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Awareness of the Violence Against Persons Prohibition Law and its Association with Female Genital Mutilation Prevalence among Youths in Oyigbo, Rivers State

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Article history: Received 28 July 2025, Reviewed 09 September 2025, Accepted for publication 14 September 2025

Abstract

Background: The study assessed the "awareness of violence against persons prohibition (VAPP) law and its association with prevalence of female genital mutilation among youths in Oyigbo, Rivers State, Nigeria.
Methods: This cross-sectional study involved 496 youths (15-24) years old. It employed a multistage sampling technique. Data was collected via a semi-structured interviewer-administered questionnaire. Data analysis was done with SPSS version 27, using Pearson's Chi-square test for statistical associations.
Results: The median age is 23 years, females; 387 (78.0 %) and 330 (66.5%) had secondary education. The awareness about female genital mutilation was 164 (33.1%), while the prevalence of FGC among female youths was 95 (24.5%), and 109 (22.0%) among all respondents. Only 88 (17.7%) were aware of the VAPP law. Age ($\chi2 = 12.97$; $p < 0.001$), occupation ($\chi2 = 9.82$; $p < 0.019$), marital status ($\chi2 = 32.27$; $p < 0.001$) awareness of FGC ($\chi2 = 12.26$; $p < 0.001$), and awareness of male circumcision ($\chi2 = 40.73$; $p < 0.001$) were significantly associated with female genital cutting (FGC). Specifically, those who were married were 5.2 times more likely to have had FGC compared to those who were single (aOR=5.2, 95% CI: 1.0-27.4, p=0.050), additionally, those who were aware of female circumcision were less likely to have had FGC (aOR=0.32, 95% CI: 0.10-0.12, p=0.001).
Conclusion: The awareness of the VAPP law is low, and the prevalence of FGC remains high. There is a need to scale up public health awareness and sensitistion efforts to improve preventive measures against FGC.
Keywords: Female Genital Mutilation/Cutting, Violence Against Persons Prohibition Law (VAPP), Legal Awareness, Youth, Prevalence, Rivers State, Nigeria

How to cite this article

Ogbonna, V.I, Opara C., Joseph C., Okongwu N., Adetomi B. Awareness of the Violence Against Persons Prohibition Law and its Association with Female Genital Mutilation Prevalence among Youths in Oyigbo, Rivers State. The Nigerian Health Journal 2025; 25(3): 1047 – 1057. https://doi.org/10.71637/tnhj.v25i3.1127

INTRODUCTION

Despite the advances made in many fields by women globally, the rights of millions of women are still being violated in many countries through the continued practice of female genital mutilation or cutting. Every procedure that involves the removal of the external female genitalia, whether partial or is called female genital mutilation or cutting (FGM/C).[1] The term is also applied to all other injuries to the female genitalia for non-medical reasons. Therefore, partial or total removal of the clitoris and/or the labia minora, narrowing of the vaginal opening, pricking, incising, piercing, scraping and cauterising of the female genital area are all considered forms/types of female genital mutilation.[1] Female genital mutilation/cutting is practised in many parts of the world, and is better called female genital cutting (FGC)

The practice goes back to an era that pre-dates both Christianity and Islam and persists in varying degrees among different peoples, communities and societies [2]. Irrespective of where, when and by whom it is performed, FGC causes both physical and psychological harm to its victims and is therefore internationally recognised and considered a human rights violation against girls and women. Despite the beliefs and claims of the supporters of this violation, the procedure has not been shown to provide any health benefit to its victims but rather can lead to serious health risks both in the long and the short-term including anxiety, depression, pain, haemorrhage, shock, infections, infertility and childbirth complications.[2–4] Globally, the prevalence of FGC is very high though the exact global prevalence is unknown due to the paucity of data from some of the countries that practice FGC yet do not provide nationally representative data, however, available data shows that over 230 million females in 92 countries in the world are estimated to have experienced the procedure.[1,2]

The majority of these females are in Africa (over 144 million), followed by Asia with over 80 million cases, the Middle East with about 6 million cases, and the remaining 1-2 million in migrant communities scattered all over the world, constituting of migrants from countries where FGC is a norm.[1,5] In addition, 3 million females annually are at risk of undergoing female genital mutilation before they turn the age of 15.
With an FGC prevalence of 20% among women aged 15-49 years, Nigeria is one of the African countries that contributes to the global burden of FGC, along with 30 others. For several decades, there have been concerted global efforts to eliminate the violation of female children and women caused by the continued practice of FGC in many countries with varying degrees of success. However, following the passage of the World Health Assembly's resolution WHA61.61 on the elimination of FGC in 2008, the United Nations Fund for Population Activities (UNFPA) and United Nations Children's Fund (UNICEF) jointly partnered with governments, civil society leaders, the academia and faith based organisations in different countries to raise awareness of FGC and its dangers to influence a shift in social norms towards the collective abandonment of FGC in affected communities. Seventeen (17) out of the 31 high-burden countries in Africa (including Nigeria) were supported by a Joint Programme on FGC and have made significant progress. [5,6] These efforts were sustained and given more visibility and attention by the incorporation of the elimination of FGC into the 2030 Agenda Sustainable Development Goals as the 3rd target of the 5th goal which itemises harmful practices against women such as child, early and forced marriages and female genital mutilations as practices earmarked for elimination from human societies by the year 2030.[6]

Report on the progress of African countries in their journey to the elimination of FGC shows that countries are at different levels of progress; while some countries show a consistently low prevalence of FGC at all age groups, some others have recorded minimal or no decline in prevalence, but the last group of countries have shown significant decline in prevalence. Nigeria is in this last group.[7]

Nigeria has many ethnic groups/communities that still practice FGC and the three major forms that are found to be predominant in the country include 'female circumcision', hymenectomy and 'gishiri cuts' (cutting off the vaginal wall with introduction of corrosive substances to tighten or narrow it).[8,9] The prevalence of FGC is highest in the South (South-East 35%, South-West 30%) and lowest in the North (North-East 6%). Based on the findings from the NDHS, Nigeria has made some progress in the elimination efforts of FGC such that the prevalence of FGC among women aged 15-49 years decreased from 25% to 20% between 2013 and 2018 and contrary to previous surveys, the prevalence of FGC was found to be higher in the urban

Print ISSN: 0189-9287 Online ISSN: 2992-345X

than in the rural area.[8,9] However, Nigeria also has a 9% and 7% prevalence of medicalised FGC for women and girls, respectively, and this trend of medicalisation has been noticed in several African countries, with the medicalisation rates highest in 5 countries, namely Sudan, Egypt, Kenya, Guinea and Nigeria.[10,11] The medicalisation of FGC refers to the practice or performance of FGC by any health worker in any location, whether public or private (at home or elsewhere. In an attempt to reduce the various known complications of FGC, many people turn to medicalized FGC as a safer option, however, engaging in FGC is a violation of women's and girls' right to life, physical integrity and right to health and is a violation of the fundamental principle of "doing no harm" as FGC has no known health benefit. [12–14] Furthermore, the medicalisation of FGC constitutes an additional hurdle to the elimination of FGC because it gives the impression, to those who practice it, that the procedure is good for health or, at best, harmless, therefore giving a form of legitimacy to the practice and institutionalising it. However, it is now a violation of the law in many countries.[10,11]

Globally, 84 countries (including Nigeria) have passed legislation that outright prohibits FGC or allows offenders to be prosecuted through other existing laws.[11,15] In 2015, Nigeria approved legislation against FGC by passing the Violence Against Person Prohibition Law (VAPP law), banning FGC and other harmful traditional practices in the country representing remarkable progress in the process of FGC elimination in the country with many states in Nigeria domesticating the law and making violators eligible for punishments including jail terms.[2,16] There is, however, a need to build on the momentum of these gains to meet the target of elimination of FGC in the shortest possible period, especially as gains that are made can be eroded. This is shown by the situation in The Gambia, where despite the passage of legislation against FGC in 2015, the country has regressed to ongoing debates to repeal the law to now allow FGC for citizens who desire it.[1,7]

Rivers State, which is in the Southern region of Nigeria, as determined by the 2018 demographic and health survey, has a 9.3% FGC prevalence, which is less than the national prevalence of 20%. While the prevalence of FGC in Rivers State is low relative to the national prevalence, it is pertinent to note that the global target for FGC is the elimination of the practice and not just a reduction in prevalence.[8,17] Several studies done in Nigeria and Rivers State in particular show that there are several factors for which people have continued the practice of FGC in the region and these include culture, level of education of parents, religious beliefs, reduction of sexual passion and promiscuity, rite of passage of womanhood and also ensuring virginity and chastity in marriage. [18,19] Furthermore, the medicalisation of FGC has been shown to exist in Rivers State. A study done several years ago in a semi-urban town in Rivers State showed medical doctors to be the highest practitioners of medicalised FGC.[20] Despite the criminalisation of FGC by the passage of the VAPP law in Nigeria in 2015 and the domestication of the same law in Rivers State in 2022, health workers are still engaging in FGC in the state.

There is a gap in understanding the effectiveness of the VAPP law and policies intended to prevent FGC. This research is needed to assess how well these laws are enforced and their impact on the prevalence of FGC. This study was therefore undertaken in Oyigbo, a semi-urban local government area in Rivers State, Southern Nigeria, and determine the prevalence of FGC, the level of awareness of the VAPP law, and to determine the factors influencing the prevalence of FGC in the area.

MATERIALS AND METHODS

Study area: the study area is Oyibo Local Government Area (LGA) of Rivers State, South-South, Geo-political zone of Nigeria. The State has 23 Local Government Areas (LGAs), each consisting of wards made up of rural and urban communities. Rivers State has an estimated population of 7,303,924 as of 2016. [21]

Study design: A cross-sectional study design was used

Study Population: The study population comprises youth residents of Oyibo Local Government Area (LGA) of Rivers State

Inclusion criteria: youths aged 15 to 24 years who have resided in Oyibo community for at least one year.

Exclusion criteria: Adult residents who are too ill to complete the questionnaire/interview.

Sample size determination: Cochran's formula for determining the sample size in a Cross-sectional study, as outlined by Israel et al., was used.[22] where $n = \frac{Z^2pq}{e^2}$

In this equation, n represents the desired sample size, Z represents the standard normal deviate, 1.96 at the 95% Confidence level, e denotes the precision margin (5%,

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0.05), and P represents the prevalence of FGC in Rivers State from a previous study, [23] (77%, 0.077), and q equals 1-p (23%, 0.23) derived from a similar study. Inputting the formula gave a sample size of approximately 272. A non–response rate of 10% was factored in, bringing the sample size to 302. Considering that a multistage sampling technique was employed, a design effect of 1.6 was applied, which made the minimum sample size 454. However, 496 participants responded.

Sampling Technique: A multistage sampling technique was employed. Stage one was selection of wards. There are 10 wards in the Oyigbo Local Government Area. four wards were randomly selected by ballot (wards 3, 5, 8 and 9). Stage 2: Selection of communities. Four communities were selected randomly, one from each ward using the balloting method (Obgeru, from ward 3, Umuagbai from ward 4, Umundino from ward 8 and Umuokolobo in ward 9). Stage 3: Selection of participants. A bottle was spun in the middle of the community, and the households that fell within the area where the bottle stopped were chosen. All the all youth who fell within that area and fit our study population criteria were picked until the sample size for that community was achieved (124 per community.

Study instrument: The study tool used was a semi-structured interviewer-administered questionnaire designed by the researcher after reviewing the literature and face and content validity was ensured by content experts. The questionnaire was pretested in a different community before the commencement of data collection. The questionnaire has three (3) sections, section 1 is on sociodemographic characteristics, and section 2 is on **a**wareness of the VAPP law, level of understanding of the VAPP law was assessed on a 5-point Likert scale).
female genital mutilation/cutting. Section 3 is on the prevalence of female genital mutilation/cutting.

Data collection method: Data was retrieved from the questionnaires, cleaned, sorted, and pre-processed in Microsoft Excel version 2016, before being imported and analysed using IBM SPSS version 27 by IBM Corporation, Armonk, New York, United States. Categorical data would be presented in the form of frequencies and percentages (%). The Chi-square (χ^2) tests were used to examine associations between categorical independent variables and the outcome variable. Multivariate logistic regression was then conducted to determine the strength and direction of associations. Open-ended questions were analysed thematically.

Ethical considerations: ethical approval was sought and obtained from the research and ethics committee of the Pamo University of Medical Sciences (PUMS/REC/2025/020). Informed consent was sought and obtained from the participants, who were assured of confidentiality

RESULTS

Table 1: Socio-demographic profile of Youths 15-24 years in Oyigbo

Variable	Frequency (n=496)	Percentage (%)
Age group		
15-19	121	24.4
20-24	375	75.6
Sex		
Female	387	78.0
Male	109	22.0
Education Completed		
No Education	16	3.2
Primary Education	75	15.1
Secondary	330	66.5
Tertiary	75	15.1
Occupation		
Student	108	21.8
Employed	300	60.5
Unemployed	78	15.7
Others	10	2.0
Marital Status		
Divorced/Separated	5	1.0
Married/ Cohabiting	236	47.8
Single	249	50.2
Widow/Widower	6	1.2
Religion		
Catholic	180	36.3
Muslim	6	1.2
Others	80	16.1
Protestants	222	44.9
Traditionalist	8	1.6

Table 1 shows that the mean age is 21.4 ± 2.9, median age is 23 years, most of them were females, 387 (78.0 %), 330 (66.5%) had secondary education, 300 (60.5%) were employed, 236 (47.8 %) were married/cohabiting, and 222 (44.9%) were protestants.

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Table 2: Awareness and prevalence of female genital mutilation/cutting

Variable	Frequency No. n=496	Percentage (%)
Aware of any form of circumcision		
No	421	84.9
Yes	75	15.1
Aware of female genital cutting		
No	164	33.1
Yes	332	66.9
Had female genital cutting (n=387)		
No	292	75.5
Yes	95	24.5
A daughter or sister had female genital cutting		
No	387	78.0
Yes	109	22.0

The awareness about female genital cutting was 164 (33.1%), while the prevalence of FGC among female youths was 95 (24.5%)

Table 3: Awareness and Knowledge of Laws and Policies related to female genital cutting

Variable	Frequency No. n=496	Percentage (%)
Aware of any Laws and Policies prohibiting FGM/C		
No	373	75.2
Yes	123	24.8
Aware of the VAPP Law		
No	408	82.3
Yes	88	17.7
Aspect of the VAPP awareness (n = 88)		
Prohibits of FGM/C	17	19.3
Prohibits Domestic Violence	7	7.9
Prohibits emotional abuse	1	1.1
Prohibits Harmful Traditional	3	3.4
Protection Against sexual violence	8	9.1
All of the above	51	57.9
Level of understanding/knowledge of the VAPP Law (n = 88)		
Very Poor	13	14.8
Poor	13	14.8
Fair	38	43.2
Good	18	20.5
Very Good	5	5.7

As shown in Table 3, only 123 (24.8%) were aware of any law or policy prohibiting FGC, and only 88 (17.7%) were aware of the Violence Against Persons Prohibition (VAPP) law. Among those aware, the level of understanding about the law was good in 18 (20.5%) and very good among 5 (5.7%) of the respondents

Table 4: Perception of effectiveness and the enforcement of the VAPP Law among youth respondents.

Variables	Frequency	Percentage (%)
Perceived Effectiveness of the VAPP Law n=86		
Very ineffective	17	19.8
Somewhat ineffective	15	17.4
Neutral	28	32.6
Somewhat effective	14	16.3
Very effective	12	14.0
Heard of any enforcement of the VAPP Law (n=87)		
No	70	82.3
Yes	17	17.7

Table 4 shows that most of the respondents were neutral, 28 (32.6%), on the perception of the enforcement of the VAPP law, followed by those who perceived the VAPP law as ineffective, 17 (19.8%). Only 17 (17.7 b%) have heard about the enforcement of the law.

Barriers to the enforcement of the VAPP law: This was assessed with multiple responses; the commonest barrier was lack of awareness, 50 (57%) out of 87 respondents, followed by cultural resistance, 37 (42.5%) out of 87 respondents, and fear of social backlash, 27 31. 0%) out of 87 and corruption 26 (29.9 %).

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Table 5: Factors associated with the prevalence of FGC among all respondents

Variable	Undergone FGC		Total (%)	Chi-square (P-value)
	No=387 (78.0%)	Yes =109 (22.2%)	n=496 Freq (%)	
Age				**4.71 (0.03) ***
15-19	103 (85.1)	18 (14.9)	121 (100.0)	
20-24	284 (75.7)	91 (24.3)	375 (100.0)	
Education Completed				2.208 (0.530)
No Education	13(81.2)	3 (18.8)	16 (100.0)	
Primary Education	59 (78.7)	16 (21.3)	75 (100.0)	
Secondary	252 (76.4)	78 (23.6)	330 (100.0)	
Tertiary	63 (84.0)	12 (16.0)	75 (100.0)	
Occupation				5.705 (0.127)
Student	92 (85.2)	16 (14.8)	108 (100.0)	
Unemployed	59 (75.6)	19 (24.4)	78 (100.0)	
Employed	230 (76.7)	70 (23.3)	300 (100.0)	
Others	6 (60.0)	4 (40.0)	10 (100.0)	
Religion				3.74 (0.442)
Traditionalist	6 (75.0)	2 (25.0)	8 (100.0)	
Catholic	135 (75.0)	45 (25.0)	180 (100.0)	
Protestants	174 (78.4)	48 (21.6)	222 (100.0)	
Muslim	4 (66.7)	2 (33.3)	6 (100.0)	
Others	68 (85.0)	12 (15.0)	80 (100.0)	
Marital Status				**16.71 (0.001) ***
Single	212 (85.1)	37 (14.9)	249 (100.0)	
Married/ Cohabiting	169 (71.6)	67 (28.4)	236 (100.0)	
Divorced/Separated	3 (60.0)	2 (20.0)	5 (100.0)	
Widow/Widower	3 (50.0)	3 (50.0)	6 (100.0)	
Awareness of any form of circumcision				**10.07 (0.002) ***
Yes	69 (92.0)	6 (8.0)	75 (100.0)	
No	318 (75.5)	103 (24.5)	421 (100.0)	
Awareness of Female Circumcision				**57.99 (0.001) ***
Yes	161 (98.2)	3 (1.8)	164 (100.0)	
No	226 (68.1)	106 (31.9)	332 (100.0)	
Awareness of VAPP law				0.144 (0.704)
Yes	70 (79.5)	18 (20.5)	88 (100.0)	
No	317 (77.7)	91 (22.3)	408 (100.0)	

*Statistically significant ($p \leq 0.05$).

As shown in Table 5, the factors associated with the prevalence of FGC among all respondents were age ($\chi^2 = 4.71$; $p < 0.030$), marital status ($\chi^2 = 16.71$; $p < 0.001$), awareness of any form of circumcision ($\chi^2 = 10.07$; $p < 0.001$), and awareness of female circumcision ($\chi^2 = 57.99$; $p < 0.001$),

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Table 6: Factors associated with the prevalence of FGC among the female respondents

Variable	Undergone FGC (Freq%) n=387		Total (%)	Chi-square (P-value)
	No=292	Yes =95		
Age				**12.97 (0.001) ***
15-19	84 (89.4)	10 (10.6)	94 (100.0)	
20-24	208 (71.0)	85 (29.0)	293 (100.0)	
Education Completed				3.079 (0.384)
No Education	7 (63.6)	4 (36.4)	11 (100.0)	
Primary Education	39 (68.4)	18 (31.6)	57 (100.0)	
Secondary	202 (77.7)	58 (22.3)	260 (100.0)	
Tertiary	44 (74.6)	15 (25.4)	59 (100.0)	
Occupation				**9.819 (0.020) ***
Student	73 (88.0)	10 (12.0)	83 (100.0)	
Employed	39 (67.2)	19 (32.8)	58 (100.0)	
Unemployed	174 (73.1)	64 (26.9)	238 (100.0)	
Others	6 (75.0)	2 (25.0)	8 (100.0)	
Religion				5.062 (0.281)
Catholic	5 (83.3)	1 (16.7)	6 (100.0)	
Muslim	101 (69.7)	44 (30.3)	145 (100.0)	
Others	137 (77.4)	40 (22.6)	177 (100.0)	
Protestants	4 (80.0)	1 (20.0)	5 (100.0)	
Traditionalist	45 (83.3)	9 (16.7)	54 (100.0)	
Marital Status				**33.27 (0.001) ***
Single	157 (89.2)	19 (10.8)	176 (100.0)	
Married/ Cohabiting	129 (63.9)	73 (36.1)	202 (100.0)	
Divorced/Separated	3 (75.0)	1 (25.0)	4 (100.0)	
Widow/Widower	3 (60.0)	2 (40.0)	5 (100.0)	
Awareness of any form of circumcision				**12.26 (0.001) ***
Yes	56 (93.3)	4 (6.7)	60 (100.0)	
No	236 (72.2)	91 (27.8)	327 (100.0)	
Awareness of female circumcision				**40.73 (0.001) ***
Yes	122 (95.3)	6 (4.7)	128 (100.0)	
No	170 (65.6)	89 (34.4)	259 (100.0)	
Awareness of VAPP Law				0.30 (0.486)
Yes	242 (75.6)	78 (24.4)	320 (100.0)	
No	50 (74.6)	17 (25.4)	67(100.0)	

*Statistically significant (p≤0.05).

Table 6 shows the factors associated with the prevalence of FGC among female youths. As shown, age ($\chi^2 = 12.97$; $p < 0.001$), occupation ($\chi^2 = 9.82$; $p < 0.020$), marital status ($\chi^2 = 32.27$; $p < 0.001$) awareness of FGC ($\chi^2 = 12.26$; $p < 0.001$), and awareness of male circumcision ($\chi^2 = 40.73$; $p < 0.001$) were significantly associated with FGC. Specifically, those who were aware were less likely to be circumcised.

Binary and multivariable logistic regression analysis of the respondents

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Table 7: Predictors of the prevalence of FGC respondents among youths in

Variable	FGM NO = 387	FGM Yes = 109	OR (95% CI)	p-value	AOR (95% CI)	p-value
Age						
15-19[R]	103 (85.1)	18 (14.9)	-	-	-	-
20-24	284 (75.7)	91 (24.3)	1.8 (1.1 – 3.2)	**<0.032**	1.3 (0.68-2.3)	0.468
Marital Status						
Single [R]	212 (85.1)	37 (14.9)	-	-	-	-
Married/ Cohabiting	169 (71.6)	67 (28.4)	2.3 (1.4-3.6)	**< 0.001**	5.2 (1.0-27.4)	**0.050***
Divorced/Separated	3 (60.0)	2 (20.0)	3.8 (0.6-23.6)	0.150	2.4 (0.49-12.6)	0.272
Widow/Widower	3 (50.0)	3 (50.0)	5.7 (1.1-29.5)	**0.037**	1.4 (0.13-15.8)	0.77
Awareness of any form of circumcision						
Yes	69 (92.0)	6 (8.0)	0. 27(0.1- 0.6)	**< 0.003**	1.4 (0.47-3.9)	0.572
No [R]	318 (75.5)	103 (24.5)	-	-	-	-
Awareness of female circumcision						
Yes	161 (98.2)	3 (1.8)	25.2(7.9-80.0)	**< 0.001**	0.35 (0.10-0.12)	**<0.001***
No [R]	226 (68.1)	106 (31.9)	-	-	-	-

R is reference categories. Table 7 shows that following the multivariate analysis, at the adjusted odds ratio, those who were married were 5.2 times more likely to have had FGC compared to those who were single (AOR=5.2, 95% CI: 1.0-27.4, p=0.050), likewise, those who were aware of female circumcision were less likely to have had FGC (AOR=0.32, 95% CI: 0.10-0.12, p=0.001).

DISCUSSION

The level of awareness of FGC among female youths in the study population was relatively low, with less than half reporting awareness. Notwithstanding global advocacy and education efforts, this low level of awareness may suggest continued gaps in reproductive health education and limited public health messages on harmful traditional practices. The prevalence rate of about a quarter among respondents indicates that FGC remains a significant issue within the community. This indicates that the practice is still perpetuated notwithstanding global and national campaigns for its eradication. This prevalence rate is consistent with the rate of 21.4% in a 2021 multi-indicator cluster survey done in the South-South region of Nigeria.[4] This discrepancy between awareness and prevalence may imply that FGC is often carried out without the individual's full awareness or understanding, particularly at a younger age when informed consent may not be feasible. It also suggests that many victims of FGC may only come to understand the practice retrospectively.

Regarding legal awareness and perception of enforcement, only about a quarter of respondents were aware of any law or policy prohibiting FGC, and an even smaller proportion, 88, 17.7%, were aware of the Violence Against Persons Prohibition (VAPP) Act. This limited awareness significantly weakens the potential deterrent effect of the law. Among those who were aware of the VAPP law, only a minority had a good (18, 20.5%) or very good (5, 5.7%) knowledge of its provisions. This suggests a gap not just in awareness but also in civic and legal mastery. In keeping with this finding, a study of 210 women in Enugu state showed a low level of awareness of VAPP Act 2015 existence and what the act says or means, only 4.8% have ever heard of VAAP Act but 90.5% of respondents welcomed the idea of pushing for the domestication of the VAAP Act in the state. [4,16]

Print ISSN: 0189-9287 Online ISSN: 2992-345X

Perception of enforcement was similarly poor. A large proportion (32.6%) remained neutral, possibly due to uncertainty or lack of exposure to any active legal enforcement, while 19.8% perceived the law as ineffective. Only 17.7% had ever heard about actual enforcement efforts. This perception of weak or absent enforcement likely contributes to the continued practice of FGC despite its being criminalised. This finding is consistent with the findings of A Nigerian study that noted Lack of effective enforcement of the existing VAPP law, lack of enforcement mechanisms, lack of monitoring mechanisms and no identified prosecutions for FGC since the enactment as reasons for continued practice of FGC. [24].

Regarding barriers to enforcement of the VAPP Law, the key barriers identified for the poor enforcement of the VAPP law were primarily lack of awareness (57%), followed by cultural resistance (42.5%), fear of social backlash (31.0%), and corruption (29.9%). These findings are consistent with broader literature [3,18] suggesting that profoundly rooted traditional norms and inadequate institutional capacity hinder the success of legal interventions in addressing gender-based violence and harmful traditional practices. Remarkably, cultural resistance and social backlash highlight the role of community norms in sustaining FGC, signifying that enforcement efforts must be coupled with culturally sensitive community engagement and education.

For factors associated with FGC, bivariate analysis revealed significant associations between FGM/C prevalence and variables such as age, marital status, awareness of any form of circumcision, and awareness of female circumcision, all with p-values ≤ 0.05. These findings suggest that these variables play an important role in the perpetuation or avoidance of FGC. Multivariate analysis further underscored the role of marital status and awareness. Married individuals were 5.2 times more likely to have undergone FGC compared to singles (aOR = 5.2, 95% CI: 1.0-27.4, p=0.050), likely reflecting historical practices where FGC is conducted as a rite of passage into womanhood or preparation for marriage. This is in tandem with a study done in Imo state, Southeast Nigeria, that reported that higher age of the women, marital status (married), were more likely to have under gone FGC. [25]

In contrast, those who were aware of female circumcision were less likely (aOR = 0.32, 95% CI: 0.10-0.12, p=0.001) to have been cut, bringing to light awareness as a protective factor. This reinforces the importance of targeted awareness programs to reduce the incidence of FGC. A study done in the Tai local government area of Rivers State, did not show any significant factor associated with the practice of FGC.[23] Another study done in Nigeria showed that the likelihood of FGC increased with age, and prevalence was highest among married women.[25] Unmarried women were more likely to report a lower prevalence of FGC. The effect of age on prevalence was noted to be highest in women aged 15-20 and declined with increasing age.[2,4,12,25] In Nigeria, 24.2% of women aged 15-49 and living in urban areas have undergone FGC compared with 15.6% living in rural areas [24]. A Nigerian study showed that 17.2% of women aged 15-49 with no formal education were more likely to have undergone FGC, prevalence was also highest among Catholic Christians and lowest among traditionalist women these findings suggested that mother's level of education and religious inclination may be linked to whether her daughters will be cut. [25] A study in Nigeria and Senegal showed that the region of residence played a role in the perpetuation or decline of the practice of FGC. Highest likelihood of practice was in women living in urban areas.[12,25]

Awareness of the VAPP law was not significantly associated with the prevalence of FGC among the study participants. However, the prevalence of FGC was lower among those who were aware of the VAPP law. This tends to suggest that awareness may have a protective effect, and it may indicate a potential benefit of raising awareness thought not a standalone solution

CONCLUSION

Despite legal frameworks, awareness of the VAPP law remains low and FGC prevalence persists, underscoring its persistence as a pressing public health challenge. This study shows that marital status and awareness are key predictors, with informed youths, women of reproductive age are more likely to resist the practice. Raising awareness therefore offers protection by empowering individuals and communities to reject harmful practice. Sustained progress requires more than legislation, it demands culturally sensitive advocacy, community education, and active involvement of

Print ISSN: 0189-9287 Online ISSN: 2992-345X

traditional leaders, supported by trained healthcare workers, educators, and law enforcement. Pilot programs tailored to specific communities could enhance both the reach and impact of the VAPP law. While self-reported data and limited geographic coverage are study limitations, as it may affect the generalizability of findings. Nonetheless, the implications are clear: stronger awareness and enforcement mechanisms can reduce the risk of FGC and protect vulnerable populations. The findings highlight the urgent need for targeted strategies to enhance VAPP law visibility and credibility. A coordinated, community-driven, and legally enforced approach is vital to finally ending FGC.

Declarations

Authors' Contribution: Conceptualization, material and methods, questionnaire design, data collection/ analysis, manuscript writing Ogbonna, V.I Conceptualization, background, manuscript writing-Opara C. Conceptualization, literature review and manuscript writing Joseph C., and Adetomi, B Discussion, manuscript writing Okongwu N.

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

Funding: Nil

Acknowledgment: The authors would like to acknowledge all the research assistants who took part in the study.

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Print ISSN: 0189-9287 Online ISSN: 2992-345X