PARENTAL SOCIO-DEMOGRAPHIC CHARACTERISTICS AND THE PRACTICE OF FEMALE GENITAL MULTILATION IN SOUTHERN NIGERIA.

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CERTIFICATION

This is to certify that OLUWAFEYISAYO MARY EBURU of the Department of Demography and Social Statistics, Faculty of Social Sciences, carried out a Research on the Topic "PARENTAL SOCIO-DEMOGRAPHIC CHARACTERISTICS AND THE PRACTICE OF FEMALE GENITAL MULTILATION IN SOUTHERN NIGERIA " in partial fulfillment of the award of Bachelor of Science (B.Sc.) in Federal University Oye-Ekiti, Nigeria under my Supervision.

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DEDICATION

The project is dedicated to the Supreme God, the principal source of my strength, insight and wisdom, who has helped me immensely all through my stay on campus.

Nonetheless, it is also dedicated to every woman of Nigerian citizen or any other Nationality who have at one time or another experienced at least one form of female genital mutilation.

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All glory and adoration to the Lord Almighty for his sustenance and immeasurable grace and **strength that has** kept me throughout my stay on campus.

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Table of content

Chapter Three

Chapter Four

Chapter Five

References

ABSTRACT

Nigeria is a religiously diverse country and due to its large population has the highest absolute number of female genital mutilation (FGM) worldwide, accounting for about one-quarter of the estimated 115-130 million circumcised women in the world. All efforts to end female genital mutilation (FGM) in Nigeria have intensified in recent decades because of the rising awareness that such practice is an act of extreme torture posing a great risk on the reproductive and sexual health of girls and women.

This study aims to determine the parental socio-demographic characteristics on the practice of female genital mutilation in southern Nigeria. In Nigeria, female genital mutilation has the highest prevalence in the south-south (77%) (among adult women), followed by the south-east (68%) and south west (65%).

The quantitative data used in the study was extracted from the 2013 NDHS data sets. Analysis was done at the univariate, bivariate and multivariate level using appropriate statistical techniques. The major reason for the quest for continuation of the practice of female genital mutilation is due to the existing cultural practices the practitioners are accustomed to overtime.

This study concludes that more policies need to be put in place especially in the regions where it is prevalent in a bid to reduce the prevalence of female genital mutilation if not totally eradicate it. There is need to eradicate female genital mutilation in Nigeria and education of the general public at all levels with emphasis on the dangers and undesirability of female genital mutilation is paramount.

CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND OF STUDY

Female Genital Mutilation refers to all procedures involving the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. (World Health Organization, 2008). Female Genital Mutilation (FGM) also called Female Genital Cutting (FGC) or Female Circumcision (FC) has been in existence for a very long time. Although, the history is not well known but the practice dates back to 2000 years and is internationally recognised as a violation of the human rights of females (girls and women).

According to WHO (2008), Female Genital Mutilation varies from country, tribe, and religions, from one state and cultural setting to another. No continent in the world has been exempted. In most part of Nigeria, it is carried out at a very young age (minor) and these are no possibility of individual consent. Also, in Nigeria there is a greater prevalence of type 1 (which is removal of clitoral hood) in the south, with extreme form of its prevalence in the North, Adegoke (2005).

According to the population reference bureau, it was estimated that 100-140 million girls worldwide live with the aftermath of FGM/C at present, approximately 3.3 million girls are likely to be at the risk of FGM every year (Feldman-Jacobs and Clifton, 2016).

The World Health Organization stated that Female Genital Mutilation is also practiced among immigrant communities throughout the world, for instance; in Benin, Chad, Guinea, Mali, Niger and Senegal, families tend to migrate to France to continue the practice whereas those from Nigeria. Kenya and Uganda generally settle in the United Kingdom. (WHO, 2006).

In Africa, FC (Female Circumcision) or FGM (Female Genital Mutilation) is practiced in Nigeria and other 27 African countries (Ibekwe *et al*, 2012). The practice of FGM is prevalent in 27 African countries, also, in some countries in the Middle east and Asia with over 101 million girls aged 10 years and above are living with the consequence(s) of FGM, especially in the western, eastern and the north-eastern regions of Africa. However, the national prevalence rates varies amongst those 27 African countries and for women aged 15 years and above ranging from 0.6% in Uganda to 97.9% in Somalia which has the highest rate as at 2006. The practice is however of a very low proportion in India, Indonesia, Malaysia and Pakistan (Isiaka and Yusuff, 2013).

Based on the latest United Nations estimates for year 2019, the current population of Nigeria is over 199 million and due to its large population, it has the highest absolute number of the practice as stated by the United Nations Population Fund (UNFPA) accounting for about one-quarter of the estimated 130 million survivors of Female Genital Mutilation in the world.

Furthermore, the Nigeria demographic and Health Survey showed estimates of the total prevalence of FGM amongst circumcised women of reproductive ages by geo-political regions; 2.9% for the North Eastern region – thereby amounting to the region with the least prevalence level, 9.9% for the North Central, 20.7% for the North Western region while the South Eastern region had the total highest prevalence rate of 49.0%, as well as 47.5% for the South Western zone and 25.8% for the South -South (NDHS, 2013).

1.1 STATEMENT OF RESEARCH PROBLEM

Nigeria has the highest absolute number of cases of Female Genital Mutilations in the world, accounting for about one-quarter of the estimated 115-130 million circumcised women

worldwide. Female Genital Mutilation is still deeply entrenched in Nigeria society where critical decision makers are grandmothers, mothers, women, opinion leaders, and so on (WHO, 2008). Female Genital Cutting is an extreme example of discrimination based on sex and is believed to have a way of controlling women sexuality. Female Genital Mutilation has been discovered to be a serious harmful traditional practice. It can be described as a cause of serious health hazard for the girl child or woman, inflicting pain, trauma and body injuries (Mutilation). It offers no benefit to anyone other than a misplaced sense of satisfaction. FGM could be carried out in infancy, early childhood, at puberty, shortly before marriage, during first pregnancy and even on the uncircumcised dead woman, regrettably under circumstances that does not take into consideration sepsis, pain, bleeding, trauma and other psychological and physiological implications or knowledge of the female external genitalia (Durkenoo et al., 2007).

There is a general norm/belief that female circumcision prevents female promiscuity, some view it as an hygienic process that should be adopted and others as a religious requirement, fear of being rejected/isolated etc.

Parents who continue this practice are compassionate and loving. They believe that they are protecting their daughters from harm. Reasons that parents and practitioners give for the procedure include rite of passage, preserving chastity, ensuring marriageability, improving fertility, religious requirement, hygiene, and enhancing sexual pleasure for men. Parents who insist that their daughters undergo FGC are driven by a fear that their daughters may never marry. Thus, they believe it improves survival, ensures beauty, and preserves their daughter's reputation.

However, there are lots of complications associated with the practice of female genital mutilation ranging from; shock due to loss of blood and severe pain, increased risk of HIV infection due to

the use of the same sterile instruments in group circumcisions, mortality as a result of chronic pain and shock, morbidity as a result of accumulation of infections difficulties with urination etc. (Oluogunjobi, 2016).

1.2 RESEARCH QUESTIONS

By the end of the study, the following questions must have been justified in details:

i. What is the prevalence of female genital mutilation in southern Nigeria?

ii. What are the socio-demographic characteristics of parents in southern Nigeria?

iii. What influence do parental socio-demographic characteristics have on the practice of female genital mutilation among daughters in southern Nigeria?

1.3 OBJECTIVES OF THE STUDY

GENERAL OBJECTIVE:

The general objective of the study is to determine the influence of parental socio-demographic characteristics on female genital mutilation in southern Nigeria.

SPECIFIC OBJECTIVES:

The specific objectives of this study are to:

(i) Examine the prevalence of female genital mutilation in southern Nigeria;

(ii) Describe the socio-demographic characteristics of parents in southern Nigeria;

(iii) Determine the relationship between socio-demographic characteristics of parents and FGM experience in southern Nigeria.

1.4 JUSTIFICATION OF THE STUDY

This study will be of great importance as Female Genital Mutilation is still prevalent in virtually every part of Nigeria, although gradually reducing over the years. The knowledge from this research will contribute to the existing knowledge on the reasons for the practice of Female Genital Mutilation in Southern Nigeria, and factors that have influenced parent's decision on the practice of Female Genital Mutilation on their daughters, in relation to respondents' background socioeconomic and demographic characteristics in Southern Nigeria.

1.5 DEFINITION OF TERMS

CIRCUMCISION: Surgery that removes the foreskin (the loose tissue) covering the glans of the penis.

FEMALE GENITAL MUTILATION: A procedure performed especially as a cultural rite that typically includes the total or partial excision of the female external genitalia and especially the clitoris and labia minora and now outlawed in many nations including the United States.

FEMALE GENITALIA: The female reproductive organ including the internal and external structures. The female internal genitalia include the ovaries, fallopian tubes, uterus, cervix and vagina, while the female external genitalia are the labia minora and majora (the vulva) and the clitoris.

CLITORIDECTOMY: The surgical removal of the clitoris: a form of female circumcision especially practiced as a religious and ethnic rite.

INFIBULATION: The practice of excising the clitoris and labia of a girl or woman, and stitching together the edges of the vulva to prevent sexual intercourse.

MUTILATION: To injure, disfigure or make imperfect by removing or irreparably damaging external or internal parts.

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.

RITE OF PASSAGE: This is a ritual that marks a change in a person's social status. (Maligaye, 2007).

FEMALE GENITAL MUTILATION: Female Genital Mutilation is a practice which involves a procedure or a variety of operations involving partial or total removal of the external part of female genital organ or other injury to female for cultural, religious or some other non-therapeutic purposes (WHO 2007, Ibekwe, *et al.* 2012:117). FGM has also been defined by medical experts as a destructive, invasive procedure during which part of the entire clitoris is surgically removed, usually before puberty. This practice usually leaves the victims with the reduced or no sexual feeling; orgasm is sometimes impossible to be experienced later in life during sexual intercourse (WREP, 2006).

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

This section reviewed related materials and studies on, incidence, practices, prevalence of female genital mutilation and parent's socio-demographic characteristics. The identification of factors contributing to female genital mutilation is therefore of considerable importance, and so this section shows the parent's socio-demographic factors that were reported to influence the prevalence of female genital mutilation.

2.1 OVERVIEW OF FEMALE GENITAL MUTILATION

According to a WHO estimate, between 100 and 140 million women and girls in the world have undergone some form of Female Genital Mutilation or Cutting (World Health Organization, 2000). Female Genital Mutilation is an internationally recognized term for operations that involve cutting away part or all of the female genitalia. The practice is erroneously termed as "female circumcision", which implies equivalence to male circumcision. Historical origins of female circumcision are unknown. Some reference estimated 2,000 years and stated during what Muslims call "algahiliyyah" the error of ignorance. The term to define the practice of female genital mutilation has undergone a number of changes. According to Boyle (2005), it was stated that WHO adopted to use the term female circumcision because this practice was referred to as a social and cultural issue as opposed to a medical issue (Boyle, 2005).

According to Shell-Duncan et al (2000), the term female genital mutilation (FGM) was adopted at the Third Conference of the Inter African Committee on Traditional Practices

Affecting the Health of Women and Children in 2000 and is now used in the World Health Organization and other United Nations documents to emphasize the violation of human rights involved. At the community level, using the term mutilation can be viewed as being judgmental and condemnatory commonly used by practicing communities.

Violence against women remains a significant problem in all societies and Female Genital Mutilation (FGM) is one of the most severe manifestations. FGM is a harmful traditional practice and a form of violence that directly infringes upon women's (and children's) rights to physical, psychological and social health. In a joint statement, the World Health Organization (WHO), United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA) collectively defined Female Genital Mutilation/Cutting as an act, which "comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for culture or other non-therapeutic reasons" (WHO, UNICEF, UNFPA, 1997: 3).

UNICEF estimates that approximately 135 million women and girls have undergone FGM/C, with 3 million girls and women remaining at risk of the procedure each year (Murphy, 2006). It is also calculated that 100,000 women and teenagers die from complications related to FGM/C in childbirth per annum (Abbas, 2006). Female Genital Mutilation/Cutting is known to be performed in at least 28 African, Middle Eastern and Asian countries (Jabre et al., 1997). The prevalence of FGM/C varies widely from country to country. For example, it ranges from "nearly 90 per cent or higher in Egypt, Eritrea, Mali and Sudan, to less than 50 per cent in the Central African Republic and Cote d'Ivoire, to 5 per cent in the Democratic Republic of Congo and Uganda" (Rahman and Toubia, 2000: 6)2. Increased immigration to Europe has meant that a cultural practice previously associated with the developing world has become an issue, indeed a

problem that needs to be overcome in a culturally sensitive manner in European societies, including Ireland (Leye and Deblonde, 2004; Momoh, 2005).

2.1.1 FEMALE GENITAL MUTILATION IN NIGERIA

Nigeria has the world's third highest FGM/C prevalence. It was estimated that 25 percent or 19.9 million Nigerian girls and women aged 15 to 49 years old underwent female genital mutilation between 2004 and 2015. These absolute numbers are one third of Egypt's 27.2 million victims and Ethiopia's, 23.8 million (UNICEF, 2016a). The Nigerian estimate is consistent with prevalence rates derived from the analysis of the 2013 Nigeria Demographic and Health Survey data (NPC Nigeria and ICF International 2014). According to the US Department of State (2001) report, Type I (commonly referred to as clitoridectomy), Type II (commonly referred to as excision), and Type III (commonly referred to as infibulation) are historically the most common forms of FGM/C in Nigeria. Type IV is practiced to a much lesser extent (Mandara, 2004). It is important to note, however, that analysis of current data shows a high level of prevalence of Type IV across Nigeria, with a total national prevalence of up to 30 percent, a level unusually high for Sub-Saharan Africa, and not often emphasized by practitioners and campaigners in the country.

FGM/C is widely practiced in many Nigerian cultures and is considered important for women's socialisation, curbing their sexual appetites and preparing them for marriage (NPC Nigeria and ICF International 2014). In a study of circumcised women's attitudes towards female circumcision in a Nigerian community where the practice is accepted, Briggs (1998) showed that 62 percent of the 100 interview subjects, from all social strata, favored the practice as an instrument for controlling female sexuality and cultural pride (Briggs, 1998). According to Bodunrin, Mockery, loss of respect, and reduced marriage offers are social sanctions against

non-circumcised females in Nigerian cultures where FGM/C is practiced (Bodunrin 1999). Despite the cultural justifications for the practice, as in many other countries, evidence in Nigeria of declining levels of FGM/C is supported by almost monotonic decrease in the proportion of women circumcised, from oldest to youngest age cohorts. The proportion of circumcised women decreased from 35.8 percent among women ages 45 to 49 to 15.3 percent (NPC Nigeria and ICF International 2014). Despite decreasing support for the practice, however, millions of girls remain in considerable danger of being circumcised. The UNICEF report reveals that a majority of people in most countries where the practice is concentrated oppose it, yet about 30 million girls are still at risk of being cut in the next decade (UNICEF 2013a).

FGM/C has drawn considerable criticism, particularly because of its potential short- and long term medical complications, harm to victims' reproductive health, and infringement on women's rights (Toubia 1995). Despite the medical implications of FGM/C, it persists, as it is deeply rooted in culture (Yerima and Atidoga 2014), and its eradication by government and other stakeholders is challenging. A 1985-1986 national study by the National Association of Nigerian Nurses and Midwives found FGM/C practiced in all states, and in five states at least 90 percent of women had been cut. FGM/C prevalence from 1999 to 2013 remained relatively constant, around 25 percent, or one out every four women of reproductive age (NPC Nigeria and ICF International 2014). Several FGM/C eradication efforts in the last two decades have emphasized the health and psychological consequences suffered by women, although Babalola and Adebajo (1996) found that FGM/C in Nigeria is a cultural practice persisting despite its social and health detriments. The United Nations (UN) banned FGM/C worldwide in 2012. The Nigerian states of Bayelsa, Cross River, Edo, Ekiti, Enugu, Imo, Ogun, Osun, and Rivers each banned the practice, beginning in 1999. Although no federal law banned FGM/C in Nigeria until 2015, opponents of

the practice relied on Section 34(1)(a) of the 1999 Constitution, "No person shall be subjected to torture or inhuman or degrading treatment," as the basis for campaigning for its ban nationwide (US Department of State 2001). In 2015, however, Nigeria's federal government passed a law criminalizing FGM/C in the Violence against Persons (Prohibition) Act 2015, making female circumcision or genital mutilation illegal, with several other forms of violence including forceful ejection from homes and harmful widowhood practices. This marks the first time that the entire country committed to stopping FGM/C through an Act of the National Assembly. Under Nigeria's federal system, acts of the National Assembly such as the VAPP 2015 need to be ratified by each of the 36 state's House of Assembly to apply in those respective states.

Despite all this progress, FGM/C is still actively practiced in six states (Nkwopara 2015), and prevalence rates have remained relatively stable over time. In states such as Edo, where the practice was banned in October 1999, opponents applauded the ban as a step in the right direction but criticized the small fine and lack of enforcement. In fact, persons convicted under the national Act are subject to a paltry 1,000 Naira (US$10) fine and six months imprisonment. A gap in comprehensive knowledge of FGM/C in Nigeria remains, even after the recent developments (Nigeria's 2015 VAPP Act and the new UNFPA/UNICEF global target and call to eliminate FGM/C by 2030), with no rigorous review of the most recent literature and interventions in the country. No study or report has comprehensively examined the types, and effectiveness, of abandonment interventions in the country. This scoping review, therefore, provides a unique opportunity for generating such vital information and providing evidence of the state of research on FGM/C practices in all regions of Nigeria. This review profiles past and present interventions implemented in the country and the indicators of their effectiveness, or

otherwise. This review principally aims to inform FGM/C research and intervention strategies in Nigeria.

2.1.2 TYPES OF FEMALE GENITAL MUTILATION

The meaning of FGM/C is embedded in localized historical, social and cultural practices. Because of the multitude of culturally specific meanings attached to its continuance, its eradication often poses complex challenges and requires a prolonged multifaceted effort (Greunbaum, 2005). The World Health Organisation has outlined four broad types of FGM/C depending on the severity and extent of mutilation that has occurred (WHO, 2000).

World Health organization (WHO) has classified FGC into four types, which are:

Type I (Clitoridectomy): refers to the partial or total removal of the clitoris and/or the prepuce.

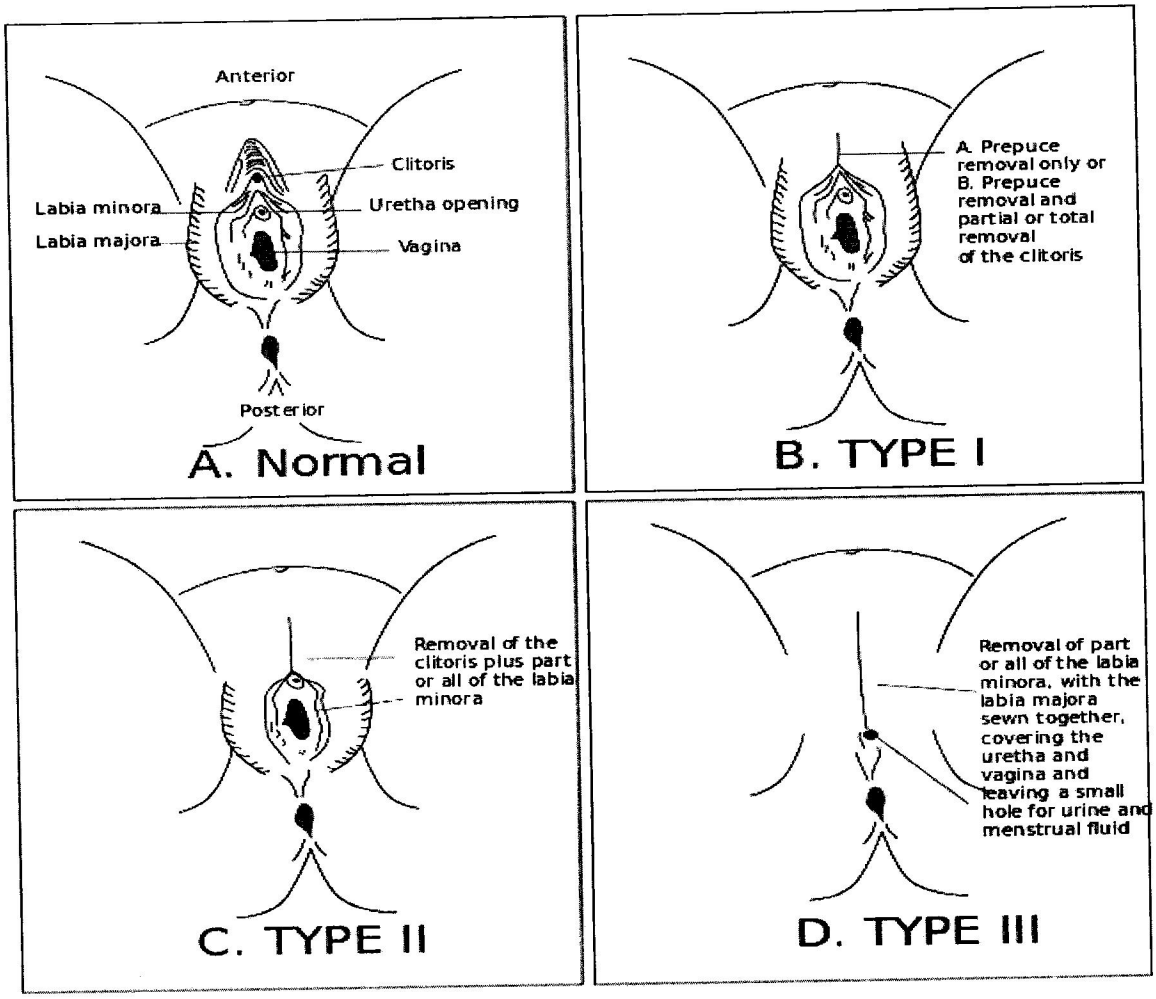
Type II (Excision): refers to the partial or total removal of the clitoris together with the labia minora with or without excision of the labia majora. (The labia are the 'lips' that surround the vagina).

Type III (Infibulation): excision of part or all of the external genitalia and stitching of the vaginal opening, providing a covering seal. This type III is also known as Pharaonic circumcision.

Type IV (Unclassified): Other forms, including pricking, piercing, or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the opening of the vagina (angurya cuts) or cutting of the vagina (gishiri cuts); and introduction of corrosive substances or herbs into the vagina to cause bleeding or to tighten or narrow the vagina.

Various reasons accounted for the type of FGM that is being embraced in different regions. For instance, in a bid to prevent the head of the new baby to get in contact with the clitoris, the type III form of FGM is being widely practiced among the Yorubas from Ekiti and Atakumasi in Osun State, and usually performed before the female child reaches age 1, while in some parts of Edo, Igbo and Yoruba people, FGM is practiced at adolescence before marriage, whereas, others are being performed during pregnancy or owing to the complications with which the first child was given birth to (Mandara 2005; Kolawole 2010). Surprisingly in Nigeria, with exception to the South-South which observes the major form of infibulation, milder forms of the procedure are being observed in other places. Hence, Type I, II, and III are the most common types practiced. And with exception to the Fulanis, all other 5 largest ethnic groups practice at least one form of FGM (U.S. Dept. of State, 2001).

The diagram below shows a representation of the different types and variations of the practice of FGM:



SOURCE: UNICEF, 2013.

2.1.3 EFFECTS OF FEMALE GENITAL MUTILATION

This effect of female genital mutilation can be broadly classified into two:

The immediate, short-term problems faced by women are death, the threat of death from hemorrhaging, and shock due to severe pain, failure to heal as a result of infection and level of violence associated with carrying out the procedure.

The long term effect were infertility due to chronic pelvic infections causing irreparable damage to the reproductive organs, difficulties with menstruation, increased risk of hiv transmission, chronic pelvic, difficulties with urination (Oluogunjobi).

2.1.4 CONSEQUENCES OF FEMALE GENITAL MUTILATION

Reproductive Health Implications

Complications from FGM/C in the long term relate specifically to a woman's sexual and reproductive health, and as such are found to affect her roles in the community, in particular as a wife and mother. Upon marriage, women who have undergone FGM/C, particularly Type III (infibulation), will have to be 'opened' by their husbands on their wedding night, or by a midwife sometime afterward if penetration is not successful. Knives and glass are known tools used in the defibulation6 of women with Type III FGM/C (Black and Debelle, 1995). Women can also face difficulties with conception, due to associated increased risk of infection from unsanitary conditions, for example pelvic inflammatory disease and related infertility problems (Brady, 1999). Labour and delivery has been found to pose significant problems for women who have the procedure (WHO, 2000). A recent study involving 28,509 women by the WHO found that "women with FGM are significantly more likely than those without FGM to have adverse obstetric outcomes. Risks seem higher with more extensive FGM" (WHO, 2006: 1835). Women with FGM/C Types I, II and III were more likely to experience the following: caesarean section, post-partum hemorrhage, extended maternal hospital stay, infant resuscitation, stillbirth or neonatal death, and low birth weight.

The formation of fistulae is another health risk associated with FGM/C. Fistulae are holes that are created between the vaginal wall and the bladder and holes created between the vaginal

wall and the rectum. These holes are usually the result of obstructed labour but FGM/C also to play a part in their formation, and they can result in permanent urinary and faecal incontinence. Some two million women in Africa, Asia and the Arab region are affected, and it is estimated that 50,000-100,000 cases develop each year (UNFPA, 2006).

Psychological and Sexual Health Implications

Post-traumatic stress disorder (PTSD) in both women and children who have undergone FGM/C has been widely documented (Momoh, 2005). According to Behrendt and Moritz (2005), in their pilot study on 23 circumcised Senegalese women in Dakar found that the circumcised women showed a significantly higher prevalence of PTSD (30.4%) and other psychiatric syndromes (47.9%) than the uncircumcised women. In the instance of pregnancy, cases have been noted whereby what are seen as 'routine' procedures, for example internal examinations, can cause a traumatic flashback of the event. Further studies by El-Defrawi et al., (2001) found that circumcised women were statistically more likely to report psychosexual difficulties than non-circumcised women. Statistically significant difficulties were found in circumcised women to include a lack of sexual desire, less initiation of sexual activity with husbands and being less likely to experience climax. The transmission of HIV due to the unsanitary conditions and the use of un-sterile equipment also pose health risks to women and girl children who undergo the procedure (Kun, 1997). A study involving 7,350 girls less than 16 years old found that in 97% of cases, the same equipment could be used on 15-20 girls. The study concluded that the use of the same equipment facilitated HIV/AIDS and infection transmission (Morris, 1999). Moreover, the tissue trauma and lacerations inevitably associated with FGM/C leaves girls and women more likely to contract STIs in general and also HIV specifically, which is often very widespread in the areas in question (WHC, 2006). Research

over the past 10 years has correlated dirty cutting equipment, hemorrhages requiring blood transfusion, and injurious sexual intercourse causing vaginal tearing and lesions with rising rates of HIV transmission among women in countries where FGM/C is still widely practiced (IPPF, 2007).

Negative Social Repercussions of Female Genital Mutilation

The negative implications of FGM/C also extend to the social realm. It has already been noted that women without the procedure risk being outcasts in their communities. It should also be noted that some related health consequences might also cause a woman to be rejected. For example, the majority of women who develop fistulae are abandoned by their husbands because of their inability to have children, and ostracized from their communities because of their foul smell (UNFPA, 2006). Fistula formation is sometimes a recognized ground for divorce, and causes a lack of marriageability, therefore, FGM/C can have the opposite effect of what it sets out to achieve.

Male complications from FGM/C have also been documented; Almroth et al., (2001) report that men experience problems such as difficulty with penetration and associated pain, and the development of wounds and/or infections to the penis. Related psychological problems were also found in that men were concerned about inflicting pain upon their wives. The men also discussed problems after reinfibulation, and the associated medical care costs. A study that included 30 grandfathers and 29 young men, where all but one were married to infibulated women, found that none of the male respondents cited positive health effects from the FGM/C (Adams, 2004). The key finding was that the men involved sympathized with the suffering their wives endure because of FGM/C, and regretted their contribution to that suffering.

2.1.5 FACTORS AFFECTING FEMALE GENITAL MUTILATION

Sensitization and the practice

The clinical care of women with FGM and identified four areas with significant evidence gaps, and controversy regarding optimal management. These include; obstetric outcomes and post-partum care, defibulation (surgical opening of the labia) outside of pregnancy or labour, clitoral reconstruction and training, skills and confidence of healthcare providers. FGM captures popular imagination and triggers emotional responses. They show that it is impossible to offer simplistic solutions or answers, and they attempt to show the importance of the intersection of global discourse and local practice (Shell-Duncan and Ylva, 2000).

According to Gruenbaum (2006), argues that FGM is seen by some as both socially oppressive and physically harmful to women and girls, and the discontinuance of the genital surgeries is seen by others as improving the status of women. She adds that FGM evokes strong negative reactions that are based on humanitarian and feminist values rather than prejudice. (Gruenbaum, 2006).

Attitudes (Opinions) toward the Furtherance or Cessation of FGM

From the previous Demographic and Health Survey conducted in Nigeria, it was reported that 23% of women and 27% of men believe that the procedure of FGM should continue, while a larger proportion of 64% of women and 62% of men were of the opinion that was favourable to the continuation of FGM. Nonetheless amongst the circumcised women, 40% believe that the practice should be continued, while 50% of the circumcised women were not in support of the continuation of the practice. More so, since there is a 41% support for the continuation of FGM amongst the traditional women and men and a 42% percent support for its continuation amongst

men and women from other religion, there is therefore a higher probability that the practice of FGM will continue amongst traditional women than people from other religious groups. In addition, 32% of the Fulani women, 30% of Hausa women and 30% of the Yoruba women have a higher tendency to believe that FGM should continue. However, more rural (25 percent than urban (20 percent) women think that female circumcision should be continued; conversely, urban men (29 percent) are more likely than rural men (26 percent) to think that the practice should continue. Women at higher levels of education and those in the higher wealth quintiles think that female circumcision should be discontinued; however, the pattern by wealth among men is not distinct (NDHS, 2013).

In accordance with the study by Behrendt (2011) in her study on the 'Attitudes of African Immigrants in Hamburg to the practice of FGM'. In her study, she listened to the voices of people in Hamburg – Germany from different African countries as regards whether the procedure should continue or not (Behrendt, 2011).

2.1.6 SOCIO-DEMOGRAPHIC CHARACTERISTICS

Age

The World Health Organization (2010) stated that Female Genital Mutilation is carried out mostly on young girls between infancy and age 15 and an estimated 92million girls in Africa aged 10 and above have undergone Female Genital Mutilation which is internationally recognized as a violation of the human rights of girls and women (WHO, 2010). Female Circumcision is seen as a rite of passage for young girls in some communities and mostly performed between the ages of 4 and 10 (Heather et al, 2011). UNICEF described the procedure

as generally carried out on infants, girls between the ages of 4 and 14, women who are about to be married and sometimes, to women who are pregnant with their first child or who have just given birth (UNICEF, 2005).

Literacy Level

According to UNESCO (2005) inclusive method is the way forward for the hearing impaired. This is the inclusion of training to eliminate illiteracy by mainstreaming schools. The hearing impaired face great challenges in their struggle to attain the academic goals. FGM compounds the problems further as it does not discriminate against them where it is practiced. This study will focus on the impact of FGM on the education of girls with hearing impairment. The impact will be measured in terms of Class attendance, discipline, academic performance, transition to the next level of education and if there are administrative arrangements to assist girls continue with their studies.

Furthermore, the subjects discussed should relate to Female Genital Mutilation, early marriage, human reproduction, pregnancy, childbirth, breastfeeding, hygiene, and nutrition. Educational ceremonies may last for several weeks or months and girls would leave these as women who are ready for marriage (Pracht, 2011). The difference is, she really is ready and prepared mentally. Traditional birth attendants and retired excisors will play a major role in the campaign against the harmful traditional practices. It will be these women, who have proven to be very determined in carrying out social practices, which will continue to carry on the revised practice of education. They will also be provided income for teaching girls to become women in the educational programs. In order for them to educate, these 'mothers of the community' women must first attend training workshops on the educational process (Pracht, 2011).

Place of Residence

It is generally assumed that people in the rural areas are more likely to practice Female Genital Cutting than those in the urban areas due to their level of education concerning FGC. Information about the prevalence of FGC had been collected since 1989 in a series of demographic and health surveys and multiple indicator cluster surveys funded by the United State Agency for international development (USAID) and the United Nation Children Fund (UNICEF). In 2013 UNICEF published a report based on 70 of these surveys, indicating that FGC 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 (UNICEF, 2013).

The national prevalence rate of FGC is 41% among adult women. Prevalence rate progressively decline in the young age group and 37% of circumcised women do not want FGC to continue. 61% of women who do not want FGC to say it was a bad harmful tradition and 22% and it was against religion. Other reasons cited were medical complications (22%) painful personal experience (10%) and the view that FGC 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.

Religion

Female Genital Mutilation under the confident of religion is practiced in numbers of communities who commonly perceive it to be demanded as a religion obligation. Some religious scholars from Sudan believe both male and female circumcision is obligatory, and others encourage female excision as a "preferable good deed" (Dorkenoo, 2004). This may have been

initiated when Egypt's prominent Islamic leader issued, "FGM is an Islamic duty to which all Muslim women should adhere." Regions that are mostly Christian actually have the highest percentage of women affected by FGM (Boyle, 2002). However, neither the Koran, which is the sacred Muslim text, nor the Bible has mention of FGM or a requirement to follow such traditions (Davis, 2011). It will be difficult to convince believers of these communities to stop the practice of FGM without a strong stand by religious leaders forbidding it (Dorkenoo, 2004).

The right to religious freedom is an important human right to everyone. The Universal Declaration of Human rights protects the right to freedom of the thought and conscience and religion. The issue of religious freedom arises because some of the religious institutions are practicing FGM as a matter religion. There is no support of FGM in the Koran, but a number of African communities, where Islam is practiced they believe that FGM is a part of religion. Therefore, Interference of the practice in those religions to discontinue the practice is regarded as a violation of their religious right. The education of the communities must be a kind of ritualistic replacement for the bloody ritual of female genital mutilation. The education needs to be able to keep the other foundations in the community constant while replacing the actual genital mutilation. The main support for FGM comes from the women who enforce it. Education must therefore find an alternative economic option for the women who depend on the income that FGM provides. These women will then find they no longer need to rely on harming young girls for income and will eventually reject the practice (Lightfoot-Klein, 2011). Societies that practice FGM believe that women are better after excision. Women's virginity is highly valued and it is believed that FGM proves to verify this trait in girls. Education will include the common myths of FGM and how it does not ensure virginity. In addition, women can maintain a higher level of hygiene and be more enjoyable for their husbands if they are not excised (Davis, 2011).

Cultural Beliefs

According to Kanitsaki (2004) "Culture includes a particular people's beliefs, value orientations and value systems, which give meaning, logic, worth and significance to their existence and experience in relation to both the universe and other human beings". Culture determines both who you are and what you are, and critically is the determiner of gender roles and identity (Kanitsaki, 2004). It was recognized that each culture has a distinctive moral code. FGM was traditionally associated with rites of passage ceremonies. Demographic and Health Despite the increased awareness of the dangers of FGM on the girl child, particularly on her educational development and empowerment, FGM has persisted in practice by both the elites and the less educated worldwide, especially in Africa (Jones, 2000).

Cultural relativism postulates that any practices grounded in cultural beliefs are not appropriate to be analyzed by anyone outside of that culture (Gruenbaum, 2006). As it is the culture that determines the ethical framework any externally referenced analysis would leave the analyst open to the accusation of moral imperialism. This occurs where a culture believes 'that their way of moral knowing and thinking is not only superior but 'right', and is thus something to be applied universally to others whose moral systems they have judged to be inferior even 'savage'.' When confronted with the trauma of FGM Type III from a western cultural perspective, it is difficult to avoid the trap of moral imperialism (Midgley, 2011). FGM is a matter of custom and tradition or an abuse of human rights. The argument, brought forward by Hughes, is the World Health Organization's (2009) view that Female Genital Mutilation is a deeply rooted, traditional practice that has adverse physical and psychological consequences, in effect making FGM a form of violence against women (Hughes, 2006).

Female genital mutilation (FGM) is a psycho-socio-cultural phenomenon known to most as simply female circumcision. The main aim of this chapter is to examine scholarship on the subject and determine which part of the practice of FGM has rarely or never been researched. This study showed a gap in the literature that my research has attempted to fill. Societies that practice female genital mutilation a number of cultural elements are present. According to these include particular beliefs, behavioural norms, custom rituals, and social hierarchies, religious, political and economic syste0ms. She goes on to write that culture is learnt and children learn from adults. Female genital mutilation has been supported by centuries of tradition, culture and false beliefs and it is perpetuated by poverty, illiteracy as well as the low status of women in societies (Momoh, 2005).

2.2 THEORETICAL FRAMEWORK

Female Genital Mutilation has been interpreted variously, ranging from cultural practice to feminist perspective. Those perspectives have importance to define how FGM is judged and dealt under a human rights premise. One of the underlining theories best suitable to explain the concept of the Female Genital Mutilation is the Feminist theory.

However, feminism refers to the theory that men and women should be politically, economically and socially equal. The definition could as well be referred to as the "Core Feminism" or "Core Feminist Theory" because it is the core of all feminism theories. Whereas, a Feminist is one who believes that both women and men should be politically, economically and socially equal. The feminists' debate over women's rights as human rights poses complex questions on cultural, political, social, and economic conditions. Women, particularly in developing countries, are faced with constant challenges to maintain tradition in the face of rapidly changing social conditions due to globalization and culture change. When maintaining

tradition which involves violating human rights, these challenges can become life threatening, and female genital mutilation is one of the traditions that can become life threatening of women and girls that involved to this practice. According to Morriso (2008) one of the most important activities to feminists is the eradication of Female Genital Mutilation as a harmful practice and promoting integration and empowering women in all societies (Morriso, 2008).

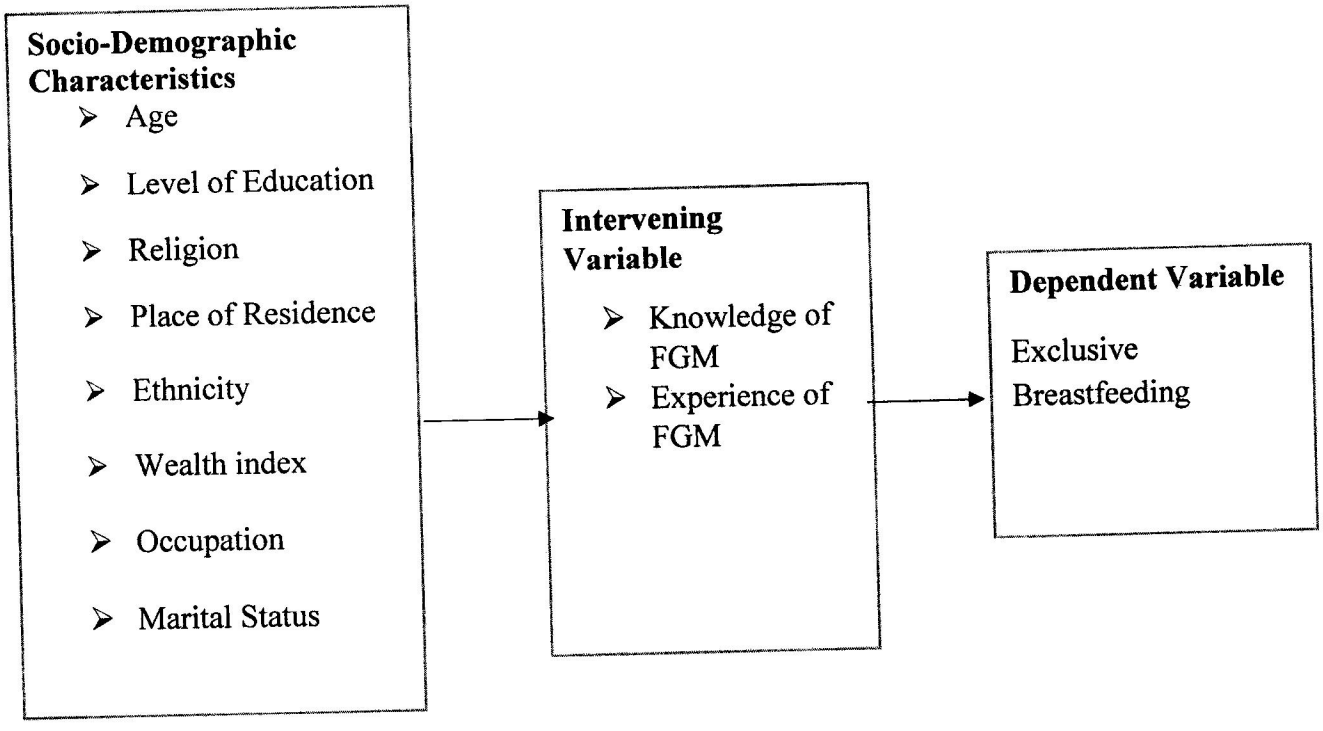
Moreover, there are different variations of the Feminist Theory. The theory differs not only based on the view of the proponents but also because of the environmental or situational context within which it was formulated. The types of Feminist theory are the Liberal Feminism (otherwise referred to as the Individualist or Libertarian Feminism), the Marxist Feminism, the Radical Feminism, Socialist Feminism, Psychoanalytic Feminism, Existentialist Feminism, Postmodern Feminism, Multicultural and Global Feminism: the lenses of sex/gender, class, race, imperialism and colonialism, Cultural Feminism, Maternal Feminism, Amazon Feminism, Gender Feminism, Ecofeminism as well as the Separists.

Of all only two theories the types of feminist theories listed above, there are only two theories that can adequately relate to the concept of Female Genital Mutilation- the **liberal feminism theory** which focuses mainly on gender and gender equality, with specific emphasis on the understanding of human nature, individual autonomy, equality of opportunities, and development of rational and moral capacities as well as self-fulfilment and the **gender feminism theory** which holds that women and men should be open to equal rights. More specifically, women are said to be accorded some superior with exceptional privileges, and men should neither be the primary, core or central focus of development, nor pose a barrier or an impediment in Feminism.

2.3 CONCEPTUAL FRAMEWORK

The conceptual framework goes a long way to providing explanations for how well the selected socioeconomic and demographic variables that serve as predictor variables for Female Genital Mutilation influences parental decisions on the practice among daughters in Southern Nigeria. As shown in the diagrammatical representation below, there are dependent, independent, as well as intervening variables between them. It not only demonstrates the direct relationship that exists between the independent and the dependent variables, but also showcases the mediation that occurs between the independent and dependent variables via the intervening variables. However, the conclusion of the relationships between the variables would form a central part of the analysis and the conclusions of the study.

THE CHART OF CONCEPTUAL FRAMEWORK



Source: Author, Construct, 2018

HYPOTHESIS TESTING

H_0: There is no significant relationship between parent socio-demographic characteristics and female genital mutilation in the southern region of Nigeria

H_1: There is a significant relationship between parent socio-demographic characteristics and female genital mutilation in the southern region of Nigeria

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 INTRODUCTION

This chapter presents the research design, description of study area, study population, sample size and sampling technique, methods of data analysis and other procedures to be followed with a view to achieving the research objectives.

The purpose of this chapter is also to show the research method employed for the collection of data as well as the study limitations.

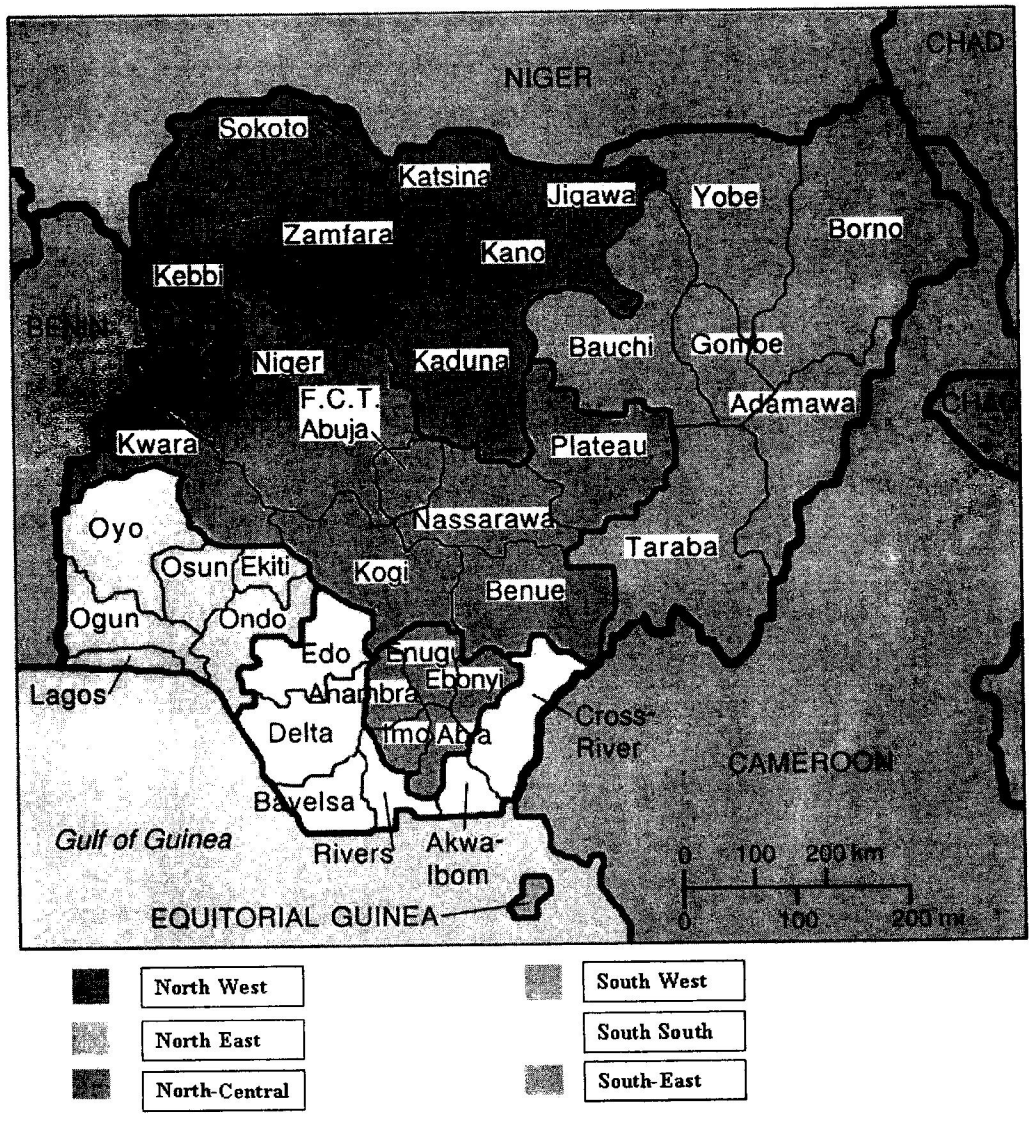
3.1 DESCRIPTION OF THE STUDY AREA

The study area, Southern Nigeria was a British protectorate in the coastal areas of modern-day Nigeria founded in 1900 from the union of the Niger coast protectorate with territories chartered by the Royal Niger Company. In 1914, Southern Nigeria merged with Northern Nigeria to form the colony of Nigeria. In 1939, the Southern provinces were divided into the Eastern and Western regions and on the 1st of October, 1960 these were incorporated into the Federation of Nigeria.

In 1990, the two most important groupings were the Igbo and the Yoruba -both linguistic communities rather than single ethnic units. History, language, and membership in the modern nation-state, however, had led to their identity as ethnic groups. Yoruba land takes in most of south-western Nigeria and the peoples directly west of the Nigerian border in the independent country of Benin. In Nigeria alone, Yoruba land included 20 million to 30 million people in 1990

(i.e., about double the 1963 census figures). Each of its subunits was originally a small to medium-sized state whose major town provided the name of the subgrouping. Over time seven subareas-Oyo, Kabba, Ekiti, Egba, Ife, Ondo, and Ijebu--became separate dominations that differentiated culturally and competed for dominance in Yoruba land.

3.1.1 THE MAP OF NIGERIA



The southern region of Nigeria is sub-divided into three sub-regions, namely:

1. **The South-West Region**

This comprises of 6 states. They are Lagos, Ogun, Oyo, Osun, Ondo and Ekiti states. However, the prominent cities here are Lagos, Ibadan, Akure, Abeokuta, Ogbomoso, Osogbo, Ado-Ekiti. While the Oyo State has the highest population density of 28,454 km^2, Lagos State has the least with a density of 3,345km^2. This region is predominantly occupied by the Yoruba people and their religious beliefs are being held in high esteem, because majority find comfort in it.

2. **The South-East Region**

There are 5 major states in this region, namely: Abia, Anambra, Enugu, Ebonyi and Imo states. The prominent cities in it are Aba, Onitsha, Enugu, Owerri and Abakaliki. Enugu State is the largest with a population density of 7,161 km^2 while Anambra State with a population density of 4,844 km^2 is the least. There are mainly Igbos in the South East. They are well known for their rich culture, trade or business orientation, receptiveness to strangers and being quite hardworking.

3. **The South-South Region**

The South-South Region is majorly made up of Edo, Delta, Rivers, Bayelsa, Cross-River and Akwa-Ibom States, making 6 in total. The major cities in the South-South are Benin, PortHarcourt, Calabar, Warri, Uyo, Yenagoa and Asaba with a population density of 20, 156 km^2 and 7, 081 km^2 for Cross-River and Akwa-Ibom States respectively, the former is the largest in the South-South region, while the latter is the smallest in that region. The ethnic groups that emerged subsequently are the Ijaw in Bayelsa State, Bini and Esan in Edo State, Urhobo and Itshekiri in Delta State, Ikwere and Ogoni in Rivers State, Ibiobio and Amang in Akwa-Ibom State as well as the Efik and Ejagham in Cross River State.

3.2 RESEARCH DESIGN

The sample for the 2013 NDHS was nationally represented and covered the entire population residing in non-institutional dwelling units in the country. The survey was used as a sampling frame, the list of enumeration areas (EAs) prepared for the 2006 Population Census of the Federal Republic of Nigeria, provided by the National Population Commission. The sample was designed to provide population and health indicator estimates at the national, zonal, and state levels. The sample design allowed for specific indicators to be calculated for each of the six zones, 36 states, and the Federal Capital Territory, Abuja.

Administratively, Nigeria is divided into states. Each state is subdivided into local government areas (LGAs), and each LGA is divided into localities. In addition to these administrative units, during the 2006 population census, each locality was subdivided into census enumeration areas. The primary sampling unit (PSU), referred to as a cluster in the 2013 NDHS, is defined on the basis of EAs from the 2006 EA census frame. The 2013 NDHS sample was selected using a stratified three-stage cluster design consisting of 904 clusters, 372 in urban areas and 532 in rural areas. A representative sample of 40,680 households was selected for the survey, with a minimum target of 943 completed interviews per state.

A fixed sample take of 45 households were selected per cluster. All women age 15-49 who were either permanent residents of the households in the 2013 NDHS sample or visitors present in the households on the night before the survey were eligible to be interviewed. In a subsample of half of the households, all men age 15-49 who were either permanent residents of the households in the sample or visitors present in the households on the night before the survey were eligible to be interviewed. The survey used household and questionnaires disseminated by well skilled and proficient enumerators in the use of Global Positioning System (GPS) receivers to aid the calculation of the coordinates, and saddled with the role of administering the questionnaires to

women aged 15-49 who were either permanent residential owners or visitors present in the housing unit the night prior to the enumeration.

The questionnaires used by the 2013 NDHS was structured to suit the country's requisites and reflect on relevant issues relating to female circumcision, maternal and child health, HIV/AIDs among others and without neglecting their evident and prospective socioeconomic and demographic determinants such as age, sex, ethnic group, religious denomination, marital status, wealth quintile, level of education and other household features. More appropriately, the questionnaires were presented in Yoruba, Hausa and Ibo languages to ensure transparency and guard against every occurrence of content errors.

3.3 SAMPLING SIZE AND SAMPLING PROCEDURE

The total number of representative household samples that were selected for the survey was 40,680, 16,740 from urban areas and 23,940 from rural areas. Data on 24,473 currently married women aged 15-49 years was collected from the 2013 NDHS dataset on whether or not they have undergone at least one form of circumcision.

For the sampling procedure, in the first stage, 893 localities were selected with probability proportional to size and with independent selection in each sampling stratum.

In the second stage, one EA was randomly selected from most of the selected localities with an equal probability selection. In a few larger localities, more than one EA was selected. In total, 904 EAs were selected. The resulting list of households served as the sampling frame for the selection of households in the third stage.

In the third stage of selection, a fixed number of 45 households were selected in every urban and rural cluster through equal probability systematic sampling based on the newly updated household listing.

3.4 DATA COLLECTION METHOD

A secondary data was used for this research and the data used for this study is from the 2013 Nigeria Demographic and Health Survey (NDHS). The 2013 Nigeria Demographic and Health Survey (NDHS) is the fifth DHS in Nigeria, following those implemented in 1990, 1999, 2003, and 2008. As the agency charged- with the responsibility of collecting, collating, and analysing demographic data, the Commission has been unrelenting in its efforts to provide reliable, accurate, and up-to-date data for the country.

3.5 METHOD OF DATA ANALYSIS

The data will be analyzed with a quantitative analysis using STATA 13.0 software. The test of significance in each of the hypotheses in this study was based on 0.05 levels of significance.

Also, three levels of analysis were used (univariate, bivariate and multivariate analysis). At the univariate level of analysis, the simple statistics of frequency distributions and tabulations were employed to examine the distribution of respondents according to selected demographic and socio-economic variables. Bivariate analysis will be done using the Pearson Chi-square (X^2) test to establish the level of significance and degree of relationship between parent's demographic characteristics and female genital mutilation. Logistic regression was used in the multivariate analysis in testing the study hypothesis.

3.6 MEASUREMENT OF VARIABLES

The dependent variable is the Female Genital Mutilation, which is determined by the values of the independent variables.

Variables	Measurement/definition
LEVEL OF EDUCATION	No formal education Primary Secondary Post-secondary
REGION	South-east South-west South-south
RELIGION	Christianity Islam Traditional Others
PLACE OF RESIDENCE	Urban Rural
ETHNICITY	Yoruba Ibo Hausa
MARITAL STATUS	Single Married Divorced Separated

3.7i STRENGTHS OF THE STUDY

Some of the advantages or merits embedded in the use of secondary data such as the 2013 NDHS are as follows:

- It is economical: Secondary data are data that have already been collected and readily available from other sources and as a result of this, it saves cost and efforts that would have been used in printing questionnaires or conducting focus group discussions/interviews.
- It saves time, easy to analyze and makes analysis of data faster.
- It makes available some enquiries that cannot be collected through primary data.
- It provides a basis for conducting/investigating other researches.

ii LIMITATIONS OF THE STUDY

The 2013 NDHS data is the data that will be used for this study which is a secondary data. It is a national sample survey, although, a few inadequacies and shortcomings are rather inevitable.

- It is not a descriptive survey, the dataset used for the analysis of this study were derived from the 2013 NDHS.
- It is not updated. The last NDHS data was in 2013 which has an interval of six years from now. Therefore, there must have been countless alteration of socioeconomic and demographic characteristics of the respondents among the sample proportion. As a result of the data which would have been likely been faulted with errors, inadequacies and inconsistencies, a recent data would have been much more preferable.
- Secondary data are not available for all types of enquiries.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.0 INTRODUCTION

This chapter showed the presentation, analysis and interpretation of the data collected from the 2013 Nigeria Demographic and Health Survey (NDHS) to show the influence of parent's socio-demographic characteristics on female genital mutilation among daughters in Southern Nigeria. For the purpose of analysis, this study will make use of descriptive analysis and inferential analysis. However, in support of descriptive statistics and inferential analysis, Pearson Chi-square test will be used to ascertain relationship while logistic regression analysis was used in testing the study hypothesis.

4.1.1 The Prevalence of Female Genital Mutilation by Weighted Percentage.

Background Characteristics	Frequency	Percent
Female Genital Mutilation		
No	36	2.6
Yes	1350	97.4
Total	**1,386**	**100.0**
Removal of clitoris, partial or total excision of the labia minora		
No	684	49.4
Yes	702	50.6
Total	**1,386**	**100.0**
Infibulation: removal of clitoris, labia minora, medial part of labia majora,		
No	1,329	95.9
Yes	57	4.1
Total	**1,386**	**100.0**
Scraping of tissue surrounding the vaginal orifice		
No	830	59.9
Yes	556	40.1
Total	**1,386**	**100.0**

Cutting of the vagina		
No	1,287	92.9
Yes	99	7.1
Total	**1,386**	**100.0**
Ever heard of Female Circumcision		
No	293	21.1
Yes	1,093	78.9
Total	**1,386**	**100.0**

Table 4.1.1: The Prevalence of Female Genital Mutilation by Weighted Percentage.

The results in Table 4.1.1 shows the merging of 'Female Genital Mutilation' and 'Prevalence of Ever Heard Female Genital Mutilation'. The removal of clitoris, partial or total excision of the labia minora was reported ''YES'' by 50.6% and ''NO'' by 49.4%. The Infibulation: removal of clitoris, labia minora, medial part of labia majora, was reported ''NO'' by 95.9% and ''YES'' by 4.1%. The Scraping of the tissue surrounding the vaginal orifice were reported ''YES'' by 40.1% and those that reported ''NO'' were 59.9%. Cutting of the vagina were reported ''YES'' by 7.1% and ''NO'' by 92.9%.

The four types of Female Genital Mutilation were merged together to give their prevalence, those that said ''YES'' were 97.4% and those that reported ''NO'' were 2.6%. Ever heard about female genital mutilation were reported ''YES'' by 78.9% and those reported ''NO'' were 21.1%.

4.1.2 Distribution of Parent's Socio-Demographic Characteristics by Weighted Percentage.

Background Characteristics	Women		Men	
	Frequency	Percent	Frequency	Percent
Age				
15-19	125	8.3	1	0.1
20-24	259	17.1	48	3.2
25-29	371	24.5	145	9.6
30-34	328	21.7	289	19.1
35-39	260	17.2	305	20.1
40-44	129	8.5	337	22.3
45-49	42	2.8	388	25.7
Total	**1,513**	**100.0**	**1,513**	**100.0**
Place of Residence				
Urban	618	40.8	618	40.8
Rural	895	59.2	895	59.2
Total	**1,513**	**100.0**	**1,513**	**100.0**
Level of Education				
No education	660	43.6	442	29.2
Primary	305	20.1	410	27.1
Secondary	434	28.7	481	31.8
Higher	114	7.6	180	11.9
Total	**1,513**	**100.0**	**1,513**	**100.0**
Ethnicity				
Yoruba	243	16.0	248	16.4
Hausa	741	49.0	731	48.3
Igbo	248	16.4	254	16.8
others	281	18.6	279	18.5
Total	**1,513**	**100.0**	**1,513**	**100.0**
Region				
North Central	70	4.6	70	4.6
North East	33	2.2	33	2.2
North West	763	50.5	763	50.5
South East	211	14.0	211	14.0
South South	187	12.4	187	12.4
South West	249	16.5	249	16.5
Total	**1,513**	**100.0**	**1,513**	**100.0**
Religion				
Christianity	599	39.8	585	38.8
Islam	889	59.0	894	59.4
Traditional	18	1.2	27	1.8
Total	**1,505**	**100.0**	**1,506**	**100.0**
Wealth Status				
Poor	642	42.5	642	42.5
Middle	246	16.4	246	16.2
Rich	625	41.3	625	41.3
Total	**1,513**	**100.0**	**1,513**	**100.0**

Employment Status				
Not employed	388	25.7	14	1.0
Employed	1,124	74.4	1,496	99.0
Total	**1,511**	**100.0**	**1,510**	**100.0**

The results in Table 4.1.2 shows the socio-economic and demographic characteristics of Women. It was reported that women in age group 25-29 years were 24.5%, followed by age group 30-34 years by 21.7%, age 35-39 years and age 20-24 years by 17.2 and 17.1 respectively, age 40-44 years and age 20-24 years were 8.5% and 8.3% respectively and the least reported were age 45-49 years by 2.8%. Women from rural area reported were 59.2% and those from urban area were 40.8%. Women with no formal education reported were 43.6%, secondary and primary education reported were 28.7% and 20.1% respectively and the least reported were those attained higher education by 7.6%. Hausa women were more reported by 49.0%, igbo and yoruba by 16.4% and 16.0% respectively, the least were other ethnicity by 18.6%. Women from north-west region accounted for more than half of the population by 50.5%, followed by north-central and north-east by 4.6% and 2.2% respectively, Women from south-west were more reported in southern region by 16.5%, followed by south-east and south-south by 14.0% and 12.4% respectively. Also muslim women were mostly reported by 59.0%, Christian women by 39.8% and the least were traditional women by 1.2%. Based on wealth quartile poor women were more reported by 42.5%, rich women by 41.3% and the least were those in the middle quartile by 16.4%. Employed women were mostly reported by 74.4% and not employed women by 25.7%.

Also, the results in Table 4.1.2 below showed men socio-economic and demographic characteristics. Men age 45-49 years were mostly reported by 25.7%, followed by age 40-44 years and age 35-39 years by 22.3% and 20.1% respectively, age 30-34 years and age 25-29 years by 19.1% and 9.6% respectively, age group 20-24 years and age 15-19 years by 3.2% and

0.1% respectively. Men were mostly reported from rural area by 59.2% and urban area by 40.8%. Men with secondary education were highly reported by 31.8%, those with no formal education by 29.2%, those with primary and higher education were 27.1% and 11.9% respectively. Hausa men were mostly reported by 48.3%, followed by igbo and Yoruba by 16.8% and 16.4% respectively, and other ethnicity were reported by 18.5%. Men from north-west region accounted for more than half of the population by 50.5%, followed by north-central and north-east by 4.6% and 2.2% respectively, Women from south-west were more reported in southern region by 16.5%, followed by south-east and south-south by 14.0% and 12.4% respectively. Muslim men were more reported by 59.4%, Christian men by 38.8% and the least were those with traditional religion by 1.8%. Based on wealth quartile poor men were more reported by 42.5%, rich women by 41.3% and the least were those in the middle quartile by 16.4%. Employed men were mostly reported by 99.0% and not employed by 1.0%.

4.2.: Distribution of Parent's Socio-Demographic Characteristics and Female Genital Mutilation.

	Women		Men	
	FGM		FGM	
Background Characteristics	**No**	**Yes**	**No**	**Yes**
Age				
15-19	14.1	8.1	0.0	8.80E-04
20-24	19.7	17.1	10.4	3.0
25-29	32.7	24.3	11.5	9.5
30-34	6.6	22.0	22.0	19.0
35-39	13.8	17.3	32.9	19.8
40-44	13.0	8.4	7.4	22.6
45-49	0	2.9	15.8	25.9
Statistics	**X^2= 7.57**	**Pr= 0.3663**	**X^2= 12.51**	**Pr= 0.0851**
Place of Residence				
Urban	34.4	41.0	34.4	41.0
Rural	65.6	59.0	65.6	59.0

Statistics	**X^2= 0.55**	**Pr= 0.5811**	**X^2= 0.55**	**Pr= 0.5811**
Level of Education				
No education	55.6	43.4	38.2	29.0
Primary	13.4	20.3	25.6	27.2
Secondary	26.1	28.7	27.7	31.9
Higher	4.8	7.6	8.6	12.0
Statistics	**X^2= 2.17**	**Pr= 0.5379**	**X^2= 1.40**	**Pr= 0.6999**
Ethnicity				
Yoruba	12.7	16.1	11.6	16.5
Hausa	56.4	48.8	54.0	48.2
Igbo	25.0	16.2	27.3	16.6
Others	5.9	18.9	7.0	18.7
Statistics	**X^2= 4.80**	**Pr= 0.2708**	**X^2= 5.05**	**Pr= 0.2425**
Region				
North Central	1.6	4.7	0.016	0.0467
North East	0.0	2.2	0	0.0223
North West	54.0	50.4	0.5404	0.5037
South East	23.8	13.7	0.2379	0.1372
South South	6.7	12.5	0.0667	0.1248
South West	13.9	16.5	0.1389	0.1654
Statistics	**X^2= 4.62**	**Pr= 0.5165**	**X^2= 4.62**	**Pr= 0.5165**
Religion				
Christianity	37.8	39.9	37.8	38.9
Islam	62.2	59.0	62.2	59.3
Traditional	0.0	1.1	0.0	1.8
Statistics	**X^2= 0.47**	**Pr= 0.8894**	**X^2= 0.6314**	**Pr= 0.8379**
Wealth Status				
Poor	57.9	42.1	57.9	42.1
Middle	10.1	16.4	10.1	16.4
Rich	32.0	41.5	32.0	41.5
Statistics	**X^2= 3.21**	**Pr= 0.3109**	**X^2= 3.21**	**Pr= 0.3109**
Employment Status				
Not employed	19.0	25.8	0.0	1.0
Employed	81.0	74.2	100.0	99.0
Statistics	**X^2= 0.74**	**Pr= 0.5841**	**X^2= 0.31**	**Pr= 0.6591**

Table 4.2.: Distribution of Parent's Socio-Demographic Characteristics and Female Genital Mutilation.

The results from table 4.2 revealed that there is a significant association between parent's socio-demographic characteristics and female genital mutilation ($P<0.05$). The outcome of the result showed that there is no significant association between parent's socio-demographic characteristics and female genital mutilation.

4.3: Odd Ratio Based on Logistic Regression Analysis of Parent's Socio-Demographic Characteristics and Female Genital Mutilation.

	Women		Men	
	Model 1		Model 2	
Background Characteristics	**Odd Ratio**	**Confidence Interval**	**Odd Ratio**	**Confidence Interval**
Age				
15-19 (RC)	**1.00**		**1.00**	
20-24	1.27	(0.32-5.15)	2.22E-05	(1.91E-06-0.000257)
25-29	1.28	(0.34-4.77)	4.99E-05	(2.44E-06-0.00102)
30-34	6.25*	(1.43-27.34)	5.03E-05	(3.60E-06-0.000702)
35-39	2.08	(0.35-12.47)	3.37E-05	(2.86E-06-0.000398)
40-44	1.27	(0.26-6.24)	0.000197	(1.74E-05-0.002233)
45-49	1.0	(0.0-0.0)	9.42E-05	(9.97E-06-0.000891)
Place of Residence				
Urban (RC)	**1.00**		**1.00**	
Rural	0.75	(0.37-1.54)	0.71	(0.32-1.60)
Level of Education				
No education (RC)	**1.00**		**1.00**	
Primary	2.84*	(1.17-6.91)	1.41	(0.36-5.46)
Secondary	2.36	(0.60-9.26)	1.55	(0.23-10.44)
Higher	2.63	(0.28-24.42)	1.17	(0.16-8.51)
Ethnicity				
Yoruba (RC)	**1.00**		**1.00**	
Hausa	0.62	(0.09-4.49)	0.51	(0.12-2.22)
Igbo	1.58	(0.17-14.39)	0.44	(0.07-2.63)
Others	4.34	(0.28-67.05)	1.62	(0.23-11.19)
Region				
North Central (RC)	**1.00**		**1.00**	
North East	1.00	(0.0-0.0)	1.00	(0.0-0.0)
North West	2.12	(0.16-28.99)	1.59	(0.19-13.12)
South East	0.13	(0.01-2.54)	0.28	(0.02-3.70)
South South	0.23	(0.01-6.70)	0.29	(0.02-4.29)
South West	0.46	(0.06-3.28)	0.33	(0.04-2.56)
Religion				
Christianity (RC)	**1.00**		**1.00**	
Islam	0.96	(0.17-5.60)	0.55	(0.08-3.50)
Traditional	1.00	(0.0-0.0)	1.00	(0.0-0.0)
Wealth Status				
Poor (RC)	**1.00**		**1.00**	
Middle	2.24	(0.64-7.83)	2.19	(0.57-8.46)
Rich	1.70	(0.35-8.42)	2.12	(0.42-10.75)
Employment Status				
Not employed (RC)	**1.00**		1.00	
Employed	0.51	(0.11-2.47)	1.00	(0.0-0.0)

RC means the reference categories *P<0.05 **p<0.01 ***p<0.001.

Table 4.3 shows the result of logistic regression of the effect of parent's socio-demographic characteristics on Female Genital Mutilation. The results from Model 1, reveals that women's level of education significantly influenced Female Genital Mutilation whereby women with primary education were 2.84 and more likely to practice Female Genital Mutilation than women with no formal education (RC).

The results from Model 2 shows that there is no significant relationship between men's socio-demographic characteristics and Female Genital Mutilation.

HYPOTHESIS TESTING

H_0: There is no significant relationship between parent socio-demographic characteristics and female genital mutilation in the southern region of Nigeria

H_1: There is a significant relationship between parent socio-demographic characteristics and female genital mutilation in the southern region of Nigeria

DECISION

From the binary logistic regression, the relationship between parent's socio demographic characteristics and female genital mutilation is statistically significant in ($P< 0.05$), from this, we can conclude that there is a significant relationship between women level of education and female genital mutilation. Whereby there is no significant relationship between men socio-demographic characteristics and female genital mutilation. Therefore we partially accept the null hypothesis.

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 study. The overall objective of this study is to explore the influence of parental socio demographic characteristics on female genital mutilation in Southern Nigeria. The study was based on the sample size of 1,513 couples of reproductive ages in the study area.

5.1 DISCUSSION OF FINDINGS

These findings were supported by the literature which indicates, that each culture has a distinctive moral code. Female Genital Mutilation was traditionally associated with rites of passage ceremonies. Demographic and Health Despite the increased awareness of the dangers of FGM on the girl child, particularly on her educational development and empowerment, FGM has persisted in practice by both the elites and the less educated worldwide, especially in Africa (Jones, 2000).

According to Ongong'a, it was suggested that in most regions of the world, women receive less formal education than men do, and at the same time, women's knowledge, abilities and coping mechanisms often go unrecognized. Education is one of the most important means of empowering women with the knowledge, skills and self-confidence necessary to participate fully in enhancing socioeconomic change. Another issue was the issue of educational influence which motivated them to get married of which they must undergo the "cut" for them to attain that objective (Ongong'a 2000). It was stated that educational ceremonies may last for several weeks

or months and girls would leave these as women who are ready for marriage and in this case they must undergo FGM to attain this objective (Pracht, 2011).

The absences of expertise in the influence of the community members to eradicate Female Genital Mutilation was a major problem, this does not only affect the girl physically but also psychologically. According to Gruenbaum, he argued that Female Genital Mutilation is seen by some as both socially oppressive and physically harmful to women and girls, and the discontinuance of the genital surgeries is seen by others as improving the status of women. Those who are from Islamic religion had different perception about the practice compared to Christians. Islamic believers were at first supporting Female Genital Mutilation because of the information they received from their parents and community elders when they were young that it was part of the Islamic rule. Some women mentioned that after the practice, one feels incomplete, she meant one of their important parts of their body that makes them feel as women is missing. She also mentioned some of the churches in her own country, which have shown cooperation in campaign against Female Genital Mutilation these were: Evangelical Lutheran churches, Seventh Day Adventist church, Catholic Church, Anglican Church.

The Female Genital Mutilation beliefs, religion and bride wealth may be more complicated in the belief revision. In order to stop Female Genital Mutilation followers who practice for the sake of religion, religious leaders must take a firm stand of forbidding the practice. Otherwise it will still be considered a requirement by religion, therefore, individuals and whole communities will continue to fulfill their religious duty despite its severe consequences (Dorkenoo, 2004).

5.2 SUMMARY OF THE FINDINGS

Based on the outcome of parent's socio-demographic characteristics and practice of female genital mutilation, the results from Table 4.1.1 showed the practice of female genital mutilation, this showed that the practice of female genital mutilation is most rampant among parents and this vary around various type of FGM. Parents reported more to heard about female genital mutilation.

Also, result from table 4.1.2 showed various socio-demographic characteristics of parents. The result from table 4.2 further showed no significant association between parent's socio-demographics characteristics and female genital mutilation at p-value less than 0.05 level of significant.

In the multivariate analysis, the result showed the effect of parent's socio-demographic characteristics on female genital mutilation. From model 1, Result from Model 1, reveals that women level of education significantly influenced female genital mutilation whereby women with primary education were 2.84 more likely to practice female genital mutilation than women with no formal education (RC).

Result from Model 2 showed that there is no significant relationship between men's socio-demographic characteristics and female genital mutilation.

5.3 CONCLUSION

The discussion is focused on the results, challenges, and limitations encountered during this research process. The result confirms that the practice of Female Genital Mutilation is a social consequence that is affecting a number of women and young girls socially, psychologically and physically. To eradicate the practice, there are need for educational

campaigns in the communities that practice Female Genital Mutilation. Although many African countries have criminalized the practice of Female Genital Mutilation, this is not enough because the practice is deeply rooted in cultural and traditional practices. The campaigns needed to include topics on human rights violations and the harmful effects caused by FGM. Issues dealing with culture are so sensitive and therefore those planning to tackle the issue of female genital mutilation that is deeply rooted in culture and traditional beliefs, should have enough knowledge on other people's culture and should not generalize culture.

Thus this study conclude that base on the facts from the result that women level of education influenced female genital mutilation where p-value less than five percent level of significant.

5.4 RECOMMENDATION

The following are recommendations of the study:-

1. Local leaders should come together with other stakeholders and should enforce women and girls' rights through participatory/advocacy for education-in-culture and culture-in-education.

2. The Ministry of Education, Science &Technology needs to strengthen its facilities and supervise mechanisms in both rural and urban area to stop its staff from performing the practice. The Ministry should develop guidelines for the local government supervisors on the appropriate actions to take to detect and prevent the practice.

3. Education on existing policies and laws are needed so that providers and other community leaders and even religion leaders can understand and discuss female genital cuttings issues competently, dissuade communities from continuation, support women and girls who oppose the practice, and manage complications arising from it.

4. More severe punishment should be taken against those that are caught in the practice of female genital cuttings. Local administration personnel (such as police, chiefs, children's officers, and social workers) should actively pursue those known to be involved and to close unregistered facilities and seasonal clinics and also those that practice it in isolation.

5. Finally, research on the knowledge and practice of female genital cuttings and other socio-demographic and economic variable must be done in other to figure out more factors that may influence and promote the practice in Nigeria.

SUGGESTION FOR FURTHER RESEARCH

The practice of Female Genital Mutilation is rampant and when studying about people and their culture, the historical, economical, social, political and geographical factors need to be taken into consideration, because they are part of the people and their life.

REFERENCES

Adetunji, S .(2018). The Impact of Parental Education Level, Wealth Status, and Location on Female Genital Mutilation Prevalence in North western Liberia.

Ahanonu, E.L., & Victor,O.(2014). Mothers'perceptions of female genital mutilation, *29*(4),683–689. https://doi.org/10.1093/her/cyt118

Berg,R.C.,Underland,V.,Odgaard-jensen, J., & Fretheim, A. (2014). Effects of female genital cutting on physical health outcomes: a systematic review and meta-analysis,1–12. https://doi.org/10.1136/bmjopen-2014-006316

C,I.P.,C,O.R.,K,O.A.,O,E.P.,&O,I.R.(2012). Female genital mutilation in Southeast Nigeria: A survey on the current knowledge and practice, *4*(May),117–122. https://doi.org/10.5897/JPHE11.194

Centre, N.K.,& Services, H.(2014). *Immediate health consequences of female genital mutilation /cutting (FGM/C).*

Clark,V.,Bc,G.,Davis,V.,On,S.,Rutherford,M.,Ns,H.,...Ns,H.(2013). Female Genital Cutting, *35*(299).

Complications,H.(n.d.). Female Genital A Student's Manual Female Genital, 1–104.

Edna,T.,Maternity,A.,&Hospital,T.(2009). Female Genital Mutilation Survey In Somali land.

Journal,S.E.,&Milde,F.(2017). Department of Cultural Anthropology Author: Farnoosh Rezaee Ahan Theories on Female Genital Mutilation Advanced Study of Anthropological Theory Department of Cultural Anthropology October 2012 Professor :Jan Ovesen By :Farnoosh Rezaee Ahan Electronic copy available at :http://ssrn.com/abstract=2250346, (October). https://doi.org/10.2139/ssrn.2250346

Kandala, N., & Komba,P.N.(2015). Geographic Variation of Female Genital Mutilation and Legal Enforcement in Sub-Saharan Africa: A Case Study of Senegal, *92*(4),838–847. https://doi.org/10.4269/ajtmh.14-0074

Mberu, B.U. (2017). Female genital mutilation/cutting in Nigeria: A scoping review,(May).

Ministry, F., Health,O.F.,Iii,P.,& Secretariat, F.(2007). Elimination of Female Genital Circumcision in Nigeria, (December).

Mitike, G.,& Deressa,W.(2009). Prevalence and associated factors of female genital mutilation among Somali refugees in eastern Ethiopia across-sectional study, *10*. https://doi.org/10.1186/1471-2458-9-264

Monjok C. E.,Essien,E.J.,& Holmes,L.(2007). Female Genital Mutilation :Potential for HIV Transmission in sub-Saharan Africa and Prospect for Epidemiologic, (713).

Moreover,C.(n.d.). Towards an African Future Without FGM/C Amref Health Africa is committed to end FGM/C in Sub-Saharan Africa by 2030,13–15.

Morrison, B.S.,& Ph,D. (2008). Feminist Theory and the Practice of Female Genital Mutilation (FGM), 125–130.

Olaitan, O.L., & Ph,D. (2010). Knowledge of female genital cutting among parents in south west Nigeria,*1*.

Olaniran, A.A. (2013). The Relationship between Female Genital Mutilation and HIV Transmission in Sub-Saharan Africa, *2013* (December), 156–160.

Profile, C. (2016). COUNTRY PROFILE : FGM IN NIGERIA, (October).

R,A.A., O, O.A., & Asabi, O.(2012). Knowledge and Practice of Female Circumcision among Women of Reproductive Ages in South West Nigeria, *2*(3), 38–45.

Report, T.(n.d.). Global Consultation.

Ruiz, I.J., Martínez, P.A., Facultad, V., Enfermería, D., Pastor, M., & Demusa, A. (2016). Keypoints for abolishing Female Genital Mutilation from the perspective of them en involved. *Midwifery*, *34*,30–35. https://doi.org/10.1016/j.midw.2016.01.017

Sakeah, E., Beke, A., Doctor, H.V, & Hodgson, A.V. (2006). Males' Preference for Circumcised Women in Northern Ghana, 37–47.

Sakeah, E., Debpuur, C., Oduro, A.R., Welaga, P., Aborigo, R., Sakeah, J.K., & Moyer, C.A. (2018). Prevalence and factors associated with female genital mutilation among women of reproductive age in the Bawku municipality and Pusiga District of northern Ghana, 1–10.

Samson, T. (2015). Factors influencing the practice of female genital mutilation among women : A case of kajiado west constituency, Kajiado county,.

Tc, O., Usb, A. & Cck, E. (2016). An Overview of Female Genital Mutilation in Nigeria, (January). https://doi.org/10.4103/2141-9248.96942

Thill, M. (2017). FGM/C and triple otherness, the feminist theory as an interpretative framework ASPECT OF SOCIO CULTURAL ESY LEGALES DELA MUTILACIÓN GENITAL FEMENINA : DEPREVENCIÓNY PROTECCIÓN Actasdel Congreso Internacional SOCIO-CULTURAL AND LEGAL ASPECTS OF FEMALE GENITAL MUTILATION /CUTTING :TRANSNATIONAL EXPERIENCES Papers of the International Conference, (October).