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Social Determinants of Female Genital Mutilation Practices among Married Women in Ilorin West Local Government, Kwara State

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Abstract: *Nigeria is Africa's most populous country and it has a very high prevalence of cases of female genital mutilation (FGM) in the world, accounting for about one-quarter of the estimated 110–140 million circumcised women worldwide. This study assessed the social determinants of FGM among married women in Ilorin West local government of Kwara state. A descriptive research design was used for the study. The population were married women in Oro, Kwara State. The sample for this study consisted of 142 married women from households in Oro, Kwara State, Nigeria and they were selected using convenience sampling procedure. A self-developed instrument was used to collect data for the study from the married women. The findings revealed married women still engage in female genital mutilation practices irrespective of their religion (F-cal value of 0.617 is not significant because the P value (0.623) > 0.05 at 0.05.) and age (F-cal value of 0.823 was not significant because the P value (0.559) > 0.05 at 0.05). It was recommended that the promotion of campaigns against FGM practices should be strengthened using widely accessible forms of communication, including as radio and*

television shows and posters, in order to increase awareness and disseminate correct information amongst others.

Keywords: social, determinants, female genital mutilation, married women

INTRODUCTION

Female circumcision has existed for over 4,000-5,000 years originating in a period predating God's covenant with Abraham to circumcise his people. It began in Egypt where it was believed that the foreskin was the feminine part of the male and the clitoris the masculine part of a woman (Megafu, 2022). Incidences of FGM practices have been documented in countries like India, Indonesia, Iraq, Israel, Malaysia, Thailand and the United Arab Emirates, but no national estimates have been made (WHO, 2020). In addition, the practice of FGM and its harmful consequences are also of concern to a growing number of women and girls in Europe, North America, Australia and New Zealand as a result of international migration. The exact number of women and girls living with FGM in Europe is unknown, but it is estimated to be around 500 000, and 180 000 girls are estimated to be at risk of being subjected to the practice (WHO, 2020). Based on the current rates of population increase and with the slow decline in these procedures, it is estimated that each year, 2 million girls are at risk from the practise worldwide (Wright, 2016).

Nigeria is Africa's most populous country and it has a very high prevalence of cases of FGM in the world, accounting for about one-quarter of the estimated 110–140 million circumcised women worldwide (Leo & Judd-Leonard, 2016). Evidence also suggests that Nigeria accounts for the largest absolute number of female residents that have undergone the procedure (National Population Commission NPC, 2014; Noah, 2019). Some hotspots with very high prevalence were also documented in different geopolitical zones in Nigeria: Osun State 76.6% (Southwest), Ebonyi State 74% (South East), Ekiti State 72.3% (South-West), Imo State 68% (South-East), and Oyo State 65.6% (Southwest) (Alo & Babatunde 2021). Female Genital Mutilation (FGM) most likely to take place in Nigeria during childhood. The major exception is when women in certain ethnic groups undergo FGM practice before the birth of their first child, because of a belief that it is an abomination for a baby's head to touch its mother's clitoris (Alo & Babatunde, 2021). Many girls are circumcised at infants (16% of girls aged 0 to 14 undergo FGM before their first birthday), and most women (82%) aged 15 to 49 who have had FGM stated that they experienced it before the age of five (NDHS, 2016)

The procedure differs from one ethnic group to the other. They include removal of the clitoral hood and clitoral glans (the visible part of the clitoris), removal of the inner labia and in most severe form is the removal of the inner and outer labia and closure of the vulva known as infibulation (Anita & Stinson, 2019). Despite the fact that female genital mutilation is illegal and unlawful in practice in some part of the world, this practice is still very much common, mostly in developing countries such as Nigeria and in particular the target setting (Leo & Judd-Leonard 2016) which is the reason for this study. The long term consequences of this practice are many, and could be irreversible too. They include psychological and physiological problems associated with depression, frigidity, low self-concept, complication during sexual intercourse due to dyspareunia (painful sexual intercourse), keloid, scars and cysts formation. These growths and discomfort are disfiguring and distressful and could discourage sexual intercourse. Also, reproductive tracts infection could lead to infertility and hepatitis.

It is important to note that the level of education of a person could determine greatly his/her perception to culture, tradition and exposure to information concerning certain controversial issues such as FGM. This disparity in terms of educational level is seen to portray divergent views on the attitude towards FGM. The researcher seeks to investigate if the more learned a person is, the more flexible he/she becomes in adapting to changes. Education is perceived as an important factor in the abandonment of

FGM. Women and girls with little or no education are less able to make positive contributions to society than those with education. Educated women and girls contribute to social and economic development, and can support the improvement of health and productivity in their families and communities as a whole (UNFPA, 2015).

It is obvious that employment status and economic conditions of women most often determine their level of participation in decision making both at the family, community, state and national levels. There is generally an unequal burden of domestic maintenance and childcare responsibilities allocated to women as compared to men. Women who totally depend on men seem to have a low decision making power as compared with men. The prevailing patriarchal ideology, which promotes values of submission, sacrifice, obedience and silent suffering often undermines the attempts by women to assert themselves or demand for share of resources and right. Employment status relates to such factors that concern the well-being of individuals. Employment status of women is considered to have great influence on decisions of individuals, including their decision to practice FGM.

It appears that prevalence rates progressively decline in the younger age groups. Age is an important social factor that is expected to have great influence on the practice of FGM. The influence of age factor could be positive or negative. Older women may be more active in FGM practices than the younger ones as a result of cultural beliefs. Young people have also been found to be less receptive to cultural beliefs. These attributes could make them to be less active in the practice of FGM. The effect of age on the practice of FGM is therefore a function to several other factors such as religious background, level of education, employment status, among others

It is on the bases of these observations that the present study wishes to investigate the Social determinants of female genital mutilation practices among married women in Kwara State Nigeria.

Specifically, this study examined:

1 if women in Kwara State Nigeria practise female genital mutilation;
2 the difference in the practice of female genital mutilation among married women based on their religion;
3 the difference in the practice of female genital mutilation among married women based on their level of education;
4 the difference in the practice of female genital mutilation among married women based on their employment status;
5 the difference in the practice of female genital mutilation among married women based on their age;

RESEARCH METHOD

The descriptive research design of the survey type was used in this study and the population consisted of all married women in Oro, Kwara State. The sample for this study consisted of 142 married women from households in Oro, Kwara State, Nigeria and they were selected using convenience sampling procedure. A self-developed instrument was used to collect data for the study from the married women. The instrument consists of three sections, namely, section A, B and C. Section A is for socio-demographic information, Section B is on practices of female genital mutilation and sexual satisfaction while Section C is on awareness of women to FGM and attitude of women to female genital mutilation.

The face, content and validity procedures of the instrument were ascertained. Fifty items constructed were presented to Public health Nurses, Guidance & Counselling experts and Tests & Measurements experts to scrutinise them in order to ascertain its face and content validity. For the face and content validity, experts indicated that the items and the build-up of the instrument have facial relevance and acceptability to what it claims to measure. A reliability co-efficient of 0.84 was gotten after an internal

consistency test was done. Data was collected and analysed descriptively and inferentially using Analysis of Variance (ANOVA). All hypotheses would be tested at 0.05 level of significance.

Results

Table 1: Distribution of respondents by socio-demographic characteristics N= 142

Socio-demographic characteristics	Frequency	Percentage
Education Level		
No Formal Education	15	10.5
Primary	23	16.1
Secondary	29	20.4
ND/NCE	22	15.4
HND/BSC	45	31.6
Post Graduate	8	5.6
Age		
21 - 43	38	26.7
44 - 60	71	50.0
> 60 years	33	23.3
Employment Status		
Self Employed	36	25.3
Govt Employed	43	30.3
Private Establishment Employed	32	22.5
Not Employed	31	21.8
Religion		
Christianity	46	32.3
Islam	89	62.7
Traditional	7	4.9

The table presents a summary of the socio-demographic characteristics of the participants, illuminating the makeup of the questioned group. The majority of respondents (67.6%) have achieved a minimum of a secondary education, while 31.6% possess a Higher National Diploma (HND) or Bachelor of Science (BSc) degree. However, a significant 26.6% of respondents possess either elementary education or lack

any formal education. The respondents' age distribution is very even, with the majority lying between the ages of 44 and 60, making up 50% of the sample.

Respondents display a wide range of occupational backgrounds in relation to their work status. The largest proportion of persons in the workforce are employed by the government, accounting for 30.3% of the total. Self-employed individuals make up a little smaller percentage at 25.3%. The diverse range of work statuses suggests a combination of viewpoints from both the public and private spheres. Regarding religious affiliation, the majority of respondents (62.7%) describe themselves as Muslim, while 32.3% align with Christianity. Only a minority (4.9%) follows traditional faiths.

Table 2: Percentage and Mean of Female Genital Mutilation Practices among Women

S/N	ITEMS	N	Mean	Remark
1.	I usually encourage Female Genital Mutilation Practice for my female child/children	142	2.65	Agreed
2.	I practice Female Genital Mutilation because my parents carried out the same practise on me	142	2.97	Agreed
3.	Female Genital Mutilation is a common traditional practice in my community.	142	3.01	Agreed
4.	The practice of FGM is important before childbirth	142	2.55	Agreed
5.	Female genital mutilation practice has a negative health implication on women.	142	1.88	Disagreed
6.	FGM is a traditional belief and practice which I cannot deviate from	142	2.36	Disagreed
7.	My practice of FGM is because of societal demand	142	2.29	Disagreed
8.	The practice of FGM reduces promiscuity among women	142	2.30	Disagreed
9.	The practice of FGM is difficult to eradicate in my community	142	2.76	Agreed
10.	I am interested in the practice of FGM because it controls sexual libido	142	2.36	Disagreed
11	Female genital mutilation is an important act in women’s life	142	2.67	Agreed
12	The practice of FGM is an interesting act	142	2.56	Agreed
13	I like the act of mutilating female genital	142	2.62	Agreed

14	I always feel happy whenever women engage in FGM	142	2.65	Agreed
15	I only practice the act of FGM because of cultural belief	142	2.45	Disagreed
16	The practice of FGM should be made mandatory for females	142	2.57	Agreed
17	The practice of FGM should be encouraged among females	142	2.68	Agreed
18	I voluntarily practice female genital mutilation	142	2.87	Agreed
19	I like the practice of FGM because my parents mutilated my genital	142	2.63	Agreed
20	Genital mutilation is a welcome practice among the women folk	142	2.92	Agreed

Mean Cut-off: 2.50

Table 2 indicates female genital mutilation practices among married women. Based on the mean cut-off mark of 2.50, majority of the items were accepted except item 5, 6, 7, 8, 10 and 15 because their mean marks were greater than mean cut-off mark of 2.5. Based on the above, it seems that women in Ilorin West LGA of Kwara State practise female genital mutilation.

Table 3: Level of Female Genital Mutilation Practices

Levels of female genital mutilation practises	**No of Respondents**	**Percentage**
Low (20.00 – 52.48)	8	5.6
Moderate (52.49 – 67.77)	35	24.6
High (67.78 – 80.00)	99	69.7
Total	**142**	**100**

Table 3 reveals the level of female genital mutilation practices among the respondents. The mean score and standard deviation of the responses were used to determine the levels as either low, moderate or high. The result shows that out of 142 respondents, 8 respondents representing 5.6 percent agreed that level of female genital mutilation practices is low. Those who agreed that female genital mutilation practices is at a moderate level were 35 respondents representing 24.6 percent while 99 respondents representing 69.7 percent agreed that the level of female genital mutilation practices is high. This shows that the level of female genital mutilation practices among married women in Ilorin West LGA of Kwara State was high. *Testing of Hypotheses*

Ho 1: There is no significant difference in female genital mutilation among married women based on their religion.

Table 4: Analysis of Variance (ANOVA) for Religious Difference in Female Genital Mutilation Practices among Married Women.

Groups	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	9.252	2	4.626	0.617	0.623
Within Groups	1042.451	139	7.500		
Total	**1051.702**	**141**			

P > 0.05

The result presented in Table 4 shows that F-cal value of 0.617 is not significant because the P value (0.623) > 0.05 at 0.05. Hence, the null hypothesis was not rejected. This implies that there was no significant difference in female genital mutilation practices among married women based on their religion.

Ho 2: There is no significant difference in female genital mutilation practices among married women based on their level of education.

Table 5: Analysis of Variance (ANOVA) for Difference in Female Genital Mutilation Practices among Married Women based on their Level of Education

Groups	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	41.020	3	13.673	1.699	0.317
Within Groups	1110.682	138	8.048		
Total	**1151.702**	**141**			

P > 0.05

The result presented in table 5 showed that F-cal value of 1.699 was not significant because the P value (0.317) > 0.05 at 0.05. Hence, the null hypothesis was not rejected. This implies that there is no significant difference in female genital mutilation practices among married women based on their level of education.

Ho 3: There is no significant difference in female genital mutilation practices among married women based on their employment status.

Table 6: Analysis of Variance (ANOVA) for Difference in Female Genital Mutilation Practices among Married Women Based on their Employment Status

Groups	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	32.088	3	10.696	1.448	0.407
Within Groups	1019.614	138	7.389		
Total	**7751.702**	**141**			

P > 0.05

The result presented in Table 6 shows that F-cal value of 1.448 was not significant because the P value (0.407) > 0.05 at 0.05. Hence, the null hypothesis was not rejected. This implies that there is no significant difference in female genital mutilation practices among married women based on their employment status.

Ho 4: There is no significant difference in female genital mutilation practices among married women based on their age.

Table 7: Analysis of Variance (ANOVA) for Difference in Female Genital Mutilation Practices among Married Women Based on their Age

Groups	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	18.484	3	6.161	0.823	0.559
Within Groups	1033.219	138	7.487		
Total	**7751.702**	**141**			

P > 0.05

The result presented in Table 7 shows that F-cal value of 0.823 was not significant because the P value (0.559) > 0.05 at 0.05. Hence, the null hypothesis was not rejected. This implies that there was no significant difference in female genital mutilation practices among married women based on their age.

DISCUSSION

The research found that the prevalence of female genital mutilation practices in Ilorin West Local Government Area of Kwara State was substantial. The likely explanation for this discovery might be attributed to the cultural significance associated with it and the favourable disposition women have towards it. This discovery aligns with Rahman's (2010) research, which revealed a prevalence of 61% for FGM among the Yoruba population, 45% among the Ibo population, and 1.5% among the Hausa-Fulani tribes. Consequently, it highlights the significant issue of FGM in the Ilorin West Local Government Area of Kwara State.

The research found no statistically significant variation in the prevalence of female genital mutilation among married women, irrespective of their religious affiliation. This suggests that all religions engage in the practice of FGM, with no one faith doing it to a greater extent than any other religion. Consistent with this discovery, Ashimi (2021) observed that the practice of FGM is not limited to any one faith and is prevalent among Muslims, Christians, Jews, and adherents of indigenous religions. The results of Berg

et al. (2020) are in opposition to the current findings, since they discovered that the prevalence of FGM is higher among women who follow the Islamic faith.

The survey also found that the prevalence of female genital mutilation among married women did not vary significantly dependent on their educational attainment. Consequently, the practice of female genital mutilation (FGM) is not influenced by a woman's educational attainment. Both educated and uneducated women engage in the practice of Female Genital Mutilation (FGM) in Ilorin West Local Government Area (LGA) of Kwara State. This discovery aligns with the research conducted by Gajaa (2016), which concluded that there is no correlation between women's educational attainment and the prevalence of female genital mutilation (FGM). Obionu (2006) discovered a significant inverse relationship between the extent of formal education and the prevalence of FGM, which contradicts this conclusion. He deduced that well-educated spouses are improbable to deliberately do unwarranted injury to their children, even if the customary practice requires it. In contrast to this discovery, Chikhungu and Madise 2015 ; Anuforo (2016) observed that the prevalence of FGM among women with no education was greater than that among women with elementary and higher education.

There was no discernible disparity in the prevalence of female genital mutilation among married women, regardless of their work position. This indicates that the kind of work is not linked to Female Genital Mutilation (FGM). These results align with the research conducted by Adeokun (2006), which concluded that work level does not have any impact on the prevalence of FGM practices. Furthermore, there was no discernible difference in the prevalence of female genital mutilation practices among married women, regardless of their age. Adeokun (2006) discovered that the occurrence of circumcision was 13% among the youngest women and 28% among the oldest, demonstrating a disparity based on age.

CONCLUSION

Sequel to the findings of this study, it was concluded that married women still engage in female genital mutilation practices irrespective of their religion, level of education, employment status, and age.

Recommendations

Based on the findings of this study, the following recommendations were made.

1. To mitigate the prevalence of Female Genital Mutilation (FGM), it is imperative to actively pursue measures such as enacting laws and promoting female literacy to effectively eradicate this practice.
2. It is important to engage in community counselling sessions with community members and stakeholders to educate them about the detrimental practices and their impact on maternal and newborn mortality.
3. The economic empowerment of women would improve their financial standing, hence increasing the importance of a woman's eligibility for marriage (a fundamental factor that perpetuates the practice of female genital mutilation). This is because women would have access to other avenues for stability and security.
4. The promotion of campaigns against FGM practices should be strengthened using widely accessible forms of communication, including as radio and television shows and posters, in order to increase awareness and disseminate correct information.
5. Information about the hazards of FGM should be spread among communities via religious and community leaders

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