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Assessing Female Genital Mutilation Practice in South-Western Nigeria

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Authors' contributions

This work was carried out in collaboration between both authors. Both authors read and approved the final manuscript.

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ABSTRACT

Background: With always dwindling resources in mitigating against various negative effects of female genital mutilation among girls/women in Nigeria, identifying factors that encourage the practice is highly imperative.
Aim: This research assesses the Female Genital Mutilation (FGM) practice and knowledge practice among states in the South-West of Nigeria.
Methods: Data were collected across states in the South-West using a structured questionnaire. The hierarchical sampling technique is used to select a locality in each of the 18 senatorial districts across six states in the region. The convenience sampling technique is then used to select respondents.
Results: It was found that the age, resident, wealth status, and educational background of respondents are significant factors in the circumcision status of respondents. The odds of being circumcised is highest among respondents from Ekiti state, followed by those from Osun state while it is lowest in Ogun state. The highest percentage of respondents who had their daughters' circumcised used the help of traditional practitioners while removal of the clitoris is the most prevalent form of mutilations among residents in states in the South-West.

Keywords: Female genital mutilation; knowledge; method; practice.

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1. INTRODUCTION

Female Genital Mutilation (FGM) is an old practice that reflects human rights abuse with the potential for medical complications [1]. This has triggered various efforts that are aimed at the eradication of FGM at community, national, and international levels. The practice however remains endemic in about 29 countries in Africa, Asia, and the Middle East. Advocacy in form of information about the necessary treatments, education and counselling of women that are mutilated had been identified as pertinent [2]. The creation of awareness and education as essential instruments towards attitudinal change towards the eradication of the practice was identified by [3]. Many socio-cultural beliefs of indigenes had been attributed to the practice. As defined by [4], FGM (also called Female Genital Cutting, FGC) comprises all procedures involving partial or total removal of the external part of the female genitalia or a form of injury to the female genital organs outside medical necessities. It is a form of gender-based violence and hence has been documented as a harmful practice and a defilement of the human rights of girls and women. In countries where FGM is practiced, over 200 million girls/women who are alive today have been genitally mutilated [5]. Although the practice has obscured origins, it has been in practice for over two millennia [6]. Historical and anthropological research found the history of FGM in traditional group and community cultures that have patriarchal structures. The practice was traced to the 5th century BC in Egypt by some anthropologists, where the infibulation was known as '*Pharaonic Circumcision*' [6]. Others believed that the practice existed among herders in Equatorial Africa as armour against rape for young female herders [7]. The idea is motivated by convictions concerning what is viewed as suitable sexual conduct for certain communities with the belief that it protects and saves virginity and conjugal honesty and forestalls indiscrimination.

FGM is always traumatic with immediate complications including tetanus or sepsis, urine retention, severe pain, shock, haemorrhage, and injury to proximate genital tissue of urethra, vagina, rectum, and perineum [8]. Its long-term consequences include recurrent bladder and urinary tract infections, cysts, infertility, an increased risk of newborn deaths and childbirth complications including fistula, and the need for later surgeries [8].

According to [8] FGM is grouped into four classes (Table 1). The classes are based on the extent of amputation of the tissues [9-11]. Both types I and II belong to a group called *clitoridectomy* (reduction operation) and type III belongs to *infibulation* (covering operation). Other harmful procedures distinct to Nigeria include *angurya* (scraping of tissue surrounding the opening of the vagina) and *gishiri* (cutting of the vagina). Some also introduce herbs or corrosive substances to narrow the vagina. To allow for sexual intercourse and convenient childbirth, a woman with type III needs to be cut open later [4]. In most cases, the practice is often done in the first month after birth [12]. Types I and II are predominantly found in Southern parts of Nigeria with high prevalence in Akwa Ibom, Cross River, Delta, Anambra, Imo, Ondo, Osun, and Rivers states. Type III is common among the Igbos (in Imo and Delta states) while Type IV is generally practiced among Hausas in Northern states of Nigeria [13].

Justifications for FGM are numerous. These include purification; tradition and custom; the increased sexual pleasure of husband; enhancing fertility; hygiene; aesthetic reasons and protection of virginity and prevention of promiscuity. Traditionally, FGM is a specialization of traditional healers and birth attendants. The practice is widespread in Nigeria with the identification of some sociocultural determinants as supporting it. FGM is still deeply in the Nigerian society where serious resolution makers are mothers and grandmothers [14]. Efforts to abolish FGM in Nigeria have not been largely fruitful. A multidisciplinary methodology is suggested [15] to tackle the legendary practice. Intensification of education of the general public at all levels was also suggested [16].

Nigeria is divided into six geo-political zones with 36 states and the Federal Capital Territory. Large variation in the prevalence across the zones has been documented from women in reproductive ages (15-49 years) [17]. South-West Nigeria consists of predominantly *Yorubas* who make up about 21% of the entire population of the country. It was reported that both Type I and type II infibulations are the predominantly practice of FGM in the region [18]. Nigeria's government has responded to the call for the elimination of FGM in diverse ways. One of these is the passage of federal legislation, the *Violence against Persons (Prohibition) Act 2015*, banning Female Genital Mutilation (FGM) and other forms of Gender-Based Violence (GBV) [19]. In 2003, the country

adopted the Maputo Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, ensuring that survivors of Gender-based Violence (GBV) and of gross human rights violations can obtain redress before a domestic or regional court such as the Court of Economic Community of West Africa States (ECOWAS) [20]. Although the practice of FGM prevalence in Nigeria is actually not the highest in the region sub-Saharan Africa countries, at 24.8% among women aged 15 to 49 [17], this rate is globally significant with some 20 million women and girls who have been cut or are at risk of being cut [17].

Among the six regions in Nigeria, the South-West was reported to have a prevalence of more than 50% for FGM which is the second-highest in the country [17]. Therefore, this research is focused on identifying some factors that may affect the practice and knowledge of FGM with intention of identifying significant areas to channel enlightenment and education about the risk involved in FGM among states in the South-West of Nigeria.

2. METHODOLOGY

This study utilizes a structured questionnaire to assess the practice and knowledge of female genital mutilation among states in South-West, Nigeria. The hierarchical sampling technique is used to select a locality in each of the 18 senatorial districts across six states in the region. The convenience sampling technique is then used to select respondents.

Descriptive analysis is used to explore various variables examined in the study. Chi-square test of independence is used to assess the relationship between each factor considered and the variable of interest (knowledge of FGM and FGM status of respondents). Binary logistic regression is then performed on each of the two variables of interest. Data cleaning is done using Microsoft Excel while the analysis is performed using IBM SPSS ®23.

3. RESULTS

The descriptive statistics for the responses obtained are shown in Table 2. The age group of respondents is approximately equally distributed except for those aged 45-49 with only 9.0% of total respondents. Being the most populous state in the region, Lagos state has the highest responses with 29.9% while Ekiti state has the least with only 9.8% respondents.

The wealth index for each respondent is measured by the presence of some basic essentials (like television, radio, access to the internet, household income, etc.) in respective households. 75% of the respondents are categorized as being wealthy while only 10.5% are categorized as *poor*. Almost three-quarters (72.6%) of respondents reside in urban environments while 67.1% are Christians.

Responses on knowledge of female genital mutilation are presented in Table 3. Overall, 68.9% of total respondents have prior knowledge of FGM practice. With a consistent increase in percentage knowledge as age increases, age is a significant factor in knowledge about FGM among respondents. The least percentage of knowledge is observed for those aged 15-19 years (46.5%) while those aged 40-44 have the highest percentage knowledge level of 80.1%. respondents from Osun state has the highest knowledge percentage (87.5%) among the six states in the region, followed by Ekiti (78.9%) and Lagos (78.2%) states in that order while Ogun state has the least with only 37.7%.

Respondents in the *rich* category of the wealth index have the highest percentage of knowledge of FGM with 70.1% while those in the *poor* category have the least (63.6%). Urban residents have a significantly higher percentage of knowledge (72.6%) in comparison with those from rural set up with 59.1%. Table 3 also shows that religion is not a significant factor in knowledge about FGM, although the Muslims have a slightly higher percentage of knowledge. Educational level is a significant factor in the knowledge of FGM. The highest percentage knowledge level is observed for those with a higher level of education.

Using knowledge about FGM as a binary Yes/No response variable, Table 4 shows the result of binary logistic regression of the knowledge about FGM on the examined socio-demographic variables. Among the age groups, the odds of knowledge are highest among those aged 40-44 years. This is more than double for those in 15-24 years and slightly above the odds for those ages 45-49 years. The odds of knowledge is more than 16 times among respondents from Osun state in comparison to those from the reference state (Ogun state). This is also more than double the next high odds observed from Ekiti and Lagos states.

Table 1. Classifications of FGM

Type I (Sunna)	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type II	Partial or total removal of the clitoris and the labia *minora*, with or without excision of the labia *majora* (excision). Note also that the term 'excision' is sometimes used as a general term covering all types of FGM.
Type III (Infibulation/Pharaonic)	Narrowing of the vaginal orifice with the creation of a covering seal by cutting and positioning the labia *minora* and/or the labia *majora*, with or without excision of the clitoris infibulation.
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping, and cauterization.

Source: WHO, 2008

Table 2. Socio-demographic background of respondents

Characteristics	**Frequency (Percentage)**
Age Group	
15-19	467 (17.5%)
20-24	374 (14.0%)
25-29	415 (15.5%)
30-34	419 (15.7%)
35-39	429 (16.1%)
40-44	326 (12.2%)
45-49	241 (9.0%)
State	
Oyo	311 (11.6%)
Osun	408 (15.3%)
Ekiti	261 (9.8%)
Ondo	431 (16.1%)
Lagos	799 (29.9)
Ogun	461 (17.3)
Wealth Index	
Poor	280 (10.5%)
Middle	389 (14.6%)
Rich	2002 (75.0%)
Residence	
Urban	1940 (72.6%)
Rural	731 (27.4%)
Religion	
Christian	1793 (67.1%)
Islam	875 (32.8%)
Other	3 (0.1%)
Educational Level	
No Education	190 (7.1%)
Primary	414 (15.5%)
Secondary	1520 (56.9%)
Post-Secondary	547 (20.5%)

Source: 2021 Survey

The odds of knowledge are highest among respondents in the *rich* category of wealth index while it is the lowest among those in the *poor* category. Those residing in the urban areas have a slightly higher odds of knowledge than those residing in rural environments. As noted earlier from Table 3, religion is also found to be an insignificant factor in the knowledge about FGM. Although Table 4 shows that the respondents in the *"other"* category of religion have higher odds, this is largely due to the low responses obtained for the option as noted in Table 3.

Education is a significant factor in the knowledge of FGM. The odds of knowledge are highest among those with post-secondary education while it is least among those with primary education.

Table 5 shows that the odds of being circumcised is highest among older respondents. Among the states, Ekiti state residents have more than 25 times the odds of being circumcised in comparison with those from Ogun state. Residents in Osun state also have a significantly higher odds of being circumcised when compared with other states except for Ekiti state. Among the three wealth categories, the odds of being circumcised become higher as the wealth status increases. Although the odds of being circumcised are slightly higher among respondents residing in the urban area, there is no disparity between the two residential categories. The odds of circumcision is highest among those with secondary and post-secondary education while it is least among those with primary education.

From Table 6 below, Ekiti state has the highest percentage of circumcised respondents while Ogun state has the least with only 14.4%.

Among circumcised respondents, Table 7 shows the techniques of FGM adopted across states among respondents. The table reveals that "*removal of flesh from the genital area*" is the most common form.

Table 8 shows that respondents across states in the South-West indicated that most circumcisions are performed by traditional "*circumcisers*". Trained doctors performed 2.7% of the total reported cases in the study.

Table 3. Socio-demographic characteristics of respondents on knowledge of FGM

Characteristics	Ever Heard of Female Genital Mutilation		Chi-Square P-value (α=0.05)
	No 831 (31.1%)	*Yes 1840 (68.9%)*	
Age Group			*0.000**
15-19	250 (53.5%)	217 (46.5%)	
20-24	125 (33.4%)	249 (66.6%)	
25-29	129 (31.1%)	286 (68.9%)	
30-34	105 (25.1%)	314 (74.9%)	
35-39	103 (24.0%)	326 (76.0%)	
40-44	65 (19.9%)	261 (80.1%)	
45-49	54 (22.4%)	187 (77.6%)	
State			*0.000**
Oyo	112 (36.0%)	199 (64.0%)	
Osun	51 (12.5%)	357 (87.5%)	
Ekiti	55 (21.1%)	206 (78.9%)	
Ondo	152 (35.3%)	279 (64.7%)	
Lagos	174 (21.8%)	625 (78.2%)	
Ogun	287 (62.3%)	174 (37.7%)	
Wealth Index			*0.042**
Poor	102 (36.4%)	178 (63.6%)	
Middle	131 (33.7%)	258 (66.3%)	
Rich	598 (29.2%)	1404 (70.1%)	
Residence			*0.000**
Urban	532 (27.4%)	1408 (72.6%)	
Rural	299 (40.9%)	432 (59.1%)	
Religion			*0.351*
Christian	574 (32.0%)	1219 (68.0%)	
Islam	256 (29.3%)	619 (70.7%)	
Other	1 (33.3%)	2 (66.7%)	
Educational Level			*0.000**
No Education	61 (32.1%)	129 (67.9%)	
Primary	142 (34.3%)	272 (65.7%)	
Secondary	509 (33.5%)	1011 (66.5%)	
Post-Secondary	119 (21.8%)	428 (78.2%)	

*Source: 2021 Survey; * Significant factors at α = 0.05*

Among respondents who have daughters that had gone through genital mutilation, Table 9 shows that the prevailing methods are the "*removal of the clitoris*" and *gishiri*.

4. DISCUSSION

FGM constitutes a prerequisite for inheritance in some practicing societies which serve as a social stratification mechanism whereby circumcised females are perceived to be in higher status [21]. Some evidence indicates that disadvantaged socioeconomic position (usually measured by education and wealth index) compels some women to admit the practice [22]. However, some cultures believe that FGM reduced a woman's libido, hence assisting women in preventing adulterous sexual actions [23].

In this research, the age of respondents is found to be a significant factor in the knowledge of FGM and being circumcised. The odds of knowledge about FGM and uptake of FGM increase as the ages of respondents increase. It is highest among respondents between ages 40-44 while it is lowest among the youngest groups (15-19). This gradual decrease in uptake may indicate that there is a drastic reduction in FGM among respondents as fewer younger females are observed to have had their genitals mutilated.

The percentage of knowledge is highest in Osun state followed by both Lagos and Ekiti states while respondents in Ogun state have the least knowledge. The odds of knowledge about FGM is more than sixteen times in comparison to that of Ogun state and more than twice of the closest state (Ekiti). The study also shows that among the six states in the region, FGM is most prominent in Osun state with more than 16 times the odds of uptake when compared with Ogun state for example. The chance of uptake of FGM is also significantly higher in Ekiti and Lagos states.

The wealth status of respondents is found to have a significant effect on the knowledge about FGM and the chance of FGM uptake. Rich people exhibit more knowledge than other categories. The odds of knowledge about FGM among the *rich* is almost twice those from the *poor* category of the wealth index. Literature [24] has shown that affluent women have strong decision-making power on harmful traditional practices like FGM on themselves and their daughters because of their wealthy status. Although the study shows that wealth status is not a significant factor in the chance of being mutilated, the odds are higher among those that belong to the *rich* category.

Knowledge is higher in urban centers than in rural. Urban residents have higher odds of knowledge than those from rural settings. Rural areas have stronger community ties and traditions with more influential social norms. Although FGM is more likely to occur in rural areas where livelihood is more archaic with its attending challenges, statistics from the Nigeria Demographic Health Survey [17] showed that over 32% of women of reproductive ages who are living in urban areas have undergone FGM while only 19.3% of women living in rural areas have had FGM. This implies that prevalence by current place of residence may not be a reliable factor but rather the place of residence as at when the FGM was done [17]. In relating to the uptake of FGM, place of residence is not a significant factor as it is difficult to separate the likelihood of being mutilated from respondents in both urban and rural residences.

Table 4. Binary logistic of knowledge of female circumcision on some factors

Factor	P-value	Odds Ratio (OR)	95% C.I. for OR
Age			
15-19	0.000	0.175	(0.118, 0.261)
20-24	0.000	0.481	(0.319,0.725)
25-29	0.000	0.558	(0.372, 0.836)
30-34	0.005	0.712	(0.473, 1.073)
35-39	0.105	0.764	(0.510, 1.145)
40-44	0.192	1.066	(0.690, 1.648)
45-49 (reference category)	0.772	1.000	
State			
Oyo	0.000	2.604	(1.869, 3.628)
Osun	0.000	16.069	(10.908, 23.672)
Ekiti	0.000	7.512	(5.079, 11.111)
Ondo	0.000	3.952	(2.890, 5.404)
Lagos	0.000	6.073	(4.554, 8.100)
Ogun (reference category)	0.000	1.000	
Wealth Index			
Poor	0.008	0.571	(0.401, 0.813)
Middle	0.002	0.861	(0.639, 1.160)
Rich (reference category)	0.324	1.000	
Place of residence			
Urban	0.239	1.157	(0.908, 1.474)
Rural (reference category)		1.000	
Religion			
Christianity	0.137	0.224	(0.011, 4.724)
Islam	0.336	0.270	(0.013, 5.698)
Other (reference category)	0.400	1.000	
Education Status			
No Education	0.009	0.699	(0.434, 1.126)
Primary	0.141	0.545	(0.369, 0.805)
Secondary	0.002	0.654	(0.495, 0.865)
Post-Secondary (reference category)	0.003	1.000	
Constant	0.259	5.865	

*Source: 2021 Survey *Significant factors at α = 0.05*

Table 5. Binary Logistic of Uptake of Circumcision on some factors

Factor	P-value	Odds Ratio (OR)	95% C.I. for OR
Age	0.000		
15-19	0.000	0.007	(0.002, 0.022)
20-24	0.000	0.123	(0.077, 0.198)
25-29	0.000	0.308	(0.206, 0.461)
30-34	0.002	0.548	(0.373, 0.804)
35-39	0.143	0.761	(0.528, 1.097)
40-44	0.983	1.004	(0.687, 1.467)
45-49 (reference category)		1.000	
State	0.000		
Oyo	0.000	4.438	(2.663, 7.393)
Osun	0.000	12.244	(7.496, 19.999)
Ekiti	0.000	25.406	(15.091, 42.773)
Ondo	0.000	8.721	(5.339, 14.246)
Lagos	0.001	2.244	(1.382, 3.646)
Ogun (reference category)		1.000	
Wealth Index	0.210		
Poor	0.078	0.771	(0.486, 1.039)
Middle	0.581	0.912	(0.657, 1.266)
Rich (reference category)		1.000	
Place of residence			
Urban	0.522	1.096	(0.828, 1.451)
Rural (reference category)		1.000	
Religion	0.001		
Christianity	0.495	0.343	(0.016, 7.432)
Islam	0.688	0.532	(0.024, 11.566)
Other (reference category)		1.000	
Education Status	0.147		
No Education	0.356	0.775	(0.452, 1.331)
Primary	0.230	0.758	(0.483, 1.191)
Secondary	0.656	1.076	(0.778, 1.488)
Post-Secondary (reference category)		1.000	
Constant	0.398	0.264	

*Source: 2021 Survey *Significant factors at α = 0.05*

Table 6. Circumcision status of respondents across the states

	No (%)	Yes (%)	Don't Know (%)
Oyo	115 (57.8)	73 (36.7)	11 (5.5)
Osun	162 (45.4)	140 (39.2)	55 (15.4)
Ekiti	42 (20.4)	139 (67.5)	25 (12.1)
Ondo	96 (33.3)	129 (43.2)	57 (20.4)
Lagos	458 (73.3)	99 (15.8)	68 (10.9)
Ogun	140 (80.5)	25 (14.4)	9 (5.2)
TOTAL	1010 (54.9)	605 (32.9)	225 (12.2)

Source: 2021 Survey

Table 7. Forms of genital mutilation for respondents

	Yes (%)	No (%)
Flesh removed from the genital area	221 (70.2)	94 (29.8)
Genital area nicked without removing any flesh	37 (35.6)	67 (64.4)
Genital area sewn closed	11 (3.3)	319 (96.7)

Source: 2021 Survey

In research conducted on women of reproductive age in Northern Malaysia [25] with a vast majority of respondents being Muslim, religion was reported to be the main reason for the practice of FGM. This is mostly performed by a traditional practitioner as also observed in this study [25]. Although religious leaders in Islam had said the FGM is not a religious requirement, respondents in another Malaysian study wanted the practice to continue [23]. Results obtained in this study

Table 8. Person who performed circumcision

	Frequency (%)
Doctor	14 (2.7)
Trained nurse/midwife	36 (6.9)
Traditional "circumciser"	432 (83.1)
Traditional birth attendant	33 (6.3)
Other traditional	5 (1.0)
Total	520 (100.0)

Source: 2021 Survey

Table 9. Forms of Genital Mutilation for respondents' daughter

	Yes (%)	No (%)
Removal of clitoris	109 (35.5)	198 (64.5)
Infibulation	29 (9.3)	282 (90.7)
Angurya	32 (10.6)	271 (89.4)
Gishiri	91 (28.1)	233 (71.9)

Source: 2021 Survey

reveal that the religion of respondents is found to be non-significant in the knowledge about FGM, although practitioners of Islam have a slightly higher knowledge percentage. Also, Islam is found to have higher odds of uptake of FGM when compared to Christianity, the religion of respondents in this study does not significant effect on the likelihood of FGM uptake. Another study [26] also suggested that Muslims are more likely to have their daughters circumcised although this has been reported to be un-Islamic because there is no Islamic evidence to support the practice [27].

The educational status of the respondents plays a significant role in the knowledge about FGM. Those who are more educated are found to be more knowledgeable about FGM. Those with *Post-Secondary* education have about twice the odds of knowledge in comparison with those who only have *Primary School* education. Similar findings had been reported [28-30]. Educated women are more exposed and have convincing reasons not to abide by societal-cultural norms that may be harmful to their health. In a similar study among the Chadian populace [24], the educational status of respondents, religion and wealth index were all found to be significant in the practice of FGM. Also, [31] reported that the educational status of mothers, residence area and wealth status are all significant factors on the uptake of FGN among different countries in Africa. However, educational status is not significant on being mutilated as the results show no much disparities in circumcision status of respondents and their respective education attainment.

Among forms of genital mutilations, the removal of flesh from the genital area is ranked highest mostly carried out by *Traditional "circumcisers"*. This is related to finding in another Malaysian study [25]. Also, the WHO has strongly warned the traditional "*circumcision*" and advised that neither FGM must be institutionalized nor should any form of FGM be performed by any health professional in any setting, including hospitals or in the home setting [14]. The traditional "*circumciser*" procedure has no health benefits for girls and women where the adverse consequences of FGM are shocked from pain and haemorrhage, infection, acute urinary retention which could harm the victim's urethra or anus during the process, causing the extent of the operation to be dictated in many cases by chance, acquired gynatresia resulting in hematocolpos, chronic pelvic infection, sexual difficulties with anorgasmia, and vulval adhesions [32].

5. CONCLUSION

In this research, it has been found that the practice of female genital mutilation is on the downward trend among respondents evidenced by the continual decline in uptake among younger women. Efforts towards ensuring total eradication should be sustained on all fronts. In states with high prevalence, interventions should focus on lobbying and instructional tactics such as focus group talks, peer teaching, and mentor-mentee programmes. Negative effects of FGM should always be showcased to debar further engagement in the practice.

Although the research has shown religion not to be a significant factor in the uptake of FGM, agencies of government can use various religious groups to mount campaigns on the negative effects of the practice since there is no basis for the practice among the two major dominant religions in the region.

Different women capacity-building such as entrepreneurial training, media advocacy, and community dialogue could also help in addressing the FGM public health challenge as earlier opined by [33]. Both Governmental and non-governmental organizations must implement policies that would improve dialogue and media

advocacy to turn the tide against the practice of FGM among states in South-West Nigeria.

The importance of informing the public and education in ending the practice of female genital circumcision that has no religious basis and endangers the future of children and affects them is evident. Also, society must acquire a high level of consciousness with the capacity to handle and resolve the problems of children to protect them instead of maiming them by circumcision. Families that want these harmful customs and traditions to come to an end want to enlighten the public and also demand laws and punishments that the whole society will be bound by.

CONSENT

As per international standard or university standard, patients' written consent has been collected and preserved by the author(s).

ETHICAL APPROVAL

As per international standard or university standard written ethical approval has been collected and preserved by the author(s).

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COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. United Nations Children's Fund- UNICEF. Female genital mutilation/cutting: A statistical overview and exploration of the dynamics of change; 2013. Available:http://www.unicef.org/publications/index_69875.html.
2. World Health Organization-WHO. Female Genital Mutilation. Fact sheet No. 241; 2014. Available:http://www.who.int/mediacentre/factsheets/fs241/en/
3. Adeniran AS, Fawole AA, Balogun OR, Ijaiya MA, Adesina KT, Adeniran IP,. Female genital mutilation/cutting: Knowledge, practice and experiences of secondary school teachers in North Central Nigeria. SAJOG. 2015;21(2):39-43.
4. World Health Organization-WHO. Female Genital Mutilation; 2015. Available:http://www.who.int/topics/female_genital_mutilation/en/
5. United Nations Children's Fund-UNICEF. Female Genital Mutilation/Cutting: A Global Concern; 2016.
6. Slack A. Female circumcision: A critical approach, human rights quarterly. 1988;10:437-486.
7. Wilson A. How the methods used to eliminate foot binding in China can be employed to eradicate female genital mutilation, Journal of Gender Studies. 2013;22(1):17-37. Available:http://www.everyculture.com/wc/Mauritaniato Nigeria/Yoruba.html.
8. World Health Organization-WHO. Eliminating female genital mutilation: An interagency statement; 2008. Available:http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf.
9. Klouman E, Manongi R, Klepp K. Self-reported and observed female genital cutting in rural Tanzania: associated demographic factors, HIV and sexually transmitted infections Trop Med Int. Health. 2005;10(1):105-115.
10. Feyi-Waboso P, Akinbiyi A. Knowledge of, Attitudes about, and Practice of female Genital Cutting in Antenatal Patients among Igbos in Nigeria. J Gynaecol Surg. 2006;22(3):89-95.
11. Baron EM, Denmark FL. An exploration of Female Genital Mutilation. Ann. NY Acad. Sci.; 2006;1087:339-355.
12. World Culture Encyclopedia-WCE. Yoruba; 2016.
13. Federal Ministry of Health, Nigeria. Eliminating Female Genital Circumcision in Nigeria. 2007:1-8
14. World Health Organization-WHO. Elimination of FGM in Nigeria Plot 617/618 Diplomatic drive, Central District Abuja. Family Health Department, Federal Ministry of Health Phase II Federal Secretariat Abuja; 2007.
15. Okeke TC, Anyaehie USB, Ezenyeaku CCK. An Overview of Female Genital

Mutation in Nigeria. Annals of Medical and Health Sciences Research. 2012;2(1):70-73:
DOI: 10.4103/2141-9248.96942

16. World Health Organization-WHO. Health Population and development. WHO Position. Paper presented at the International Conference on Population and Development (ICPD), Cairo 1994. WHO/AIE 1994:/94 – 2. Geneva: Word Health Organization; 1994.
17. NDHS 2013: National population commission [Nigeria] and ICF international. Nigeria Demographic and Health Survey 2013. Abuja and Rockville, Maryland: NPC and ICF International; 2014.
18. Kandala N, Nwakeze N, Kandala S. Spatial Distribution of Female Genital Mutilation in Nigeria, The American Journal of Tropical Medicine and Hygiene. 2009;81(5):784-792.
19. Briggs LA. Male and female viewpoints on female circumcision in Ekpeye, Rivers State. Nigeria Afr. J. Reprod. Health. 2002; 6(3):44-52
20. Kandala N, Komba PN. Female genital mutilation around the world. Springer International Publishing; 2018.
DOI: 10.1007/978-3-319-78007-8
21. United Nations Population funds (UNFPA). Female genital mutilation (FGM) frequently asked questions; 2020.
Available:https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions#sthash.lLBanQT3.dpuf. Accessed 29 Mar 2021
22. Karmaker B, Kandala NB, Chung D, Clarke A. Factors associated with female genital mutilation in Burkina Faso and its policy implications. Int J Equity Health. 2011;10(1):20.
23. Rashid A, Iguchi Y. Female genital cutting in Malaysia: a mixed-methods study. BMJ Open 2019;9:e025078.
DOI: 10.1136/bmjopen-2018-025078
24. Setegn T, Yihunie-Lakew KD. Geographic variation and factors associated with female genital mutilation among reproductive-age women in Ethiopia: a national population based survey. PLoS ONE. 2016;11(1):e0145329
25. Khan AR. The practice of female genital mutilation among the rural Malays in North Malaysia, Internet Journal of Third World Medicine. 2010;9(1):1-8.
26. Hayford SR, Trinitapoli J. Religious differences in female genital cutting: A case study from Burkina Faso. Journal for the scientific study of religion. 2011; 50(2):252–271.
Available:https://doi.org/10.1111/j.1468-5906.2011.01566.x
27. Birge Ö, Serin AN. The Relationship between Female Circumcision and the Religion. In A. Zaghal, & N. Rahman (Eds.), Circumcision and the Community. Intech Open;2019.
Available:https://doi.org/10.5772/intechopen.86657
28. Ahinkorah BO. Factors associated with female genital mutilation among women of reproductive age and girls aged 0– 14 in Chad: a mixed effects multilevel analysis of the 2014– 2015 Chad demographic and health survey data, BMC Public Health. 2021;21:286
Available:https://doi.org/10.1186/s12889-021-10293-y
29. Ahinkorah BO, Hagan JE, Ameyaw EK, Seidu AA, Budu E, Sambah F, Yaya S, Torgbenu E, Schack T. Socio-economic and demographic determinants of female genital mutilation in sub-Saharan Africa: analysis of data from demographic and health surveys. Reprod Health. 2020: 17(1):1–14.
30. Oyefara LJ. Female genital mutilation (FGM) and theory of promiscuity: myths, realities and prospects for change in Oworonshoki Community, Lagos State, Nigeria. Genus. 2014;70(2–3): 7-33
31. Sabahelzain MM, El-din AG, Babiker S, Kabiru CW, Eltayeb M. Decision-making in the practice of female genital mutilation or cutting in Sudan: a cross-sectional study. Global Health Res Policy. 2019;4(1):5.
32. Fagbamigbe AF, Morhason-Bello IO, Kareem YO, Idemudia ES. Hierarchical modelling of factors associated with the practice and perpetuation of female genital mutilation in the next generation of women in Africa. PLoS ONE. 2021;16(4) :e0250411.
Available:https://doi.org/10.1371 /journal.pone.025041
33. Bright OA, John EH, Edward KA, Abdul-Aziz S, Engene B, Francis S. Socio-economic and demographic determinants

of female genital mutilation in Sub-Saharan Africa: analysis of data from demographic and health surveys, a reproductive health. 2020;17:162.

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