Bivariate Logistic Regression of Knowledge as Predictor of the Practice of Female Genital Mutilation in Ekiti State, Nigeria

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Female genital mutilation/cutting (FGM/C) is a harmful traditional practice with severe health implications among women and girls. This study determined whether knowledge reduced the practice of female genital mutilation and identified the socio-demographic factors that predicted the practice of female genital among parents in Ekiti State, Nigeria. A cross-sectional quantitative research method was employed among 600 selected parents in the three senatorial districts of Ekiti-State, Nigeria between March and June 2019. A pretested structured questionnaire was used to collect data. Our analysis revealed that 468 (78%) of the respondents believed that the practice was high as against 132 (22%) who said the practice was low. Female is two times more likely to practice FGM than male (OR = 1.614, B = 0.479, \( p < 0.05 \), CI = 1.088-2.394). Respondents with low knowledge were significantly 11 times likely to practice female genital mutilation compared with respondents with high knowledge (OR = 10.597, B = 2.361, \( p < 0.05 \), CI = 6.813-16.483). Those who lived in rural areas were two times significantly (OR = 1.690, B = 0.525, \( p < 0.05 \), CI = 3.246-13.197) likely to practice female genital mutilation than the urban dwellers. The study concluded that respondents’ knowledge, location (urban/rural), sex, age, and ethnicity were strong predictors of the practice of FGM/C in Ekiti-State, Nigeria. With these findings in mind, the community institutions would play a great role in changing the community through spreading information about the health implications of FGM/C for the practice to be drastically reduced.

Keywords: female genital mutilation/cutting, practice measure, knowledge measure, Ekiti State, predictor

Introduction

Traditional cultural practices reflect the standards and views sustained within the community for a certain period of time. Every society has specific traditional cultural practices and beliefs, some of which are beneficial while many are detrimental especially to the health of women and the girl child. Beneficial Africa cultural practices such as breastfeeding babies, settling of quarrels, community development, and care of old people and orphans within the community are encouraging.

The Office of the United Nations High Commissioner for Human Rights revealed that harmful traditional health practices (HTHPs) are widespread in Africa and especially Nigeria. These practices as the name implies...
are detrimental to the health of the mother and her child (OHCHR, UNDP, & UNESCO, 2008; UN OHCHR, 1995). These include but are not limited to female genital mutilation (FGM), hot bath in the puerperium, early marriage, early pregnancy, use of herbs, and charms to control fertility. Others are force-feeding of children, wife inheritance, widow bathing with the same water used to bathe her late husband’s corpse, forced squatting during labour, and nutritional related practices like food taboos (Denison, Berg, Lewin, & Fretheim, 2009; Mohammed, Seedhom, & Mahfouz, 2018).

Female genital mutilation (FGM) is described as the traditional surgical operation in which part or all of the external female genitalia is cut off (Odukogbe, Afolabi, Bello, & Adeyanju, 2017). Some scholars perceived FGM as ritualistic sexual mutilation of the female genital organ that dated back to the fifth century BC. The origin of circumcision dated back to the holy book, the Bible as a covenant between God and Abraham. A male child was mentioned to be circumcised but today both male and female were being mutilated under the guise of circumcision (Knight, 2001).

Afolabi (2020) noted that female genital mutilation is well supported in Africa and other continents which is practiced because of the cultural belief that it controlled sexuality and preserved virginity and chastity of women till marriage. Many circumcisers were not willing to leave the trade because it was economically profitable to them (Afolabi, 2020). The type of female genital mutilation performed varies mainly with ethnicity in countries where it is performed. Assessments of the types of FGM/C revealed that about (90%) of cases include Types I or II and cases where girls’ genitals were nicked but no flesh removed (Type IV) and about 10% are Type III. Hence the prevalence of FGM/C in Ekiti State, Nigeria was reported high. Ekiti State (72.3%) ranked third behind Osun (76.6%) and Eboyin in the prevalence of FGM/C in Nigeria (Demographic, 2019; Kandala et al., 2020). The high prevalence of FGM/C has called for serious public health concern among scholars and policy-makers in Nigeria and across the world.

**Literature Review**

The World Health Organisation (WHO) (2011) defined female genital mutilation/cutting (FGM/C) as “all procedures that involve partial or total removal of the external female genitalia or other injuries to the female genital organs for non-medical reasons” (p. 1). The term “female genital mutilation” in favour of “female genital cutting” was rejected because some scholars believe that the word “cutting” is less judgmental and relates better to the terms used in many local languages than mutilation (World Health Organization, 2016).

They observed that “Mutilation” differentiates the practice from male circumcision and stressed its severity (WHO, 2008; 2016). According to the World Health Organisation (2011), FGM/C was practised in 28 countries in western, eastern, and north-eastern Africa, and parts of Asia, and the Middle East. It was estimated that 140 million women and girls around the world had been cut including 101 million African women/girls (World Health Organization, 2011).

Other researchers confirmed that FGM was carried out in African countries including Nigeria, Middle East, Senegal, Britain, and international countries like USA, Europe, Canada, France, Australia, and Asia, though illegal. Female genital mutilation many times was conducted in rural communities by unskilled midwives or traditional birth attendants with the aid of instruments like knives, razor blades, and even broken glasses. The instruments were often not sterilized and the ritual was very often performed in unsanitary conditions. In urban areas, some families went for the operation and this trend was on increase (Mohammed et al., 2018).

In a study carried out in Cairo, Egypt, 79.3% of genital surgeries happened at home while 0.3% only was
done in the hospital (Abdel-Tawab, Oraby, Hassanein, & El-Nakib, 2018) and infibulation was seen as a way to control sexual desire. More so, that a large proportion of circumcised women were from rural areas where uncircumcised women were not socially accepted (Abdel-Tawab et al., 2018).

Available pieces of literature on FGM/C revealed that the people usually subjected to FGM were infants, children, and young adults with the age of operation varying from one country to another, tribe to tribe (Adetoro & Ebomoyi, 1986). The researcher noted that in Nigeria, the Yorubas of south-western states usually did it on infants before their first birthday. Some Ibos, Edos, and Ketu (Yoruba) performed it around puberty or just before marriage while others did it in pregnancy or after first delivery with serious complications (Kolawole & Anke, 2010). Okoronkwo (2000), Onodu (2016), and Orisaremi (2017) asserted that this practice was done within the first eight days of life among the Afriplos of Igbo tribe and Yorubas in Nigeria.

In a study conducted in Ekiti State on the prevalence of genital abnormalities among primary school pupils, it was revealed that female pupils between ages 2-16 years were already mutilated (Temi et al., 2014). Some studies (Kadiri, Ahmad, & Mustaffa, 2014; Kehinde, 2016) had revealed that the most common type of circumcision was excision of the clitoris, in about 80% of the victims, it was done between the first week of life and time of puberty. In the Okpe community of Delta State and among the Ibibio in Akwa Ibom State it was between 13 and 18 years (Kehinde, 2016; Oyefara, 2014; Titilayo, Palamuleni, Olaoye-Oyesola, & Owoeye, 2018).

World Health Organization (2016) studied on the types of FGM/C practised in Nigeria, the South Western States results were: Lagos State, 20%-30% (type I), Ogun State, 35%-45% (type I and II), Ondo State, 90%-98% (type I), Osun State, 80%-90% (type I), and Oyo, 60%-70% (type I). Researchers had mentioned that women and girls that have died through this practice were unknown since few records were kept (Kandala, Nwakeze, & Kandala, 2009; Okeke, Anyaehie, & Ezenyeaku, 2012).

However, a recent national survey revealed that there was a slight decline in prevalence of FGM/C in the Southern and Eastern Nigeria, the practice was still widely practiced (Demographic, 2019; Kandala et al., 2020). About 19.9 million women had been cut resulting into 16% of the global prevalence. The regional prevalence report established that the South-West had 41.1%, South-East 32.5%, 25.8 % was reported in South-South, 20.7% in North-West, 9.9% in North-Central and 2.9% was observed in the North East of Nigeria. Ekiti-State had the second overall prevalence of 62.6% after Osun-State with 67.8%, Oyo-State and Kwara-State was third with 55% each and Imo-State was fourth with 51.6% (Demographic, 2019; Kandala et al., 2020).

Culture and beliefs have been implicated to prominently play a great role in the practice of FGM as individuals from some culture believed that female genital mutilation promoted hygiene, protected virginity and family honour, improved the female attractiveness and male sexual pleasure, and enhanced fertility (Ndikom, Ogungbenro, & Ojeleye, 2017). It was assumed that girls were not eligible for marriage if not circumcised, and they would be unfaithful to their husband. Some culture saw it as a rite of passage that signified girls becoming women and whoever opted out risked being stigmatized. Girls who did not partake were believed to grow abnormally large reproductive organs which could be a hindrance during childbirth (Samson-Akpan, Edet, Akpabio, & Asuquo, 2013).

Onodu (2016) established that cultural factors like faithfulness in marriage, control of sexual desire, and promiscuity among women, and increased sexual pleasure in male encouraged FGM/C practice. Due to poor knowledge and the powerful influence of tradition, many girls accepted circumcision as necessary and even a natural part of life and adopted the rationale given for its existence. With socio-economic factors, FGM/C was
seen to have some economic advantages. In some culture, girls who went through this ritual were showered with gifts from people in the community which motivates girls from a poor family to subject themselves willingly to the procedure (World Health Organization, 2016).

The World Health Organisation (2016) had found that religion correlated with FGM/C. FGM/C was practised by all religions. Though some religions claimed that was related to their religion while some advocated that it was just to follow tradition and culture, but had no basis for their religious belief. However, in Africa, a higher percentage of circumcised women were of Islamic religion though female circumcision was not even mentioned in the Koran and unknown in predominantly Muslim countries outside Africa, such as Saudi Arabia and Iraq (Bowyer, 2009; World Health Organization, 1996).

In the area of education, female genital mutilation (FGM) was usually encouraged by the elders and mostly illiterate people in the community because they were oblivious of the health implications. Mostly, the belief in tradition and socialization promoted female genital mutilation, many who practised FGM/C were socialized into it. They had a misconception that girls that were not cut would become prostitutes (Kolawole & Anke, 2010). More so, existing literature on FGM/C revealed that more literate were joining the campaign to eradicate FGM/C since they had undergone the practice before, knew the effect, both immediate and later in life (Kaplan, Hechavarría, Bernal, & Bonhoure, 2013). With this, it meant that people needed to be educated more about the health implications of this practice.

The practise of FGM/C in Nigeria varied by ethnicity and class, about 90% of the adults in South Western Nigeria, are engaged in female genital mutilation, whereas in another section of the same ethnic group, the Ijebus, this tradition which was formerly widespread in the community had been unreservedly rejected (World Health Organization, 2014).

The health implication of FGM/C on the girl child was huge; many children had been reported to drop out of school because of serious health hazards which included bleeding, shock, infections, and a higher rate of death for newborn babies (Okeke et al., 2012; Sipsma, Chen, Ofori-Atta, Ilozumba, Karfo, & Bradley, 2012; World Health Organization, 2016). FGM/C was considered a ritualized form of child abuse and violence against women, a violation of human rights (Rahman & Toubia, 2000; Rahman & Tareque, 2013). As a result of this, there has been a serious concern to eradicate FGM/C in many countries especially in Nigeria by creating awareness on the effects of FGM on girls and creating alternative occupation for the practitioners of FGM through training them to become traditional birth attendants (TBAs) (Dabo, 1999; Epundu, Ilika, Ibeh, Nwabueze, Emelumadu, & Nnebue, 2018; World Health Organization, 2016).

It was highly of concern that despite its prohibition by International Human Rights Law, National and State laws FGM/C persisted in Nigeria because the perpetrators were not questioned and punished. More so, most women in developing countries were unaware of their basic human rights. Even when women acquire a degree of economic and political freedom, they often felt powerless to bring about the change necessary to eliminate gender inequality (Njogu & Orchardson-Mazrui, 2013).

The Objective of the Study

The main objective of the study was to investigate the bivariate logistic regression of knowledge as a predictor of the practice of female genital mutilation/cutting among parents in Ekiti State.

The specific objective of the study was:

(1) Determine if knowledge would reduce the practice of female genital mutilation among parents in Ekiti
(2) Assess which socio-demographic factors would predict the practice of female genital mutilation among parents of Ekiti State, Nigeria.

Materials and Methods

This research adopted a cross-sectional survey design. The population for the study comprised the parents within the three (3) Senatorial Districts in Ekiti State. The sample for this study was 600 respondents drawn from one urban and one rural area in each of the three (3) senatorial districts of Ekiti-State, Nigeria. Multi-stage sampling technique which involved, simple random, stratified, and purposive sampling techniques was adopted in selecting the eligible respondents for the study with the instrument tagged “Bivariate Logistic Regression of Knowledge as Predictor of the Practice of Female Genital Mutilation (BLRKPPFGM)”. Questions measuring the knowledge and practices of FGM were measured on a four-point Likert scale of rating; Strongly Agreed (SA), Agreed (A), Disagreed (DA), and Strongly Disagreed (SD) was used with scoring as follows: SA = 4 points, A = 3 points, DA = 2 points, SD = 1 point.

To fit the logistic regression model, the outcome variable which was the practice measure of FGM was rated and coded as high = 0 and low = 1. The primary explanatory variable was the knowledge of FGM, which was also coded high = 1 (31-60) and low = 0 (1-30). Besides the main explanatory variables, six other determinants were examined as the predictors of the practice of female genital mutilation. They were: age of respondents (18-27 years, 28-37 years, 38-47 years, 48 years and above), location (rural/urban), level of education (literate/illiterate), sex, religion, and ethnicity.

Data Analysis

The data were analyzed using SPSS version 21.0 package (SPSS Inc., Chicago, IL, USA). Frequencies and cross-tabulations were used to summarize descriptive statistics of the data. All variables that were significant in bivariate analysis (chi-square) were entered into multiple logistic regressions. Finally, the variables that had significant association were identified based on the unadjusted odds ratio (OR) with 95% confidence interval (CI) and a p-value < 0.05 to fit the final regression model.

Results

Table 1 showed the distribution of the practice of female genital mutilation by socio-demographic determinants. There were 600 respondents in all, 468 (78%) of the respondents were engaged in the high practice and 132 (22%) in the low practice of FGM/C in Ekiti State, Nigeria. The table showed that out of 240 (40%) respondents who dwelled in rural areas of Ekiti State, 174 (29%) regarded the practice of female genital mutilation as being high and 66 (11%) considered it as being low, among the urban dwellers 360 (60%), 294 (49%) believed that female genital mutilation was high while 66 (11%) said the practice was low. This implied that the practice of female genital mutilation was higher among urban than rural dwellers. More so, there was an association (p < 0.05) between the practice of female genital mutilation and the geographical location of the respondents in Ekiti State, Nigeria.

The distribution of the age revealed that of a total of 152 respondents who were aged between 18 years and 27 years, 88 (14.7%) said that the practice of female genital mutilation was high while 64 (10.7%) said it was low. Among 179 respondents aged 28 to 27 years, 143 (23.8%) said the practice was high and 36 (6%) was
low. In addition to this, 159 respondents aged between 38 and 47 years, 138 (23%) added that the practice was high while 21 (3.5%) said that it was low. Among those who were 48 years and above, 99 (16.5%) revealed that the practice of FGM was high while 11 (1.8%) said that the practice was low. Further analysis revealed that age had a significant association ($p < 0.05$) with the practice FGM in Ekiti State, Nigeria.

For sex as a socio-demographic variable out of a total of 211 males, 153 (25.5%) and 58 (9.7%) said the practice of female genital mutilation was high and low respectively. For females, 315 (52.5%) and 74 (12.3%) revealed that the practice was high and low respectively. More so, a significant association ($p < 0.05$) existed between sex and practice of female genital mutilation. As for the level of education, out of 476 literate respondents, 364 (60.7%) and 112 (18.7%) said the practice of female genital mutilation was high and low respectively. Out of 124 respondents, 104 (17.3%) and 20 (3.3%) respondents observed that the practice of FGM was high and low respectively. The Chi-Square analysis showed that there was no significant association ($p > 0.05$) between the educational status of respondents and the practice of female genital mutilation.

For religious affiliation of respondents out, of the 437 respondents who were Christians, 338 (56.3%) said the practice of female genital mutilation was high while 99 (16.5%) revealed it was low. Among 148 respondents who practised Islamic religion, 116 (19.3%) and 32 (5.3%) revealed the practice of FGM was high and low respectively. Religion did not have a significant association ($p > 0.05$) with the practice of female genital mutilation. Analysis of ethnicity showed that out of the total of 450 respondents from Yoruba ethnic group, 356 (59.3%) and 94 (15.7%) believed the practice of FGM was high and low respectively. Among 52 Igbo respondents, 47 (7.8%) and 5 (0.8%) said that the practice was high and low respectively. Analysis of other religions indicated that 65 (10.8%) and 33 (5.5%) of the respondents opined that the practice of FGM was high and low respectively. In addition to this, ethnicity was significantly associated ($p < 0.05$) with the practice of female genital mutilation.

Table 1
Socio Demographic Factors and Practice of Female Genital Mutilation in Ekiti State, Nigeria

| Socio-demographic factors | Practice measure (%) | (%) | $\chi^2$ | $p$ value |
|--------------------------|----------------------|-----|---------|-----------|
|                          | High | Low | Total  |           |
| Location                 | 468 (78%) | 123 (22%) | 600 (100%) |           |
| Rural                    | 174 (29) | 66 (11) | 240 (40) | 7.051 | 0.008 |
| Urban                    | 294 (49) | 66 (11) | 360 (60) |           |
| Age                      | 18-27 years | 88 (14.7) | 64 (10.7) | 152 (25.3) |           |
|                          | 28-37 years | 143 (23.8) | 36 (6) | 179 (29.8) | 52.571 | 0.000 |
|                          | 38-47 years | 138 (23) | 21 (3.5) | 159 (26.5) |           |
|                          | 48 years and above | 99 (16.5) | 11 (1.8) | 110 (18.3) |           |
| Sex                      | Male | 153 (25.5) | 58 (9.7) | 211 (35.2) | 5.712 | 0.017 |
|                          | Female | 315 (52.5) | 74 (12.3) | 389 (64.8) |           |
| Level of education       | Literate | 364 (60.7) | 112 (18.7) | 476 (79.3) | 3.140 | 0.076 |
|                          | Illiterate | 104 (17.3) | 20 (3.3) | 124 (20.7) |           |
| Religion                 | Christianity | 338 (56.3) | 99 (16.5) | 437 (72.8) | 2.177 | 0.337 |
|                          | Islam | 116 (19.3) | 32 (5.3) | 148 (24.7) |           |
Table 2 expressed knowledge as determinants of the practice of female genital mutilation in Ekiti State, Nigeria. More than two-thirds (468, 78%) of the respondents said that the practice of FGM was high compared to 132 (22%) in Ekiti State, Nigeria. Out of 142 who had low knowledge of female genital mutilation, 81 (13.5%) and 61 (10.2%) said that the practice was low and high respectively. Out of 458 respondents with high knowledge of female genital mutilation, 51 (22%) and 468 (78%) revealed the practice was low and high respectively. The study also, established that there was a significant association ($p < 0.05$) between knowledge and practice of female genital mutilation in Ekiti State, Nigeria.

Table 3 showed the unadjusted binary logistic regression of knowledge and socio-demographic factors as determinants of the practice of female genital mutilation in Ekiti State, Nigeria. The analysis revealed that respondents with low knowledge were significantly (OR = 10.597, $B = 2.361$, $p < 0.05$, CI = 6.813-16.483) 11 times likely to practice female genital mutilation compared with respondents with high knowledge. For the geographical location of respondents, those in rural areas were two times significantly (OR = 1.690, $B = 0.525$, $p < 0.05$, CI = 3.246-13.197) likely to practice female genital mutilation than the urban dwellers. Age was also a strong predictor of the practice of FGM in Ekiti State, respondents who were between 28-37 years old were seven times more likely (OR = 6.545, $B = 1.879$, $p < 0.05$, CI = 6.32-2.969) to predict the practice of female genital mutilation than those who were between 18 and 27 years of age. Also, those between 38 and 47 years old were two times more likely (OR = 2.266, $B = 0.818$, $p < 0.05$, CI = 1.100-4.665) to practice female genital mutilation compared to those who were between 18 and 27 years of age.

Table 2

| Knowledge measure | Practice measure | Low (%) | High (%) | Total (%) | $\chi^2$ | $p$ value |
|-------------------|------------------|---------|----------|-----------|----------|-----------|
| Low               | Low              | 81 (13.5) | 61 (10.2) | 142 (23.7) |          |           |
| High              | High             | 51 (8.5)  | 407 (67.8) | 458 (76.3) | 133.119  | 0.000     |
| Total             |                  | 132 (22)  | 468 (78)  | 600 (100)  |          |           |

Note. $p \leq 0.05$.

Table 3

| Determinants | B    | S.E  | Wald  | $p$ value | Exp (B) | Lower | Upper |
|--------------|------|------|-------|-----------|---------|-------|-------|
| Low knowledge (high$^b$) | 2.361 | 0.225 | 109.682 | 0.000 | 10.597 | 6.813 | 16.483 |
| Location (urban$^a$) | 0.525 | 0.199 | 6.974  | 0.008 | 1.690 | 1.145 | 2.494 |
| Age 28-37 years (18-27 years$^b$) | 1.879 | 0.354 | 27.577 | 0.000 | 6.545 | 3.246 | 13.197 |
| 38-47 years | 0.818 | 0.368 | 4.927  | 0.026 | 2.266 | 1.100 | 4.665 |
| 48 years and above | 0.314 | 0.395 | 0.635  | 0.426 | 1.370 | 0.632 | 2.969 |

Note. $^a$Urban, $^b$High, $^b$Low.
Additionally, sex was a predictor of the practice of female genital mutilation, the female was two times more likely to practice FGM than male (OR = 1.614, B = 0.479, \( p < 0.05 \), CI = 1.088-2.394). Ethnicity was another predictor of the practice of female genital mutilation in Ekiti State, respondents who were Yoruba were 48% less likely (OR = 0.520, B = -0.654, \( p < 0.05 \), CI = 0.323-0.838) to practice female genital mutilation compared to other ethnic groups in Nigeria. More so, the Igbo ethnic group was 79% less likely (OR = 0.210, B = -1.563, \( p < 0.05 \), CI = 0.076-0.577) to practice female genital mutilation than other ethnic groups in Nigeria. Our analysis also revealed that educational attainment and religious affiliation of respondents were not predictors of the practice of female genital mutilation in Ekiti State, Nigeria.

**Discussion**

Recently, there has been progressive response to eradicate FGM across the globe because of the implications on women’s health and it’s severely violation of basic human right. This bivariate analysis revealed that knowledge, age, sex, location (rural and urban), education, and ethnicity of the respondents were strongly associated with the practice of FGM/C in Ekiti State, Nigeria. Among all participants studied, 78% were engaged in the high practice and 22% in the low practice of FGM/C. The finding agrees with the Ekiti State prevalence rate of 71.2% earlier established (Demographic, 2013; Gebremariam, Assefa, & Weldegebreal, 2016; Kaplan et al., 2013). More educated, urban, female, Yoruba, respondent age 28 to 49 years and the Christians demonstrated a higher practice of FGM/C. This finding corroborates a similar study in Egypt by Mohammed et al. (2018b).

Moreover, previous studies (Dalal, Lawoko, & Jansson, 2010; Mohammed et al., 2018a) had revealed that knowledge was associated with the practice of FGM/C. The finding of the study underscored the importance of public education, urbanization, and information dissemination in changing attitudes to FGM/C which agrees earlier findings (Barstow, 1999) that in most countries where FGM/C was practised, knowledge of the harmful effects of FGM/C had been an effective method in changing the practice and reducing the prevalence of FGM than just legislation against FGM/C. Scholars (Dalal et al., 2010; Onuh, Igberase, Umeora, Okogbenin, Otoide, & Gharoro, 2006) had suggested adequate educational and awareness-raising campaigns as a weapon to fight this menace and counselling on the unsafe consequences of FGM/C by the healthcare providers who can also help to inform women about the health-related consequences of this practice. These findings by Dalal et al. (2010), and Onuh et al. (2006) agree with the present study.

FGM/C was institutionalized in Ekiti State, Nigeria. The result from the logistic regression model showed that knowledge, age, location, sex, and ethnicity were significant predictors of the practice of FGM/C among the respondents in the state. More so, rural dwellers were likely to have less access to adequate information about their health and that of the girl child. Rural dwellers are more likely to maintain inclinations to maintaining customary traditions like FGM/C which may have harmful effects on them than the urban dwellers.
When logistic regression analysis was done among dependent and independent variables of the study mainly to see the association among factors associated with the FGM/C, those in rural areas had more odds to practice female genital mutilation than the urban dwellers, more so, as earlier revealed (Gebremariam et al., 2016) that young adult females in rural Jigjiga district, eastern Ethiopia were more likely to practice FGM/C compared to their counterpart in urban residence.

Even though education had been discovered by Gebremariam et al. (2016) to be a major predictor of female genital mutilation, however, the finding of this study opposes this because it did not reveal religion and education as predictors of female genital mutilation in Ekiti State. Both Muslims and Christians, illiterates and literates practised FGM/C as it was more of cultural belief than religion in this part of the world. This finding may be attributed due to the increasing understanding and awareness created about the harmful effects of FGM/C by religious bodies, the educational institutions in the study area, and the advancement of educational provision as compared to the previous times.

Also regarding the intention of practice FGM/C, the odds of the practice of female genital mutilation was statistically significant among the ethnic groups in this study. Yoruba were less likely to practice female genital mutilation compared to other ethnic groups in Nigeria. More so, the Igbo ethnic group practiced more female genital mutilation than other ethnic groups in Nigeria. This is consistent with Kaplan et al. (2013).

Conclusion and Recommendation

This study concluded that respondents’ knowledge about FGM/C, age, sex, location, and ethnicity was proved to be significant predictors of the practice of FGM/C practice. With these findings in mind, the community institutions would play a great role in changing the community through spreading good information about the health implications of FGM/C. Community leaders and health promoters should also take advantage of the town hall meetings to broadcast educational information about the health implications of FGM/C to the members of the community.

A book should be published in the four major Nigerian languages in Nigeria (English, Yoruba, Hausa, and Igbo) on the side effects of female genital mutilation and other reasons why the practice should be abolished for both urban and rural duelers to read. More so, it is essential to strengthen and scale up the implementation and uphold gender justice and equality through enforcement of Ekiti State gender-based violence prohibition law of 2011, female genital mutilation prohibition law of Ekiti State, and other laws protecting the girl child and women in Nigeria.

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