

# **Awareness, Perception and Practice of Female Genital Mutilation among Woman of Reproductive Age in Akure South Local Government Area, Ondo State**

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**Abstract:** Female genital mutilation (FGM) also known as female genital cutting (FGC) is defined by World Health Organization as all procedure that involve partial or total removal of the external genital or other injury of the female genital organs for non-medical reason. The practice of female genital mutilation is one of most significant health and human right issue in the world. The aim of the study is to investigate the awareness, perception and practice of female genital mutilation among women of reproductive age (15-49 years). A descriptive study was conducted on women of reproductive age in Akure South Local Government Area. Cluster random sampling techniques was used in selecting the 391 respondents. Consents of respondents were sought before the administration of questionnaires. The data was analysed using the IBM SPSS Statistics version 27.0.1.0. The study showed that 77% of the respondents agreed that female genital mutilation can result in genital tear during child birth. Also 82.6% agreed female genital mutilation can cause severe bleeding while 61.4% of the respondents agreed that uncircumcised can get more infection and that female genital mutilation should be encourage on the other hand most of the respondents 81% agrees that no woman should be circumcised and that female genital mutilation can put female at risk of HIV. Whereas level of education of respondents was significantly associated with practices of female genital mutilation at  $p < .005$ , age and marital status was not. The study revealed high awareness, negative perception and low practice of female genital mutilation in the local government while all the mothers were aware of female genital mutilation. The survey also showed that most of the mothers had some understanding about the procedure but weren't fully perceive the level of anatomical damage and its negative consequences.

**Keywords:** Awareness; Perception; Practice; Female genital mutilation; Women of reproductive age.

## **1. Introduction**

Female Genital Mutilation (FGM) also referred to as Female Genital Cutting, is defined by World Health Organization (WHO, 2020, p.1) as all procedures which involves partial or total removal of the external female genitalia or other injury of the feminine genitalia organs for non-medical reasons. In a similar vein, (Amnesty International, 1997) states that female circumcision is the removal of all or part of the labia minora or cutting of the majora to create raw surface which are then held firm by a collar over the vagina when they heal. Female genital mutilation is an unhealthy traditional practice inflicted on girls and women worldwide. It is widely recognized as a desecration of human rights which is deeply ingrained in cultural beliefs and perception over decades and generations without easy task for change (Okeke et al., 2012, p.70-73). FGM constitutes an extreme form of discrimination and violation of human rights of girls and women with health consequences now acknowledged and documented (Dare et al., 2004, p.281-283; Behrendt & Moritz, 2005, p.1000-1002; Alsibiani & Rouzi, 2010, p.722-724; Morison et al., 2001, p.643-653; WHO et al., 2006, p.1835-1841).

Although the precise origin of the female genital mutilation can't be stated, there are some evidences suggesting that it originates from ancient Egypt (WHO, 1996). An Alternative explanation is that the practice was an old African rite that came to Egypt by diffusion according to (UNICEF, 2005). It is more accurate however to review female genital mutilation as being practiced by specific ethnic group, rather than by practicing female Straddle Nation Boundaries. Until the 1950s, female genital mutilation was performed in England and the United States as a common treatment for less lesbianism, masturbation, hysteria, epilepsy and other so called female deviance (Raymond, 2007) in the study in Kenya and Sierra-Leone. Data from the 2004 Sudanese survey of women 15 to 49 years old show that eighty percent (80%) of women with no education support or only fifty-five percent (55%) of those with senior secondary or higher education. It was also reported that female genital mutilation is practiced among Muslim populaces in Indonesia, and the Philippine (UNICEF, 2008). As a result of immigration and refugee movement, female genital mutilation is now being practiced by ethnic Minority population in other parts of world such as, USA, Canada, Europe, Australia and New Zealand.

More than 28 countries in Africa currently experienced FGM and some communities globally. Its constraints is felt more in countries like Nigeria, Egypt, Mali, Eritrea, Sudan, Central African Republic and Northern part of Ghana where it has been in existence for ages (Chibber et al., 2011, p.833-836; UNICEF, 2001, p.195-200). The highest prevalence is observe in Somalia and Djibouti where FGM is almost the norm (Chibber, 2011). FGM is widely practiced in Nigeria been the country with the highest number of cases of FGM worldwide and accounting for 25% of the estimated number of women circumcised worldwide. Despite the fact that the health risks associated with FGM are countless, this harmful practice has continued unabated and the burden is high in low-income countries especially Nigeria. It is thus very crucial to create awareness of the health risks to prevent the physical and psychological sexual trauma that follows the practice of female genital mutilation.

The aim of the study is to investigate the awareness, perception and practice of female genital mutilation among women of reproductive age in Akure South Local Government Area of Ondo State.

The objectives are:

1. To determine prevalence of FGM among mothers and their girl child/children in Akure South L.G.A
2. To access the notice of health implications of FGM among mothers in Akure south L.GA
3. To identify factors related to the practice of FGM in Akure south
4. To determine the association between mothers perception attitude and practice of FGM in Akure south L.G.A

## **2. Methods**

### **2.1 Research Design**

Descriptive survey design was used for this study. This is because of its ability to describe characteristics of population or phenomenon being studied. It will also assist in the retrieval of useful information from a stratified sample of the population.

## **2.2 Study Area**

Akure South is a Local Government Area in Ondo State, Nigeria. Its headquarters are in the town of Akure. It has an area of 331 km<sup>2</sup> and a population of 353,211 at the 2006 census. It comprises of three (3) local government areas which are Ifedore, Akure North and Akure South with corresponding land area coverage of 583.1, 676.7 and 318.0 km respectively. The entire Akure region is 1,577.8 km<sup>2</sup>. Each of those government Areas constitutes a sub-region that forms the Akure region in Ondo State of Nigeria.

## **2.3 Study Population**

The population for this study comprises of the potential women of reproductive age (15-49 years) which are 22% of Ondo State population who reside in Akure Community of Akure South government of Ondo State.

## **2.4 Sample Size Determination**

Given the finite population size of 423, the study will adopt to work out the proper sample size:

Sample size,  $n = u$

$$n = z^2pq/e^2$$

where

$z$  is the confidence level of 1.96,  $e$  is the desired level of precision (i.e. the margin of error, which is 0.05),  $p$  is the prevalence of FGM in previous study among women of reproductive age on awareness, perception and practice in Bayelsa State, South South Nigeria (Ibrahim et al., 2014) and  $q$  is  $1-p$ .

$$z = 1.96$$

$$p = 0.5 \text{ (50\%)}$$

$$q = 1-P$$

$$e = 0.05$$

$$n = 1.96^2 * 0.5 * (1-0.5) / 0.05^2 = 384$$

With a provision of 10% attrition, non-response or incomplete data in the study was considered. Therefore approximately 423 respondents were questioned using structured questionnaire.

## **2.5 Sampling Technique**

Cluster sampling technique was adopted for this study in which women of reproductive ages of 15-49 years were randomly drawn from Akure South local government area. The primary stage involved the representative sampling of 11 wards Aponmu, Gbogi/isinkan1, Gbogi/Isinkan 2, Ijomu/Obanla, Ilisa-Irowo, Oda, Odopetu, Oke-Aro, Oshodi/Isolo, and Owode/ Imuagum. The 2 wards in Akure South government was stratified into rural and concrete. Akure has 7 urban and 4 rural wards. At stage 1 of the choice procedures, 2 urban wards were selected and a couple of rural wards were also selected. Communities within the 4 selected wards were used and a couple of communities each were selected randomly by balloting. This 8 Communities, 4 rural and 4 urbans were selected altogether. Women of reproductive age within the selected communities were interviewed using semi-structured questionnaire.

## **2.6 Study Instrument**

A pre-tested administered questionnaire was used to collect information from the respondents on their awareness, perception and practice of female genital mutilation among women of reproductive age. The research instrument has three sections; Section A, Section B, Section C and Section D. Section A deals with the bio-data of every respondent, this section entails questions like gender, age, educational level and religion of varied women. Section B consists of questions drawn in line with research questions raised in chapter one among this research work. Section C deal with perception of female genital mutilation and Section D deals with practice of female genital mutilation. The questionnaire was also translated to Yoruba language for ease of understanding by the respondents.

## **2.7 Reliability and validity of measurements or data**

The quality of data was assured by properly designing and pre-testing of the questionnaire. The questionnaire was reviewed routinely and checked for completeness by the investigator and the necessary feedback was given to data collectors before data collection.

## **2.8 Data collection**

The data was collected through the use of a structured questionnaire. The questionnaire was administered to the respondent and was retrieved after it had been duly responded to. The data was sorted out in order to select the completely filled questionnaires. The data was analysed on International Business Machines Corporation Statistical Package for Social Sciences (IBM SPSS version 27.0.1.0), using simply percentage with frequency table.

## **2.9 Data Analysis**

The data were checked, coded and entered to IBM SPSS v.27.0.1.0 for window and MS excel to get range and percentage. Analysis was made for determination of relationship between associated factor age, religion, gender and education level. The alpha was at.005 level of significance.

## **2.10 Ethical approval**

Ethical clearance was obtained from the Research Ethics Committee, Ondo State Ministry of Health. Informed consent was also obtained from each of the respondents.

# **3. RESULTS**

Four hundred and twenty-three structured questionnaires were but three hundred and ninety-one were retrieved completely in Akure South local government area and analyzed. The following data were collected and interpreted:

## **3.1 Socio-demographic Variables of the Respondents**

This section discussed the background information of the respondents and were analysed. The variable will be analysed using frequency and percentage distribution.

### **Age, religion and employment status of the Respondents.**

The result shows that majority (58.6%) of the respondents were lower than or equal to 30 years, while the remaining respondents (41.1%) were above 30 years. Most of the respondents (69.3%) were Christians followed by the Islam religion (28.6), while the traditional religion was 2.0%.

Also, the percentage of respondents that were currently working was higher (58.3%) than the unemployed respondents (41.7%).

**Table 1: Age, religion and employment status of the Respondents**

Variable	Frequency	Percent
<b>Age group (years)</b>		
≤ 30	229	58.6
> 30	162	41.1
Total	391	100.00
<b>Religion</b>		
Christianity	271	69.3
Islam	112	28.6
Traditional	8	2.0
Total	391	100.0
<b>Currently Employed</b>		
Yes	228	58.3
No	163	41.7
Total	391	100.0

*Source: Author's Field Work, 2021*

### **Marital status, type of marriage and occupation of the Respondents**

The marital status of the respondents showed that most of the respondents (48.3%) were students, followed by the married respondents (47.3%). The type of marriage showed that monogamy has greater percentage (88.6%) than polygamy (12.0%).

Looking at the respondents based on the type of occupation they engage in, only 4.1% of the total respondents were farmers, followed by housewife (6.6%), artisan and petty traders shared the same population (14.1%). The respondents that were professionals 25.8% while the students sample were 35.3% of the total population.

**Table 2: Marital status, type of marriage and occupation of the Respondents**

<b>Variable</b>	<b>Frequency</b>	<b>Percent</b>
<b>Marital Status</b>		
Single	189	48.3
Married	185	47.3
Divorced	5	1.3
Separated	12	3.1
Total	391	100.0
<b>Type of Marriage</b>		
Monogamy	194	88.6
Polygamy	47	12.0
Total	241	61.6
<b>Types of occupation</b>		
Farming	16	4.1
Artisan	55	14.1
Petty Trading	55	14.1
Housewife	26	6.6
Professional	101	25.8
Students	138	35.3
Total	391	100.0

*Source: Author's Field Work, 2021*

### **Educational status of the Respondents**

Based on the education distribution of the respondents, only 1.5% of the respondents had no formal education. 8.4% had primary education, while 41.4% had secondary education. The table showed that tertiary education had the highest percentage of respondents (48.6%).



**Table 3: Educational Status of the Respondents**

Variable	Frequency	Percent
<b>Education Status</b>		
No Formal Education	6	1.5
Primary Education	33	8.4
Secondary Education	162	41.4
Tertiary Education	190	48.6
Total	391	100.0

*Source: Author's Field Work, 2021*

#### **Respondents level of knowledge on female genital mutilation**

Table 4 above showed that most of the respondents (79.3%) agreed that they are aware of types of Genital Mutilations, most of the respondents (77.6%) agreed that all forms of Female Genital Mutilation (FGM) harmful, most of the respondents (84.1%) agreed that possible complications in Female Genital Mutilation are Hemorrhage, Difficult labor/childbirth, Genital tears during childbirth, Infection, HIV transmission, Infertility, Scar and Keloid formation. However, most of the respondents (70.3%) disagreed that Female Genital Mutilation decrease promiscuity, while a considerable proportion of the respondents (47.6%) agreed that Female Genital Mutilation decrease sexual pleasure. Most of the respondents (74.2%) agreed that Female Genital Mutilation cause sexual dysfunction (dyspareunia, frigidity, psychosexual disorder). Nevertheless, most of the respondents (46.8%) disagreed that being circumcised makes no difference during childbirth. Most of the respondents (77.0%) agreed that Female Genital Mutilation can result to genital tears during birth, and that circumcise mother are likely to catch STI (62.9%), that Female Genital Circumcision can cause several bleeding (82.6%), while 61.4% of the respondents disagreed that uncircumcised women get more infections, and that Female Genital Circumcision should be encouraged (78.0%). On the other hand, most of the respondents (81.8%) agreed that no woman should be circumcised and that Female Genital Mutilation put female at risk of HIV transmission (80.3%).

Table 4: Respondents' Knowledge on Female Genital Mutilation

Variable	Yes (%)	No (%)	Don't Know (%)
Are you aware of any type of Genital Mutilation?	310 (79.3)	69 (17.6)	12 (3.1)
Are all forms of Female Genital Mutilation (FGM) harmful	303 (77.6)	58 (14.8)	30 (7.7)
Possible complications of Female Genital Mutilation are Hemorrhage, Difficult labor/childbirth, Genital tears during childbirth, Infection, HIV transmission, Infertility, Scar and Keloid formation	329 (84.1)	31 (7.9)	31 (7.9)
Does Female Genital Mutilation decrease promiscuity	83 (21.2)	275 (70.3)	33 (8.4)
Does Female Genital Mutilation decrease sexual pleasure	186 (47.6)	133 (34.0)	33 (8.4)
Does Female Genital Mutilation cause sexual dysfunction (dyspareunia, frigidity, psychosexual disorder)?	290 (74.2)	84 (13.8)	47 (12.0)
Being circumcised makes no difference during childbirth	164 (41.9)	183 (46.8)	44 (11.3)
Female Genital Mutilation can result to genital tears during birth	301 (77.0)	55 (14.1)	35 (9.0)
Circumcise mother are likely to catch STI	246 (62.9)	74 (18.9)	71 (18.2)
Female Genital Circumcision can cause several bleeding	323 (82.6)	47 (12.0)	21 (5.4)
Uncircumcised women get more infections	82 (21.0)	240 (61.4)	69 (17.6)
Female Genital Circumcision should be encouraged?	76 (19.4)	305 (78.0)	10 (2.6)
No woman should be circumcised	320 (81.8)	54 (13.8)	17 (4.3)
Female Genital Mutilation put female at brisk of HIV transmission?	314 (80.3)	42 (10.7)	35 (9.0)

Source: Author's Field Work, 2021

### **Respondents' perception on female genital mutilation**

The table showed that most of the respondents (78.8%) disagreed that Female Genital Mutilation makes genitalia more attractive, also most of the respondents (78.3%) disagreed that if the clitoris is not removed, the baby will die during delivery, most of the respondents (76.0%) disagreed that if the clitoris is not removed, it will grow so large like a penis, that Being circumcised makes no difference during childbirth (58.8%), while most of the respondents (70.6%) agreed that circumcised women are more likely to suffer from urinary incontinence. However, most of the respondents (79.0%) disagreed that Female Genital Mutilation makes genitalia more attractive. that the removal of the clitoris connotes cleanliness (65.5%). Also that Female Genital Circumcision is necessary (80.6%), that, if the clitoris is not removed, a woman cannot please a man sexually (63.2%).

Most of the respondents (38.6%) agreed that an uncircumcised woman is happier, although 31.7% of the same population claimed ignorance of the effect while 29.7% of the same population claimed negative. Most of the respondents (77.5%) claimed that one is not a proper woman until you are circumcised, while 78.0% of the respondents claimed that Female Genital Circumcision improves fertility, while 75.2% of the same population claimed that Female Genital Circumcision is not dangerous.

Table 5: Respondents' perception on Female Genital Mutilation

<b>Variable</b>	<b>Yes (%)</b>	<b>No (%)</b>	<b>Don't Know (%)</b>
Female Genital Mutilation makes genitalia more attractive	53 (13.6)	308 (78.8)	30 (7.7)
If the clitoris is not removed, the baby will die during delivery	40 (10.2)	306 (78.3)	45 (11.5)
If the clitoris is not removed, it will grow so large like a penis	42 (10.7)	297 (76.0)	52 (13.3)
Being circumcised makes no difference during childbirth?	104 (26.6)	230 (58.8)	57 (14.3)
Circumcised women are more likely to suffer	276 (70.6)	67 (17.1)	48 (12.3)

from urinary incontinence

The removal of the clitoris connotes cleanliness	80 (20.5)	256 (65.5)	55 (13.6)
Female Genital Circumcision is necessary	57 (14.6)	315 (80.6)	19 (4.6)
If the clitoris is not removed, a woman cannot [please a man sexually?	79 (20.2)	247 (63.2)	65 (16.6)
An uncircumcised woman is happier?	151 (38.6)	116 (29.7)	124 (31.7)
One is not a proper woman until you are circumcised?	60 (15.3)	303 (77.5)	28 (7.2)
Female Genital Circumcision improves fertility?	48 (12.3)	305 (78.0)	38 (9.7)
Female Genital Circumcision is not dangerous	73 (18.7)	294 (75.2)	24 (6.1)

*Source: Author's Field Work, 2021*

### **Response of the respondents on the practice of female genital mutilation**

Table 6 presents the respondents on Female Genital Mutilation among women of Reproductive Age. The table showed that most of the respondents (82.4%) disagreed that Female Genital Mutilation a good practice, also most of the respondents (79.8%) disagreed on whether that respondents will encourage Female Genital Mutilation. However, most of the respondents (74.4%) agreed that Female Genital Mutilation should be legislated against, while over 50% of the total respondents claimed not to have been circumcised. On whether the respondent routinely perform Female Genital Mutilation in their community, most of the respondents (52.2%) disagreed on the assertion. And that most of the respondents (70.3%) disagreed that circumcised their female children. On whether the respondents would circumcise their daughter or have intension of doing it in later, most of the respondents answered in the negative. On the reasons for engaging in circumcision, most of the respondents (58.8%) claimed to decrease sexual promiscus, to increase sexual pleasure (61.1%). However, majority (70.8%) disagreed that infants of uncircumcised mothers are most likely to die than those of circumcised mother. While, most of the respondents (41.2%) agreed that circumcised women are less likely to catch sexual transmitted infection.

Table 6 Response on Female Genital Mutilation among women of Reproductive Age

Variable	Yes (%)	No (%)	Don't Know (%)
Is Female Genital Mutilation a good practice?	54 (13.8)	322 (82.4)	15 (3.8)
Will you encourage Female Genital Mutilation?	62 (15.9)	312 (79.8)	17 (4.3)
Should Female Genital Mutilation be legislated against	291 (74.4)	79 (20.2)	21 (5.4)
Are you circumcised?	122 (31.2)	197 (50.4)	72 (18.4)
Do you routinely perform Female Genital Mutilation in your community?	66 (16.9)	204 (52.2)	121 (30.9)
Do you have a female child? If yes, do you circumcised her?	79 (20.2)	275 (70.3)	37 (9.5)
Will you have your daughter circumcised if no?	51 (13.0)	320 (81.8)	20 (5.1)
Do you have intension of doing it for her later?			
If you have female child in the future will you perform Female Genital Mutilation on her?	53 (13.6)	317 (81.1)	21 (5.4)
What are your reason for perform Female Genital Mutilation?	70 (17.9)	207 (52.9)	114 (29.2)
What are your reasons for performing Female Genital Mutilation financial gain?	30 (7.7)	276 (70.6)	85 (21.7)
To decrease sexual promiscus?	95 (24.3)	230 (58.8)	66 (16.9)
To increase sexual pleasure?	80 (20.5)	239 (61.1)	72 (18.4)
Infants of uncircumcised mothers are most likely to die than those of circumcised mother?	44 (11.3)	277 (70.8)	70 (17.9)
Circumcised women are less likely to catch sexual transmitted infection?	181 (46.3)	161 (41.2)	49 (12.5)

*Source: Author's Field Work, 2021*

### Hypotheses Testing

The socio-demographic variables of the respondents would be examined on the female genital mutilation. The section would be analysed using chi-square distribution which is a non-

parametric test which is used to determine whether there would be an association between each of the socio-demographic variable and the practice of female genital mutilation.

### Chi-square distribution on respondents' demographic profile, knowledge and practices of FGM.

The null hypothesis states that there is no association between respondent demographic profile and practices of FGM.

Decision rule: If probability value (p-value)  $< \alpha$ , where  $\alpha$  is the level of significance and it is considered at 5% level of significance, reject the null hypothesis, otherwise, do not reject.

Table 7: Chi-square table showing the association between respondent demographic profile and practices of FGM in Akure South

Practice of Female Genital Mutilation						
Variables	Yes	No	$\chi^2$	Df	p	Remark
Age group (years)						
≤ 30	64 (27.9)	165 (72.1)	2.727	1	.099	Not Significant
> 30	58 (35.8)	104 (64.2)				
Marital Status						
Single	54 (28.6)	135 (71.4 )	3.147	1	.362	Not Significant
Married	61 (33.0)	124 (67.0)				
Divorced	1 (20.0)	4 (80.0)				
Separated	6 (50.0)	6 (50.0)				
Religion						
Christianity	84 (31.0)	187 (69.0)	158	2	.926	Not Significant
Islam	35 (31.3)	77 (68.8)				
Traditional	3 (37.5)	5 (25.0)				
Currently Working						
Yes	29 (12.7)	199 (87.3)	326	1	.588	Not Significant
No	24 (14.7)	139 (85.3)				

Type of Occupation						
Farming	5 (31.3)	11 (68.8)	4.588	5	.471	Not Significant
Artisan	21 (38.2)	34 (61.8)				
Petty Trading	14 (25.5)	41 (74.5)				
Housewife	7 (26.9)	19 (73.1)				
Professional	37 (36.6)	64 (63.4)				
NA	38 (27.5)	100 (72.5)				
Type of Marriage						
Monogamy	71 (36.6)	123 (63.4)	.362	1	.548	Not Significant
Polygamy	15 (31.9)	32 (68.1)				
Education Status						
No Formal Education	11 (16.7)	5 (83.3)	3.517	3	.319	Not Significant
Primary Education	4 (12.1)	29 (87.9)				
Secondary Education	28 (17.3)	134 (82.7)				
Tertiary Education	20 (10.5)	170 (89.5)				
Location						
Rural	59 (45.0)	72 (55.0)	17.589	1	.000	Significant
Urban	63 (24.2)	197 (75.8)				
Knowledge Category						
Good Knowledge	78 (31.2)	172 (68.8)	13.377	1	.000	Significant
Poor Knowledge	44 (31.2)	97 (68.8)				
Perception Groups						
Good	47 (23.4)	154 (76.6)	11.780	1	.001	Significant

Knowledge						
Poor Knowledge	75 (39.5)	115 (60.5)				

Source: Author's Field Work, 2021

From the table able, the inferential statistics showed that age of the respondents does not have significant association with whether the respondents are circumcised or not ( $\chi^2=2.729$ ,  $p < .099$ ). In addition, marital status does not have significant association with whether the respondents have circumcised or not ( $\chi^2 = 3.147$ ,  $p < .362$ ). There is also no significant association between religion with whether the respondents are circumcised or not ( $\chi^2 = .158$ ,  $p < .926$ ). Furthermore, there is no significant association between currently working and state of circumcision ( $\chi^2 = .326$ ,  $p < .588$ ). Also, there is no significant association between type of occupation and state of circumcision ( $\chi^2 = 4.588$ ,  $p < .471$ ). We also have no significant association between type of marriage and state of circumcision ( $\chi^2 = .362$ ,  $p < .548$ ) while there is also no significant association between education status and state of circumcision ( $\chi^2 = 3.517$ ,  $p < .319$ ). However, there is significant association between location and state of circumcision ( $\chi^2 = 17.589$ ,  $p < .000$ ). The table also showed that there is significant association between the respondent level of education and practice of FGM in Akure South LGA ( $\chi^2 = 29.410$ ,  $p < .000$ ). There is also significant association between the respondent level of education and practice of FGM in Akure South LGA ( $\chi^2=13.835$ ,  $p < .008$ )

### **Chi-square distribution on respondents' demographic profile and practices of FGM by mothers on their daughters**

The null hypothesis states that there is no association between respondent demographic profile and practices of FGM by mothers on their daughters.

Decision rule: If probability value (p-value)  $< \alpha$ , where  $\alpha$  is the level of significance and it is considered at 5% level of significance, reject the null hypothesis, otherwise, do not reject.



Table 8: Chi-square table showing the association between respondent demographic profile and practices of FGM on their daughters in Akure South

Practice of Female Genital Mutilation on their Daughter						
Variables	Yes	No	$\chi^2$	Df	p	Remark
Age group (years)						
≤ 30	28 (12.2)	201 (87.8)	3.147	1	.369	Not Significant
> 30	25 (35.8)	137 (84.6)				
Marital Status						
Single	24 (12.7)	165 (87.3 )	17.569	1	.000	Significant
Married	26 (14.1)	159 (85.9)				
Divorced	0 (0.0)	5 (100.0)				
Separated	3 (25.0)	9 (75.0)				
Religion						
Christianity	40 (14.8)	231 (85.2)	2.563	2	.278	Not Significant
Islam	11 (9.8)	101 (90.2)				
Traditional	2 (25.0)	6 (75.0)				
Currently Working						
Yes	29 (12.7)	199 (87.3)	326	1	.588	Not Significant
No	24 (14.7)	139 (85.3)				
Type of Occupation						
Farming	5 (31.3)	11 (68.8)	4.588	5	.471	Not Significant
Artisan	21 (38.2)	34 (61.8)				
Petty Trading	14 (25.5)	41 (74.5)				
Housewife	7 (26.9)	19 (73.1)				
Professional	37 (36.6)	64 (63.4)				
NA	38 (27.5)	100 (72.5)				
Type of Marriage						
Monogamy	28 (14.4)	166 (85.6)	.362	1	.548	Not Significant
Polygamy	5 (10.6)	42 (89.4)				

Education Status						
No Formal Education	11 (16.7)	5 (83.3)	3.517	3	.319	Not Significant
Primary Education	4 (12.1)	29 (87.9)				
Secondary Education	28 (17.3)	134 (82.7)				
Tertiary Education	20 (10.5)	170 (89.5)				
Location						
Rural	31 (23.7)	100 (76.3)	13.337	1	.000	Significant
Urban	22 (8.5)	238 (91.5)				
Knowledge Category						
Good Knowledge	22 (8.8)	228 (91.2)	13.377	1	.000	Significant
Poor Knowledge	31 (22.0)	110 (78.0)				
Perception Groups						
Good Knowledge	17 (8.5)	184 (91.5)	9.172	1	.002	Significant
Poor Knowledge	36 (18.9)	154 (81.1)				

*Source: Author's Field Work, 2021*

Findings from table above, the inferential statistics showed that age of the respondents does not have significant association with whether the respondents will circumcise their female child or not ( $\chi^2=3.147$ ,  $p < .369$ ). However, there is a significant association between marital status and whether the respondents will circumcise their female child or not ( $\chi^2=17.569$ ,  $p < .362$ ). The table also showed no significance association between religion with whether the respondents are circumcised or not ( $\chi^2=2.563$ ,  $p < .278$ ). However, there is significant association between location and whether the respondents will circumcise their female child or not ( $\chi^2=13.337$ ,  $p < .000$ ). The analyses in the table able also showed that there is significant association between the

respondent knowledge and whether the respondents will circumcise their female child or not ( $\chi^2 = 13.337$ ,  $p < .000$ ). Finally, there is also a significant association between the respondent perception and whether the respondents will circumcise their female child or not ( $\chi^2 = 9.172$ ,  $p < .002$ ).

## **4. Discussion, Conclusion and Recommendations**

### **4.1 Discussion**

This study assesses the awareness of health implications and the prevalence of Female Genital Mutilation among mothers and their girl child/children in Akure South local government area of Ondo state. In addition, it also identified factors associated with the practice of FGM and determined the association between mother's perception, attitude and practice of FGM with the view to proffering relevant solution. Findings from the study showed that most of the respondents were aware of the many types of Female Genital Mutilations and most of them also agreed that all forms of Female Genital Mutilation (FGM) are harmful, and that possible complications as a result of it are hemorrhage, difficult labor/childbirth, genital tears during childbirth, infection, HIV transmission, infertility, scar and keloid formation. This agreed with the study of Obijiofor et al. (2020, p.145-160). However, most of the respondents disagreed that Female Genital Mutilation decrease promiscuity, while most of them agreed that Female Genital Mutilation decrease sexual pleasure. Most of the respondents agreed that Female Genital Mutilation cause sexual dysfunction (dyspareunia, frigidity, psychosexual disorder). Nevertheless, most of the respondents disagreed that being circumcised makes no difference during childbirth, while most of the respondents agreed that Female Genital Mutilation can result to genital tears during birth, and that circumcised mother are likely to catch Sexually Transmitted Infection (STI), that Female Genital Circumcision can cause several bleeding, while most of the respondents disagreed that uncircumcised women get more infections, and that Female Genital Circumcision should be encouraged. On the other hand, most of the respondents agreed that no woman should be circumcised and that Female Genital Mutilation put female at risk of HIV transmission. This report aligned with the study conducted by Ibrahim et al. (2013) during which all the respondents were conscious of Female Genital Circumcision and displayed an appreciable knowledge of the practice as evident from their responses. This universal knowledge is

comparable to that found in similar studies conducted by Onuh et al. (2006) and Adekanle et al. (2011). Female Genital Mutilation is still a major public health challenge and even though it may no longer be a topical issue in some states, majority of the respondents were old enough to have remembered the campaigns that led to a decline in the practice and culminated in the ban of the practice in some states in Nigeria including Ondo state (United States Department of State Nigeria, 2012). Also in a study conducted by Dattijo et al. (2010), 94.6 percent of the respondents were aware of FGM. He noted that while awareness of the practice was high, identifying the types of FGM was low. Clitoridectomy was known by only 33.2% with majority 66% not aware of the types of FGM. This finding was observed in a study in Kano State Nigeria and also the NDHS where Clitoridectomy was the foremost sort of circumcision reported. There were wide differences in awareness of the types among the various ethnic groups. The study also showed that the perception on Female Genital Mutilation was positive. However, the study showed that most of the respondents disagreed that Female Genital Mutilation makes genitalia more attractive, and that if the clitoris is not removed, the baby will die during delivery. Also, most of the respondents disagreed that if the clitoris is not removed, it will grow so large like a penis and that being circumcised makes no difference during childbirth, that Female Genital Mutilation makes genitalia more attractive, that the removal of the clitoris connotes cleanliness. Also that Female Genital Circumcision is necessary, that, if the clitoris is not removed, a woman cannot please a man sexually, while most of the respondents agreed that circumcised women are more likely to suffer from enuresis. Most of the respondents agreed that an uncircumcised woman is happier while 29.7% of the same population claimed negative. Most of the respondents claimed that one is not a proper woman until you are circumcised, while 78.0% of the respondents claimed that Female Genital Circumcision improves fertility, and 75.2% of the same population claimed that Female Genital Circumcision is not dangerous. The result of this study is in consonance with the report of study conducted by Ojeleye et al. (2017) where it was identified that about one-third of the respondents believed that Female Genital Circumcision helps to conserve virginity and promotes cleanliness; while only a few perceived it as a religious obligation. This was in contrast with the findings of Ahanonu and Victor (2014) in which majority of the mothers disagreed that, FGC promotes a woman's faithfulness to her husband and also disagreed that

FGC is beneficial for the female. Although expected, the belief pattern expressed by mothers in the study have been declared by WHO to be a social convention which is connected to different concrete sociocultural perceptions, most of which are linked to local perceptions of gender, sexuality and religion (World Health Organization, 2011). The study showed that some others people use FGM as a means of controlling and desexualizing desire by reducing the women and repressing sexual desire (WHO, n.d). This is with the aim of reducing the chance of sexual promiscuity in marriage on the part of the women. In the opinion of Idowu (2008), the practice is carried out as a means of purification and assuring that a woman is clean. The study further showed that most of them disagreed that Female Genital Mutilation is a good practice, and that they cannot and will not encourage Female Genital Mutilation. Furthermore, most of the respondents agreed that Female Genital Mutilation should be legislated against. Findings from the study also showed that over 50% of the total respondents claimed not to have been circumcised. While, most of the respondents disagreed on whether they routinely perform Female Genital Mutilation in their community, and disagreed on circumcising their female children. On whether the respondents will circumcise their daughter or have intension of doing it in later, most of the respondents answered in the negative. On the reasons for engaging in circumcision, most of the respondents claimed to decrease sexual promiscus, to increase sexual pleasure. However, majority disagreed that infants of uncircumcised mothers are most likely to die than those of circumcised mother. While, most of the respondents agreed that circumcised women are less likely to catch sexual transmitted infection. The result of this study contradict the study conducted by Ojeleye et al. (2017) who claimed that over 63% of the women sampled had undergone FGC at one time or the other, but none said the procedure was carried out with her permission. Another 17.0% claimed to not know whether or not that they had FGC; while only but one-fifth (19.8%) claimed to not have undergone FGC. These figures yet exceeds those documented in NDHS in 2013 of the percentage of women circumcised with respect to age, tribe, level of education and religion (National Population Commission ICF International, 2013). On the reasons for practicing FGC, 56.7% of the mothers sampled would circumcise their daughters due to their mother or mother-in-law's insistence; another 20% would do so because it is a cultural heritage that should be promoted. This was corroborated by another study which also found that, tradition/culture

was the most typical reason for FGC among mothers of female infants (Garba et al., 2012). Only one mother affirmed that, she would circumcise her daughter thanks to the husband's insistence. This result depicted a robust indication of the consequences of the combination of interlinked sociocultural factors which evidently influenced the practice of FGC among these women within the study setting. This social convention is connected to different concrete sociocultural perceptions, most of which are linked to local perceptions of gender, sexuality and religion (World Health Organization, 2011). Gebremariam et al. (2016) highlighted various factors determining FGC which include Religion, residence, respondents' educational level, maternal education, attitude, and belief in religious requirement were the foremost important predictors of FGC. Ashimi et al. (2015) study on predictors of female genital mutilation among infants in a semi urban community in northern Nigeria also showed that, maternal occupation, education and religion and type of facility accessed were significantly related to occurrence of FGM in infants. Study of mothers and daughters in Southern Iran by Dehghankhalili (2015). Ancient traditions in the area (57.1%) were mentioned as the most important factor leading to FGC. Religious belief seems to be a consistent and an important variable predicting this practice as seen in various studies (Biglu et al., 2016). Furthermore, the study also showed that there is no significant association between age of the respondents and practice of Female Genital Mutilation and that marital status does not have significant association with practice of Female Genital Mutilation. However, the study showed significance association between religions with practice of Female Genital Mutilation. In addition, the study showed that there is no significant association between the currently working and practice of Female Genital Mutilation and no significant association between type of occupation and practice of Female Genital Mutilation. There is also no significant association between type of marriage and practice of Female Genital Mutilation. However, there is significant association between location and practice of Female Genital Mutilation. This report is in agreement with the report of study conducted by Dattijo et al. (2010) who identified that majority of the women that engage in FGM are young women with about 75.4% of them at least 30 years and below. This is similar to population studied in Kano and that of National Demographic Health Survey (NDHS) but different to the population studied in Lagos where over 60% of them were above 30 years Christians constituted 58% of the respondents while the rest were

Muslims. Also in the study, about 89% had at least secondary education or higher. The high level of education may be due to selection bias associated with seeking tertiary health care. In contrast, the parental education status revealed over 72% of them had none or primary education only. This further lends credence to the different perception of the practice among the ethnic groups that were captured in the study. Further subgroup analysis revealed that ethnic group strongly influenced the attitude of the respondents.

Ashimi et al. (2015) in his study, after controlling for confounders, having a mother without formal education were six (6) times more likely to circumcise their female infants than those with formal education. In a study to examining the determinants of mothers' intentions to allow their daughters to undergo Female Genital Mutilation among women in Ravansar, Kermanshah Province in Iran, Pashaei et al. (2016) noted that, less educated mothers and mothers living in rural areas were more inclined toward FGM and experience intense social pressure for FGM to take place. Tamire and Molla (2013) Southern Ethiopia School girls' study shows that, girls whose fathers and mothers had educational status under high school level were 2 times more likely to have FGC when compared to those whose parents had attended high school and above.

The study further showed that there is significant association between the respondent's religion and practice of FGM in Akure South LGA. This result deviate from the study conducted by Dattijo et al. (2010) where they noted that religion of the respondents has no association with the practice in their study ( $p=0.254$ ). In addition, there is significant association between the respondent level of education and practice of FGM in Akure South LGA ( $\chi^2=13.835$ ,  $p < .008$ ). This is in accord with the study conducted by Dattijo et al. (2010). The study claimed that while educated mothers are less likely to have the intention to circumcise their daughters ( $p<0.001$ ), the influence of culture may. Another study by Ahanonu and Victor (2014) affirmed that mothers with a tertiary education were least likely to agree that an uncircumcised female will be promiscuous (25.9%), compared with about half of the mothers with a secondary education or less ( $P<0.003$ ). This present study showed that the practice of FGM declined with academic advancement of the respondents. Contrary to the findings, it is worth noting that, Kandala et al. (2009) posited that modernization (education and high socioeconomic status) had minimal impact on the likelihood of FGM, but education plays an important role in the mother's decision not to circumcise her daughter. This study found a significant association in the mother's level of



education and the practice of FGM in the local government ( $P=0.03$ ), which implies that mothers' practice of FGM is influenced by their level of education. This was substantiated in a study which supports that education plays an important role in the eradication of FGM as it broadens one's outlook and increases one's ability to understand more complex information, and question attitudes, beliefs and practices (Dike et al., 2012).

## **4.2 Conclusion**

From the findings from the study, it is concluded that there is high awareness, negative perception and low practice of female genital mutilation in the local government. All the mothers were aware of female genital mutilation showing that practice is still ongoing in some quarters. The findings on perception showed that many of the mothers had some understanding about the procedure but they did not fully perceive the extent of anatomical damage and its negative consequences. Many of the respondents experienced female genital mutilation, a few carried it out on their children and some still intend to practice it.

The study has shown that the practice of FGM is however still taking place in the Local Government Area of Ondo State mainly due to the influence of the significant others especially, their mothers or mothers-in-law's insistence. Many women in the LGA are also living with the horrible effects of Female genital cutting. There is therefore, the need to intensify and consolidate educative and advocacy efforts in order to ensure that the practice is completely eradicated so as to promote the reproductive health of women.

## **4.3 Recommendations**

The findings of the study have revealed that all the factors investigated are important in the efforts to completely eradicate FGM and the following recommendations were made:

- There is need for more public campaigns and enlightenment on the harmful effects of FGM in order for the practice to be totally eradicated.
- There is a need for male involvement in FGM eradication strategies, as men also influence the mothers' decision to, or not to, circumcise their girl-child.
- Integration of efforts with the practitioners of FGM to facilitate its abolishment is imperative, including the deterrence of medicalization of FGM.



- Establishment of a policy and law banning the practice of FGM in Nigeria may also facilitate its eradication.
- Encouraging and facilitating early girl-child education and female empowerment would go a long way in enhancing mothers' decision-making ability regarding their health and that of their children, including their female children.
- FGM eradication strategies should be targeted not only at the mothers but also at those with a huge influence on the mothers' decision to, or not to, circumcise their girl-child; especially the elderly women.

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