stop FGM/C, 53(93.0%) are willing to stop the act if support is provided in form of money to establish a trade 33(57.9%) or new employment 12(21.1%).

Conclusions: Circumcisers are willing to discontinue FGM/C if necessary support including vocational skill acquisition, credit facilities to start a trade or new employments are provided. Efforts should be expedited to support their rehabilitation to achieve the eradication.

Key words: Female genital mutilation, Female circumcision, Circumcisers, Violence against women

Introduction

Female Genital Mutilation/Cutting (FGM/C) also called female circumcision remains a global problem despite efforts targeted at its eradication at local, national, regional and global levels (1,2). It remains endemic in some countries mostly in Africa, parts of Middle East and Asia. New cases continue to be recorded especially in endemic areas with attendant complications (1). Substantial number of cases of FGM/C in the UK were among immigrants who had undergone it at their home countries where FGM/C is endemic (2). This necessitated the recommendation to ask all women about FGM/C at booking and same documented in the record although others present with complications noticed during sexuality counselling or delivery. Indications for FGM/C differ across localities but common reasons include control of female sexuality, cultural, religious and attempts at ensuring female virginity till marriage (3). The major stakeholders in FGM/C include men, the mothers, older women in

the community and the potential victims as newborns, infants, young children or adolescents depending on the timing in the particular culture. A major stakeholder that appears not to have been adequately evaluated is the circumcisers; these are usually lay men or women without formal medical training involved in FGM/C. They include older men and women in the community, traditional birth attendants; herbalists and in recent times health care personnel in developed countries. However, it has been difficult to evaluate circumcisers because of the criminalisation that has driven them underground although they continue the practice. The practice of FGM/C is often upheld by local structures of power and authority such as traditional leaders, religious leaders, elders, traditional circumcisers and some medical personnel or older women who have been mutilated previously (4). It is opined that circumcisers might not favour eradication of FGM/C; however, when they decide to abandon the practice and join the campaign, they can be very influential (4). Therefore, it may not be possible to eradicate FGM/C

without paying adequate attention to the circumcisers. This study evaluates the perception, attitude, practice and disposition of circumcisers to the eradication of FGM/C.

Materials and Methods

Study design: Descriptive (pilot) study.

Study setting: A total of six Local Government Areas (LGA) with two from each of the three senatorial districts of Kwara state in north-central Nigeria.

Study population: Participants were individuals (male and female) involved in performing FGM/C in the study area. The inclusion criteria were individuals recognised for the conduct of FGM/C in the study area irrespective of duration of practice but willing to participate in the study. Individuals who were not involved in FGM/C or those unwilling to participate were excluded from the study. A list of all Local Government Areas (LGA) in the three senatorial districts in the state was compiled and a total of six LGA with two from each senatorial district in the state were selected by balloting. Thereafter, a list of the wards from each LGA was compiled and four wards were selected from each LGA by balloting to give a total of 24 wards which constituted the study area. Twenty four research assistants were recruited and trained for the study- these were LGA health information data collectors for each ward. The researchers and research assistants approached the traditional leaders and women who have circumcised their children in the wards to identify a circumciser. The identified circumciser was informed about the study; assured of no link with law enforcement agents and provided a link to other circumcisers in the area.

Data collection and management: Data collection was by the researchers and twenty four research assistants who were health information data collectors in the state. The data collection tool was an interviewer-administered questionnaire which was designed for the study. The information collected included biosocial data, knowledge, perception and practice of FGM/C as well as attitude of circumcisers to efforts aimed at its discontinuation. The study was designed as a total population study to include all circumcisers in the study area because they were a hard to reach population due to the fear of arrest by law enforcement agents. In addition, the number or description of circumcisers is unknown making it difficult to calculate a study sample. This pilot study was designed to provide an insight into the number of circumcisers in the area.

Data analysis approach: Data analysis was done using SPSS version 20.0 and $p < 0.05$ was significant.

Ethics: Ethical approval was obtained from the ethical review committee of the University of Ilorin Teaching Hospital, Ilorin before the commencement of the study

while an informed consent was obtained from all participants at recruitment.

Results

There were a total of 57 participants, 21 (36.8%) were females, a majority were farmers 17 (29.7%) and 49 (86.0%) acquired the skill for circumcision as a family tradition. Only 8 (14%) did not charge a fee, 49 (86%) derived higher income from other vocations apart from circumcision while 15 (26.3%) belonged to an informal association of circumcisers (Table 1).

Table 1: Experience of circumcisers performing FGM/C

Parameter	Frequency	(%)
Gender		
Female	21	36.8
Male	36	63.2
Main occupation		
Student	1	1.8
Circumciser	3	5.3
Trading	5	8.7
Artisan	8	14.0
Housewife	11	19.3
Farming	17	29.7
Others	12	21.2
Skill acquisition for FGM/C		
Apprenticeship	8	14.0
Family tradition	49	86.0
Duration of practice (years)		
<10	6	10.5
10-19	22	38.6
≥20	29	50.9
Do you charge fee for FGM/C?		
Yes	49	86.0
No	8	14.0
Fee per child (USD)		
None	8	14.0
<5	19	33.4
>5	30	52.6
Comparison of average monthly income		
More income from FGM	8	14.0
More income from other activities	49	86.0
Do you belong to association of circumcisers?		
Yes	15	26.3
No	42	73.7

Most of the circumcisers 51 (89.5%) used a knife for FGM/C, 42 (73.7%) used same instruments for multiple clients, 44 (77.2%) cleaned instrument before use. The commonest cleaning agent was water and soap 26 (45.6%). Only 17 (29.8%) wore protective gloves. Wound care was performed by 55 (96.5%) mostly using iodine 15 (26.3%). Twenty seven circumcisers (47.4%)

had dealt with complications following FGM/C, these were mostly treated using local herbs (Table 2).

Table 2: Evaluation of FGM/C practice among circumcisers

Parameter	Frequency	(%)
Instrument used for FGM/C		
Razor blade	6	10.5
Knife	51	89.5
Same instrument used for multiple clients		
Yes	42	73.7
No	16	26.3
Clean instrument before use	44	77.2
Agent used to clean instrument		
Water only	2	3.4
Bleach / Jik	3	5.3
Methylated spirit	13	22.7
Water /soap	26	45.6
Do you wear gloves during circumcision?		
Yes	17	29.8
No	40	70.2
Where is the procedure performed?		
Circumciser's home	11	19.3
Client's home	46	80.7
Do you practice wound care after FGM/C?		
Yes	55	96.5
No	2	3.5
Agent for wound care		
None	2	3.5
Penicillin	3	5.3
Engine oil	5	8.8
Black soap	9	15.7
Shea butter	11	19.3
Local herbs	12	21.1
Iodine	15	26.3
Have your client experienced complications in the past?		
Yes	27	47.4
No	30	52.6
Management of complications (n=27)		
Offered sacrifice	2	7.4
Used drugs from drug store	7	25.9
Referred to hospital	8	29.7
Used local herbs	10	37.0
Major reason for denying request for FGM/C		
Vulva congenital anomaly	1	1.8
No parental consent	2	3.5
Pallor	6	10.5
Rashes on the vulva	13	22.8
When child is ill	35	61.4

The circumcisers continue with the practice for various reasons, however a majority; 44(77.2%) opined that it prevents sexual promiscuity. Most of them

31(54.4%) were aware of campaign to stop FGM/C and 53(93.0%) were willing to stop the act if financial assistance is provided for them to start an alternative trade 33(57.8%) (Table 3).

Table 3: Attitude and perception of circumcisers about FGM/C

Parameter	Frequency	(%)
Should females be circumcised?		
Yes	57	100
No	0	0.0
Why should females be circumcised*		
To achieve womanhood	15	26.3
As a religious obligation	19	33.3
To ease childbirth	29	50.9
As a cultural rite	36	63.2
To prevent sexual promiscuity	44	77.2
Are you aware of the campaign to stop FGM/C?		
Yes	31	54.4
No	26	45.6
Are you willing to stop circumcising females?		
Yes	53	93.0
No	4	7.0
Condition for stopping circumcising females		
Support to improve existing vocation	12	21.1
Employment in civil service	12	21.1
Financial assistance to start a trade or business	33	57.8

*Multiple answers allowed

We evaluated for factors that could influence the circumcisers to stop their trade and there were no significant predictor of willingness to stop FGM/C (Table 4).

Table 4: Multivariate analysis of predictors of willingness to stop FGM/C

Variable	B	OR	95% CI	P value
Age of circumciser	0.022	1.023	0.939 - 1.114	0.606
Duration of practice	0.037	1.037	0.955 - 1.127	0.385
Fee charged per client	0.041	1.042	0.582 - 1.866	0.889
Average monthly income from FGM/C	0.010	1.001	0.998 - 1.004	0.357
Previous client with complication	0.236	1.267	0.107 - 15.031	0.851
Awareness about campaign against FGM/C	0.580	1.786	0.153 - 20.908	0.644

Discussion

This study shows that about a third of circumcisers are young and mostly males who acquired the skill by observing the practice as a family tradition. Majority had other major occupations besides circumcision

and charged a service fee. Most circumcisers did not use protective gloves and used the same instrument on multiple clients posing a danger of infection transmission both to themselves and their clients. Complications following FGM/C were common although most were managed using non-conventional methods with very few being referred to health facilities. A majority of circumcisers were willing to discontinue the practice if they found alternative sources of income.

Similar to other reports (1-8), FGM/C in Nigeria was performed principally by local circumcisers and mostly at the clients' home (7, 9). Many of the circumcisers were young; this may suggest a possible trend towards acceptance of the act among some youths and may favour its continuation. In addition, male involvement as circumcisers may be an expression of male dominance in endemic areas or as direct beneficiaries of controlled female sexuality or guaranteed virginity at marriage (3).

However, preponderance of female circumcisers corroborated previously reported support of older women in FGM/C endemic communities who supported the act and performed it (10). Circumcisers in the study were laymen and women without contemporary surgical knowledge who were handling removal of human body parts (3). The acquisition of skill mainly through observation shows a clear lack of formal training in the practice (11). It is therefore not surprising that complications abound.

FGM/C was mainly performed as a part-time vocation to supplement other sources of income. This provides an opportunity that could be explored by providing support or new stable vocations to dissuade the circumcisers from the act. The cost of fees charged cannot be overlooked bearing in mind that 54.4% of the population in Nigeria live on less than USD1.25 per day (12). This shows the value attached to the act as people pay such high fees (minimum of USD 1) to ensure their daughters were circumcised.

Previous studies have reported similar practice in instruments use and the handling by circumcisers (11). While herbal remedies were the first line choice for managing complications following FGM/C, there was referral to health facilities or assistance from patent medicine stores among circumcisers in this study. However, FGM constituted a big risk to both the circumcisers and the clients, infection transfer between clients and circumcisers remains a reality (13, 14). Shea butter, a locally prepared substance widely used for wound care in the study has been shown to have medicinal values. It has been scientifically proven to possess anti-inflammatory properties (15).

The perception that FGM/C prevents promiscuity, eases childbirth and was an important cultural or religious obligation remains a major argument in support of the act (2, 16, 17). This justifies a case for education

to correct the misconceptions which still thrive in the community. The willingness of circumcisers in this study to discontinue the act reflected an improvement compared to previous reports. Circumcisers have been reported not to favour discontinuation of FGM/C since it reduced their relevance in the community as well as threatened their income and position in society. However, whenever it is reported, willingness of circumcisers to stop FGM/C has been a major boost in the discontinuation of the act (4, 10).

The strength of this study is that it explores the contribution of a poorly investigated group of individuals (circumcisers) who are a hard to reach population but may contribute to eradication of FGM/C. This will add to the available list of interventions that will contribute to the eradication of FGM/C. The study is limited by the small sample size and the difficulty in assessing the circumcisers. The implication of this study is that circumcisers represents a potential addition to the list of interventions to stop FGM/C if actively explored.

Conclusion

Although the practice of Female Genital Mutilation/Circumcision (FGM/C) persists, most circumcisers are willing to abandon the practice. There is therefore need for significant support from government and donor agencies to encourage the desire of these circumcisers. Rehabilitation of the circumcisers in form of vocational skill acquisition, financial support in form of aids or loans for small businesses as well as employment opportunities will go a long way in ensuring their commitment to the eradication of FGM/C.

Conflict of interest: The authors declare no conflict of interest.

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