THE PREVALENCE OF FEMALE GENITAL MUTILATION/CUTTING (FGM/C) AND MEN'S ROLE IN ITS PRACTICE IN SOUTHEAST NIGERIA

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Abstract

Studies on the prevalence and practice of Female Genital Mutilation/Cutting (FGM/C) have focused on women alone while no attention has been paid to men's roles in the practice. This study therefore investigated the prevalence of FGM/C and men's role in its practice in South-East Nigeria. The mixed methods research design was adopted. Quantitative data were collected through questionnaire while the qualitative data were generated through In-depth interview. Multi-stage sampling procedure was used to select 1,067 respondents for the quantitative study while 54 interviews were conducted to generate the qualitative data. The quantitative data were processed using Statistical Package for the Social Sciences (SPSS) Version 20.0 and was analyzed using descriptive and inferential statistics. The QDA Miner software was used to analyse the qualitative data. The stated hypothesis was tested using ANOVA. The findings showed that FGM/C is still practiced in South-East Nigeria even though the extent of its practice is diminishing compared to what it was in the past. The practice has persisted because of men's financial and moral sponsorship. Men encourage FGM/C-practice because they perceive women with FGM/C as being more sexually appealing than women without FGM/C. It was therefore recommended that FGM/C-eradication efforts should not be gender-biased. Public enlightenment campaigns should also be targeted at the men folk.

Keywords: Female genital mutilation/cutting, prevalence, men's role, FGM/C-practice, South-East Nigeria.

Introduction

Female Genital Mutilation (FGM/C) still persists in many societies of the world today despite the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and other concerted advocacy efforts to end practices that are harmful to women (UNICEF, 2008; Ibekwe, Onoh, Onyebuchi, Ezeonu, and Ibekwe, 2012; Ofor and Ofole, 2015; UNICEF, 2016; Population Reference Bureau, 2017; Gbadebo, 2017).It is important to note that Female Genital Mutilation/Cutting is not discriminatory per se, since men also go through circumcision but its effects (health and otherwise) seem to be more detrimental to women than men. This phenomenon tends to be more prevalent in developing nations such as Nigeria where it is strongly anchored on culture and tradition (WHO, 2008; Ibekwe, et al, 2012; UNICEF, 2016; Esho, 2017; O'Neil and Richard, 2017). Female genital mutilation/cutting (FGM/C) comprises all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, 2008;Population Reference Bureau [PRB], 2013; National Population Commission and ICF International 2014).

Female Genital Mutilation/Cutting (FGM/C) is traditionally called Female Circumcision (FC) but the realization of its harmful effects led to the use of the terms "Female Genital Mutilation" (FGM) or "Female Genital Cutting"(FGC) to describe more accurately the consequences of the procedure that distinguishes it from much milder "Male Circumcision" (Nnorom, 2007; UNICEF, 2008). The use of the term "mutilation" showcases that the practice is harmful, especially to the girl-child and women, thereby promoting intensified advocacies to end it, while the use of the word "cutting" underscores the importance of employing a less judgmental expression especially at community levels to avoid stigmatizing the FGM/C-practicing communities (UNICEF, 2008). It is, however, better to talk about FGM/C than either FGM or FGC because the expression Female Genital Mutilation/Cutting (FGM/C) captures the significance of the term "mutilation" at the policy level and at the same time recognizes the need to use a non-judgmental terminology within the practicing communities (UNICEF, 2008).

The World Health Organization (WHO) estimates that between 100 and 140 million women and girls worldwide have undergone FGM/C; 91.5 million girls and women aged 9 years and above have undergone the procedure in Africa;

and about three million girls in Africa alone are at risk of undergoing FGM/C every year (PRB, 2013; Nwaokoro, Ede, Dozie, Onwuliri, Nwaokoro, and Ebiriekwe, 2016;). In North-Eastern Africa, the prevalence rate varies from 97 percent in Egypt to 80 percent in Ethiopia. In western Africa, 99 percent of women in Guinea, 71 percent in Mauritania, 17 percent in Benin and 5 percent in Niger have undergone FGM/C. Where data are available for South-Eastern Africa, the prevalence rates are relatively lower at 32 percent in Kenya, for example, and 18 percent in the Republic of Tanzania (UNICEF, 2005). The cultural practice of FGM/C has spread to some parts of the world other than the developing world such as Europe, Australia, Canada and the USA primarily because of the increase in the number of people migrating out of FGM/C prevalent countries (Norman, Gegzabher and Otoo-Oyortey, 2016). In Nigeria, the 2013 Nigeria's Demographic and Health Survey (NDHS) reveals that 25 percent of women have undergone FGM/C and the practice is highest among traditional women (35 percent), followed by Catholic women (31 percent), and lowest among Muslim women (20 percent). The practice of FGM/C is more prevalent among Yoruba women (55 percent), followed by the Igbo women (45 percent), and the practice is higher in the urban areas (32 percent) than rural areas (19 percent).

The issue of FGM/C has not been left unattended to as various interventions have been made by government agencies, national and international agencies towards the eradication of the practice. For instance, USAID officially incorporated the elimination of FGM/C into its development agenda and created the official U.S government policy towards FGM/C. In 2008, the Donors Working Group produced 'a platform for action towards the abandonment of FGM/C'. In that same year, UNFPA and UNICEF formed a strategic partnership known as the UNFPA-UNICEF on FGM/C Accelerating Change. They have been on partnership in the areas of developing funding and implementing policies and programmes to accelerate abandonment of the practice (Population Reference Bureau, 2013).In Nigeria, 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). Despite these interventions, FGM/C still persists. The prevalence rate among states in Nigeria shows that Osun State is the highest

(77 percent), followed by Ebonyi State (74.2 percent) while Katsina is the lowest (0.1 percent), meaning that FGM/C is more prevalent in the Southern Nigeria than in the Northern Nigeria (NPC and ICF International, 2014).Again, three major forms of FGM/C common in Nigeria are female circumcision (litoridectomy, excision and infibilations), hymenectomy (angurya) and "gishiri" cuts (NPC and ICF International, 2014). Ofor and Ofole (2015) describe these types mainly practiced in Nigeria as clitoridectomy, excision and some infibilations. This means that the major forms of FGM/C practiced in Nigeria are: clitoridectomy, excision, some infibulations, angurya and gishiri cuts (NPC and ICF International, 2014; Ofor and Ofole, 2015).

Extensive efforts have also been made to understand why the practice of FGM/C still persists in Nigeria despite all attempts to eradicate it. The general assumption is that men force women to engage in it and that those women are victims of barbaric patriarchy (Eisele, 2011), but some research works have countered it and hold that more women support the continuation of the practice of FGM/C than men (Shell-Duncan and Herniund, 2006; Draege, 2007). In Nigeria today, for example, NPC and ICF International (2014) report that more women (64.3%) than men (62.1%) want the practice to be discontinued, while more men (27.4%) than women (23.1%) want the practice to continue. In all the states in South-East Nigeria (Abia, Anambra, Ebonyi, Enugu, Imo), more men than women want the practice to continue, while more women than men want it to stop (NPC and ICF International, 2014). This shows the perceived role of men in the continued practice of FGM/C in South-East Nigeria. Men in their role as fathers, husbands, community and religious leaders may play a pivotal function in the continuation of FGM/C (Varol, Turkmani, Blacks, Hall and Dawson, 2015), just as the fertility of individual women in some parts of the developing world reflects mostly the preferences of men (Akpandara, Isiugo-Abanihe and Fayehun, 2015). Men, for example, may play a passive role in approving FGM/C by refusing to marry uncut women or an active role by initiating the practice (Varol, Turkmani,Blacks, Hall and Dawson, 2015).

Evidence provided by Varol et al (2015) from a study of 400 Nigerian men and women shows that 71% of the respondents believe that the decision that established FGM/C was made by their paternal grandfathers and fathers, and the continuation of the practice has been perpetuated by two major factors of social obligation and marriageability that have kept women under social

pressure to adhere to norms which vary among communities. These norms may pertain to perceived religious requirement, family honour through premarital virginity of daughters and marital fidelity of wives (Varol et al, 2015).

Some research works in Nigeria have also attributed the continued practice of FGM/C to the inactions of men in the area of decision of whether or not to cut their daughters' genitalia, even women are accused of deliberately refusing to involve men in this regard (Eisele, 2011). A large majority of men in Nigeria, for example, are indifferent to reproductive health issues (Nwokocha, 2008). The implication of such attitude in a male-dominated society is that activities that influence maternal outcomes (FGM/C inclusive) are taken for granted, ultimately resulting in maternal crises (Akpandara, Isiugo-Abanihe and Fayehun, 2015). The fact is that a deeper understanding of men's views about FGM/C will illuminate their roles in either its eradication or continuation (Shell-Duncan, 2006; Varol et al, 2015). This is the focus of this study. It is against this backdrop that this study investigated the prevalence of FGM/C and men's role in the practice of FGM/C in South-East Nigeria.

Statement of the Problem

Globally the practice of FGM/C had been mobilized against partly due to new medical findings that attribute such practice with harmful health effect. Though it tends to be culturally-oriented, however, the culture is perceived as patriarchy oriented that must be extricated from societies partly due to the fact that the process is mostly done with crude tools leading to severe detrimental health effect ranging from sexually transmitted diseases to death. In Nigeria,for example, 82 percent of females who had undergone FGM/C had it before their fifth birthday; 4 percent had it between age 4 and age 9; 5 percent between age 10 and age 14; and 15 percent had it at age 15 or older. It has been reported that ninety percent (90%) of females in the South-East Nigeria underwent FGM/C before age 5 and almost all the females who had undergone FGM/C in Imo, Enugu and Abia had it before their fifth birthday (NPC and ICF International, 2014).

The practice of FGM/C, apart from being one of the most persistent, pervasive and silently endured human rights violations especially denial of girls and women the full enjoyment of their rights and liberties (UNICEF, 2008), is deeply associated with health, physical, sexual and psychological consequences

to women and girls. The practice is not intended to harm women, but infringes on the health of women. This calls for investigations of certain socio-cultural complexities (such as gender roles in its sustenance) that hinder its eradication in Africa and in Nigeria especially in South-East Geopolitical zone. Furthermore, FGM/C has a wide range of consequences including obstetric and delivery complications, pregnancy complications, reproductive problems, infections including HIV/AIDS, adverse sexual and psychological effects and even death (Yount and Abraham, 2007).

Apart from the health and other related consequences, there are a lot of information available in literature about those responsible for carrying out FGM/C and the study setting. For example, Akinsulure-Smith and Chu (2017) conducted a survey of 107 West African immigrants including 36 men on their Knowledge and attitudes toward Female Genital Mutilation/Cutting among West African male immigrants in New York City. They found that men, no doubt, were knowledgeable about the health consequences of FGM/C as women, though with less nuanced understanding, and also rejected the practice at the rate comparable to women based on their knowledge of it, yet a majority of men did not express personal preference for women with or without FGM/C in intimate relationships. This is the gap in knowledge that this study can fill. This study would find out men's personal preferences for women in relationships in terms of FGM/C status in the study area.

FGM/C decision in the past seemed to be an exclusive women affair, especially mothers and sometimes grandmothers, but the pattern has changed as men's participation in FGM/C decisions seems to have increased (Varol, Turkmani, Blacks, Hall, and Dawson, 2015). Men seem to have taken over the role of FGM/C decision-making from women and the major reason for this bothers mainly on the men's association of FGM/C with sexuality (El-Mouelhy, et al, 2013; Varol, et al, 2015). FGM/C tends to be mainly carried out by women but the purpose is to control women's body and sexuality, all for men's gain (UNFPA, 2006; Monogan, 2010; Yerima and Atidoga, 2014; UN Women, UNFPA and UNICEF, 2017). From availabe literature, men also tend to use women in maintaining FGM/C by making them place high regard for social approval more than the negative consequences of FGM/C (Yerima and Atidoga, 2014; UN Women, et al, 2017).

Furthermore, Female Genital Mutilation/Cutting is an invisible hand of patriarchy and gender inequality that tend to privilege the male and makes the practice a requirement for women's survival (Monogan, 2010). For example, some of the consequences of patriarchy and gender inequality that sustain the continuing practice of FGM/C include: less participation of women in formal education and in paid jobs, male-child preference, promotion of polygyny, male violence, male dominance in socio-political sphere and infringement on women sexual rights (Makama, 2013). It is, however, important to note that there are other vital information that still lack in literature, and such also constitute gaps in knowledge about men's roles in FGM/C that can be filled by this study. For example, the information on how men use women in achieving the continuing practice of FGM/C, whether men use physical force, decisions, attitudes or whether it is through their perspectives about FGM/C is not specified. It only tells us that men make women to see the gains of FGM/C more than they see its dangers, hence, its continuing practice. This is a gap in knowledge that this study can fill by trying to find out those specific instruments that men use to encourage the continuing practice of FGM/C. The next missing information in literature is the extent to which FGM/C is associated with infidelity. Men tend to believe that FGM/C prevents prostitution and promiscuity but failed to realize that a woman being faithful to her husband may be a question of morality and not FGM/C status since some genitalia-cut women do involve in infidelity too. This is a gap in knowledge that this work can fill by trying to find out the extent to which the practice of FGM/C is associated with infidelity and whether or not FGM/C do reduce infidelity.

Given the consequences of FGM/C, it is evident that the practice has the capacity of affecting the image of Nigeria and portraying her as a barbaric nation. It is, therefore, against the backdrop of the foregoing problems that this study investigated FGM/C prevalence and men's role in its practice in South-East Nigeria.

Objectives of the Study

1. To ascertain if FGM-C is still practiced in Southeast Nigeria
2. To find out the major roles of men in the practice of FGM/C in Southeast Nigeria
3. To find out the reasons for men's involvement in FGM/C practice in Southeast Nigeria

Study Hypotheses

Men who take major family decisions alone are more likely to encourage the continuing practice of FGM/C than men who jointly take major family decisions with their wives.

Brief Review of Relevant Literature

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) which 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 and ICF international, 2014; PRB, 2014).

NPC and ICF International (2014) reported that FGM/C is more prevalent in the Southern Nigeria than in the Northern Nigeria. They argued that FGM/C is more prevalent in the Southern Nigeria than in the Northern Nigeria that 25 percent of women have undergone FGM/C and the practice is highest among traditionalist women (35 percent), followed by Catholic women (31 percent), and lowest among Muslim women (20 percent). Their report further show that the practice of FGM/C is more prevalent among Yoruba women (55 percent), followed by the Igbo women (45 percent), the practice is higher in the urban areas (32 percent) than rural areas (19 percent). Based on their report, the prevalence rate among states in Nigeria shows that Osun State is the highest (77 percent); followed by Ebonyi State (74.2 percent) while Katsina is the lowest (0.1 percent).

Monagan (2010) holds that men do not play a direct role in the cultural practice of FGM/C but they, however, set the standard and define how a woman is suitable for marriage, thereby encouraging the continued practice of FGM/C. It is important to note here that the view of Monagan (2010) does not necessarily mean that men do not have any direct involvement in the continued practice of FGM/C since he already pointed out in the same document that the role of the man in traditional patriarchal societies is provision of funds. One can, against this backdrop, also imply that men finance the cultural practice of FGM/C in many societies, Nigerian societies inclusive. Alcaraz, Gonzalez and Rulz (2013) assert that there is a strong social pressure to which women are subjected as regards the practice of Female Genital Mutilation/Cutting (FGM/C). Even though the gender behind the mounting of social pressure remains unmasked here but one can still deduce accusing fingers being pointed to men as family heads and community leaders. According to El-mouelhy, Johansen, Ragab and Fahmy (2013), men are reported to increasingly take part in the decision-making about daughters' FGM/C because of their strong belief in the relationship between FGM/C and women's sexuality. The authors argue that the ambivalence created by the relatively recent debate in Egypt which put women between the cultural belief that FGM/C is a protective measure to safeguard girls' virginity and to secure women's marriages, and the message that FGM/C is unnecessary and a harmful practice, has made women to increasingly involve their husbands in the FGM/C decision-making processes. Although this view may be anchored on what obtains in Egypt but this is not far from what is obtainable in Nigeria and as such could be applied to Nigerian case also .Men see FGM/C as the key to ensuring women's sexual morality and the key to controlling sexual relationships and this warrants their increased involvement in the decision-making about their daughters FGM/C status (EL-Mouelhy, Johansen, Ragab and Fahmy, 2013).

Theoretical framework

This paper is anchored on gender oppression theory/Radical feminism by Shulamith Firestone (1970). This theory is known as radical feminism and it is an aspect of gender oppression theory. It was propounded in 1970 and the major proponent was Shulamith Firestone (1945-2012).According to Firestone (1970:8), "the major assumptions of the theory include that: Women are at a disadvantage biologically through experiencing, pregnancy, childbirth, breastfeeding, and menopause which place physical burdens on them thereby

imposing serious social consequences on them. Women's dependence on men is increased by long periods during which infants are nursed which is longer than infants of other animal species. The interdependence which exists between a mother and her child, and their dependence on men has been found in every society which produces unequal power relationship and power psychology".

One can say that it explains the role of men as heads of biological families in sustaining Female Genital Mutilation/Cutting and related practices that might likely favour them. This is to say that many modern societies are patriarchal **(**Nigeria inclusive**).** Men are the ruling class, while women are the subordinate class. The key institution oppressing women in modern societies is the family where men use violence to secure and maintain their power. Female genital mutilation/cutting in some societies is considered to play significant role in men's sexuality. For example, WHO (2008) holds that a narrow vaginal opening is believed to enhance a husband's sexual pleasure and the challenge of penetrating a tight opening is considered to be linked to a man's virility. Firestone (1970) identifies biology or sex as the first and primary source of women's oppression which is the outcome of the division of labour among male and female sexes because women are placed as subordinates in the society. Specifically, Firestone (1972) argued that sexual division of labour existed before the economic social class and it points to persistent class struggle between men and women. Family is consequently a site of female oppression and a source of male control over women. Radical feminists believe that the family is a male-dominated institution in which men have concrete interest in controlling, using and oppressing women (Olubunmi and Shade, 2015). Women are oppressed through overt cruelty (spouse rape/abuse, enforced prostitution, abuse of widows, practice of clitoridectomy, to mention but a few and covert cruelty (tyrannical ideas of motherhood, and unpaid household drudgery) (Olubunmi and Shade, 2015; Ritzer, 2008). This is the root of many practices that seem to oppress women in society today such as the female genital mutilation/cutting in South-East Nigeria and even Nigeria at large which tends to have negative effects on women. This theory provides a general picture of the oppression of women anchored on the way different societies are organized to favour men, while women remain dependants. This general picture has the tendency of providing a platform for more specific inquiries into how the roles and perspectives of men as fathers, husbands, lovers and custodians of culture, have encouraged or may encourage the continuation of the practice of FGM/C.

This is the advantage this study is leveraging on. The radical feminist theory does not only associate Female Genital Mutilation/Cutting (FGM/C) with oppression of women but also reveals the platform (i.e patriarchy) on which FGM/C functions as one of the major tools for oppression. That is, it conveys very important information that FGM/C persist because men's roles, towards its practice remain dominant.

Materials and Methods

This study was based on a mixed research design. The design was considered appropriate and adopted mainly because it allowed the researcher to use both quantitative and qualitative methods 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. South-Eastern Nigeria used to be one of the 12 states created during the Nigerian Civil War which was later broken down into the present Akwa Ibom and Cross-River States, before it became the name of one of the six geopolitical zones in Nigeria in 1990s.

The South-East Nigeria is presently made up of 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 the majority of its people are Christians.The socio-cultural organization of the South-Eastern people of Nigeria is mainly based on membership in kinship groups and parallel but complementary dual-gender associations which are important to societal integration.

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. However, the target population for the study was 26,895, being the population of some nine (9) relevant population categories for this study which cut across the study area. The population categories were as follows:- traditional titled men, native doctors/herbalists, religious leaders, teachers, market women associations, umuada associations, men's unions/associations, women's unions/associations and health workers.

The study was limited to the role of men in the continuing practice 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 2013 NDHS report on the FGM/C prevalence rates in the South-Eastern states were: Ebonyi, 74.2%; Imo, 68.0%; and Enugu, 40.3% (NPC and ICF International, 2014).The study participants were drawn from relevant population categories in the study area.

The sample size for this study was 1,067 persons and it was statistically generated by using Taro Yamane Statistical method of determining sample size. The Multi-stage sampling procedure involving purposive sampling, cluster sampling technique, simple random sampling, proportionate stratified sampling and availability 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 (Arum Inyi), Egberemiri Eziudo, and Atta. In order to collect appropriate data for the study, nine relevant population categories were created in each community. The members of each population category formed the respondents for the study. The stratified proportionate sampling technique was used in selecting the respondents from each population category in view of the fact that the population categories did not have equal size. The availability sampling technique was used to select the actual respondents from each population category. For the qualitative data (in-depth

interview data), 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 instruments for data collection of this study were questionnaire and in-depth interview because of the need for a mixed-method research (in this case, 50% quantitative and 50% qualitative). The questionnaire, specifically, was used to collect quantitative data, and it was highly structured with only few unstructured questions. It also had two different sections. The first section contained the socio-demographic characteristics of respondents while the other section addressed the substantive issues in the prevalence of FGM/C and men's roles in the continuing practice of FGM/C in South-East Nigeria, derived from the research questions, specific objectives and hypotheses. The in-depth interviews on the other hand, were employed to gather qualitative data to complement the quantitative data for deeper understanding of the roles that men play in the sustenance of FGM/C in the area of study. The IDIs were anchored mainly on unstructured questions with necessary probes.

The questionnaire was administered by the researcher himself with the help of 6 research assistants. The research assistants were recruited on the basis of ability to read and write, speak and understand both English and the local dialects of the communities. They were people (males and females) that hail from either the communities or LGAs of the study. They were trained for three (3) days on the objectives of the study, relevance of the study, administration and retrieval of questionnaire. The in-depth interviews were conducted by the researcher with the help of three of the research assistants who were drawn from the community or LGA whose community and religious leaders were to be interviewed at appropriate time. This means that all the six research assistants were involved in the in-depth interviews at one point in time or the other depending on the community to be interviewed. 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 easy distribution and retrieval of the questionnaire, and 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 quantitative data collected through the questionnaire were processed with Statistical Package for Social Sciences (SPSS) Version 20.0. The socio-demographic characteristics of respondents and the substantive issues in all sections of the questionnaire were analyzed using descriptive statistics such as simple frequency distribution tables, percentages, graphs and charts. Inferential statistics, particularly, ANOVA was used to test the stated hypothesis. The qualitative data collected through in-depth interview 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 the categorization of responses into objectives of the study where they match. The interview transcripts were further analyzed using the qualitative data software (QDA Miner).

Research Findings/Results

Out of 1067 copies of questionnaire distributed, 906 (84.9%) were found usable while 161 (15.1) were not found usable. The socio-demographic characteristics of the respondents are presented in Table 1 below

Table 1: Socio-Demographic Characteristics of the Respondents

Description	**Demographic Variables**	**Frequency**	***Percentage* (%)**
Distribution of Respondents by Gender	Male	463	51.1
	Female	443	48.9
	Total	**906**	**100**
Distribution of Respondents by Age	18-25	92	10.2
	26-33	176	19.4
	34-41	156	17.4
	42-49	134	14.8
	50-57	219	24.2

	58-65	68	7.5
	66 and above	61	6.7
	Total	**906**	**100**
Distribution of Respondents by Marital Status	Single	81	8.9
	Married	422	46.6
	Separated	88	9.7
	Divorced	97	10.7
	Widow	218	24.1
	Total	906	100
Distribution of Respondents by Place of Residence	Ugwuegu	158	17.4
	Okue	102	11.3
	Amoli	142	15.7
	Alum-Inyi	112	13.0
	E/Eziudo	108	11.9
	Attah	278	30.7
	Total	**906**	**100**
Distribution of Respondents by educational qualifications	No formal Edu	131	14.5
	FSLC	238	26.3
	WASCE/SSCE/GCE	234	25.8
	NCE/OND	124	13.7
	BSC/HND	149	16.4
	MSC/PhD	30	3.3
	Total	**906**	**100**
Distribution of Respondents by Occupation	Unemployed	159	17.5
	Student	13	1.4
	Self-employed	175	19.3
	Public Servant	175	19.3

	Business and Trading	269	29.7
	Apprentice	5	0.6
	Retirees	18	2.0
	Farmers	92	10.2
	Total	**906**	**100**
Distribution of Respondents by Religious Affiliation	Christian	641	70.8
	Muslim	92	10.2
	Judaism	26	2.9
	African Traditional Religion	147	16.2
	Total	**906**	**100**

Table 1 shows that 463(51.1 %) of the respondents are males, while 443 (48.9%) are females. The table also indicates that a majority of the respondents 219 (24.2%)are aged between 50-57 years while 61 (6.7%) are aged 66 years and above. The tableshows that more of the respondents 422 (46.6%) are married, while 81 (8.9%) are single. The table also indicates the respondents' places of residence which shows that a majority 278 (30.7%) are resident in Attah Community of Imo State while 102 (11.3%) are resident in Okue Community of Ebonyi State. In the area of the educational attainment, the table indicates that, a majority of the respondents 238 (26.3%) have first school leaving certificates while only 30 (3.3%) are M.Sc holders and above.In terms of occupational distribution, the table shows that more of the respondents 269 (29.7%) engage in trading, while5 (0.6%) are into apprenticeship. Furthermore, in terms of religious affiliation, the table shows that a majority of the respondents 641 (70.8%) are Christians, while 26 (2.9%) practice Judaism.

Analysis of Research Objectives

Research Objective 1: To ascertain if FGM-C is still practiced in Southeast Nigeria

Table 2: Is FGM/C Still Practiced in Your Community?

Variables	Frequency	Percent %
Yes	802	88.5
No	104	11.5
Total	**906**	**100.0**

Source: Field Survey, 2018

Table 2 shows that a majority of the respondents 802 (88.5%) indicated that Female Genital Mutilation/Cutting (FGM/C) is still practiced in the study area while 104 (11.5%) said no. This finding is not totally in agreement with the qualitative data as the extent of the practice of FGM/C is, however, diminishing as reflected in the in-depth interview (IDI) data which portrayed the waning practice of female genital mutilation/cutting in many of the communities studied. A significant number indicated that it is still going on but practiced in secret and that new methods are currently being adopted. To buttress the diminishing practice of female genital mutilation in his community, one of the respondents put it into perspective using percentages. He said*:* "Well, I have said it before the people that are still practicing female circumcision are not up two percent. How can two percent influence ninety-eight percent? Female circumcision is completely fading away in this community. Men are now sensitized and exposed"[Male, teacher, 31years old, Ebonyi State].The disparity between the quantitative and qualitative data is likely because the IDI respondents did not want to be directly associated with accepting that FGM/C is still in practice in their communities probably due to social stigma attached to communities that still practice such. In another dimension, instead of genital cutting, a new method that involves the massaging of a female's genital region with hot water, powder and/or Vaseline is currently being used. This was simply termed the 'pressing method' by some of the IDI respondents. A respondent had this to say: "In this community there is no method of cutting anymore. What we practice is the pressing method" [Female, traditional birth attendant, 59years old, Imo State].

Research Objective 2: To find out the major roles of men in the practice of FGM/C in Southeast Nigeria

Table 3: Distribution of Respondents by the Major Role of Men in the Continued Practice of FGM/C

Variables	Frequency	Percent
Providing the money required to perform FGM/C on the wife/daughter	251	31.3
Encouraging the wife/daughter to undergo FGM/C	226	28.2
Deciding whether or not their wives/daughters should be allowed to undergo FGM/C	171	21.3
Deciding who the circumcisers should be, whether traditional or orthodox option	154	19.2
Total	802	100.0

Source: Field Survey, 2018

Table 3 shows that 351 (38.7%) of the respondents are of the view that men provide the money required to perform FGM/C on the wife/daughter while 156 (17.2%) are of the view that it is by deciding who the circumcisers should be, whether traditional or orthodox option. This implies that more of the respondents believe that the major role of men in the continuing practice of FGM/C is the provision of money required to perform FGM/C on the wife/daughter. From the IDI analysis, the roles played by men in the practice of female genital mutilation/cutting may be described as minimal but relevant. The three roles identified include authorization, joint decision-making with the wife and provision of supports for the process.

Based on the IDI data, the man was seen as the head of the family whose consent is required before anything could be done in the family including the circumcision of the daughters and wives. The perceptions and narratives of the respondents demonstrate this. One of the IDI respondents asserted: "I believe that the role of the man is to give approval with regards to whether the girl will be circumcised or not, and if the exercise costs money he should be the one to foot the bills"[male, traditional ruler/retired teacher, 113 years old, Ebonyi State]. Some of the respondents explained why the man's consent is important. One of the respondents said: "A woman circumcising the daughter without the consent of the husband may bring problem in our community, if that happens there will be fight".[male ,retired police officer/teacher, aged 68years, Enugu State].

It is also believed that father's consent is necessary for a successful FGM/C without which there would be crisis during the procedure. A respondent, for instance, said:

> If the man refuses to circumcise the daughter and the woman carries her to be circumcised against his wish, the child will bleed, this is why it is usually said 'it is the father's mouth that is holding her daughter' and that is why it is not good for the father to first say that her daughter will not be circumcised before accepting, because the daughter might bleed and die [female, traditional birth attendant, 77years old, Ebonyi State]

Therefore, men's consent is seen as relevant in the practice of female genital mutilation/cutting. The IDI data also showed that men provide financial and material supports during the performance of FGM/C and this was demonstrated by the some of the views of the respondents. From the foregoing, a majority of the IDI respondents were of the view that supports provided by the man are on the basis of the conception of the man as the head of the family in Nigerian culture. For example one of the respondents said:"I believe it was the role of the father to provide the materials" [**male, carpenter, 35years old, Ebonyi State**].

This same position was highlighted by another respondent: "The role of men is mainly the provision of financial assistance, sometimes; men go to the market themselves to buy all the prescribed items and materials for the circumcision. The normal practice however, is to give money to their wives to buy all the required items".[**male, traditional ruler/filter, 70years old, Imo State**].

The IDI data also demonstrated that in the case of newly married girl, the husband takes up the responsibility of providing the things needed for the circumcision. This was described this way: "If the woman enters a man's family as a wife before performing Female circumcision, it is the husband that will sponsor all the requirements for the exercise. He will provide the money, the yam and the instrument needed for the practice [female, civil servant, 55years old, Ebonyi State].

Research Objective 3: To find out the reasons for men's involvement in FGM/C practice in Southeast Nigeria

Table 4: Distribution of Respondents by the Reasons for Men's Encouragement of FGM/C

Variables	Frequency	Percent %
Men express strong preference for women with FGM/C than women without FGM/C	226	28.2
FGM/C encourages men to marry more than one wife	127	15.8
FGM/C is a religious obligation that must be fulfilled	139	17.3
FGM/C is required by ancestors to purify women	80	10.0
FGM/C makes a woman to be faithful in marriage	173	21.6
FGM/C is arite of passage to womanhood	34	4.2
FGM/C makes genitals look beautiful	6	.8
FGM/C makes a genital organ neat	17	2.1
Total	802	100

Source: Field Survey, 2018

Table 4 show that more of the respondents 226 (28.2%) said that FGM/C is still practiced because men express strong preference for women with FGM/C than women without FGM/C while 6 (.8%) said FGM/C is practiced because it makes a woman's genital look beautiful. Further explanation of thiswas captured in the IDI data that demonstrated that the overarching reason for men's preference of women with FGM/C is the perception that FGM/C reduces sexual urge and promiscuity among women. A significant number of IDI respondents portrayed FGM/C as a means of inhibiting women's sexual urge and curtailing promiscuity in women. Some of the respondents presented this idea like this:

> In this community we want the practice to continue because of what is happening nowadays, you will see a child of 10 years that is already exposed to men. Once this start happening, if you are not strong enough, then you can't stop her from becoming wayward. However,

> female that are circumcised are not running after men, they grow and become mature before they become exposed to men. This is because circumcised women don't have unusual sexual urge, for this reason I support the continuing practice of female circumcision [male, excavator operator, 39years old, Imo State].

Test of Hypothesis

Men who take major family decisions alone are more likely to encourage the continuing practice of FGM/C than men who jointly take major family decisions with their wives.

Table 5: Difference between Men Who Takes Major Family Decision and Support for Continuing Practice of FGM/C.

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	3.417	4	.854	1.394	.234
Within Groups	552.231	901	.613		
Total	555.648	905			

Source: Field Survey, 2018

The ANOVA statistical tool was run to determine if men who take major family decision alone were more likely to support the continued practice of FGM/C compared to those who take decisions with their wife's. The result of the test indicates that there is no statistically significant difference between the groups as determined by one-way ANOVA ($F(4, 901) = .1.394$, $p = .234$). This goes to suggest that there is no variation in the behaviour of men who take major family decision alone and those who do not, with regards to the continued support of FGM/C. This may imply that men who take major family decisions alone are not more likely to encourage the continuing practice of FGM/C than men who jointly take major family decisions with their wives.

Discussion

The study found that FGM/C is still practiced in South-East Nigeria and the major reason for its practice is men's strong preference for women with FGM/C to women without FGM/C. Data from the qualitative component of the study also corroborated the findings of quantitative data. The finding is also partly in tandem with the view of Monagan (2010) that FGM/C is often carried out by female practitioners but the intent is to control the female body and sexuality for the benefit of men. The finding also corresponds with the Gender Oppression/radical Feminists theory by Firestone (1970), who opined that the interdependence which exists between a mother and her child, and their dependence on men has been found in every society and it produces unequal power relationship and power psychology. This explains the roles of men as heads of biological families in sustaining Female Genital Mutilation/Cutting and related practices that might likely favour them.

The study further found that the major role that men play in the continuing practice of FGM/C in South-East Nigeria is to provide money required to perform FGM/C on their wives/daughters. This finding was corroborated in the qualitative data as it even revealed the extent of men's financial support of FGM/C in the study area. This finding is in accordance with Monagan (2010) who found that the role of the man in traditional patriarchal societies with regards to FGM/C is financial provision. Based on the test of the related hypothesis with ANOVA, there was no statistical significant difference ($F(4, 901) = .1.394$, $p = .234$) in the behavior of men who take major family decisions alone and men who jointly do it with their wives with regard to the continuing practice of FGM/C. The implication of this is that decisions taken by husbands are partly influenced by wives. This is in tandem with El-mouelhy, Johansen, Ragab and Fahmy (2013), who held the view that men are reported to increasingly take part in the decision-making about daughters' FGM/C because of their strong belief on the relationship between FGM/C and women's sexuality.

Conclusion/ Recommendations

This study investigated men's role in the practice of Female Genital Mutilation/Cutting in South-East Nigeria. FGM/C issue is not an exclusive

women's matter as people think. Men's roles of financial and moral supports as fathers, husbands and family heads have contributed also to the continuing practice of FGM/C in South-East Nigeria.

Based on the findings of this study, the following recommendations were made:

1. Government and Non-Governmental Organisations (NGOs) should intensify the already existing awareness campaign 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.
2. 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, especially elderly men. This will help to improve men's understanding of the consequences of FGM/C and prevent them from giving financial and moral support to the practice at the family level.

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