CERTIFICATION

This is to certify that this research work determinants of female genital mutilation intention among women in Oye Local Government out by FANIMO, FEMI AUSTINE with Matriculation Number DSS/11/0129 of the Department of Demography and Social Statistics, Faculty of Humanities and Social Sciences, Federal University Oye Ekiti, Ekiti State, Nigeria under the supervision of

MISS CHRISTIANA ALEX OJEI. DATE

PROJECT SUPERVISOR

DR. OLUWAGBEMIGA ADEYEMI DATE

HEAD OF DEPARTMENT

EXTERNAL SUPERVISOR DATE

DEDICATION

This research work is dedicated to God Almighty, the Alpha and the Omega, the source of all wisdom and understanding to whom I give all glory to, for given all I needed to see the completion of a first degree in my academic journey pursuit.

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ABSTRACT

Female Genital Mutilation also known as female circumcision is defined by the World Health Organization (WHO) as "all procedure that involves partial or total removal of the external female genitalia or other injury to the female genital organ for non-medical reasons.

The study was carried out in Oye Local Government Area, with a sample size of 200 women with at least a female live birth. A simple random sampling technique was employed in this survey. 2 level of analysis were employed.

The result shows that age, religion and occupation of respondents was significant to their FGM practice ($P<0.005$), while marital status, education, income and number of children was not significant with FGC practice ($P>0.005$).

CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND OF THE STUDY

Female Genital Mutilation (FGM)refers to "all procedure that involves partial or total removal of the external female genitalia or other injury to the female genital organ for non-medical reasons (WHO). Also known as female circumcision, FGM is a cultural ritual by ethnics groups in 27 countries sub-Sahara and North Africa and to lesser extent in Asia and the Middle East (Masinde 2013). It is typically carried out with or without anesthesia by traditional using knife or razor. The age of the circumcised girls varies from weeks after birth to puberty. However, studies reveal that most girls were cut before the age of five [WHO, 2013]. An estimated 100 to 140 million girls and women worldwide are correctly living with consequence of female genital mutilation (Adegoke, 2005).

According to UNICEF (2001), Female Genital Mutilation is recognized international as a violation of human rights of girls and women. It reflects deep rooted inequality between sexes and constitutes in extreme form of discrimination against women. It is nearly always carried out on minor and is a violation of right of children. The practice also violates a person's treatment and right to life. The procedure has no health benefits for girls and women but fatal consequences. Some of such effects are shock, hemorrhage, infection and acute urinary retention. Other complications are sexual dysfunction and keloid. (Mackie G. 2007).

Also, according to WHO (2008), Female Genital Mutilation varies from country, tribe, and religions from one state and cultural setting to another. In most parts of Nigeria, it is carried outon minorswho cannot give individual consent. There is a higher prevalence of Type I (which is removal of clitoral hood) in the south, with extreme form of FGM prevalence in North.

Adegoke (2005). Women of child bearing age most equally those at the fertility period between age (15-49yrs) are those in direction contact with the girls child and they are the major determinant of whether a baby girl should be circumcised or not. These mothers have direct access to the girl child who is the victim of genital mutilation Adegoke (2007 Education of these categories of women is very pertinent in abolition of the unhealthy practice other steps include: multi-disciplinary approach like legislation and empowerment of women in the society. Senior coordination for international health issue (2005).

World Health organization (WHO) has classified FGM into four types, which are: Type I: clitoridectomy of the prepuce with or without excision of or part of the clitoris. It is also known as Sunnacircumcicion. This type I is practiced in a broad area all across Africa parallel to the equator. Fran Hosken enumerates the following countries: Egypt, Ethopia, Kenya, Tanzania in East Africa to the West Africa Coast, from Sierra Leone to Mauritania, and in all countries in between including Nigeria, the most populous one. There are also reports of type I taking place in areas of the Middle East such as in Oman, Yemen, Saudi-Arabia and United Arab Emirates.

Type II: excision of the prepuce and clitoris together with partial or total excision of the labia minora. This takes place in countries where infibulation has been outlawed such as Sudan.

Type III: Excision of parts or all of the external genitalia and stitching of the vaginal opening. This type III is also known as infibulation or Pharaonic circumcision. Hosken also reports that infibulation is practiced on all females, almost without exception, in all Somalia and wherever ethnic Somalis like (Ethopia, Kenya and Djibouti). It is also performed throughout the Nile Valley, including Southern Egypt, and all along the Red Seas Coast.

Type IV: Unclassified (but may include)

- Pricking, piercing or excision of the clitoris and or labia

- Stretching of the clitoris or labia.
- Cauterization by burning of the clitoris and surrounding tissues.
- Scraping (angora cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina.
- Introduction of corrosive substances into the vagina to cause bleeding or hers into the vagina with the aim of tightening or narrowing the vagina.
- Any other procedure that falls under the definition of Female Genital Mutilation given above.

SOURCE; Female Genital Cutting; Report of a WHO Technical Working Group, Geneva, (July 1995 AND 1996).

Beyond the obvious initial pains of the operations, the unsanitary environment under which FGM takes place results in infections of the genital and surrounding areas and often results in the transmission of the HIV virus which can cause AIDs. In order to minimize the risk of the transmission of the virus, some countries like Egypt, made it illegal for FGM to be practiced by any other practitioners other than trained doctors and nurses in hospitals. While this seems to be a more humane way to deal with FGM and try to reduce its health risk, more tissue is apt to be taken away due to them lack of struggle by the child if anesthesia is used.

1.1 **Statement of Problem**

The prevalence of FGM in Nigeria and most other Africa countries has engendered scholarly enquiries. Certain socio cultural determinants have been adjudged as supporting this avoidable practice and are mostly facilitated by critical decision makers like grandmothers, mothers, women, opinion leaders (WHO, 2008). FGM is an extreme example of discrimination based on sex. It is often employed as a way to control women sexuality. There is however the phenomenon of medicalization which has introduced modern health practitioners and community

health workers into the trade despite all the complication it possesses.The WHO is strongly against the medicalization or institutionalization of any form of FGM. The non-chalet attitude of people towards these uncivilized practices has been linked to the perception of people in the community (Ahanonu E.A & Victor, O. 2013) This research work is to examine the knowledge, attitude and perception of mothers towards Female Genital Mutilation.

1.2 Justification of the Study

Any continuous exercise considered detrimental or harmful in one way or the other especially at the expense of human lives, needs a thorough examination. The continued practice of FGM despite all efforts to discourage and eradicate the practice is disconcerting Therefore, in this research, efforts will be madeto examine the knowledge and attitudes of women'sperception of Female Genital Mutilation.

The study is beneficial for the women population as well as health care agencies, the government and the society at large. The conclusions from the studymay be used for planning programs towards the total eradication of FGM.

1.3 Objectives of the Study

1.3.1 Broad Objective

The broad objective of this study is to investigate the factors influencing the perception and intention of FGM among women of reproductive age in Oye Local Government, Ekiti State.

1.3.2 Specific Objectives

The specific objectives of the study are to:

1. To identify the prevalence of FGM in Oye Local Government, Ekiti State.
2. To examine and discuss the influence of socio-demographic characteristics of women on their perception of FGM.

1.4 Research Questions

- How prevalent is FGM among women of child bearing age in Oye Local Government?
- Do socio-demographic variables have any effect on the perception of FGMamong women?

1.5 Limitation of the Study

The scope of this study is limited becauseof time constraints.It would have been a larger study if there was more time.The sample size is restricted to 200 because it has to be completed within the time given.

1.7 Definition of Terms

- **Female Genital Mutilation**: The cutting of female clitoris partially or totally. According to World Health Organization 1997 defines FGM as all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons.
- **Women:** Women are typically capable of giving birth from puberty until menopause i.e women who are within child bearing age (15-49yrs).
- **Attitude:**Beliefs, feelings, opinion related to FGM.
- **Female:** Of the sex that can bear offspring or produce eggs.
- **Puberty:** The stage in life when a person reaches sexual maturity and becomes capable of reproduction.
- **Adolescent:** A person between childhood and adulthood.
- **Clitoris:** The small sensitive organ just in front of the vagina. In order words, it is female counterpart of the penis, which contains erectile tissue but is unconnected with the urethra.

- **Culture:**This term refers to knowledge, belief, art, moral, law, custom and other capabilities and habit acquired by man as a member of society. It consists of patterns of and for behaviors acquired and transmitted by symbols.
- **Caesarean Section:** This simply refers to a surgical operation for delivering a child/baby by cutting through the wall of the mother's abdomen.
- **Morbidity:**It refers to diseases and illness, injuries and disabilities in the population.
- **Rite of passage:** This is a ritual that marks a change in a person's social status. {Maligaye, 2007}.

CHAPTER TWO

LITERATURE REVIEW

2.0. Overview of Female Genital Mutilation

Female genital mutilation is "the partial or total removal of the female external genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons" (WHO, UNICEF, 1997; NDHS, 2013). The practice is mostly carried out by traditional circumcises, who often play other central roles in communities such as attending child births. However, more than 18% of all FGM is performed by health care providers, and the trend towards medicalization is increasing (Mackie, 2002). FGM is widely recognized as a violation of human rights, which is deeply rooted in cultural beliefs and perceptions over decades and generations with no easy task for change (Odoi, 2001).

The practice of FGMis considered part of a ritual initiation into womanhood that includes a period of seclusion and education about the rights and duties of a wife. Despite its cultural importance, FGM has drawn considerable criticism because of the potential for both short- and long-term medical complications, as well as harm to reproductive health and infringement on women's rights (Toubia, 1995).According to the World Health Organization (WHO), female genital mutilation (FGM) includes all procedures involving partial or total removal of the external female genitalia, or injury to the female genital organs, for non-therapeutic reasons. FGM is recognized internationally as a violation of the human rights of girls and women, constituting an extreme form of gender discrimination with documented health consequences.

The WHO estimates that 140 million women and girls in the world have been victims of some form of FGM, and that each year, 3 million girls are subjected to, or at risk of being subjected to, this harmful traditional practice.

2.1. Classification of FGM

According to World Health Organization (2000), the following is a classification of FGM that divides the operation into four (4) types, or categories.

1.***Clitoridectomy: Partial*** or total removal of the clitoris (a small sensitive and erectile part of the female genitals) and, in very rare cases only the prepuce (the fold of skin surrounding the clitoris.

2. ***Excision: Partial*** or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).

3. ***Infibulation: Narrowing*** of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner or outer, labia, with or without removal of the clitoris

4. ***Other Variations:*** All other harmful procedure to the female genitalia for non-medical purposes, e.g pricking, piercing, incising, scraping and cauterizing the genital area.

2.1.1 Religious Perspectives

In Africa, FGM is practiced by Christians, Muslim, Jews and various tribal religions; however, FGM most commonly takes place in association with the Islamic faith (Abusharaf, 1998).There is no mention of FGM in the Bible or Quran. Although its origins are pre-Islamic, it became associated with Islam because of the religion's focus on female modesty and chastity, and is found only within or near Muslim communities. It is praised in several Hadiths (sayings attributed to Mohammed) as noble but not required, along with advice that the milder forms are kinder to women. In 2006 several leading Islamic scholar called for an end to the practice, and in 2007 the Al-Azhar supreme council of Islamic research in Cairo ruled that it has no basis in Islamic law. According to Mackie, it is not practiced in Mecca and Medina in Saudi Arabia, Islam's holiest cities, although there have been reports of it in that country, perhaps among

immigrant communities. Surveys have shown that is a widespread belief in several countries, particularly Eritrea, Egypt, Guinea, Mali, and Mauritania, that FGM is a religious requirement Makie and Lejeure wrote that practitioners may not distinguish between religion, tradition and chastity, which make it difficult to interpret the data. Outside Islam, FGM has been practiced the Christian Copts in Egypt and Sudan and by the Beta Israel of Ethiopia, the only Jewish group known to have practiced it. Judaism requires male circumcision, but does not allow FGM.

2.1.2 Level of Education

The likelihood of girls and women undergoing FGM might be related to socioeconomic factors. In this study, more than 80% of the women were illiterate and unemployed. Therefore, the practice of FGM can be considered to be a societal norm and a source of income for the perpetuators. Girls terminate their education to meet their family responsibilities at an earlier age, and the options would be marriage or becoming engaged. In Ethiopia, there is a tendency for families with no or little education to keep their sons and daughters at home to serve the family and help with agricultural work. Therefore, poverty, lack of education, insufficient information, and inadequate knowledge might put these women at risk of becoming victims of FGM. The majority of women in Ethiopia is of low socioeconomic status and thus might be forced to accept their community's harmful traditional practices and enter into early marriage. Families might also consider marriage for girls who have undergone FGM as a means of integrating them into a new life. This study did not specifically address socioeconomic risk factor related to FGM.

The arrival of the formal education thought it was resisted as a western culture serve as unmatched superior for the informal one. Formal education has come heavily with its own laid down procedures. The government, nongovernmental organization, religion, and the elite in the communities have joint effort in the fight against this tradition FGM by launching heavy

education campaigns in the communities. These education campaigns have been successful in many communities that have now understood the incomparable difference between informal education and the formal one. (Creel and Ashford 2001, 543-545).

Kenya Demographic and Health Survey (KDHS) 1998 reported that the introduction of early education has enabled people to get rid of the complications associated with Female Genital Cutting. As for promoting awareness among girls at their early age in their studies, as indicated in a report for the Human Right and Democracy who have been visiting various primary schools to young girls against the dangers of the rite and encouraging the formation of anti-FGM clubs in school and in their communities where FGM is practice (KDHS, 1998).

2.1.3 Place of Residence

It is generally assumed that people in the rural areas are more likely to practice Female Genital Mutilation than those in the urban areas due to their level of education concerning FGM. A 2013 UNICEF report, based on 70 surveys, indicated that FGM is concentrated in 27 Africa countries as well as in Yemen and Iraqi Kurdistan, and that 125 million women and girls in those countries have been affected.

The practice is mostly found in what political scientist Gerry Mackie describes as an "intriguingly contiguous zone" in Africa, from Senegal in the west to Somalia in the east, and Egypt in the north to Tanzawa in the south intersecting in Sudan. According to UNICEF, the top rates are in Somalia (with 98 percent of women affected), Guinea (96 percent) Djibouti (93 percent), Egypt (91 percent), Erithrea (89 percent), Mali (89 percent), Sierra Leone (88 percent), Gambia (76 percent), Burkina Faso (76 percent), Ethiopia (74 percent), Mauritanian(69 percent), Liberia(66 percent) and Guinea Bissau (50 percent). In Nigeria, FGM has the highest prevalence

in south-south (77%) followed by the south east (68%) and south west (65%), but practiced on a smaller scale in north paradoxically tending to a more extreme form.

Nigeria has a population of 150 million people with the women population from the 2006 census women are about 49%.The national prevalence rate of FGM is 41% among adult women. Prevalence rate progressively decline in the young age group and 37% of circumcised women do not want FGM to continue. 61% of women who do not want FGM say it is a harmful tradition and 22% and it was against religion. Other reasons cited were medical complications (22%) painful personal experience (10%) and the view that FGM is against the dignity of women (10%).

However, there is still considerable support for the practice in areas where it is deeply rooted in local tradition (Adegoke, 2005).Procedures are mostly carried out on young girls sometime between infancy and age 15, and occasionally on adult women.

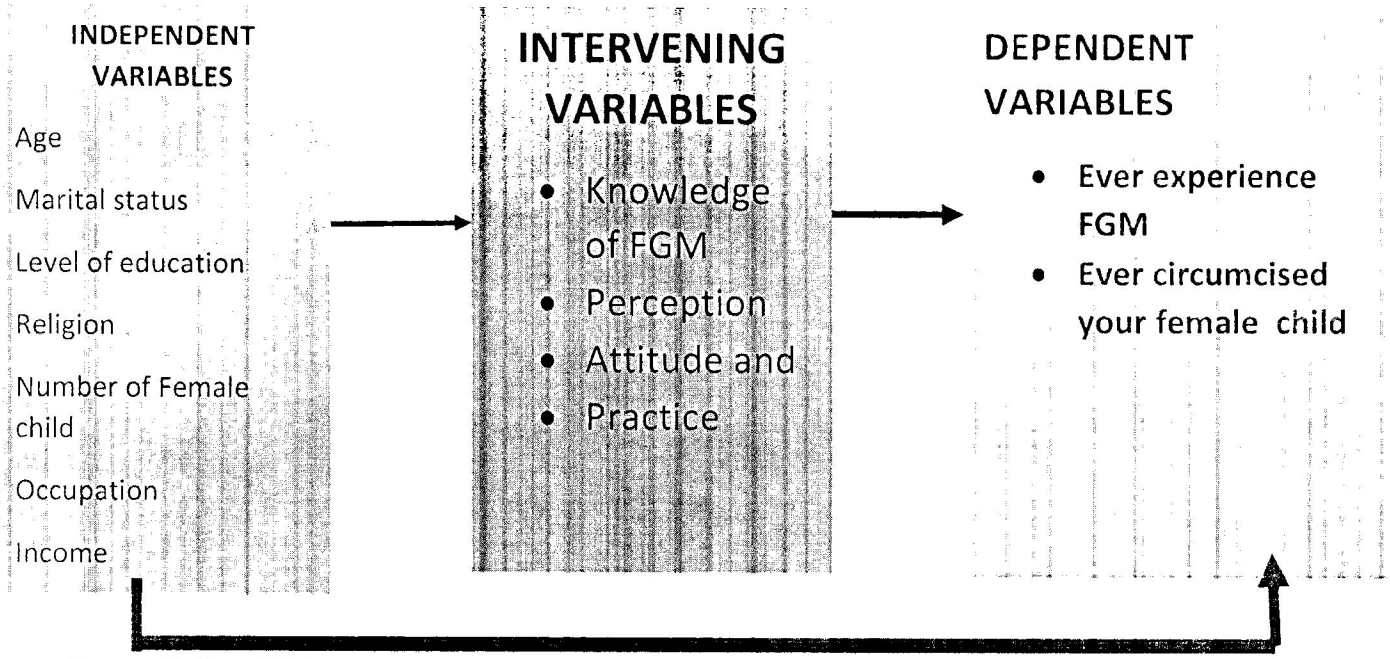
2.1.4 Sexual Behaviour

FGM was also linked with many divorces as result of sexual dissatisfaction. Many women have divorced their husbands, because the husband claim that they are not satisfied sexually. Women blame their plight on FGM, saying it damaged them permanently (Chege 1993, 550). Itis considered most significant rite of passage to adulthood, enhancing tribal cohesion, providing girls with important recognition from peers. The practice in spite of other reason is widely believed to increase a girl's chances of marriage, prevent promiscuity and promote easy childbirth. Women who do not circumcise their daughter run the risk of being seen as irresponsible, immoral and imitators of Western culture. (www.womensenews.org referred 12.7 2009).

2.2. Theoretical Framework

In this study, the theoretical framework is based upon the relationship between dependent variable and independent variables which determine their intention on Female Genital Cutting. Some selected socio- economic demographic factors like level of education of respondents, religious affiliation and place of residence could also influence their intention on FGM.

2.3 Conceptual Framework of Relationship between Background Variable of Women and Practice of FGM



Source: Pullum 1980

The practice of Female Genital Mutilation is not new to Nigeria societies. African countries, especially Nigeria women have long associated with various harmful practices which are illegal. This study tends to conceptualized the practice and attitude of women toward female genital mutilation that is based on the influenced of independent variable social-demographic characteristics of women such as age, marital status, income, education, employment status by control for knowledge and perception toward the practice of female genital mutilation.

2.4 Hypotheses

The hypotheses for this study are stated below:

H_0: There is no significant relationship between socio-demographic background of respondents and practice of Female Genital Mutilation in Oye Local government

H_1: There is relationship between socio-demographic background of respondents and practice of Female Genital Mutilation in Oye Local government

H_2: Perception and practice of FGM is the same among religion affiliation in Oye

H_1: Perception and practice of FGM is not the same among religion affiliation in Oye

H_0: Perception and practice of FGM is the same among different level of education of respondents in Oye-Ekiti

H_1: Perception and practice of FGM is not the same among different level of education of respondents in Oye-Ekiti

CHAPTER THREE
RESEARCH METHODOLOGY

3.0 Introduction

This chapter is concerned with the manner in which the research is conducted. It is the crux of this study because it is the background against which the findings and conclusions are evaluated. Therefore, the chapter provides the procedures involved in the research exercise as well as processes of data collection.The methodology involves the research design, description of study area, study population, sample and sampling technique, validity study instrument, rehabilitating of instrument, procedure for data analysis and ethical consideration.

3.1 Background of the Study Area

The study area is Oye Ekiti, Ekiti State. It is one of the 16 kingdoms of Ekiti land. The inhabitants are Yoruba. The Old Oye kingdom comprises of five villages namely Oye, Ire, Egosi, Eshetta, (Egosi and Eshetta have come together as Ilupeju) and Arigidi Ekiti (now Ayegbaju) and covers an area of about 64 square miles (National Archive, Ibadan). The population of Oye-Ekiti according to the 1952 national census was 13,696, (National Archive, Ibadan), 57,196 in 1963 and in 2006 the population was 168,251 (National Population Commission 2006). Oye-Ekiti is located at a general altitude around 1500 feet with hills and granite outcrops rising to about 200 feet. It is covered by thick forest with very small patches of high forest and is surrounded by hills which provide her protection in times of war. In fact, the hills were a blessing to the people especially during the Benin invasion in the 19th century (Akintoye 1921).

The origin of Oye Ekiti which is also known as Obalatan land is associated with the founder of the town, Oloyemoyin who was born in Imore district of Ile Ife (Owoyomi 1995).

Thus, the name Oye was coined from his name 'Oloyemoyin', a name supposedly put together because of the circumstances surrounding the birth of the founder of Oye who was said to have been born during a terrible and 'hostile' harmattan which normally blows from the Sahara desert over and across north Africa countries and to all parts of Nigeria. And to preserve his life, he was kept in a dark room with female deity called 'Obalatan' for an unspecified period of time.

Thus, he was observed as a wonderful prince whose birth had been accompanied by a horrible harmattan, while, traditional lamps were lit and arranged in the room both day and night to keep the room warm, coupled with the harmattan was the attendant dryness of his mother's breast so much that she could not breast feed him and rather he was fed with honey in place of breast milk.This is why he was named Oloyemoyin, meaning a harbinger of harmattan who fed on honey and this is express in the cognomen to the child and by extension all autochthons of Oye as; Omo Oloye, Omooraufe Ketaana Osangangan, meaning that Oloye is an aboriginal son of Ile-Ife who always put on light during the day (Oye Progressive Union 1994). According to available oral evidence, the prince left Ile-Ife in company of his brother Ogunlire, the acclaimed founder of Ire-Ekiti, with a remarkable entourage, equipped with large armies, crude weaponry, commanders, seers, oracles, priests and subtle counselors. The entourage on their way from Ile-Ife first settled at UleOyeOra (National Archive Ibadan). At Oye Odo Ora, the aborigines were not happy with such intrusion and as a result fought and scattered them. They, therefore, moved to a new settlement and called it Oye Ekiti, while Ogunlire migrated and settled in Ire-Ekiti. Some settled in Egosi, and others conquered Eshetta and Arigidi while, Oye-Ekiti became the head

of these towns and Oloye was recognized by them as their leader being the eldest son of their mother, Yeye Aiye (National Achieve, District Officer Diary Ibadan)

3.2 Sample Size and Sampling Technique

Sampling size is the number of respondents included in the research. In this study, I have obtained a sample size of two hundred (200) respondents and in which a simple random technique is employed in this survey whereby every respondents has equal chance of been selected or been part of the population.

3.2.1 Inclusion criteria

a. Mothers with at least one daughter

b. Mothers with children younger than age18 from single ton births.

3.2.2 Exclusion criteria

a. Women with no child.

3.3 Research Instrument

Self-administered survey was used to distribute the questionnaires personally to the respondents for the collection of primary data. An interview guide was also used to elicit information from the respondents. The researcher deemed it prudent to combine both structured and unstructured questionnaire in the course of the study.

The instrument for study is a semi structural questionnaire which has 58 questions items. The questionnaire is divided into seven (7) sections as follows:

Section A: Social Demographic Data

Section B: Awareness of women on Female Genital Cutting

Section C: Intention of FGM among Girl(s) and women

Section D: Perception of FGM please indicate

Section E: Knowledge questions

Section G: Practice questions

Section H: Attitude question

The questionnaire was interviewer administered to all respondents to ensure uniformity in the asking of the questions.

3.4 Validity of the instrument

Steps shall take to ensure validity of the questionnaire. First, the questionnaire will be drafted based on relevant information in the literature and the questionnaire was presented to my supervisor for corrections.

3.5 Data Collection

A structured questionnaire was administered at the study area to know the socio-economic status of respondent, attitudes, knowledge and intention of FGM and its determinant among women.Primary data collection for this study was collected based on the use of well-structured questionnaires and field observation. The questionnaire will be used for the collection of data in the sampling area two hundred (200) copies of questionnaire will be effectively administer to the subject (respondents). The researchers will make sure that respondents clearly understood what is required of them. All the two hundreds (200) questionnaire distribute will be collected. The researcher and two research assistants will interview the respondents in Yoruba and record or document their responses.

3.6 Method of Analysis and Techniques

Descriptive Analysis was adopted to analyze demographic characteristics of the respondents which were presented in section 4.1 of this research. Data obtained from the questionnaire administered to the respondents on determinants of Female Genital Mutilation

Intentions among women in Oye-Ekiti, are keyed into the STATA 12.0 program for analysis purposes. In addition, the mean and standard deviation of every item in the questionnaires will be calculated. The analysis is in three levels, the univariate, bivariate and the multivariate analysis. The univariate provides the frequency count of all variables, while the bivariate analysis explains the relationship between two variables. The chi-square test was employed to check for relationship between variables. The multivariate analysis adopted was ANOVA which explains the practice of FGM among different independent groups.

3.7 Research Design

Descriptive research design shall be employed in determining the knowledge, attitude and practice of female genital mutilation (cutting) among women of child bearing age (15 – 49yrs) among women in Oye Local Government, Ekiti State.

3.8 Ethical Consideration

The purpose of the study was explained to the participants and informed verbal consent was obtained before proceeding to the interview. Participation was voluntary with no form of coercion. There wasno undue influence on the participants as they were assured of confidentiality of all information obtained from them.

3.9 Measurement of Variables

The variables with their corresponding measurement are as follows:

Variables	Measurement/definition
Place of residence	Rural/Urban
Religion	Christianity Islamic Traditionalist/Other
Education	No education

	Primary Secondary Post- secondary
Occupation	Not Working Working

3.10 Limitations of the Study

1. Part of the limitation is the issue of time constraints/limited period of time to carry out the study.

2. Another limitation is the problem of translating the questions which were written in English to local language of the respondents which is Yoruba language. But good care was taking to see that questions were well translated without losing their meanings.

3. Part of the limitation is the refusal of respondents to cooperate.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND RESEARCH FINDINGS

4.0 Introduction

This chapter is concerned with data presentation, analysis and discussion of findings.200 women were interviewed based on the research questions raised for this study and different demographic and likert measurement variables were highlighted to track the knowledge, attitude and practice of Female Genital Mutilation in the sampled area. All the research questions were analyzed using simple percentage while the hypotheses were tested at 5% level of significance. The Pearson Chi-square and analysis of variation (ANOVA) were statistical techniques employed to test level of relationship among dependent and independent variables.

Table1: Univariate Analysis of Respondents Socio-Demographic Backgrounds

Variable	Frequency	Percentage
Age		
15-19	1	0.50
20-24	15	7.50
25-29	38	19.00
30-34	37	18.50
35-39	35	17.50
40-44	31	15.50
45+	43	21.50
Total	200	100.00
Religion		
Christian	152	76.38
Islam	37	18.59
Traditional/Others	10	5.03
Total	199	100.00

Income		
Less than 5000	56	28.72
5000-30000	93	47.69
30000-50000	24	12.31
50000-70000	16	8.21
Above 70.000	6	3.08
Total	195	100.00
Education		
No education	1	0.50
Primary	52	26.00
Secondary	90	45.00
Postsecondary	57	28.50
Total	200	100.00
Occupation		
Not working	5	2.50
Housewife	7	3.50
Artisan	27	13.50
Trading	84	42.00
civil servant	37	18.50
self-employed	40	20.00
Total	200	100.00
Number of children		
1-5 children	166	86.46
6-10 children	25	13.02
11-15children	1	0.52
Total	192	100.00
Number of female		
0	1	0.53
1	77	40.74

2	62	32.80
3	38	20.11
4	7	3.70
5	2	1.06
6	1	0.53
7	1	0.53
Total	189	100.00

Source: Author, field survey 2015.

Table 1 shows the percentage distribution of socio-demographic characteristics of women selected for this study. The table revealed that most of them are within ages 45 years above(21.5%), followed by ages 25-29years (19.0%), 30-34years (18.5%) and 35-39years (17.5%) while ages 40-45years, 20-24 and 15-19years take the percentage 15.5%, 7.5% and 0.5%. This implies that most of the respondents are experienced mothers who might have had enough knowledge on female genital cutting.

Majority of the sampled respondents are Christians (76%) while Muslims were 18.59% and 5.03% were Traditional/other religion. The income of women showed that more than two-third earned less than N30.000 monthly (76.41%) while the remaining (less than 15%) earned within N30.000-N70,000 per month. Only 0.5% had no formal education as most of them had at least secondary education (45%), higher education approximately (29%) while primary education was just (26%). Although, most of the women in the sample area are either trading or self-employed (42% or 20%), some work as civil servants (18.5%), artisan (13.5%), 2.5% are not working and full house wives are just (3.5%). The number of children ever born disclosed that most of the women had ever given birth to 1-4 children (86.46%) while those ever born 5+ children were just 13.54%. However most of them had given birth to at least one female child

(40.74%) followed by 2 female children (32.8%), 3 female children (20.11%) and the remaining had 4 or more female children.

Table 2: Awareness and Practice of Female Genital Mutilation among Oye Women

Variables	Frequency	Percentage
Ever heard of FGM		
Yes	192	96.48
No	7	3.52
Total	199	100.00
When heard of FGM		
<10yearsago	45	26.63
10-14yearsago	39	23.08
15-19yearsago	25	14.79
20-24yearsago	21	12.43
25-29yearsago	8	4.73
30-34yearsago	16	9.47
35-39yearsago	7	4.14
40-44yearsago	4	2.37
45+yearsago	4	2.37
Total	169	100.00
From which source did you hear about FGM?	Freq.	Percent
1) Media	39	20.74
2) Government Hospital	114	60.64
3) Private Clinic	19	10.11
4) Others	16	8.51
Total	188	100.00

When is it appropriate to perform the act in young girls?		
Neonate	75	39.06
Infant	103	53.65
Toddler	4	2.60
Adolescent	9	4.69
Total	192	100.00
Have you as a woman ever been circumcised?		
Yes	166	85.13
No	29	14.87
Total	195	100
How old are you then?		
<28days	102	58.96
1-3months	43	24.86
4-6months	1	0.58
7-12months	3	1.73
1-4years	10	5.78
5-9years	5	2.89
10+years	9	5.20
Total	173	100.00
If you have a child in future did you intend to circumcise her		
Yes	138	69.00
No	52	26.00
No response	10	5
Total	200	100.00
Number of girl(s)you have		

1	77	40.53
2	61	32.11
3	40	21.05
4	6	3.16
5	2	1.05
6	1	0.53
7	1	0.53
Total	190	100.00
How many of them done it?		
0	30	15.38
1	73	37.44
2	49	25.13
3	31	15.90
4	9	4.62
5	1	0.51
6	2	1.03
Total	195	100.00
Have you ever heard about FGM		
Yes	189	94.5%
No	11	5.50%
Total	200	100
Source of FGM Knowledge		
Government Hospital	88	44.47%
Private Clinic	34	17.26%
Traditional clinic	2	1.02%
Relative/others	73	37%
Total	197	100

Do you think uncircumcised women get more infection?		
Yes	64	32.82
No	131	67.18
Total	195	100.00
Do you think FGM is legal?		
Yes	108	54.55
No	90	45.45
Total	198	100
Do you think FGM improve fertility?		
Yes	120	60.61
No	78	39.39
Total	198	100
Do you think if the clitoris is not removed the baby will die during delivery		
Yes	79	39.70
No	120	60.30
Total	199	100
Do you know the FGM can prolong labour during childbirth?		
Yes	56	28.28
No	142	71.72
Total	198	100
Is there any law against FGM in your country?		
Yes	77	39.09
No	120	60.91

Total	197	100
Do you think that being circumcised makes no difference during birth?		
Yes	101	51.01
No	97	48.99
Total	198	100
Do you know that FGM is dangerous to female health?		
Yes	69	35.03
No	128	64.97
Total	197	100

Table 2 showed the percentage distribution of respondent awareness of FGM in Oye Ekiti, the results revealed that almost all of them had aware of FGM (96.48%) and only few 3.52% are not aware. In addition, most of them had heard of it even less than 10 years ago (26.63%) and 23.08% had heard about FGM since 10-14yrs ago, also those that had heard about FGM since 15-19yrs ago, 20-24yrs ago and 30-34 years ago were (14.79%), (12.43%) and (9.47%). While the main source of knowledge of FGM was from public sector (60.64%), other sources of knowledge were from media campaign (20.74%), private sector (10.11%) and others (8.51%). Most of the respondents was of the opinion that the appropriate time to perform FGM for young girl was during infant (53.65%) and neonate (39.06%), while those that suggested toddler and adolescent are negligible (2.69% and 4.69%) respectively. Also it was also found that most of the sampled women had ever been circumcised (85.13%) and those not circumcised were 14.87%. And most of them had the experienced when they were less than 28 days (58.96%) followed by

1-3 months (24.86%) while others were insignificant 4-6months (0.58%). 7-12 months (1.73%). 1-4yrs (5.78%) and 5-10yrs plus (8%).

The future intention of mothers revealed that most willcircumcise their future female child (69%) while 26% said they will not.Most respondents had their children circumcised at the government hospitals (44.47%), relatives /other source (37%) and private clinic (17.26%) while traditional clinic were just (1.02%). 67.18% of the respondents were of the opinion that uncircumcised women do not get any infection while 32.82% said they do have. Also most of the respondents said having your female child circumcised is legal (54.55%) while 45.45% said it is illegal: while (60.61%) of women said FGM improve fertility and most of them also declined that not removing clitoris do not kill baby during delivery (60.3%) while 39.7% consented with the opinion. Most of the respondents disclosed that FGM do not prolong labour during childbirths (71.72%) while 28.28%) said it actually caused prolong labour.

Table 3: Practice of FGM among Oye Women

Have you ever undergone FGM?	Yes	172(86.87%)
	No	26(13.13%)
Who takes the final decision to practice FGM in your family	Father	97(51.6%)
	Mother	46(24.47%)
	Majority	39(20.74%)
	Both parent	6(3.19%)
At what age is FGM practiced in your family?	Neonate	78(46.43%)
	Infant	49(29.17%)
	Toddler	14(8.33%)
	Child	24(14.29%)
	Adolescent	3(1.79%)
Do you take part in decision on FGM?	Yes	146(77.66%)
	No	42(22.34%)

Do you think practice of FGM should continue?	Yes No	144(73.47%) 52.(26.53%)
Is FGM a mandatory practice by your religion?	Yes No	100(52%) 92(48%)
Do you think men have role to play preventing FGM?	Yes No	108(55.7%) 86(44.3%)

Table 3 above which show the practice and attitude of respondents to FGM. Most of the respondents disclosed that the father has the final say on child FGM practice (51.6%) while 24.47% said the mother followed by majority / both partner (20.7% and 3.19%) respectively. In addition most of the respondent's family practiced FGM when the child is neonate (< 28days) followed by infant (29.17%) child (14.29%) while toddler and adolescent were (8.33% and 1.17%) respectively. It was also discovered that most of the women took part in the decision of FGM (77.66%) while (73.47%) of the respondents was of the opinion that the practice should continue while only 26.53% said it should not continue.

Table4: Perception on Female Genital Mutilation among women in Oye-Ekiti

Perception by Culture	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Female genital are regarded as dirty and ugly so it must be sanitized	9%	31%	11.5%	23.5%)	25%)
Preference for female genitalia to be flat and dry	5.03%	42.71%	28.64%	18.1%)	5.53%)
Clitoris may harm a new born baby if it comes in contact with it	13%	40%	9%)	22%)	16%)
The clitoris makes a girl behaves like a boy	6.5%	19.5%	16.5%	29.5%	28%

Benefit Perception	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
FGM promotes female virginity	31.5%	37%	9%	14%	8.5%
FGM promotes personal hygiene	17%	41%	15%	17.5%	9%
FGM lower female sexual desire	33%	33.5%	8.5%	17%	8%
It is an essential element in raising a girl child	16%	40%	16%	12%	16%
FGM promotes fertility	21%	41.5%	12.5%	12.0%	13.0%
FGM makes a women/girl accepted among her peers	10%	34.5%	15.5%	19.5%	20.5%

Table 4 disclosed the distribution of women perceptions toward FGM. It was found out that most respondents agree that FGM is an ugly and dirty practice and must be sanitized (31%) with the Mean=2.75 and Standard deviation (SD)=1.36 which above average 2.50 of 5 level of liker scale. Most of the respondents agreed that clitoris may harm a new born baby (40%) with Mean (M)=3.12 and SD=1.32 which is above average 2.50 of 5 level of likert scale. Also most of the respondents disagreed that clitoris make a female child behave like a boy (29.5% and 28%) with Mean (2.47) and SD=1.26 which is below average 2.50 of 5 level of likert scale. The perception benefit that the respondents seek from FGM suggested that most FGM promote female virginity (37% and 31.5%) agreed and strongly agreed with mean (M) 3.69 and SD=1.28 which is above average 2.50 of 5 level of likert scale. FGM promote personal hygiene most of the respondents agree and strongly agreed (41% and 17%) with M=3.40 and SD=1.21 which is above average 2.50 of 5 level of likert scale. it was also found that FGM lower female sexual desire as most of the respondent agreed and strongly agree (33.5% and 33.5%) with mean (M)=3.66 SD=1.31.

while most of the women perceive FGM as an essential element in raising a girl child [illegible]

16%) with mean=3.28 and SD=1.31

Table 5: Bivariate Analysis of women Socio-Demographic characteristics and knowledge of FGM in Oye

Variables	Ever heard of FGM		
Age	**Yes**	**No**	**Total**
15-19	0	1	1
	0.00	100.00	100.00
20-24	14	1	15
	93.33	6.67	100.00
25-29	36	2	38
	94.74	5.26	100.00
30-34	35	2	37
	94.59	5.41	100.00
35-39	34	1	35
	97.14	2.86	100.00
40-44	29	2	31
	93.55	6.45	100.00
45+	41	2	43
	95.35	4.65	100.00
Total	189	11	200
	94.50	5.50	100.00
Pearson chi2(6) = 17.8098 Pr = 0.007			
Marital Status			
Married	168	10	178
	94.38	5.62	100.00
widowed/Divorce/Separated	21	1	22
	95.45	4.55	100.00
Total	189	11	200
	94.50	5.50	100.00
Pearson chi2(1) = 0.0433 Pr = 0.835			
Religion			
Christian	143	9	152
	94.08	5.92	100.00
Islam	37	0	37
	100.00	0.00	100.00
Traditional/Others	8	2	10
	80.00	20.00	100.00
Total	188	11	199
	94.47	5.53	100.00

Pearson chi2(2) = 6.2208 Pr = 0.045			
Income			
Less than 5000	50	6	56
	89.29	10.71	100.00
5000-30000	90	3	93
	96.77	3.23	100.00
30000-50000	23	1	24
	95.83	4.17	100.00
50000-70000	15	1	16
	93.75	6.25	100.00
Total	184	11	195
	94.36	5.64	100.00
Pearson chi2(4) = 4.1949 Pr = 0.380			
Education			
No education	1	0	1
	100.00	0.00	100.00
Primary	49	3	52
	94.23	5.77	100.00
Secondary	86	4	90
	95.56	4.44	100.00
Postsecondary	53	4	57
	92.98	7.02	100.00
Total	189	11	200
	94.50	5.50	100.00
Pearson chi2(3) = 0.5109 Pr = 0.916			
Occupation			
Not working	3	2	5
	60.00	40.00	100.00
Housewife	7	0	7
	100.00	0.00	100.00
Artisan	26	1	27
	96.30	3.70	100.00
Trading	83	1	84
	98.81	1.19	100.00
Civil servant	33	4	37
	89.19	10.81	100.00
Self –employed	37	3	40
	92.50	7.50	100.00
Total	189	11	200

	94.50	5.50	100.00
Pearson chi2(5) = 17.3425 Pr = 0.004			
Number of children 1-5 children	160	6	166
	96.39	3.61	100.00
6-10 children	24	1	25
	96.00	4.00	100.00
11-15children	1	0	1
	100.00	0.00	100.00
Total	185	7	192
	96.35	3.65	100.00
Pearson chi2(2) = 0.0472 Pr = 0.977			

The bivariate analysis shows the distribution of women and their knowledge of FGM.Italso revealed that age of respondents, religion and occupation are significant to knowledge of FGM with respective chi-square ($X2=18.8098, p<0.05$).($X2=6.22, p<0.05$) and ($X2=17.3425, p<0.05$) while other background characteristics of the respondents are not significant at 5% level of significance. Therefore we can conclude that age, religion and occupation of women help in the knowledge of Female Genital Mutilation while other variables like marital status, income, education number of children ever born do not necessarily associated with knowledge of FGM.

Table 6: Bivariate Analysis of women Socio-Demographic characteristics and practice of FGM in Oye-Ekiti

Variables	Ever Practiced FGM on Children		
Age	**Yes**	**No**	**Total**
15-19	0	1	1
	0.00	100.00	100.00
20-24	12	2	14
	85.71	14.29	100.00
25-29	32	5	37
	86.49	13.51	100.00
30-34	31	6	37
	83.78	16.22	100.00
35-39	29	6	35
	82.86	17.14	100.00
40-44	27	4	31
	87.10	12.90	100.00
45+	41	2	43
	95.35	4.65	100.00
Total	172	26	198
	86.87	13.13	100.00
Pearson chi2(6) = 10.1512 Pr = 0.118			
Married	153	23	176
	86.93	13.07	100.00
widowed/Divorce/Separ	19	3	22
	86.36	13.64	100.00
Total	172	26	198
	86.87	13.13	100.00
Pearson chi2(1) = 0.0055 Pr = 0.941			
Religion			

Christian	130	21	151
	86.09	13.91	100.00
Islam	33	4	37
	89.19	10.81	100.00
Traditional Others	8	1	9
	88.89	11.11	100.00
Total	171	26	197
	86.80	13.20	100.00
Pearson chi2(2) = 0.2846 Pr = 0.867			
Income			
Below 5000	50	6	56
	89.29	10.71	100.00
5000-30000	90	3	93
	96.77	3.23	100.00
above 300000	38	2	40
	95	5	100.00
Pearson chi2(4) = 3.3272 Pr = 0.505			
Education			
No education	1	0	1
	100.00	0.00	100.00
Primary	46	6	52
	88.46	11.54	100.00
Secondary	83	6	89
	93.26	6.74	100.00
Postsecondary	42	14	56
	75.00	25.00	100.00
Pearson chi2(3) = 10.3679 Pr = 0.016			
Occupation			
Not working	2	2	4

	50.00	50.00	100.00
Housewife	6	1	7
	85.71	14.29	100.00
Artisan	26	1	27
	96.30	3.70	100.00
Trading	74	9	83
	89.16	10.84	100.00
civil servant	31	6	37
	83.78	16.22	100.00
self-employed	33	7	40
	82.50	17.50	100.00
Pearson chi2(5) = 8.2373 Pr = 0.144			
Number of children			
1-5 children	145	20	165
	87.88	12.12	100.00
6-10 children	23	2	25
	92.00	8.00	100.00
11-15children	1	0	1
	100.00	0.00	100.00
Pearson chi2(2) = 10.4927 Pr = 0.782			

Test of hypothesis

Hypothesis I:

Ho: There is no relationship between socio-demographic background of respondents and practice of Female Genital Mutilation in Oye Local government

Hi: There is relationship between socio-demographic background of respondents and practice of Female Genital Mutilation in Oye Local government

Decision Rule:

Reject Ho if the calculates p-value is less than 0.05 level of significance, otherwise do not reject.

Conclusion

The bivariate analysis in Table 6 shows women's socio-demographic and their practice of FGM, it was revealed that only education of respondents, with chi-square ($X2=10.36, p<0.05$) has significant relationship with FGM practice while other characteristics like age ($X2=10.151, p>0.05$) religion($X2=0.28, p>0.05$), income ($X2=3.327, p>0.05$), children ever born,($X2=10.49, p>0.05$) and occupation ($X2=8.23, p>0.05$).Therefore we can conclude that only educational status of respondent has influence on the practice of Female Genital Mutilation while other variables like age, religion, occupation, marital status, income and number of children ever born do not necessarily associated with practice of FGM.

Table: Analysis of Variance (Anova) of Respondents Perception on Female Genital Mutilation by Socio-demographics and Number of Female Children

Source	Sum of Square	Degree of freedom	Mean Square	F	Prob> F
Religion					
Between groups	.201532994	2	.100766497	0.15	0.8634
Within groups	133.675992	195	.685517909		
Total	133.877525	197	.679581346		
Education					
Between groups	1.24623798	3	.415412661	0.61	0.6109
Within groups	133.356149	195	.683877687		
Total	134.602387	198	.679810035		
Number of female					

children					
Between groups	1.83130032	2	.915650158	1.36	0.2595
Within groups	124.644764	185	.673755478		
Total	126.476064	187	.676342587		

Hypothesis II

Ho: Perception towards FGM is the same among religion affiliation and education status of women in Oye.

Hi: Perception towards FGM is not the same among religion affiliation and education status of women in Oye.

Conclusion

The comparative analysis perception towards FGM by religion affiliation, educational status and number of female children ever born: find out that religion ($F = 0.15$, $p > 0.05$), education ($F = 0.61$, $p > 0.05$) and number of female child ($F = 1.36$, $p > 0.05$) give no statistical confidence for rejecting Ho, we therefore conclude that the perception of respondents toward FGM is the same among religion, education and children ever born at 5% level of confidence. This helped us to deduce that the perception towards FGM is deep in the culture and belief system of Oye people.

Table 7: Analysis of Variance (Anova) of Respondents' Practice of Female Genital Mutilation by Socio-demographics and Number of Female Children

Source	Sum of Square	Df	Mean Square	F	Prob> F
Religion					
Between groups	2.77359194	2	1.38679597	1.60	0.2054
Within groups	170.370739	196	.869238466		
Total	173.144331	198	.874466319		
Education					
Between groups	13.3677254	3	4.45590846	5.45	0.0013
Within groups	160.105051	196	.816862505		
Total	173.472776	199	.871722494		
Number of female					
Between groups	1.90888954	2	.954444772	1.18	0.3101
Within groups	150.675178	186	.8100816		
Total	152.584067	188	.811617378		

Hypothesis II

Ho: Perception and practice of FGM is the same among different level of education of respondents in Oye-Ekiti

Hi: Perception and practice of FGM is not the same among different level of education of respondents in Oye-Ekiti.

Conclusion

The comparative analysis by religion affiliation, educational status and number of children ever born on respondent practice towards FGM find out that religion ($F = 1.601$, $p > 0.05$), education ($F = 5.45$, $p < 0.05$) and number of female child ($F = 1.18$, $p > 0.05$) gives some statistical confidence for rejecting Ho for only education while based on religion and number of female children we do not reject Ho, we therefore conclude that the practice of FGM is not the same among different educational status while they are the same female children ever born and religion affiliation at 5% level of confidence.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECCOMENDATIONS

5.0 Introduction

This chapter is devoted to the presentation of the summary of findings, conclusion and recommendations drawn from the analysis of the research data.

5.1 Summary of Findings

It was discovered that majority of the women sampled in Oye local government had good knowledge of Female Genital Mutilation and the percentage of practice of same is very high in the sampled area. The study found that almost all of them were aware of FGM (96.48%) and only few 3.52% are not aware. In addition, most of them had heard of it even less than 10 years ago (26.63%) and 23.08% had heard about FGM since 10-14yrs ago, also those that had heard about FGM since 15-19yrs ago, 20-24yrs ago and 30-34 years ago were (14.79%), (12.43%) and (9.47%). While most of the source of their knowledge of FGM was from public sector (60.64%) and other source of knowledge were from media campaign (20.74%), private sector (10.11%) and others (8.51%). Most of the respondents was of the opinion that the appropriate time to perform FGM for young girl was during infant (53.65%) and neonate (39.06%), while those that suggested toddler and adolescent are negligible (2.69% and 4.69%) respectively. Also it was also found that most of the sampled women had ever been circumcised (85.13%) and those not circumcised were 14.87%. And most of them had the experienced when they were less than 28 days (58.96%) followed by 1-3 months (24.86%) while others were insignificant 4-6months (0.58%), 7-12 months (1.73%), 1-4yrs (5.78%) and 5-10yrs plus (8%).

The future intention of mothers revealed that most they had the intention of circumcising their future female child (69%) while 26% said they will not.It was revealed that most of the

respondents had their children circumcised at the government hospitals (44.47% [illegible] source (37%) and private clinic (17.26%) while traditional clinic were just (1.02% [illegible] analysis of women socio-demographic and their practice of FGM revealed that only education of respondents, with chi-square ($X2=10.36, p<0.05$) has significant relationship with FGM practice while other characteristics like age ($X2=10.151, p>0.05$) religion($X2=0.28, p>0.05$), income ($X2=3.327, p>0.05$), children ever born.($X2=10.49, p>0.05$) and occupation ($X2=8.23, p>0.05$).Therefore we can conclude that only educational status of respondent has influence on the practice of Female Genital Mutilation while other variables like age, religion, occupation, marital status, income and number of children ever born do not necessarily associated with practice of FGM.

The comparative analysis by religious affiliation, educational status and number of children ever born on respondent perception towards FGM find out that religion ($F=0.15$, $p>0.05$), education ($F=0.61$, $p>0.05$) and number of female child ($F=1.36$, $p>0.05$) give no statistical confidence for rejecting Ho.We therefore conclude that the perception of respondents toward FGM is the same among religion, education and children ever born at 5% level of confidence.

The comparative analysis by religion affiliation, educational status and number of children ever born on respondent practice towards FGM find out that religion ($F=1.601$, $p>0.05$), education ($F=5.45$, $p<0.05$) and number of female child ($F=1.18$, $p>0.05$) gives some statistical confidence for rejecting Ho for only education while based on religion and number of female children we do not reject Ho. We therefore conclude that the practice of FGM is not the same among different educational status while they are the same female children ever born and religion affiliation at 5% level of confidence.

The findings are in agreement with (Creel and Ashford 2001, 543-545) who used the Kenya Demographic and Health Survey (KDHS) 1998 reported that the introduction of early education has enabled people to get rid of the complications associated with Female Genital Cutting.

5.2 Conclusion

Female Genital Mutilation is widely recognized as a violation of human rights, which is deeply rooted in cultural beliefs and perceptions over decades and generations with no easy task for change (Odoi, 2001).

Female Genital Mutilation (FGM), also known as female circumcision or female genital mutilation, is practiced in many societies in Nigeria. This study concluded that only the educational status of respondents has influence on the practice of Female Genital Mutilation while other variables like age, religion, occupation, marital status, income and number of female children ever born do not necessarily associate with practice of FGM.

Also the perception of respondents toward FGM is the same among religion, education and children ever born at 5% level of significance. The practice of FGM is not the same among different educational status while they are the same female children ever born and religion affiliation at 5% level of confidence.

5.3. Recommendations

Motherly education plays a prominentrole in child health. The avoidance of harmful practices like FGM especially at the early age of life through the dissemination of health implications of FGM should be upheld in our society. This should be done to help avert the growing perception on this harmful practice in the area.

This study recommends that adequate sensitization against this harmful practice should continue until the mothers and intending mothers absorbed the health implication of FGM at all levels, as this is a major push to improving our maternal and child health indices. Empowering women autonomy will be of help as most of the mother practice this in submission to family command and not as will.

More sensitization, campaigns rallies, programs, media jingles should be used to rise against the practice of FGM. Persuasion strategies through religious leaders, civil rights groups and other human rights stakeholders should be embarked upon to correct the perception and practice of FGM among older populace who still propagate FGM among young mothers.

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APPENDIX

QUESTIONNAIRE

DETERMINANTS OF FEMALE GENITAL CUTTING INTENTION AMONG WOMEN IN OYE LOCAL GOVERNMENT, EKITI STATE, NIGERIA.

INTRODUCTION AND CONSENT

My name is..... and I am a final year student in the Department of Demography and Social Statistics, faculty of Humanities and Social Sciences, Federal University Oye-Ekiti. Am conducting a survey that asks the women intention on Female Genital Cutting. The questionnaire will only take you few minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Signature of interviewer..... Date.....

Respondent agrees to be interviewed.....

Respondent does not agree to be interviewed.....

SECTION A				
1	Age at last birthday?	.....		
2	Sex	Female	( )	1
		Male	( )	2
3	Marital Status	Single	( )	1
		Married	( )	2
		Separated	( )	3
		Widower	( )	4
		Divorced	( )	5
4	Religion	Islamic	( )	1
		Christianity	( )	2
		Other Christian	( )	3

		Traditionalist	( )	4
		Catholic	( )	5
5	Income	Less than 5000	( )	1
		5000- 30000	( )	2
		30000- 50000	( )	3
		50000-700000	( )	4
		Other Specify	( )	5
6	Level of Education	Primary	( )	1
		Secondary	( )	2
		Post-Secondary	( )	3
7	Occupation	House Wife	( )	1
		Artisan	( )	2
		Trading	( )	3
		Civil Servant	( )	4
		Self-employed	( )	5
8	Number of children (Specify)			
9	Number of female children (Specify)			

SECTION B Awareness of Women on Female Genital Cutting

Kindly tick the most appropriate option based on your level of awareness on each of the under listed statement

10	Have you heard about FGC?	Yes	( )	1
		No	( )	2
11	How long ago did you hear about FGC?			1
				2
12	From which source did you hear about FGC?	Media	( )	1
		Public Sector	( )	2
		Private Sector	( )	3

13	When is it appropriate to perform the act in young girls?	Neonate	( )	1
		Infant	( )	2
		Toddler	( )	3
		Puberty	( )	4
		Adolescent	( )	5

SECTION C Intention of FGC among Girls and Women

14	Have you as a woman ever been circumcised?	Yes	( )	1
		No	( )	2
15	If yes, how old are you then?			
16	If you have a child in future did you intend to circumcise her?	Yes	( )	1
		No	( )	2

17	Number of girl(s)you have	How many of them done it?	

SECTION D: Perception of FGC Please Indicate

SA – Strongly agreed. A – Agreed. U – Undecided

SD – Strongly Disagreed D – Disagreed.

The following are the reason for FGC

		SA	A	U	SD	D
18	Female genital are regarded as dirty and ugly so it must be sanitized					
19	Preference for female genitalia to be flat and dry					
20	Clitoris may harm a new born baby if it comes in contact with it					
21	The clitoris makes a girl behaves like a boy					
22	FGC promotes female virginity					

23	FGC promotes personal hygiene					
24	FGC lower female sexual desire					
25	It is an essential element in raising a girl child					
26	FGC promotes fertility					
27	FGC makes a women/girl accepted among her peers					

KNOWLEDGEOF FEMALE GENITAL CUTTING

28	Have you ever heard about FGC?	Yes	( )	1
		No	( )	2
29	If yes, Where?			
30	Do you think uncircumcised women get more infection?	Yes	( )	1
		No	( )	2
31	Do you think FGC is legal?	Yes	( )	1
		No	( )	2
32	Do you think FGC improve fertility?	Yes	( )	1
		No	( )	2
33	Do you think if the clitoris is not removed the baby will die during delivery	Yes	( )	1
		No	( )	2
34	Do you know the FGC can prolong labour during childbirth?	Yes	( )	1
		No	( )	2
35	Is there any law against FGC in your country?	Yes	( )	1
		No	( )	2
36	Do you think that being circumcised makes no difference during birth?	Yes	( )	1
		No	( )	2
37	Do you know that FGC is dangerous to female health?	Yes	( )	1
		No	( )	2

PRACTICE

38	Have you ever undergone FGC?	Yes	( )	1
		No	( )	2
39	Who takes the final decision to practice FGC in your family	Father	( )	1
		Mother	( )	2
		Majority	( )	3
40	At what age is FGC practiced in your family?			
41	Do you take part in decision on FGC?	Yes	( )	1
		No	( )	2
42	Do you think practice of FGC should continue?	Yes	( )	1
		No	( )	2
43	Is FGC a mandatory practice by your religion?	Yes	( )	1
		No	( )	2
44	Do you think men have role to play preventing FGC?	Yes	( )	1
		No	( )	2

ATTITUDE

		SA	A	D	SD
46	FGC comprises all procedure that involve in partial or total removal of external female genitalia for non-medical reason				
47	It is a tradition, that I have no power over				
48	I believe that there is no mention of FGC in Bible or Quran				
49	FGC is a violation of human right				
50	FGC is still deeply entrenched in Nigerian society				
51	FGC does not add any health benefit to me				