



A review of the underlying factors influencing female genital mutilation in Africa

Marinus Channel, Stiegler Nancy and Ogujiuba Kanayo

Abstract

Female Genital Mutilation (FGM) is a re-occurring decimal in Africa. This phenomenon is estimated to occur in over twenty-five (25) countries in Africa. It is further estimated that FGM has been performed on nearly two million adolescent women globally and more than two million adolescent women probably undergo this process on a yearly basis. This paper compared FGM features across five African countries. UNICEF and WHO datasets were used in the analysis. Results show that selected variables swayed the FGM choices differently for each of the five countries used as case studies. Furthermore, results indicate that the FGM is anchored in cultural, religious and traditional processes. If religious and cultural dynamics are ignored, the outright use of laws and education policy framework would be less effective in mitigating the practice. The paper recommends that in addition to legislation and education, a re-orientation of norms and values of African leaders, both traditional and religious, could lower the prevalence of FGM..

Introduction

The practice of FGM is dated and has been in existence for a very long period and considered an ancient practice. Nonetheless, Anyaehie and Ezenyeaku (2012), posit that FGM is globally accepted as a violation of fundamental human freedom, which is anchored in rigid tradition, spanning over many generations. According to WHO (2010), the practice of FGM is defined as, “every procedure involving partial or total removal of the external female genitalia, and any other wound to the female genital organ for nonmedical reasons”. However, the practice is a cultural practice that is equated to male circumcision most-times. According to a paper on the Marakwet of Kenya; “Female circumcision defines reproduction, sexuality, adulthood, womanhood, power, religion and diverse kinds of identity” (Kiptiony et al. 2012). According to the practitioners, and its advocates, FGM brands the woman clean, obedient, mature, faithful and marriageable (Kiptiony et al. 2012).

Over the past ten years, several terminologies have, been used to describe the FGM procedure, which is arbitrary and completely unnecessary. Female genital cutting, mutilation and circumcision have been used interchangeably.

Although, circumcision was predominantly used initially, several scholars have contended that the term implied that FGM was equivalent of the circumcision for the male; which is not the case (Cook 2003), therefore it should have been used). It is assumed that only the upper skin of the genitalia for males was detached without damaging the organ itself, whereas the female variation injured the genitals as well as the tissue adjacent (Toubia 1995). When the upper skin of the male was removed, the male organ still functions the same way when the foreskin was not removed. This is not the same story for the female. When this excision process occurs for the female, its appearance becomes different and the genitals no longer performed optimally because the woman becomes unable to experience sexual pleasure (Bourdanne 2005). According to WHO (2008), FGM has become the term of choice since the last three decade to underscore the seriousness of the issue. At the community level, FGM terminology carried an adverse suggestion and therefore mutilation is often replaced with severance in local investigations and policy crusades except in official UN and WHO documentation (WHO 2008). However, FGM was then hypothesized as the practice of removing, and stitching together part of or all of the external female genitals, without a medical cause (WHO 1996).

Statistics suggest that about one hundred and forty million young women globally have been subjected to some form of FGM from 2004 - 2005. Nonetheless, most African countries still practice FGM and incidentally only a handful of these countries have subsisting laws banning the process (LSCB 2007). In Egypt, for instance since the fifties, FGM has been on a ban. Furthermore, Egyptian courts proposed a law in 1997 supporting the earlier ban; but the FGM prevalence still persist as high as 97 percent (LSCB 2007). However, it does not suggest that FGM happens only in developing countries of Africa. The LSCB report also indicate that over 70,000 women, including adolescents are living with the effects of FGM in Britain and an additional 7,000 young women who are below seventeen (17) years of age are also at risk of going through the process. The list of those affected include but not limited to immigrants, refugees, college students or the wives of students (Caroppo et al. 2007) of African descent residing in United Kingdom.

The projected FGM prevalence in the estimated twenty-eight (28) countries practising FGM in Africa indicates four (4) prevalence categories. Countries within the first category had an over 90 percent prevalence; countries in category two exhibited a prevalence rate of 70-89 percent; countries in category three and four showed a prevalence of 90 percent and 25-69 percent respectively. The LSCB (2007) reported that in other countries outside of Africa such as Mauritania and Yemen , prevalence were below twenty-five percent despite the fact that FGM was illegal and banned in hospitals. Despite substantial campaign against this process, WHO (2008) posit that over two million young girls are still potential candidates of this gruesome procedure in many parts of the world.

It is observed that the more prevalence of FGM in a country, the more research conducted within that country. Nevertheless, three significant circumstances were observed from related review of literature. The absence of a robust methodical indication relating FGM practices to adverse reproductive health outcomes; inadequate research regarding the

suitable abandonment methods that will be justifiable over the long run; and finally the statistic that FGM related surveys are conducted mainly within definite subdivisions of a country. Thus, this paper focused on categorizing primary factors that are mutually shared across African countries. This would support the development of strategies and policy options to curb the practice.

For policy purposes, the subject of emphasis elicits a number of questions such as; What are the primary causes that support the acceptance of FGM procedure? Are the primary causes widespread among the 28 African countries still observing the practicing or are they varied? Are these primary causes so dominant that they eclipse the harmful effects that occur? Generally, which primary cause's dictates FGM reception in Africa and what is the framework that will support its termination? The paper therefore compared FGM features across select five countries with wide-ranging prevalence rates and examined the independent variables influencing the FGM decision.

Female Genital Mutilation (FGM) Categories

The WHO has convened many discussion forums that discussed the categorization of FGM and the reasons behind the persistent practice (WHO 2008). Yvonne et al. (2015) concur with WHO classification. From the first classification discussion in 1995 and more recent ones, the category of FGM has become more explicit however, with a few variations in each FGM category. The major categories are explained as follows:

1. *Category I: Female Circumcision, which is also known as Sunna:* This relates to what the female organ looks like after undergoing category I mutilation. This procedure protects the clitoris, but removes the skin fold.
2. *Category II: This is known as Excision or Clitoridectomy:* This process cuts out a part of the skin that shield the vagina and urinary opening in addition to removing the clitoris entirely. Scar tissues normally embrace the vulva region once the genital is healed.
3. *Category III: This is known as Pharaonic circumcision or Infibulation.* This category is the most extreme and most brutish type of FGM. According to WHO, (2008) Infibulation is the total or partial removal of the clitoris, which includes the labia minora. When all these parts are cut out during the process of mutilation, the sides are stitched, while an opening is left for urination and menstruation..
4. *Category IV: According to LSCB (2007); WHO (2008), this is unclassified.* It includes any other dangerous hurtful practice to the female genitalia, such as perforating, penetrating, or extending the clitoris.

Brief Review of Related Literature

There are not many studies on the subject; however, the exact beginnings of FGM are yet to be identified. Nonetheless, confirmation from Egyptian mummies suggests that some type of FGM was regularly practiced some 5000 years ago (IPPF 2008). In primordial Roman Empire, the women slaves were compulsory mandated to have rings of metal passed through their labia minora, which will prevent them from having children (OHCHR 2009; IPPF

2008). Also, during the 19th century England and some parts of America, category I mutilation were performed on women, with the intention to regulate psychological ailments (OHCHR 2009) and to moderate sicknesses such as epilepsy that causes sterilization of organs (IPPF 2008).

A paper written on the Marakwet of Kenya (Kiptiony et al. 2012) revealed that female circumcision is a deep rooted and a widely accepted cultural rite of passage. They add that the African Inland Mission (AIM) started campaigning against female circumcision at Kijabe as early as 1895. This led to serious conflicts between the missionaries and the Kikuyu - who were ardent practitioners of the practice.

The Fulani ethnic group in Nigeria are the only sect that do not practice any form of female genital mutilation, whereas, the Yoruba, Igbo, Hausa, Kanuri and Ijaw ethnic groups still have the practice amongst them (Ashimi et al. 2014; A Online News 2005). The definition of FGM used is seen as a major reason for this statistics reported for Nigeria. Also, the vagina walls are cut in new baby girls or some other traditional practices performed which fall under Category IV FGM classification of the WHO in some parts of Nigeria (FMECD 2011). However there is no known legal prohibition on the practice of FGM in Nigeria, despite Nigeria ratifying the 2005 Maputo Protocol.

Earlier studies on FGM, compiled consistent rates of prevalence from the 28 countries in Africa, including countries in which migrants from FGM practicing countries have been assimilated (Okonofua 2006). According to Briggs (2002), very few studies about the insights from both males and females on FGM showed that lack of communication between both sexes contributes to the continuing repetition of FGM practices. Inopportunately, for the majority, the men do not participate during this process because FGM is performed on the young girls when they are still unmarried. Howbeit, it is believed in many quarters that if the issue of FGM is freely discussed the possibility of the trend decreasing may occur. On the other hand, a handful of countries in Asia and the Middle East practice FGM (WHO 2008). Although FGM predates Islam and Christianity, plethora of reasons is stated for this practice. All of them are related to culture or religion. None of these reasons are based on medical issues. (Pearce and Bewley 2013; OHCHR 2009). Furthermore, in the holy scriptures of Christianity, Judaism or Islam (IPPF 2008), FGM is not acknowledged. The main idea behind the cutting of the clitoris is to make the women to be subservient to the man. Bourdanne (2005) argues that by cutting off part of the clitoris, the woman is unable during sexual intercourse to feel pleasure and is therefore completely submissive.

The LSCB (2007) pointed out a number of reasons for FGM practice in many African societies. The process indicates a rite of passage to maintain her virginity, which consequently gives the young woman and her household the relevant admiration in the immediate society prior to her marital life. OHCHR (2009) report indicate that very young girls between the age bracket of 10-13 years in Sierra Leone and Liberia are taken away from their homes for initiation (FGM Category I) into womanhood. Furthermore, some scholars have argued that the removal of female genitals makes her clean (LSCB 2007) and provides more sexual

pleasure for the spouse (OHCHR 2009). Also, some societies in African believe that the contact of the baby with the mother's clitoris during child delivery is not healthy (Bourdanne 2005) and may even cause death for the new born (OHCHR 2009). This reason most times put pressure on the women to agree to the FGM process. Also, some men in these communities agree to this practice in order to guarantee their spouse's faithfulness to them while they are away from home for a long time (LSCB 2007). Sadly enough, in some of these societies, the male folk stitches their wives genitals before staying away for a long period of time (LSCB 2007). This practice is also repeated each time the woman gives birth to a child (WHO 2008).

The African Union adopted the Maputo Protocol which advocated for the end to the practice of FGM and ensuring that the rights of women are protected. The agreement was signed in November 2005, and by December of the same year, twenty-five member countries had endorsed it (US Dept 2001). By 2013, eighteen African countries have outlawed the FGM practice, including Niger, Nigeria, Senegal, Somalia, Sudan, Tanzania, Togo, Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Ghana, Guinea, Kenya, and Uganda (Lazuta 2013; FRS 2013). Unfortunately, the countries have not done much in curbing the practice.

Female Gentile Mutilation and Reproductive Health

Documented research varies when describing the age at which FGM procedure is performed on a young woman. This variation oscillates between a seven day old girl up until the time the girl gives birth to her first child. Furthermore, adult women have this procedure also performed on them when they marry. According to Yoder et al. (2004), when this ritual is carried out on very young girls below the age of four, the initiation process is minimal in comparison to when the girls are older than twelve. The decision as to when FGM occur is tied to the inherent culture and religion practiced in the various countries (OHCHR 2009). In Egypt, about 90 percent of girls undergo FGM from the age of 5 and 14, whereas most societies in Africa, where this is done before the girl's fifth birthday. Nonetheless, Yoder, et al. (2004) report that Eritrea and Ethiopia present extreme cases because the majority of the girls are mutilated within their first year of life. The estimated mean for the FGM procedure lies between 10 and 12 years, according to LSCB (2007).

Abdi and Askew (2009) indicated that FGM has been practiced by most communities and for many decades. Nonetheless, the exact time when the practice started is still debated among scholars, yet the practice is not abating. FGM has continued from generation to generation. The older women who pass through this knowledge have also gained extra income in their communities (LSCB 2007), whereas in Egypt, OHCHR (2009) reports that men perform the operation. The type of FGM to be administered on the young girl is determined by the mother or grandmother of the child, who in turn pays for the service. In most African societies, much older women hold down the young girl while the process is performed for about 20 minutes. In most cases, the traditional birth attendant also performs this operation with no anesthetic.

Complications of Female Genital Mutilation

Globally, several complications have been attributed to the FGM procedure. They include both short and long term effects. Nonetheless, most women are unable to associate this procedure to the complications that are almost inevitable. According to the OHCHR, (2009), the least harrowing result in the short term is agonizing pain because no painkilling substance is administered while the procedure is being performed, which is attended by heavy bleeding. Expectedly, urinary tract or wound infections usually follow afterwards (OHCHR 2009). Moreover, the surrounding organs around the genitals may be affected which probably results to major problems in the future. Furthermore, if the surgical instruments are not adequately sanitized, the women could develop viruses such as HIV. Hepatitis B and C (LSCB 2007). In some other instances this procedure causes so much loss of blood loss that death is inevitable. In addition, the mental issues associated with FGM in the short term is most often emotional. However, in some societies, these women may understand the rationale behind the process and in some they may not. Nonetheless, it still does not make FGM less traumatizing for those who don't.

There is no gain saying that, if the early observed problems are not attended to, the probability of the problems progressing and maturing into more long term complications becomes higher. It is expected that persistent infections associated to the vagina, and the pelvic may be experienced by the women who were mutilated. WHO reports show that "urinary tract contaminations can affect the kidneys and subsequently in extreme cases cause death." Severe complications regarding periodic menstrual flows and the reproductive system are among long-term health risks associated to FGM. Women who have undergone FGM are even more susceptible to HIV infections.

Moreso, childbirth complications increase with each category of FGM. Medical science research indicates that frequencies of delivery by operation may be amplified as well as elevated occurrences of postnatal bleeding. This may become a normal problem for the women in her lifetime and women who are infibulated have to be opened up or de-infibulated before delivery and then re-infibulated again afterwards. The after effect of the FGM generally portends danger for the woman. Further, evidences have shown that death rates among infants during child birth delivery and instantaneously after birth delivery are higher when the mother has undergone category I, II or III of the FGM. WHO, (2008) showed that FGM category I led to 15 percent more of infant death rates, category II led to more than 30 percent infant deaths while category III led to about 55 percent, when compared with women who had not gone through the process.

Analytical Framework

A research team collected data for over twenty-eight thousand pregnant women that attended obstetric centres in six African countries. The women were observed before child birth by trained midwives who classified each person according to an FGM category. After delivery, the women and their babies were continually evaluated until discharged. The purpose of the data collection was to investigate the effects of different types of FGM on a range of maternal and neonatal outcomes during and immediately after delivery. Furthermore,

extents and sizes of FGM were calculated for specific African countries. Identification and description of the FGM process in a few countries, and subsequently grouping the 28 countries practicing FGM according to the current prevalence rates was done. One country was analyzed per the prevalence rate category to show the primary motives of FGM acceptance.

African countries were purposively selected because of the FGM practices in the societies. Lists of 28 countries were in the sample pool. These countries were further subdivided into 4 categories: Countries with FGM prevalence above 90 percent, 70-89 percent, 25-69 percent and below 25 percent were placed in the first, second, third and fourth categories respectively. Two countries were then selected from each group because they have the same excision levels. Countries analyzed had ready data sets from the UNICEF database. The selected countries are Sudan, Gambia, Cote d'Ivoire, Ghana and Sierra Leone. Descriptive statistics indicating frequencies for all the variables in relation to FGM were derived. Demographic variables were triangulated, with other identified variables to identify basic indicators.

The dependent variable in the analysis is FGM rates, whereas the independent variables are age, region, area of settlement, religion, ethnicity, education level and socioeconomic status. A general consent was obtained for the downloading of related materials.

A response rate of approximately hundred percent was recorded for the centres in Burkina Faso, Ghana, Kenya, Nigeria, Senegal, and Sudan respectively. Demographic data were collected for the mothers and their newborn babies during their visit at the treatment centre. The category of FGM which the mother was subjected to indicate substantial dissimilarity; however, we recognize that this analysis was slightly representative, the occurrence rates are same to a reasonable extent for Africa in general.

Results

The null hypothesis posits a zero relationship between the independent variable and dependent and vice versa. The p-value from the chi square test enabled the rejection or acceptance of the hypothesis tested. Estimated p-value of 0.005 showed a significance and vice versa. The questionnaires were standard for each country where they were administered including specific modules per questionnaire.

The test statistics for association confirmed if the independent variables influenced FGM or otherwise. Further, the cross tabulating results using the row percentages enhanced understanding of the association level easier. The higher percentages indicated a high relationship between the independent variable and FGM.

A look at the FGM situation in the five selected African countries in terms of the prevalence rate was done by examination of the data which addressed the excision module in the extra questionnaire due to the reason that each country included questions they assumed to be important. Therefore, it was not possible to review all the FGM variables for all five countries.

The five countries investigated in this paper had varied response rates as it relates to MICS2 and MICS3 when it was administered. The response rates of the females appeared positive since the non-responses are small. The non-responses were consequently omitted from the data sets when examined. The response rates of the five analyzed countries are shown in Table 1.

Table I: Response rates of the five analyzed countries

<i>Country</i>	<i>Eligible females</i>	<i>Females interviewed</i>	<i>Female response rate</i>
Sudan	25 200	22 946	91.1%
Sierra Leone	9 257	7 654	82.7%
The Gambia	10 252	9 982	97.4%
Cote d'Ivoire	13 020	12 888	98.6%
Ghana	6 240	5 891	94.4%

An estimation of the danger of obtaining an exact hostile maternal health circumstance as opposed to not obtaining this specific health circumstance, for both those with FGM experience or without was done. Different models were used for each category of FGM and were then likened to other women's group without excision that formed the baseline. Comparisons between women who had experienced FGM and those who had not showed the following:

1. FGM and infant birth loss weight of less than 2500g did not show any significant relationship;
2. Women with category II and category III mutilation experiences were significantly more likely to have their babies through operation than those without the experience;
3. Women who had category II and III of FGM were more at risk of postpartum blood loss more than those without the experience;
4. Women who had excision were found to have a protracted stay at the hospital after child birth than non-excised women;
5. Women exhibiting category II and III FGM have an upper risk of birth delivery that needs revitalization than women who were not excised;
6. The danger of continuous death was high amongst children of women exhibiting category II and III than women who were not excised at all.

Discussion

Statistics showed that further education amongst the women reduced the FGM prevalence. A significant with a p-value below 0.005 was obtained. Nonetheless, education level of the female respondent exhibited variations in the levels of excision. FGM prevalence in Sudan and Sierra Leone were high but definite differences in excision levels were however

noticed. Sudan produced a flat line indicator for education, though it had a slight increase in the level of excision with the education level increase, which was not expected. Howbeit, Ghana, Sierra Leone, Cote d'Ivoire and Gambia, however, reported a negative relationship between education level and excision. Education level is pointedly a tool that could be used to mitigate the practice.

The state of residence was a key variable in determining FGM prevalence in four out of the five countries investigated. Sierra Leone exhibited the least dissimilarity primarily because the FGM prevalence was about 94 percent. The other investigated countries exhibited more of dissimilarity among its regions. However, the Test Statistics for association authenticated the dissimilarity with below p-values of 0.005. This confirms that the region of residence influenced FGM choices. Furthermore, rural women experienced more of FGM than their urban female counter-parts. The magnitude of the variances between rural and urban excision was not significant in any of the five countries.

Furthermore, Sudan and Sierra Leone had similar trends of excision levels for age groups. High levels of FGM for each age group were observed for both countries, with the oldest age groups indicating high magnitudes of FGM. Persons aged between 15 and 19, had the lowest FGM prevalence rates in both countries. In addition, Gambia exhibited a normal pattern with the age groupings, where the oldest age group of 45-49 showed up with lowest prevalence level. However, Cote d'Ivoire and Ghana exhibited the utmost disparity in FGM prevalence rates, giving their respective age groupings. The two countries indicated a progressive association between age and FGM prevalence, which means that the younger women had the lower FGM prevalence and vice-versa. Howbeit, the age of the women appeared to impact on the level of FGM in two of the five countries investigated.

Test results from chi-square showed that age group and FGM were linked for all the countries except Gambia, where age was not a foremost independent variable. There were variations on the analysis of data for Sudan because the age at which the ritual was done on the women was only included in their questionnaire, but that of their daughters were not disclosed. It was expected that this variable should exhibit more variation in the level of prevalence, but unfortunately it was not collated for analysis.

The variable "religion" was analyzed for all the selected countries except Sudan because it is predominantly a Muslim population. However, results showed that Muslim women had FGM performed on them more than any other religious group in Ghana, Gambia, Cote d'Ivoire and Sierra Leone. Nonetheless, the majority of the population in Gambia are Muslims and the prevalence rates for the Muslims were found to be huge, with very low prevalence amongst the Christian females. In Sierra Leone, the least difference between Muslims and Christians as per their FGM levels was observed. Statistics from Cote d'Ivoire showed that vast difference existed based on religious affiliations. Statistics indicated that about 70 percent of Muslim females, 25 percent of Christian females and 50 percent of Animists had FGM performed on them. Furthermore, Ghana showed high prevalence for the Muslim population, while it was near zero for their Christian counterparts, even when they are about 60 percent of the population. Interestingly, the Traditionalist population in Ghana who are about 11 percent of

the population had the highest prevalence of FGM in comparison to the other religious affiliations. The association between religion and FGM for all four countries showed a p-value of 0.000.

Ethnicity showed up a strong predictor of FGM, especially when ethnic clusters are differentiated in a population. The p-values for this variable were significant. However, Sudan, Sierra Leone and Ghana were not sub-divided into ethnic clusters; thus FGM levels were not cross tabulated for these countries. Due to different ethnicities, the FGM prevalence in Cote d'Ivoire and Gambia, showed vast differences. Results from the Gambia and Sudan showed a different trend. The wealthier females were excised the most in these two countries. Gambia, however, showed a more flat pattern implying that the level of FGM was not displaying a uniform pattern. The rich women had more excision than the others. These two countries did not conform to expected results between FGM and socio-economic status. As expected, Ghana, Sierra Leone and Cote d'Ivoire reported comparable patterns and a certain reversing relationship existed between wealth index and FGM. Women from poor demographic quintiles were excised more than those that belonged to the higher quintile. This suggests that socio-economic position influenced the practice of FGM in Sierra Leone, Cote d'Ivoire and Ghana respectively. The Test result authenticated this association with below 0.005 significance p-values.

The literacy levels of women in all five analyzed countries were very low. A negative relationship was identified between education and excision for the women. Women without any form of education exhibited a high level of excision, while the reverse is the case for those who had secondary education and above. This suggests that educated females make better and informed decisions. Nonetheless, in an African household, the male is the role of the head of the household because of the patriarchal framework. This supposes that decisions by family members must be corroborated by him. This becomes a conflict when excision decisions are to be made, because they are normally deviated to the detriment of the females. Thus, it appears that involving the males in the community is valuable for the expanded reproductive health education of the women folk. Evidence from Sudanese show that small minority of females discussed FGM with their husbands. Howbeit, those not aware are usually indifferent to the process. This is also the case for most other countries.

Conclusion

The paper compared FGM pattern and features across five countries with varied excision prevalence. Furthermore, independent variables found to influence the excision decision were analyzed. Two countries, namely Sierra Leone and Sudan were in the category of high prevalence amongst the countries studied. However, comparison of variables across countries was limited because of inconsistency in the questions asked. There was also lack of homogeneity on the question set. The shortcomings led to an inconsistency in the country-wide analysis. However, this did not affect the value of the data. The independent variables were triangulated with other variables for the selected five countries.

Data limitation restricted further examination of matching variables across the five countries. Thus, analysis focused on only descriptive and cross tabulation of variables. The independent variables influenced FGM decision in different ways for all the countries. Place of residence, education were found to be highly significant for Sudan and Sierra Leone; whereas religion influenced the dominant population in Gambia. This suggests that in Cote d'Ivoire and Ghana, education showed up as a strong predictor variable.

Nonetheless, the outright usage of laws and education schemes was found to be less effective in the reduction of FGM. A remarkable result from the foregoing analysis is that FGM is firmly rooted in religion, tradition and cultural antecedents. It has also been shown that a general strategy to lower FGM prevalence in Africa may not be appropriate. Nonetheless, educating community leaders, both religious and traditional is expected to decrease FGM practice and subsequently eliminate the practice, especially when religious and cultural dimensions are major predictors of this practice. Nevertheless, specific campaigns against FGM practices are expected to reach maximum success in the long run if sustained. However, only Sudan added the husband's judgment as per FGM. Thus, education especially for the male folk is expected to be of immense value. This will further expose them to the inherent dangers their female children face from going through this procedure. It is expected that over time and with more men exposed and educated on the implication of FGM, the more chances of their getting more involved in the FGM decision making process. Formal and expanded knowledge could also assist households in Africa during a decision making process. If the men in African societies endorse the campaigns encouraging the cessation of FGM, other members of the family will easily adapt to the change. Thus, the women will no longer be required to perform this ritual. This is made easier because of their headship of families in the African setting.

The importance of knowing the dynamics behind the practice of FGM amongst women are immense. Anti-excision framework could easily be developed from this understanding, in addition, understanding the decision mechanism regarding the practice, would benefit the entire society in general. Nevertheless, education of the female folk as a result of health complications experienced by their colleagues because of FGM should be the target of policy makers. For further analysis, researchers will be needed to use more creative strategies because FGM process is deeply rooted in religious beliefs.

Howbeit, this perception is hard to alter; because religion is the cornerstone of many societies in Africa. Thus, re-orienting religious and community leaders will be an appropriate strategy to mitigate the untoward effects of FGM. Furthermore, there are a number of changes required in a future questionnaire for similar analysis:

1. Age at which excision is performed should be included subsequently because of its importance. This variable was only added for the survey in Sudan. The results were quite instructive.

2. Due to the reason that some women do not know which category of FGM was performed on them, the correct response to this question may be difficult to ascertain. Therefore the exclusion of this question is recommended.
3. Questions related to the excision acceptance of the practice of FGM by mothers should be included in subsequent questionnaires. This level of evidence would support the generalization of concepts on the subject matter. This would aid comparison between young girls and their mother.

Recommendations

Deriving from the foregoing analysis, the paper suggests a few recommendations. Firstly, changes are to be made on the questionnaire regarding a future study. This change should be focussed to the FGM module. The other is the implication of findings in the context of improving anti-FGM programs (change in orientation, education of the female and male involvement). These recommendations could possibly encourage a better understanding of the dynamics of FGM and its discontinuation. The shortcomings observed from the UNICEF data base prevented a robust review of the relationship between the dependent variable (FGM) and socioeconomic variables (independent). Thus, there is a need to include more questions in subsequent studies concerning FGM.

In the circumstances that policy makers identify the risky age groups through further research and re-orientation, consciousness, could be focused on that exact age group in danger. Therefore, for a country like Sudan, where the mother is assumed to make decisions related to FGM, policy interventions should focus on the mothers. This will enable them to make informed decisions regarding their daughters. Furthermore, responses to the type of FGM performed on the female are important variables, because for an effective policy framework or solution, policy makers need to differentiate if a community is practicing a particular category of FGM or a variation of the four categories.

The paper recommends that dynamic policies on education and the involvement of the men in the society could mitigate the practice. An expanded health education curriculum for young girls in the countries practicing FGM would expose them and enable them to take adequate decisions regarding their health. Without the support of the government, this societal gain might not materialize. If a properly designed education curriculum is in place, then the knowledge of reproductive health and its outcomes would be enhanced. In a general sense, the ability to make decisions regarding one's sexuality and reproductive life would discourage the FGM practice.

However, it should also be noted that altering a life behaviour pattern takes a long period of time, especially when the behaviour is embedded in the traditions of a community. Therefore, collection of data both demographic and health related as it relates to the FGM process should be a continuous process. This would provide further evidence on the practice and possible policy options to address persistent issues. By understanding that there is a connection between health outcomes and FGM practice, societies could probably vary their thinking mode. Recently, young women are opposing this mundane act because

of the increasing recognition of the after effects of the process. Therefore, since FGM has been shown to have undesirable consequences for women and children, a framework for the reduction and elimination of all categories of FGM may be conceptualized within the Sustainable Development Goals (SDG). A major drawback of the MDG 4 and 5 was the non-explicit target for the elimination of FGM. The negative consequences of FGM adversely affected the targets of MDG Goal 4 and Goal 5. Thus, it is recommended that the Sustainable Development Goals (SDG) which is new should plan for the reduction of FGM prevalence.

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