Advancing Efforts and Strategies to Stop Female Genital Mutilation/Cutting (Fgm/C) in South-East Nigeria: A Qualitative Approach

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ABSTRACT

This study focused on advancing efforts and strategies to stop Female Genital Mutilation/Cutting (FGM/C) in South-East Nigeria using a qualitative approach. The specific objectives included: to find out efforts made towards eliminating FGM/C in South-East Nigeria; and to identify how the practice of FGM/C can be eradicated in South-East Nigeria. The study was anchored on the social norms theory and it is purely qualitative. A combination of purposive sampling, cluster sampling and simple random sampling techniques was adopted to select respondents for this study. A total of 54 interviews were conducted across 9 qualitative population categories in 6 communities in South-East Nigeria. The QDA Miner software was used to analyze the data. The findings showed that a number of efforts have been made to stop FGM/C in South-East Nigeria which include lecture/campaigns/sensitization, health worker education of community members, punishing the offenders and skeletal involvement of men in FGM/C-eradication campaigns. Again, FGM/C can be eradicated in South-East Nigeria especially through the intensification of such culturally specific/grassroots oriented strategies already existent in the communities such as community sensitization/education, community sanctioning and male-targeted FGM/C-eradication campaigns. It was concluded that it is only the strategies that are culturally specific/grassroots oriented that can bring about FGM/C-eradication but must not be fluidly applied. It was therefore recommended that Government and Non-Governmental Organizations should intensify the already existing sensitization efforts towards the eradication of FGM/C in South-East communities.

Key words: Advancing, efforts, strategies, eradication, Female Genital Mutilation/Cutting, FGM/C-eradication

INTRODUCTION

It is a general knowledge that FGM/C has persisted despite global, national and local efforts to stop it. The ideal situation shows that 200 million and more girls and women globally have undergone FGM/C with 15 million girls in high prevalence countries at risk by 2020 (UNICEF, 2016). The practice is prevalent in 30 countries with a majority located in 27 countries from Africa, together with Iran, Yemen, the Maldives and Indonesia (UNICEF, 2016). The practice, from the reports of Norman, Grgzabher and Otoo-Oyortey (2016) and Sripad, Ndwiga and Keya, (2017) has also spread to the developed world such as Europe, Australia, Canada and the USA mainly because of the increase in the number of people migrating out of FGM/C prevalent countries. In Africa, there is evidence that FGM/C is currently widely practiced, for example, in Sudan, 47% of young women and girls between the ages of 0 to 19 years had undergone the practice and some of them are cut between 5 to 9 years (Eldin, Babiker, Sabahelzain, and Eltayeb, 2018). In Nigeria, 20% of women have undergone FGM/C and it is more prevalent in the South-East Nigeria (35%), followed by South-West (30%), and lowest in the North-East (NPC and ICF, 2019)

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Female Genital Mutilation/Cutting (FGM/C) is defined by the World Health Organization (WHO), United Nations Children's Education Fund (UNICEF) and United Nations Population Fund (UNFPA) in their 1997 joint statement, "as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons" (Costello, 2015:1). World Health Organization has classified FGM/C into four broad categories which include: Type 1 (Clitoridectomy), that is, the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals), and in very rare cases, only the prepuse (the fold of the skin surrounding the clitoris). Type 2 (Excision) is the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of the skin of the vulva). Type 3 (infibulation), means the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning of the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy). Type 4 (unclassified) means all other harmful procedures to the female genitalia for non-medical purposes e.g pricking, piercing, or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris surrounding tissue; scraping of the tissue surrounding the opening of the vagina (angurya cuts) or cutting of the vagina (gishiri cuts); and introduction of corrosive substance or herbs into the vagina to cause bleeding or to tighten or narrow the vagina (UNICEF, 2005; WHO, 2008; NPC & ICF international, 2014; PRB, 2014).

Shell-Duncan, Naik and Feldman-jacobs (2016:7) identify various sub-divisions of the three categories out of the four as follows: Type 1 (clitoridectomy) has two sub divisions- "Type 1a" and "Type 1b". "Type 1a" involves the removal of the clitoral hood or prepuce only. "Type 1b" involves the removal of the clitoris with the prepuce. Type 2 (Excision) is sub-divided into three- "Type 2a", "Type 2b" and "Type 2c". "Type 2a" involves the removal of the labia minora only. "Type 2b" involves partial or total removal of the clitoris and the labia minora. "Type 2c" involves the partial or total removal of the clitoris, the labia minora and the labia majora. Type 3 (Infibulation) is sub-divided into two- 'Type 3a' and "Type 3b". "Type 3a" involves the removal and apposition of the labia minora while "Type 3b" involves the removal and apposition of the labia majora (Shell-Duncan, Naik and Feldman-Jacobs, 2016). The most common type of female genital mutilation/cutting is type 2 which account for up to 80% of all cases and the most extreme form which is type 3 constitutes about 15% of the total procedures while type 1 and 4 of FGM/C constitute the remaining 5% (Ibekwe, Onoh, Onyebuchi, Ezeonu, & Ibekwe, 2012).

According to NDHS 2008 and 2013, three major forms of FGM/C being practiced in Nigeria is type 4 female circumcision (Angurya and Gishiri cuts) and hymenectomy. Angurya involves the scrap of the vaginal orifice and is usually performed on infants within seven days of delivery. Gishiri cuts involve the cutting of the vaginal wall. The practice of FGM/C is a manifestation of gender inequality that is deeply entrenched in social, economic, and political structures. Like the now-abandoned foot-binding in China and the practice of dowry and child marriage, female genital mutilation/cutting represents society's control over women (WHO, 2005).

World Health Organization (2006) states that female genital mutilation/cutting in some countries are usually performed by trained and untrained personnel that use unsterilized equipment such as razor blade and shards of glass. Places where anesthesia is unavailable, the pain is excruciating, it causes physical, psychological and sexual problems and the severity of health effects depends on the type of FGM/C performed, the skill of the circumciser, the cleanliness of the tools and setting used and the physical condition of the girl or woman (Nwaokoro, Ede, Dozie, Onwuliri, Nwaokoro, & Ebiriekwe, 2016).

Ofor and Ofole (2015) state that the immediate consequences of FGM/C include severe pain and bleeding, shock, difficulty in passing urine, infections, injury to nearby genital tissue and sometimes death. In addition to the severe pain during and in the weeks following the cutting, women who have undergone FGM/C

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experience various long term effects which may be physical, sexual and psychological. FGM/C is practiced not only by muslims but by Christians and Jews (Nwaokoro, Ede, Dozie, Onwuliri, Nwaokoro, & Ebiriekwe, 2016). FGM/C is not only a violation of human rights of women and girls, but also a major health problem with numerous physical and psychological consequences. FGM/C has caused a lot of havoc by rendering most women infertile (Ofor & Ofole, 2015; Nwaokoro et al, 2016). It is based on these reasons that this study advanced to investigate efforts and strategies to stop FGM/C in South-East Nigeria using qualitative approach,

Objectives of study

- To find out the efforts made towards eliminating Female Genital Mutilation/Cutting (FGM/C) in South-East Nigeria.
- To identify how the practice of Female Genital Mutilation/Cutting (FGM/C) can be eradicated in South-East Nigeria.

Research Questions

- What are the efforts made towards eliminating Female Genital Mutilation/Cutting (FGM/C) in South-East Nigeria?
- How can the practice of Female Genital Mutilation/Cutting (FGM/C) be eradicated in South-East Nigeria?

REVIEW OF LITERATURE

Efforts to Stop FGM/C

According to Population Reference Bureau (2013) significant efforts have been made at the community, national and international levels to address the issue of Female Genital Mutilation/Cutting (FGM/C) over the last two decades. Adeniran, Fawole, Balogun, Ijaiya, Adesina and Adeniran (2015) note that it is documented that there was a reduction of 1% per year in FGM/C globally between 2003 and 2010 but this has been shown to be inadequate in the achievement of its eradication as the practice has continued despite strict legislation against it.

Nigeria has no national law prohibiting FGM/C except in a few states (Adeniran, Fawole, Balogun, Ijaiya, Adesina and Adeniran, 2015). Out of the 36 states and the Federal Capital Territory, eight states were said to have enacted laws prohibiting FGM/C. These states are Abia, Bayelsa, Cross River, Delta, Edo, Ogun, Osun and Rivers State (United Nations, 2009). However, the practice of FGM/C still persists even in these states where there is a law prohibiting it (NPC and ICF International, 2014). This suggests that more works need to be done on the area of FGM/C to enhance its eradication.

Bosch (2001) holds that there is a shift from familial and community-based FGM/C towards the medicalisation of FGM/C because of the uncomfortable health consequences of FGM/C. The research holds that medicalisation is a harm reduction strategy that entails maintening the physical and aesthetic aspect of FGM/C while the procedure is done in sanitary and sterile settings by medical professionals. Shell-Duncan (2001) supports the above views by holding that medicalization is a sound and compassionate approach to improve the health of women in settings where the eradication of the practice is not immediately attained. This strategy, however, has a very serious short-coming. According to the Women Health's Council (2014) the advocates of this strategy did not consider the practical implication of the approach as it will be more available to affluent members of societies, thereby posing serious equity of access question.

UNICEF (2005) argues that involving medical professionals in FGM/C undermines the message that it is a

discriminatory act of violence that denies women and girls their right to the highest standard of health and physical integrity. This implies that the United Nations is seriously advocating for complete eradication of FGM/C through government action. Rahman and Toubia (2000) hold that even though government action is necessary to create a political and legal environment that deters people from practicing FGM/C, it is mainly the women, their families (including husbands) and their communities who must be convinced to jettison the practice.

Similarly, the Women Health's Council (2014) holds that there are six main approaches undertaken to eradicate FGM/C: (1) using symbolic ceremonies that do not harm the body (Alternative Symbolic Rituals). For example, developing activities that take the place of damaging custom instead of outrightly prohibiting what has been done traditionally. (2) Advocacies by health workers for change which emphasizes the risk to health from FGM/C (Risk to Health Approach). (3) Human Rights Approach which emphasizes FGM/C as a violation of the fundamental human rights of women and children. (4) Provision of reproductive information and educative materials that empower women and children. (5) Positive deviance approach, whereby influential individuals in the community publicly declare their opposition to the practice and strive to influence others to do the same. (6) Directly targeting excisors/traditional birth attendants and helping them to find an alternative source of income.

Among these approaches, only three have been tried in Nigeria with low success rates and they are: risk to health approach, human rights approach and provision of reproductive information and educative materials that empower women and children (United Nations, 2009; Okeke, Anyehie & Ezenyeaku, 2012; PRB, 2013; Adeniran, Fawole, Balogun, Ijaiya, Adesina & Adeniran, 2015; Muthumbi, Svanemyr, Scolaro, Temmerman & Say, 2015). The risk to health approach and the provision of reproductive information and educative materials that empower women and children are mainly done by international bodies in Nigeria.

Strategies for FGM/C Eradication

The findings of the same work of Adeniran et al. (2015) on knowledge, practice and experiences of secondary school teachers in relation to FGM/C stated in 2.2.2 above also revealed that the majority of respondents considered education and legislation to be the most important interventions to encourage the eradication of FGM/C. Karmaker, kandala, Chung, and Clarke (2011) conducted a cross-sectional survey of 12,049 women on factors associated with FGM/C in Burkina Faso and its policy implications using logistic regression modeling. They found that age and religion were the most significant variables associated with the risk of FGM/C. They also found that deep cultural issues and strong personally held belief which are not simple to predict or quantify are likely to be involved in the perpetuation of FGM/C. The researchers based on the above findings recommended that policy initiatives on FGM/C should capitalize on the differences between religious groups. They recommended that FGM/C eradication policy should focus on education for Christian women, while for muslim women and those from traditional religions, FGM/C eradication policies can only be effective by working with religious groups and leaders. The implication this has on Nigeria is that the country is a multi-ethnic and multi-religious country like Burkina Faso and working with leaders of communities and those of religious groups is not a bad idea at all as it will likely facilitate the eradication of FGM/C in Nigeria.

Similarly, the study of Edet, Eneji, Ekefre, Eneji, Unwandu and Bassey (2012) on "female genital mutilation/cutting as violence against women among Kayoro Region of Ghana", also found that almost all the interviewees were of the view that FGM/C is difficult to stop because of its integration with culture, and even if it is stopped in the towns, it would still be practiced in the hinterlands.

The study then found that the eradication of FGM/C could only be possible by gradually talking to community leaders and chiefs to find a new way of performing rite of passage for girls since it is not easy to change one's culture. This study can also be applicable to Nigeria because the distance between Nigeria and

Ghana is not much and Nigeria especially the Igbo like Ghana hold on to their culture tenaciously.

Theoretical Framework

Social Norms Theory

The theoretical framework adopted for this study in Social Norms Theory. The major reason for its adoption as the frame work of this study is because it pinpoints the potential power of community rewards and punishments in affecting family attitudes towards the continuing practice of FGM/C, therefore prolonging FGM/C eradication. For clarity, this theory is known as Social Norms theory. The proponents of the theory were Wesley Perkins and Alan David Berkowitz. It was propounded in 1986 based on research conducted at Hobart and Willian Smith Colleges in the 1980's (Berkowitz, 2004).

The major assumption of this theory is that an individual's behaviour is influenced by often times incorrect perceptions of how other members of our social groups think and act (Berkowitz 2004). This misconception occurs in relation to problem or risk behaviors (which are usually over estimated) and in relation to health protective behaviours (which are usually underestimated) (Berkowitz 2004). One of the effects of pluralistic ignorance is to cause individuals to change their own behaviour to approximate the misperceived norm (Berkowitz 2004). This in turn can cause the expression or rationalization of problem behaviour and the inhibition or suppression of healthy behaviour (Berkowitz 2004).

This theory has been used to address a wide range of public health topics including tobacco use, driving under the influence, seat belt use and more recently sexual assault prevention ((Berkowitz 2004). In relation to this study, FGM/C is a social norm, that is, a rule of behaviour that members of a community are expected to follow and are motivated to follow through a set of rewards and sanctions (UNICEF, 2010; Mackie & Lejeune, 2009). Compliance is motivated by expectations of rewards for adherence to the norm and fear of sanctions for non-adherence. The desire to have girls married could by itself be sufficient to maintain FGM/C within a given community. In most practicing communities, social approval or disapproval, manifested through community and peer pressure, and also play important role in perpetuating the practice of FGM/C. Failure to conform to FGM/C leads to social exclusion, ostracism, disapproval, rebuke or even violence- in addition to having an effect on a girl's marriageability (UNICEF, 2010).

This theory however is not very perfect as it magnifies social approval especially from communities and peers, and the fear of sanctions as the only motivating factors for FGM/C among families. Like social convention theory, it failed to consider the influence of non-cultural factor such as the cost of performing FGM/C on wives/daughters, health consequences involved in FGM/C, educational status of the man, etc.

This theory is fairly relevant to this study because it highlights the possible influence of social approval or disapproval on the attitude of men as husbands and fathers with regard to the family FGM/C decision-making. In other words, it pinpoints the potential power of community rewards and punishments in affecting family attitudes towards the continuing practice of FGM/C.

METHODOLOGY

This study was based on a qualitative research design. The design was and adopted mainly because it allowed the researcher to use qualitative method to generate extensive data for the study. This study was carried out in South-East Nigeria which is presently one of the six geopolitical zones in Nigeria, others being North-East, North-West, North-Central, South-West and South-South.

The South-East Nigeria comprises five states, namely, Abia State, Anambra State, Ebonyi State, Enugu State, and Imo. It is an Igbo speaking region with 95 Local Government Areas that cut across its five states

(Abia State has 17 LGAs; Anambra 21; Ebonyi, 13; Enugu, 17; and Imo, 27), and its people are largely Christians.

The total population of South-East Nigeria based on 2006 National Population and Housing Census was 16,395,555 people (8,184,951 for male and 8,210,604 for female). The population projected to 2017 was 23,184,769. The target population for the study, however, was 25,124, being the population of some nine (9) relevant qualitative population categories for this study which cut across the study area. The qualitative population categories were as follows:- traditional rulers, village heads, clergymen/religious leaders, women's union, men's union, the youth association, health workers, teachers, and traditional birth attendants

The study was limited to efforts and strategies towards the eradication of FGM/C in South-East Nigeria focusing on Ebonyi, Enugu and Imo states. The main reason for the choice of these three states was due to the relatively high prevalence of FGM/C in the chosen states based on the 2013 NDHS report. The three states remained the top states in South-East Nigeria in terms of FGM/C prevalence based on 2018 NDHS report (Imo 61.7%, Ebonyi 53.2%, and Enugu 25.3%) (NPC and ICF, 2019). The respondents were drawn from relevant qualitative population categories in the study area.

The sample size was 54 people who were purposively selected for interview based on their leadership positions. A combination of purposive sampling, cluster sampling technique and simple random sampling techniques was adopted to select respondents for this study. At first, three (3) out of five states in the South-East Nigeria were purposively selected based on the prevalence rate of FGM/C in zone. Secondly, the selected States were clustered into three senatorial districts and one senatorial district was selected through simple randomly sampling from each of the chosen states. Thus a total of three senatorial districts were selected for the study. The senatorial districts were Ebonyi-South, Imo-East and Enugu West. Thirdly, the Local Government Areas in the selected senatorial districts were numbered. Then, two Local Government Areas were selected with simple random sampling from each of the three selected senatorial districts, making a total of six LGAs. The selected local government areas were: Ivo, Afikpo-North (Ebonyi State), Awgu, Oji-River, (Enugu State), Ikeduru, and Ezinihitte (Imo State). Furthermore, the communities in the selected local government areas were also numbered. Then, one community was selected using simple random sampling from each of the chosen local government areas. Thus, a total of six (6) communities were chosen for the study. The selected communities were: Ugwuegu, Okue, Amoli, Inyi (Alum Inyi), Egberemiri Eziudo, and Atta. In order to collect appropriate data for the study, nine relevant qualitative population categories were created in each community. The members of each qualitative population category formed the respondents/interviewees for the study. This means that 54 people were purposively selected for interview, 9 from each of the 6 communities based on their leadership positions in the relevant qualitative population categories as follows: Six traditional rulers; Six village heads; Six clergy men; Six women leaders; Six men's union chairpersons; Six youth leaders; Six doctors/senior matrons; Six head teachers/principals; and Six traditional birth attendants, one from each of the communities.

The instrument for data collection was in-depth interview because of the need for an extensive firsthand data. The in-depth interviews were employed to gather qualitative data for deeper understanding of the efforts and strategies towards the eradication of FGM/C in South-East Nigeria. The IDIs were anchored mainly on unstructured questions with necessary probes.

The in-depth interviews were conducted by the researcher with the help of three research assistants who were drawn from the community or LGA whose community and religious leaders were to be interviewed at appropriate time. The reasons for the large number of research assistants were to close the gap of dialect differences between the researcher and the interviewees, to ensure that every bit of information given by our interviewees was captured. The researcher moderated the interviews, while the three assistants did the note-taking and recording respectively.

The data were carefully edited/cleaned, sorted, translated and transcribed. Open code content analyses were adopted. The data were isolated into various responses in accordance with the objectives of the study. It involved categorizing the responses into the objectives of the study where they match. The interview transcripts were further analyzed with qualitative data software (QDA Miner).

RESULTS

The following deductive themes were extracted from the analysis of the 54 interview transcripts. Each of the themes and their subthemes are discussed below:

Efforts to stop the practice of FGM/Cutting

A number of efforts were made to stop the practice of female genital mutilation/cutting. These were the frequently occurring efforts made:

Lecture, campaigns and sensitization

Education and sensitization of the community members on the effects of female genital mutilation/cutting is the major effort made by communities to eradicate the practice of female genital cutting. Some of these sensitizations came from the government and international organizations. How these were done was explained by some of the respondents in these words:

Local governments themselves alone have held different conferences where they will show you people who have been there before, how those people suffered and the implications why they should not do it, and if you find anybody who do it this time around, the person should be reported to the governments, it's very painful **[Male, head teacher, 46 years old, Ebonyi State]**

Each time we gather together we say it that there should not be female circumcision again. Even in the church, it is announced; at the women's August Meeting, it is usually announced also that female circumcision causes harm **[Male, traditional ruler, 63 years old, Enugu State]**

We have the UNESCO program in collaboration with national orientation agency, they have been coming, inviting us, sensitizing us and we in turn during the August Meeting, my wife who is the Ugoeze of this community went to preach against it with members of CGC and the women leader **[Male, traditional ruler, 62 years old, Imo State]**

The respondents also indicated that after the education, the practice of cutting female genital in the name of female circumcision was abolished. One of the respondents said: "Once it was announced that one could live or have a child without a problem of circumcision, they all believed it **[Male, Clergy, 84 years old, Ebonyi State]**. However the sensitization seemed not have reached certain communities and so the practiced has continued: In the words of one of the participants:

…there had never been any time we had issue regarding stopping female circumcision in this community, there has not been any gathering or meeting about stopping the practice in this community. Even the baby girl born to my family last, has been circumcised. I cannot tell what led the practice of female circumcision in this community, my father and my mother circumcised my sisters and myself when we were born, no problem resulted from it. If I hear today that the practice is beginning to cause health or life-threatening problems today, I will be the first person to encourage its stoppage **[Male, Village head, 65 years old, Ebonyi State}**

Health workers education of the community members

Another strategy adopted by some communities is the education of the community members by health workers. This education centred on the consequences of female genital mutilation/cutting. A respondent said: "so many people like health workers have been coming to this community to tell both men and women about the health implications of female circumcision" **[Male, men,s union Leader/artisan, 63 years old, Ebonyi State]**

Another noted that:

In this community health workers do conduct seminars from time to time, after the seminar; we would gather the men and women and educate them. We will tell them the reason why female circumcision should be put to stop. They do listen and hear from us, this sensitization is done from time to time **[Male, Youth leader, 35 years old, Ebonyi State]**

Apart from educating people in the villages and community, health workers were also said to have gone to schools to education people on the implication of the practice:

A lot of efforts have been made by the health practitioners, they have gone round the school even where I am still teaching now to tell them and criticize the practice and warned that whosoever wants you to circumcise a female child, you should say no, even your mother wants you to do it, you try to advise her **[Female, Traditional Birth Attendant, 42 years old, Ebonyi State]**

Punishment and Sanctions on Offenders

Punishment and sanction of offenders is another major strategy used by communities to eradicate female genital mutilation/cutting in their communities. A respondent said: "We have set a law that anybody found circumcising the daughter, when caught, the person would be punished, but we don't see anything like that now". **[Male, village head,, 84 years old, Ebonyi State]**. Another respondent gave a more detailed narrative of the specific type of punishment they adopt. He said:

We imposed Fifty Thousand Naira fine on anybody caught doing that, Fifty Thousand Naira. Nobody has been found doing that. It doesn't mean that the person that paid the fine will continue, no!He can't continue. Anybody found doing that will pay his or her own fine. The person found holding the child will equally pay fine and the parent as well will pay the fine **[Male, men,s union Leader/artisan, 63 years old, Ebonyi State]**

Men not sufficiently involved in efforts to stop the practice

A dominant pattern found in participants' narrative is that men are not adequately involved in the efforts to eradicate female genital mutilation/cutting in the communities. One of the female respondents said: "No, no, no effort made by the men, you see the men look on to the women and sometimes depend on them, like me whatever I said that I want to do, my husband will say whatever you want to do, do it, it is left for you" **[Female, Senior Health Worker, 37 years old, Ebonyi State]**. One of the male respondent's statements demonstrates that men are not involved in the eradication of this practice. He said: "The men know nothing about it because men were not involved in giving birth, so they have nothing to do about it **[Male, Clergy, 84 years old, Ebonyi State]**.

However, one of the male youths narrated his efforts to eradicate female genital mutilation/cutting. He said:

We went from house to house and educated the people, all my peer groups were going from one village to

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another, after going round, we would report to the executives, from the report, we would know those who are proving stubborn and jot down their names. Next time we would send a different group to talk more sense to those who refused to agree the first time **[Male, Youth leader, 35 years old, Ebonyi State]**

Another respondent also highlighted the roles played by men towards the eradication of this practice. In his words: "There are some involvements of men in the efforts to stop it, for example, some traditional rulers have been involved in the sensation, men at the health sectors, even those are the positions of authority have actually lent their voice in the campaign against the practice **[Male, Medical Doctor, 31 years old, Eboyi State]**. Men have also been reported to have taken decision-making role towards the eradication of the practice. "The men, of recent, made the decision that anybody taking or circumcising his or her child should be penalized with the sum of Forty Thousand Naira, and the people who organized it will be charged Twenty Thousand Naira. We have it in our constitution **[Male, Traditional ruler, 84 years old, Ebonyi State]**.

Strategies for the Eradication of FGM/C

The respondentts suggested a number of strategies for the eradication of female genital mutilation/cutting. Some of the most frequently occurring suggestions were the use of general and continuous community sensitization/education, Use of Fine, threat and Sanctions on Offenders, Use of male targeted campaigns, and Government enactment of law against FGM,.

Community Sensitization/Education

Some of the narratives and suggestions of the respondents in the area of study show that the people of south-east Nigeria believe that sensitization and education of community members can facilitate the eradication of FGM/C in the region. On this, one of the respondents said that: "everybody should join hands in telling those families that are still practicing it in this community and other places that female circumcision is not good" **(Male, Village head, 68 years old, Imo State)**.Some other respondents also gave the following narratives:

The strategy is to call them together and educate them or teach them that both women that are not circumcised and the ones that are circumcised are still equal in the face of God, and that women that are not circumcised can give birth easier than the circumcised ones. And to let them know that women that are circumcised already have wounds on their private region and it may block the delicate part of a woman, which could be a problem when giving birth while the ones that are not circumcised always give birth freely and perfectly. If a woman is going for operation during child-birth as a result of her canal being blocked was because of female circumcision and she cannot deliver because she has wound or injury in her region. This will result in her being operated on for the baby to come out safely **(Male, Clergy, 84 years old, Enugu State)**

…I will suggest if I'm permitted to say, that workshops, seminars and awareness programs should continue and that they should be told about the consequences of female circumcision. They should be told that one could bleed to death in the process, and that a circumcised woman is more likely to have problems during child-delivery. Like I said before a woman that is not circumcised still has her clitoris intact and smoothen with Vaseline, and this makes it elastic and easy-passage for the baby. If the clitoris is cut, and the labia minora and majora are out, it's either the baby will tear the mother with her hand, which causes veseco-vagina-fistula, or the midwife may tear her with knife (episiotomy). This is why we advice people against female circumcision **(Female, Senior nurse attendant, 50 years old, Imo State)**

I will suggest that for female circumcision to be completely eradicated there should be general sensitization through advertisement, programs, seminars, so that the people will have full knowledge about it. I want the

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practice to be eradicated. However, everybody is free to either engage in the practice or neglect it **(Male, head teacher, 60 years old, Imo State)**.

It is important to note at this juncture that the respondents advocated more for community sensitization instead of general sensitization through media outlet. This could be due to the fact of rural poverty that incapacitates some rural dwellers and makes it unable for them not to have certain gadgets to access media programmes. This could also mean that the respondents believe that culturally rooted/grassroot oriented strategies can do the job more than general FGM/C eradication awareness creation creation/sensitization progarmmes that have kept FGM/C persisted despite numerous efforts.

Fine/Threat/Sanction

The Igbo believe so much in the potency of fines, threat of the use of sanction and the use of sanction; and this happens to be one of the strategies largely suggested by respondents. Some respondents gave these narratives:

Well! my own suggestion regarding the eradication of the practice is, since the government has stepped into it and it should be more…, they should more emphasized on it that whosoever partakes in that practice will face the consequences, and again, being that, since the elderly mothers are now taking care of the child at the early stage, so, I will believe the fear built in people will make them stop it **(Female, Traditional birth attendant, 42 years old, Ebonyi State)**.

The strategy I will suggest is what I have put in place now. I have put in place a law, if you do it, we will sanction you but if you do it again, we will take you to government, that is my strategy so that people will stop it **(Male, Traditional Ruler. 62 years, Imo State)**

Male Targeted Campaigns

Many people believe that one of best strategies for FGM/C eradication in South-East communities is male-targeted campaigns. For example some of the respondents among many others made the following narratives:

I have already said it, the campaign should be taken to the men not just seeing it as women's affair, they should be equally involved, not just their wives coming back to tell them,'oga, they said we should not circumcise our daughters again, they should tell the man himself, I mean a married man that 'this is the risk you are getting your daughter involved when she is circumcised'. This is because I being the father might decide to circumcise my daughter, I may not see the consequences now but the husband of my daughter may be the one to suffer it. Let them to talk to the men about the consequences because they might not be alive to see their daughters go through the pains in the later years. The way the campaign is going, its going fine but what I'm saying is that they should be more inclusive so that there will be more holistic views about the practice **(Male, medical Doctor, 31 years old, Ebonyi State).**

Aha! Well, if these happens in a community, the person is asked to pay the fine and when he fails to pay the fine, he will be ostracized, we will ask him to keep aside until he pays what he/she is asked to pay, because you did it willingly, it's not out of ignorant, and ignorance of a sin is not an excuse. Keep away from the community, you know when one is being ostracized he or she feels it in a way he will never make an attempt to do such a thing again **(Male, traditional ruler, 84 years old, Ebonyi State).**

Well, I suggest just like I said earlier on, that, you know, men should be sensitized, the same thing with women and they should have a well structured orientation and not just sensitizing them when they are real men but when they are still young. When planning for marriage and all of that, at least if they get to know

all these at first, I think they will not be able to make unnecessary mistakes **(Male, head teacher, 42 years old, Enugu State)**.

This could be because the Igbo society is a patriarchal society that is largely dominated by men. It is likely that the respondents believe that men being heads of families and custodians of cultures, need to be carried along in the FGM/C eradication campaigns to stop the persistence of the practice after much efforts are invested.

Government Enactment of Laws to FGM/C practice

This is another most frequently occurred suggested strategies by respondents in South-East Nigeria's communities. One of the respondents for example said that: "For female circumcision to be completely eradicated, I will suggest that the government should enact a law against the practice"**(Male, Youth Leader, 32 years old , Enugu State)**. Another respondent who was the oldest king the state also said: "My suggestion as the king is that government both at the state level and local government level should take over and make sure that nobody practices it"(**(Male, Traditional Ruler/retired teacher, 113 years old , Ebonyi State).** A female respondent also narrated:

As a woman leader, my own contribution is that female circumcision is not good because I have witnessed tearing and bleeding as a result of the practice, and as such, I will suggest that the government should do everything possible to eradicate it in our community **(Female, woman leader/civil servant, 55 years old, Ebonyi State).**

DISCUSSION

The study investigated the efforts and strategies towards FGM/C eradication in South-East Nigeria using a qualitative approach. It was found that a number of efforts have been made to eradicate FGM/C in South-East Nigeria communities, agencies, and groups (both local and international) yet the practice persists. The researcher sees the persistence of the practice in the study area as a call for a working and workable elimination strategies which only the community members of South-East Nigeria produce through an indepth probe of the people on FGM/C issues. The study found that such efforts as lecture/campaigns/sensitization, health worker education of community members, punishing the offenders and skeletal involvement of men in FGM/C-eradication have been put in place but in skeletal measures not capable of eradicating the practice, hence, much need to be done in these areas. This is in tandem with Karmaker, Kandala, Chung and Clerk (2011) who found that deep cultural issues and strong personally held belief which are not simple to predict or quantify are likely to be involved in the perpetuation of FGM/C this further explains the use of qualitative approach to unravel some of the specific culturally informed that could break the the jinx and bring about FGM/C eradication. It is important to note here that some of these strategies have been fluidly applied in the study area in the past resulting in the waning practice of FGM/C in South0-East Nigeria, however, what is required is complete eradication and they need to be strictly applied in the affected communities for this to be achieved.

It was also found that FGM/C can be eradicated in South-Eas Nigeria especially through sensitization, sanctioning, elimination of gender biases in FGM/C-eradication campaigns and government enactment of laws against it. It is obvious from the findings that the respondents' suggested strategies are truly culturally specific strategies capable of stopping FGM/C practice if given strict attention. However, they have not been given adequate attention, hence the persistence of the practice. It is important to state here that general strategies such as media sensitization and FGM/C medicalization tend to be given more attention but such cannot produce the desired result. It is only the culturally rooted and grassroot oriented strategies that can bring about FGM/C eradication in South-East Nigeria. The researcher strongly believes that for community sanctioning and other strategies found by this study to be viewed by community members as major strategies in FGM/C eradication in South-East Nigeria, it means that FGM/C is still mainly handled at the

family and community levels and not in the hospital in South-East Nigeria. This disagrees with Bosch (2001) who asserted that there is a shift from familiar and community based FGM/C towards the medicalization of FGM/C because of its uncomfortable health consequences

CONCLUSION

The study focused on advancing the efforts and strategies in FGM/C eradication in South-East Nigeria. a lot of efforts have actually been made to stop FGM/C in South-East Nigeria ranging from lectures/campaigns/sensitization, health worker education of community members to punishing the offenders but they did not eradicate FGM/C in the area but minimized its practice because they were not strictly applied. The researcher therefore concludes that in consideration of the respondents' narratives, it is only the strategies that are culturally specific and grassroots oriented that can result in FGM/C eradication but must not be fluidly applied. Adherence to generally known strategies such as media sensitization and medicalization can hinder the complete eradication of FGM/C in South-East Nigeria.

RECOMMENDATIONS

1. Efforts towards the eradication of FGM/C by communities, government, and Non-governmental Organization (NGOs) should not be gender-biased; it should be targeted at both men and women. This will help to improve men's understanding of the consequences of FGM/C and prevent the practice at the family level.
2. Government and Non-Governmental Organisations (NGOs) should intensify the already existing sensitization efforts towards the eradication of FGM/C in South-East communities. This will go a long way to address the SDG goal 3 of good health and wellbeing of the people.

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