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# Mitigating the Prevalence of Female Genital Mutilation and Cutting (FGM/C) in Ekiti State as a Panacea for Eradicating the Practice for Sustainable National Development in Nigeria

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**ABSTRACT**

**This study sources for the prevalence of FGM/C practices in Ekiti State Nigeria in an effort to know the "why", and "how" the practice can be reduce if not eliminated in our society. The population of the study comprised all child bearing adult women in all the sixteen Local Government Area of the State. Five Local Government Area Councils were randomly selected and 240 adult women were purposively selected from the five Local Government Area Councils at equal representation. Questionnaire named Female Genital Mutilation and Cutting Prevalence Questionnaire (FGMCPQ) developed by the researcher were used to collect data from the respondents. Frequency counts, percentage mean were used to answer research questions and Chi-square used to analyze the hypotheses formulated. The findings showed significantly the prevalence of FGM/C in all the Local Government Area Council covered. There are no significant differences on the prevalence across social and educational background. Cultural beliefs were significantly responsible for such practices with little or no religious undertone. But the practices showed significance practice in the rural area than the urban settlement. Many parents believes the practice reduce sexual urge among sexually active women and as a result recommends its practice. The study also showed that FGM/C can induce sexually transmitted infections, pelvic inflammatory diseases as well as recurring urinary tract infection. The study showed that FGM/C is often performed by a nonmedical practitioner with the aim of fulfilling cultural rites and most times for economic benefits. It was therefore recommends that thorough sensitization exercise should be carried out in both urban and rural area against FGM/C practices as regards to its health impact on girl child and in order to protect the female right in the society as well as enhancing national economic growth and development. Relevant laws should be enacted to punish erring individual families that engage in FGM/C practices in the society. More importantly, the circumcisers should ne provided by alternative source of income for their living.**

**Keywords:** Ekiti State, complications, Female Genital Mutilation/Cutting (FGM/C), nonmedical and medical practitioners, religious, cultural, economic benefits, prevention

## INTRODUCTION

Female Genital Mutilation/Cutting (FGM/C), is a traditional practice that involves imposing incisions or excisions on and of the female external genitalia for sociocultural as opposed to medical reasons. FGM/C also known as Female Circumcision (FC) is an abuse and a violation of a girl's child and woman. It has becomes a common practice virtually in every community worldwide and most common in rural setting across globe but with little or no attention given

to its practice and stoppage. World Health Organization (WHO) (2016) described FGM/C as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It occurs in many forms in all societies. It involves imposed cuts or removals of the female external genitalia for sociocultural as opposed to right of the girl child or woman and medical reasons. Ayodeji (2017) refers to FGN/C as a practice in which the external female genitalia is partially or totally incised or excised for a non-therapeutic reason, usually without the consent of the individual.

According to Akinsulure-Smith AM, Chu T. (2017), the exact origin of FGM/C is not well-known but documented reports by Greek historians and geographers trace the origin to Herodotus (425–484 B.C.) and Strabo (64 B.C.–23 A.D.) FGM/C occurred in Ancient Egypt along the Nile Valley at the time of the Pharaohs and thus Egypt is often considered as the source country. The act of FGM/C was also reported long time ago among other nations of the world including the Romans where it was done in order to prevent their female slaves from getting pregnant. The practice of FGM/C in Africa is one that has persisted due to strong sociocultural influences which ensure that it is secretly done and underreported particularly since the last two centuries. Curiously, it is one practice that is embraced by practitioners of all the major faiths prevalent on the continent—Christianity, Islam and traditional worship (Akin-Tunde A. Odukogbe *et al* 2016)

It is estimated that about 200 million in 2016 practiced FGM/C and it has been associated with wide ranging medical, economic, sociocultural and women rights consequences and is presently receiving global, multifaceted attention to eradicate the practice albeit with slow progress over the years (Akin-Tunde A. Odukogbe *et al* 2016; WHO, 2016). Ellen Gruenbaum (2001) opined that FGM/C practices mostly depend on cultures, traditions, customs and religion. Okeke et al. (2012) opined that four main types of FGM/C are recognized. They include:
**Type 1- Clitoridectomy:** This involves the removal of the hood of the clitoris or part of the clitoris.
**Type 2- Excision:** The removal of the clitoris with partial or total excision of the labia minora.
**Type 3 – Infibulation:** Removal of the clitoris, labia minora and the adjacent side of labia majora as well as stitching of the vaginal opening leaving an opening the size of a pinhead to allow flow of urine and menstrual blood.
**Type 4- Unclassified forms:** Other unclassified forms of FGM/C may involve pricking, stretching, cauterization, or inserting herbs into the vagina.

Other form not fully recognized is hymenectomy which is cutting of the vagina and introduction of corrosive substances or herbs into the vagina to cause bleeding or to tighten or narrow the vagina.

Okeke *et al* (2012) opined that in Nigeria, of the six largest ethnic groups, the Yoruba, Hausa, Fulani, Ibo, Ijaw, and Kanuri, only the Fulani do not practice any form. In most parts of Nigeria, it is carried out at a very young age (minors) and there is no possibility of the individual's consent (UNICEF 2001) Type I and Type II are more widespread and less harmful compared to Type III and Type IV. In Nigeria, there is greater prevalence of Type I excision in the south, with extreme forms of FGM/C prevalent in the North. Practice of FGM/C has no relationship with religion. Muslims and Christians practice it, but it is more widely spread in Christian predominated parts of Nigeria (Siddhanta, Ankita 2018)

FGM/C is performed at varying age groups, from the first week of life, during infancy, before puberty, before the first childbirth and other periods in the woman's life dependent on the location and major reason underlying the practice. It is usually performed individually but can be done in groups of girls or women. According to the studies done by the United Nations' Children Fund (2016), the prevalence rate of FGM/C in Africa is as in table 1.

**Table 1: Prevalence rates of female genital mutilation/cutting (FGM/C) in Africa by country and age periods**

| Country | Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, 2004–2015 | Percentage of girls aged 0 to 14 years who have undergone FGM/C, 2010–2015 |
|---|---|---|
| Benin | 9 | 0.2 |
| Burkina Faso | 76 | 13.0 |
| Cameroon | 1 | – |
| C A R | 24 | 1.0 |
| Chad | 44 | – |
| Cóte d'Ivoire | 38 | 10.0 |
| Djibouti | 93 | – |
| Egypt | 87 | 14.0 |
| Eritrea | 83 | 33.0 |
| Ethiopia | 74 | 24.0 |
| Gambia | 75 | 56.0 |
| Ghana | 4 | 1.0 |
| Guinea | 97 | 46.0 |
| Guinea-Bissau | 45 | 30.0 |
| Kenya | 21 | 3.0 |
| Liberia | 50 | – |
| Mali | 89 | – |
| Mauritania | 69 | 54.0 |
| Niger | 2 | – |
| Nigeria | 25 | 17.0 |
| Senegal | 25 | 13.0 |
| Sierra Leone | 90 | 13.0 |
| Somalia | 98 | – |
| Sudan | 87 | 32.0 |
| United Republic of Tanzania | 15 | – |
| Togo | 5 | 0.3 |
| Uganda | 1 | 1.0 |

**Adapted from UNICEF, 2016**

Similar studies conducted by United Nations' Children Fund (2016) reveal the prevalence of FGM/C. for the states in Nigeria as given in table 2.

**Table 2: Prevalence and types of female genital mutilation/cutting (FGM/C) in the various states of Nigeria**

| Geopolitical zone | State | 2009 (15) | | 2013 (16) |
|---|---|---|---|---|
| | | Prevalence (%) | Types of FGM | Prevalence (%) of women aged 15–49 years |
| South West | Oyo | 60–70 | I | 47.5 |
| | Ogun | 35–45 | I, II | |
| | Lagos | 20–30 | I | |
| | Ondo | 90–98 | II | |
| | Osun | 80–90 | I | |
| North Central | Kogi | 1 | IV | 9.9 |
| | Niger | – | – | |
| | Benue | 90–100 | II | |
| | Kwara | 60–70 | I, II | |
| | Plateau | 30–90 | I, IV | |
| | Nassarawa | – | – | |
| | Federal Capital Territory | – | – | |
| North West | Kaduna | 50–70 | IV | 20.7 |
| | Kebbi | 90–100 | IV | |
| | Zamfara | – | – | |
| | Sokoto | – | – | |
| | Kano | – | – | |
| | Jigawa | 60–70 | IV | |
| | Katsina | – | – | |
| North East | Taraba | – | – | 2.9 |
| | Borno | 10–90 | I, III, IV | |
| | Bauchi | 50–60 | IV | |
| | Adamawa | 60–70 | IV | |
| | Gombe | – | – | |
| | Yobe | 0–1 | IV | |
| South East | Ebonyi | – | – | 49.0 |
| | Enugu | – | – | |
| | Imo | 40–50 | II | |
| | Abia | – | – | |
| | Anambra | 40–60 | II | |
| South South | Akwa-Ibom | 65–75 | II | 25.8 |
| | Bayelsa | – | – | |
| | Edo | 30–40 | II | |
| | Cross River | – | – | |
| | Rivers | 60–70 | I, II | |
| | Delta | 80–90 | II | |

**ADAPTED FROM UNICEF, 2016**

Ekiti State located the South West Zone of Nigeria was not captured by the report hence the need for this study.

Even though a major reason for Female Circumcision (FC) according to Balogun O. O, Hirayama F, Wariki WM, et al (2013) is control of female sexuality. Researchers in Nigeria observed no association between FC and outcomes for sexual behaviour and concluded that sexual chastity is insufficient to justify the practice (Balogun O. et al 2013; Momoh C 2005). Numerous reasons have been adduced for the sustenance of the practice spanning through tradition, religion, social, politics and economic. One of the cultural and religious reasons for justifying the practice of FGM/C is in the reduction of promiscuity and ensuring virginity before marriage (Teixeira AL, Lisboa M. 2016). Berg RC*, et al* (2010) opined that while attempting to achieve its presumed benefit through reduction in sexual drive and desire it has a negative impact on the overall woman's sexual life. FGM/C deprives women of sexual satisfaction and denies them of their right to sexual health and pleasure to achieve full psychophysical well-being. On the economic angle, it serves as an income earner for the practitioners. In some societies, it is used as a kind of social stratification mechanism with those who have been circumcised perceived to be at a higher status than others and is a prerequisite for the right to inheritance (Mpofu S, et al 2016). Still others perform the procedures for anatomic/aesthetic judgements, prevention of child mortality or for hygiene reasons. However, evidence has not supported any medical benefits.

According to Okeke et al. (2012), Nigeria previously recorded the highest absolute number of cases of FGM in the world amounting for about one quarter of the estimated 115-130 million circumcised women in the world. The practice which is founded on traditional beliefs and societal pressure to conform has drawn considerable criticism because of the potential for both short and long term complications, its risk of sexually transmission infections (STIs) thereby affecting the reproductive health and infringement on women's right (Anzaku AA, Angbalaga AG, Achetu AC, et al. 2018).

The effect of FGM/C cannot be overemphasized. The danger of unsterilized sharpened kitchen knives, scissors, glass, sharpened rocks and finger nails used in the act is enormous; the unhygienic procedures are common among the traditional circumcisers with the report of repeated use of a single instrument in up to 30 girls (Momoh C 2005). The absence of antiseptic techniques and non-use of anesthetic agents, the procedures are associated with several complications. These complications may occur during or immediately after the operations, while others manifest in the medium and long-term to cause poor quality of life for the patient or result in mortality or both (UNFPA, 2016).

According to (Teixeira AL, Lisboa M. 2016) all these complications results in urinary tract infection, pelvic inflammatory disease, chronic pelvic pain, infertility, ectopic pregnancy, tetanus infection, infections with hepatitis and human immunodeficiency viruses and abscess formation. In some local communities in Nigeria, it is customary to compensate the circumcisers with gifts and share the food and meat sacrificed during the circumcision feasts with them. This is one of the reasons why its eradication has met with a lot of obstacles since it is a source of income for the circumcisers with rather high fees in countries where it is illegal. Possible loss of life due to complications of FGM/C related to obstetric haemorrhage is another great effect.

The psychosocial and emotional effects and their consequences on the family might be unquantifiable (Nowak B. (2016). The psychological effects of FGM/C depend on the type of the procedure performed, experience of the circumciser and the social atmosphere at the time the cutting is performed (Heiman J 2007; Momoh C, Olufade O, *et al* 2016). The psychosocial consequences include Post-Traumatic Stress Disorder (PTSD), anxiety disorders, panic disorders, inhibition, depression and suppression of feeling and thinking and sometimes attempted suicide (ACOG 2011). These effects are due to psychological trauma among those who survive the acute and medium term consequences, many long-term morbidities noted are psychological disturbances, low libido, apareunia or dyspareunia, chronic pain, dysmenorrhoea, gynaetresia, cryptomenorrhoea, vaginal fistulae, labial agglutination, hypertrophic scar/keloids, clitoridal retention cysts, dermoid cysts, vaginal lacerations during coitus, straining at micturition, genital tract lacerations, especially during vaginal delivery, obstructed labour, increased rate of caesarean delivery and postpartum haemorrhage (Momoh C, Olufade O, *et al* 2016).

WHO (2016) reported that among 28,393 women with singleton pregnancies admitted for delivery at 28 obstetric centres in six African countries, a higher neonatal death rate was found among circumcised compared to non-circumcised mothers. Neonatal death rate was 15% higher for those whose mothers had type I, 32% higher for those with type II and 55% higher for those with type III FGM/C with an estimate of additional one to two babies per 100 deliveries dying as a result of FGM/C. Women who do not deliver in hospitals will have more severe obstetric complications with increased neonatal adverse outcome.

The morbidities and mortalities associated with FGM/C are enormous without any medical benefits to the patients particularly in countries where the practice are predominant. Therefore, its prevention and eradication are mandatory for human rights and socioeconomic reasons. Koukkula M, Keskimäki I, Koponen P, et al 2016 opined that the prevention of FGM/C is receiving the deserved global, local and grassroots attention but that efforts need to be focused on using strategies to build evidence and generate knowledge, to increase advocacy, enforce legislation against FGM/C and strengthen the health sector's response. Such steps should include:

- Identification of specific researches to gather baseline community information, human and material resources that are available for the control of FGM/C to determine the best methods of prevention in that community.
- Adoption of universally agreed methods of prevention to consist of advocacy, general education of men and women, health education and promotion services.
- Review existing laws and or promulgating new laws and legislation to sanction offenders as strategies to enhance the elimination of FGM/C.

Studies show that people who are against FGM/C can identify its physical, obstetric, psychological, sexuality and social consequences while those who support the practice generally deny the existence of these problems (Mcalister RD 2016). The government has a great responsibility in preventing FGM/C, in promoting its abandonment and holding those who perpetrate it responsible for inflicting harm on girls and violating the child or women's rights (Abdel-Azim S. 2012). Some countries have enacted laws against the practice but these laws are usually not enforced. Despite the bans and or legislation against any forms of FGM/C in most African Countries, the practice has not reduced significantly as expected because most

of the legislations are not complemented by measures to influence the cultural and religious expectations of the communities within its comprehensive social context (Kandala NB, *et al* 2009).

While females (particularly when young) are forced by parents, extended family members and their immediate community to undergo FGM/C in most developing countries like Nigeria and which practices are globally condemned, individuals in such countries are engaging in practices leading to physical alterations of their body parts and functions. Such practices includes piercing, tattooing, enlargement, cosmetic transplantation among others which is a topic for other studies. The prevalence of FGM/C in Ekiti State of Nigeria causes and possible remedies are the focus of this study.

## PURPOSE OF THE STUDY

The main purpose of this study is to examine the prevalence of FGM/C practices in Ekiti State Nigeria in an effort to know the "why", and "how" can the practice be reduce if not eliminated in our society

## RESEARCH QUESTIONS

In this study, answers were sought to the following questions:

1. What is the significant prevalence of FGM/C in Ekiti State?
2. Does the significant prevalence exist across social and educational background?
3. Does cultural beliefs significantly responsible for the practices FGM/C?
4. What is the influence of religious belief on the practice of FGM/C in Ekiti State?
5. What are the trends (reasons/causes) of FGM/C in Ekiti State?
6. What is the opinion of respondents on the FGM.C practices in Ekiti State?

### Hypotheses

Two hypotheses the guided the study includes:

1. Rural area and urban settlement did not significantly influence the practice of FGM/C in Ekiti State
2. Fulfilling cultural rites and economic benefits did not significantly influence the practice of FGM/C in Ekiti State.

## METHODOLOGY

The population of the study comprised all child bearing adult women in all the sixteen Local Government Area of the state. Five Local Government Area Councils were randomly selected and 240 adult women were purposively selected from the five Local Government Area Councils at equal representation. The research instruments used to gather information from respondents include a questionnaire named Female Genital Mutilation/Cutting Prevalence Questionnaire (FGM/CPQ) developed by the researcher and one-on-one interview process. The questionnaire was made of two sections. Section A was used to collect information on demography of respondents such as age, location and social status. Sections B examine the prevalence of FGM/C among girls' child and women in Ekiti State. The Interview Protocol (IP) was used by the researcher to assess the extent of the prevalence of FGM/C among female folds in the society. The instruments were validated by administering it on another group differ from the sample groups after which Person Product Correlation Moment Coefficient was used to determine the reliability coefficient of the instrument, with 0.88 obtained at level of 0.05 level

of significant. The researcher personally carried out the study with the assistance of a research assistant. Frequency counts, percentage mean were used to answer research questions and Chi-square used to analyzed the hypotheses formulated.

## RESULTS

Frequency counts and simple percentages were used to answer research questions 1 to 6, while hypotheses 1 and 2 were tested t-test.

**Research Question 1**: What is the significant prevalence of FGM/C in Ekiti State?

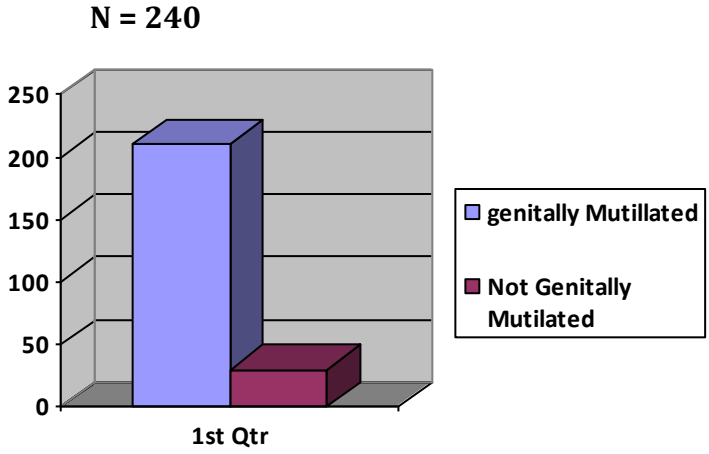



**Figure 1: Bar Chart of the Prevalence of FGM/C in Ekiti State**

From the figure 1 above, 210 (87.5%) of the study participants agreed that they were genitally mutilated while 30 (12.5%) were not. This shows a highly significant prevalence of the act in the State,

**Research Question 2:** Do the significant prevalence exist across social and educational background?

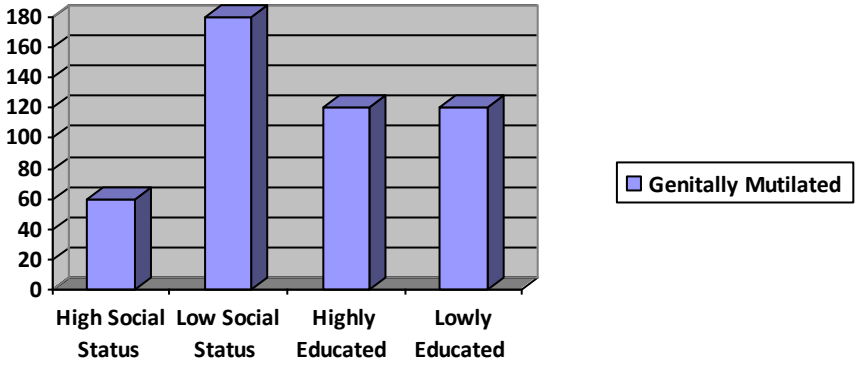



**Figure 2: Bar Chart of the Prevalence of FGM/C across social and educational background in Ekiti State N = 240**

Figure 2 above reflected the prevalence of FGM/C across social status and educational background of the respondents. Educational background does not significantly affect the practice with the 50:50 ratios of the practice but the ratio between high social status of 60 (25%) and that of low social status of 180 (75%) or ratio 1:3 shows that FGM/C is prevalence among low social status than high social status.

**Research Question 3:** Does cultural beliefs significantly responsible for the practices FGM/C?

**Table 3: Percentage views of respondents on the influence of cultural beliefs on FGM/C practices in Ekiti State**

| FGM/C | Cultural Belief (%) |
|---|---|
| Genitally Mutilated | 120 (50) |
| Not Genitally Mutilated | 120 (50) |

Table 1 shows a 50:50 ratio views of the respondents on the influence of cultural beliefs on the FGM/C practices in Ekiti State.

**Research Question 4:** What is the influence of religious belief on the practice of FGM/C in Ekiti State?

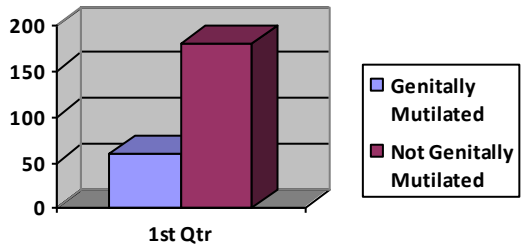



**Figure 3: Bar Chart of the Influence of religious belief on the practice of FGM/C in Ekiti State**

From the figure 3 above, 180 (75%) of the respondents does not believed that religious belief influenced the practices of FGM/C in the state while 60 (25%) of the respondents ascribed to the fact that religious beliefs strongly influenced FGM/C practices in Ekiti State.

**Research Question 5:** What are the trends (reasons/causes) of FGM/C in Ekiti State?

**Table 4: Trend Ratio of the Respondents on the FGM/C practices in Ekiti State**

| SN | Statements (Trends) | SA | A | D | SD | U | Mean | Rating |
|---|---|---|---|---|---|---|---|---|
| 1 | Female genital mutilation is a common practice in my community | 90 | 60 | - | 90 | - | 3.63 | 5 |
| 2 | It is a tradition in my community that female genital must be mutilated or cut | 120 | - | 30 | 60 | 30 | 3.5 | 6 |
| 3 | It is a taboo for anyone not to mutilate or cut female genital in my community | 30 | 60 | 60 | 30 | 60 | 2.88 | 12 |
| 4 | Only female child born at home or traditional birth attendant are mutilated or cut | 30 | 30 | 150 | - | 30 | 2.5 | 15 |
| 5 | Female genital mutilation and cutting is carried out because of poverty level of the | - | 60 | 60 | 120 | - | 2.75 | 14 |
| 6 | parent Parents of less education background | 30 | 90 | 60 | 60 | - | 3.38 | 7 |
| 7 | practices female genital mutilation and cutting | 30 | 30 | 90 | 60 | 30 | 2.88 | 12 |
| 8 | Family religion encourages female genital mutilation and cutting practices | - | 60 | 150 | 30 | - | 3.13 | 8 |
| 9 | Parents social status encourages female genital mutilation and cutting practices | 60 | 60 | 30 | 60 | - | 3.13 | 8 |
| 10 | It is believed that a female child who genital is mutilated or cut at birth is prone to be promiscuous when she is sexually active | 90 | 120 | - | - | 30 | 4.0 | 3 |
| 11 | Female genital mutilation and cutting reduces the urge for sexual desire among sexually active female adult | 30 | 30 | 60 | 120 | 30 | 3.0 | 11 |
| 12 | Female genital mutilation and cutting deny female adult from getting married | 90 | 60 | 30 | 60 | - | 3.75 | 4 |
| 13 | Female genital mutilation and cutting contributed to complication during child birth among those who undergo it | 60 | - | 90 | 90 | - | 3.13 | 8 |
| 14 | Female genital mutilation and cutting practices brings about childlessness of female adult | 120 | 90 | - | 30 | - | 4.25 | 1 |
| 15 | Female genital mutilation and cutting practices makes sexually active female adult not to enjoy sex as it's supposed to be | 150 | 30 | 30 | 30 | - | 4.25 | 1 |
| | Female genital mutilation and cutting practices brings about infection which can eventually lead to death of female adult | | | | | | | |

**Source: Author field data 2020**

Table 4 above shows significant opinions of the entire respondents because the individual mean is greater than the group average mean. Items 14 and 15 showed the highest mean of 4.25 respectively meaning that female genital mutilation and cutting practices makes sexually active female adult not to enjoy sex as it's supposed to be and also that female genital mutilation and cutting practices brings about infection which can eventually lead to death of female adult. However, item 4 showed the least significance of 2.5 which could implies that not only female child born at home or traditional birth attendant are mutilated or cut, it cut across all birth attendance practitioners. Poverty level of the parents may not necessarily influenced female

genital mutilation and cutting with mean value 2.75 but educational background influences FGM/C practices with its high mean value of 3.38. Also religion though with mean value of 2.88 which is above the average mean value but was not conclusively the causes of FGM/C in the community. Promiscuousness of a child not genital mutilated during her sexually active age produce a mean value of 3.13 so also the assumption that parents social status encourages female genital mutilation and cutting practices recorded a mean value of 3.13. That Female genital mutilation and cutting reduces the urge for sexual desire among sexually active female adult recorded a significant mean value of 4.0.

**Research Question 6:** What is the opinion of respondents on the FGM.C practices in Ekiti State?

**Table 5: Opinion of the Respondents about the FGM/C practices in Ekiti State**

| SN | Statement (Opinion) | Yes | No |
|---|---|---|---|
| 1 | Were you genitally mutilated? | 210 | 30 |
| 2 | If your answer to the above is Yes/No, Do you enjoy sex to your satisfaction from your lover (Husband)? | 180 | 60 |
| 3 | Will you like to mutilate your female child genital? | 30 | 210 |
| 4 | Is your husband and or his family members that encourage or enforce you to mutilate your female child? | 120 | 120 |
| 5 | Was the reason above in (4) attributed to family belief? | 90 | 150 |
| 6 | Did you deliver your female child in a public health centre or hospital? | 150 | 90 |
| 7 | Was it a normal practice with traditional child birth attendant to mutilate female genital at birth? | 150 | 90 |
| 8 | Do you agree that genital mutilation of female child should stop? | 210 | 30 |
| 9 | Will you report and female genital mutilation and cutting practices around you to health worker/attendant or law enforcement agent for prosecution? | 210 | 30 |
| 10 | If you have opportunity to decide on whether to be genitally mutilated, will you agree? | 150 | 90 |
| 11 | Is it only traditional health practitioners that perform FGM/C? | 90 | 150 |
| 12 | Is FGM/C required by certain religions? | 60 | 180 |
| 13 | Is there any link between FGM/C and ethnicity? | 150 | 90 |
| 14 | Will you advocate abolition of FGM/C from your experience on the practice? | 180 | 60 |
| 15 | Does health-care provider such as a community health worker, midwife, nurse or doctor engaged in FGM/C practices? | 120 | 120 |

**Source: Author field data 2020**

Table 5 above reviewed the opinions of the respondents about the FGM/C practices in Ekiti State. Most of the respondents opined that their genital were mutilated with 210 (87.5%) affirmed the statement with 30 (12.5%) said No. 210 (87.5%) of respondents agreed that FGM/C should be stopped and anyone caught in the practices should be reported to health workers or law enforcement agent for prosecution. Items 14 affirmed the abolition of the practice with 180 (75%) while 210 (87.5%) of the respondent said No in affirmative to the question "will you like to mutilate your female child genital". However, the respondents opined that FGM/C is neither required by any religion with 180 (75%) of the respondents says to the question.

**Research Hypothesis 1**: Rural area and urban settlement did not significantly influence the practice of FGM/C in Ekiti State


**URL:** http://dx.doi.org/10.14738/abr.101.11548

**Table 6: Influence of Urban and Rural location to the views on the practice of FGM/C in Ekiti State**

| Gender | Agree | Disagree | Total | $X^2$ | Df | P | Remark |
|---|---|---|---|---|---|---|---|
| Rural | 100 | 30 | 130 | | | | |
| | | | 3.028 | 1 | 0.041 | S | |
| Urban | 90 | 20 | 110 | | | | |

**p<0.05**

Table 6 above shows a significant difference between rural and urban respondents in favour of rural as Chi-square value $X^2(1, N=240) = 3.028$, $p = 0.041$ which is less than significant value 0.05, hence hypothesis 1 is rejected.

**Research Hypothesis 2:** Fulfilling cultural rites and economic benefits did not significantly influence the practice of FGM/C in Ekiti State.

**Table 7: Influence of cultural rites and economic status did not significantly influence the practice of FGM/C in Ekiti State**

| Factors | Agree | Disagree | Total | $X^2$ | Df | P | Remark |
|---|---|---|---|---|---|---|---|
| Cultural rites | 130 | 110 | 240 | | | | |
| | | | 3.039 | 1 | 0.031 | S | |
| Social status | 60 | 180 | 240 | | | | |

**p<0.05**

Table 7 above shows a significant influence of cultural rites and social status on respondents practice of FGM/C in favour of cultural rites as Chi-square value $X^2(1, N=240) = 3.039$, $p = 0.031$ which is less than significant value 0.05, hence hypothesis 2 is rejected.

## DISCUSSION OF FINDINGS

The finding showed that FGM/C is a common practice within the state with over 85 percent of the respondents reported being genitally mutilated. This was in line with the findings by UNICEF (2016) on its prevalence Osun (80-90), Ondo (90-98) and Oyo (60-70) percentage respectively. Educational background does not significantly influence the practice of FGM/C but the practice is dominant among low social status than high social status respondents. In the same vein, ccultural beliefs and religious practices do not significantly responsible for the practices FGM/C in the state. This position was supported by Ellen Gruenbaum (2001) who opined that FGM/C practices mostly depend on cultures, traditions, customs and religion.

The reasons FGM/C practices according to the study spanned through tradition, religion, social, politics and economic. One of the cultural and religious reasons for justifying the practice of FGM/C is in the reduction of promiscuity and ensuring virginity before marriage. This was in support of Teixeira AL, Lisboa M. (2016). Berg RC*, et al* (2010) findings of reduction in sexual drive and desire by adult women genitally mutilated was equally supported by this study hence, this finding affirmed that FGM/C deprives women of sexual satisfaction and denies them of their right to sexual health and pleasure to achieve full psychophysical well-being.

The findings showed that FGM/C practices cut across traditional birth attendant all other birth attendance practitioners. Poverty or economic prospect of the family does not adequately influenced female genital mutilation and cutting but educational background influences FGM/C

practices. This act can apparently create a pathway for infectious diseases to thrive into the female genitalia as well as other parts of the body, thereby resulting into a serious health complication as opined by Anzaku AA, et al. (2018).

The findings ascertained the overwhelmed effect of FGM/C as reported by Momoh C (2005) to include severe complications. These complications may occur during or immediately after the operations, while others manifest in the medium and long-term to cause poor quality of life for the patient or result in mortality or both as reported by UNFPA, (2016). The psychosocial and emotional effects and their consequences on the family are unquantifiable in support of Nowak B. (2016).

FGM/C practice occurred to be one of most serious forms of violence against the girl child/woman as shown by the report. Its practice collaborate the World Health Organization (WHO) 2008 and UNICEF (2001) reasons psychosexual, sociological, hygiene and aesthetic, religious beliefs enhance fertility and promote child survival for better marriage prospect and to help delivery of babies.

However, the Nigeria government response has given estimated prevalence of FGM/C in the country: 2003, 2006, 2008 National Demographic Health Survey and the National Baseline Survey of positive and harmful traditional practices affecting women and girls in Nigeria has led to series of advocacy by the Federal Ministry of Women Affairs in year 2000 in each of the six geo-political zones and Federal Capital Territory (FCT). These advocacies and sensitization programme involves traditional rulers, religious leaders and policy makers to increase awareness on harmful traditional practices resulting in State Legislations and consequently reduction in these practices.

## CONCLUSION

FGM/C is a practice that has gained a wide support among all segments of Ekiti State community. The practice that based on ethno-cultural and religious beliefs and involves partial or total removal of the female genitalia however is unhealthy, injurious, barbaric, and completely negates the right of a girl child and women and legislated worldwide. The government has a great responsibility in preventing FGM/C, in promoting its abandonment and holding those who perpetrate it responsible for inflicting harm on girls and violating the child or women's rights. Countries needs to enact appropriate laws against the practice and those that have done should develop the political will to enforce them. More research should be carried out on this study so as to totally eradicate the menace of violation against female in the society. Above all appropriate sensitization on the danger of FGM/C should be carried out to abolish the practice in our community. However, the action of the current Ekiti State Governors' wife to empower the FGM/C practitioners (circumcisers) with life time alternative occupation that will make them leave the practice of the act is in the right direction.

## RECOMMENDATIONS

Given the extent of FGM/C complications, the following recommendations are made:

1. Improving health services in rural areas where the practice is more rampant,
2. Development of guidelines on management and creating help lines which is toll-free for access to help as at when due.

3. Organizing periodic training for health care workers to enable case identification, reduce the obstetric and psycho-social effects of FGM/C, and prevent the occurrence of new cases
4. Adequate and effective care for girls/women who have had FGM/C, it is necessary to have accurate estimation of those affected or likely to undergo treatment procedures.
5. Appropriate legislation to empower health care professional organizations, women in the society to demand for their rights, and education of the general public at all levels with emphasis on dangers of FGM in the society.
6. Creating alternative source of income for the circumcisers by empowerment.

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