ASSESSMENT OF FEMALE GENITAL MUTILATION PRACTICES AMONG WOMEN OF REPRODUCTIVE AGE GROUP IN ILORIN METROPOLIS, KWARA STATE NIGERIA

BY

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Abstract

Female Genital Mutilation (FGM) is a pressing global health and human rights issue affecting millions of women and girls. Despite efforts to eradicate it, cultural beliefs perpetuate the practice. This study examines knowledge, attitudes, practices, and factors influencing FGM and its health consequences among reproductive-age women in Ilorin metropolis, Kwara State, Nigeria. A cross-sectional survey was conducted using structured questionnaires to gather data on FGM awareness, perceptions of health effects, reasons for continuation, and demographic information. Multistage sampling was employed, with data analyzed using SPSS version 26, utilizing descriptive and inferential statistics. High awareness of FGM (96.1%) was found, primarily viewed as a cultural practice with minimal perceived health complications (58.7%). Key reasons for its continuation included adherence to cultural norms (42.6%) and beliefs about promiscuity (82.2%). A significant knowledge gap regarding health risks was identified (66.5%), with educational attainment as a crucial influencing factor (p-value<0.001). Cultural beliefs significantly influence FGM's persistence despite awareness of its risks. Effective eradication requires comprehensive legal frameworks, educational campaigns, and community engagement, particularly with cultural leaders, to protect the health and rights of women and girls.

Keywords: Female Genital Mutilation (FGM), awareness, cultural beliefs, health risks, reproductive-age women

Introduction

Female genital mutilation (FGM) is defined by the World Health Organization as any procedure that involves the partial or complete removal of the external female genitalia and/or damage to the female genital organs, whether for non-therapeutic or cultural reasons (WHO, 2018). Female genital mutilation is a harmful custom that women and girls around the world are subjected to (United Nations, 2020). It is commonly acknowledged as a violation of human rights that has permeated cultural beliefs and perceptions for decades and generations, transforming a difficult process (Gbadebo *et al*., 2021). 200 million women and girls worldwide are estimated to have been subjected to the practice, and over three million are in danger of having it done to them each year, according to the WHO's most recent data (WHO, 2018). According to Okeke *et al*. (2012), FGM is a severe form of discrimination and a violation of girls' and women's human rights, with known negative effects on their health. More than 28 African nations as well as certain global populations experience it. Its burden is greatest in nations where it has long been present, such as Nigeria, Egypt, Mali, Eritrea, Sudan, Central African Republic, and Northern Ghana (Shakirat *et al*., 2020). According to Shakirat *et al*. (2020), FGM is almost the norm in Somalia and Djibouti, where the highest prevalence is observed. Nigeria is the country with the largest absolute number of FGM instances worldwide, accounting for 25% of all estimated female circumcised cases. FGM is a common practice in Nigeria. According to a study by Kandala et al. (2020) who conducted a descriptive analysis using the DHS and MICS found 12.8% and 16.1% prevalence of FGM in Northcentral Nigeria.

The south-south region of Nigeria has the highest prevalence of FGM (77%), followed by the southeast (68%) and southwest (65%) regions (Okeke *et al*., 2012). Even yet, it is performed in the north to a smaller extent, albeit surprisingly in a more intense form (Okeke *et al*., 2012). Based on the most recent census data and predictions from Trading Economics, Nigeria's population is predicted to be 200 million in 2019. Of this population, women make up

52% (Obijiofor *et al*., 2020). The frequency of FGM among females in Nigeria is 41% nationwide. FGM is regarded as a cultural custom in the majority of societies (Gbadebo *et al*., 2021). The FGM is divided into four categories by the World Health Organization. Subcategories within three of the four main categories are used to further classify the particular kind of mutilation that was done. Any procedure that completely eliminates the prepuce and/or clitoris is referred to as a type I clitoridectomy (WHO, 2018). Only the clitoris hood or prepuce is removed in Type Ia, whereas both the clitoris and the prepuce are removed in Type Ib (Odemerho *et al*., 2012). Excision, also known as type II, is the partial or complete removal of the labia minora without any connection to any labia majora incisions (UNICEF, 2020). The excision of the labia minora is the sole component of type IIa. Type IIb involves removing the clitoris completely or partially, as well as the labia minora (Odemerho *et al*., 2012). The clitoris, labia minora, and labia majora are removed in type IIc. The third type of mutilation procedures, known as infibulation, or Type III, is characterized by the constriction of the vaginal opening and sealing of the perineum through the mutilation and repositioning of the labia majora and minora, either with or without the removal of the clitoris. According to Obijiofor *et al*. (2020), Type IIIb covers treatments involving just the labia majora, whereas Type IIIa particularly refers to procedures including the removal and apposition of the labia minora. Type IV is a broad category that encompasses all additional damaging treatments performed on female genitalia without any medical justification. This covers any incisions made on the patient, any herbal remedies, and any burns that alter or damage their body (WHO, 2020).

Research Questions

1. What is the level of knowledge of FGM among women of reproductive age group in Ilorin metropolis?
2. What is the attitude towards FGM practices among women of reproductive age group in Ilorin metropolis?
3. What are the factors influencing FGM practices among women of reproductive age group in Ilorin metropolis?
4. What is the associated health problem of FGM among women of reproductive age group in Ilorin metropolis?
5. What are the practices of FGM among women of reproductive age group in Ilorin metropolis?

General Objective

To assess female genital mutilation practices among women of reproductive age group in Ilorin metropolis. Specific Objectives are:
1. To assess the knowledge of FGM among women of reproductive age group in Ilorin metropolis
To determine the attitude towards FGM practices among women of reproductive age group in Ilorin metropolis
2. To determine the factors influencing the FGM practices among women of reproductive age group in Ilorin metropolis
3. To identify the associated health problems of FGM among women of reproductive age group in Ilorin metropolis
4. To identify the practice of FGM among women of reproductive age group in Ilorin metropolis.
Research Hypothesis

Null Hypothesis

1. There is no association between the sociodemographic characteristics and knowledge of the health consequences associated with FGM among women of reproductive age.
2. There is no association between the sociodemographic characteristics and the practice of FGM among women of reproductive age.

Alternative Hypothesis

1. There is an association between the sociodemographic characteristics and knowledge of the health consequences associated with FGM among women of reproductive age.
2. There is an association between the sociodemographic characteristics and the practice of FGM among women of reproductive age.

Methodology

Description of the Study Area

The study was conducted in Ilorin metropolis, Kwara State, Nigeria. Ilorin is located on latitude 8° 30' N and longitude 4° 35' E. The city has a tropical climate with two seasons: dry (November to March) and wet (April to October). The population of Ilorin is predominantly Yoruba, with Fulani, Hausa, Nupe, and Bariba immigrants (Olaniran, 2002)

Research Design

This study adopted a descriptive cross-sectional study to assess the practice of FGM among women of reproductive age using a quantitative method of data collection. Data was generated through the administration of an interviewer-administered questionnaire.

Study Population

This study involved women of reproductive age in selected areas in Ilorin metropolis, Kwara State.

Inclusion criteria

This study only included women of reproductive age

Exclusion Criteria

Women not of reproductive age.

Sample Size Determination

The minimum sample size for this study in Ilorin metropolis, Kwara state, was calculated using Fischer's formula for descriptive studies as given below:

$n = z2pq/d2$

Where; n = the desired sample size when the population is greater than 10,000

Z = the standard normal deviate, set at 1.96 which corresponds to a 95% Confidence Interval

P= prevalence of FGM in Northwest Nigeria according to the 2016-17 Demographic and health survey at 12.8% = 0.13 (Kandala et al., 2020)

q= the complimentary probability of P which is $(1 − p) = (1-0.13)=0.87$

d= degree of accuracy desired at 5% or 0.05 (Araoye, 2014)

By substituting we have,

$$n = 1.96^2 \times (0.13)\ (1-0.13)/0.05^2$$
$$n = 1.96^2 \times (0.13)\ (0.87)/0.05^2$$
$$n = 173.79$$
$$n = 174\ (minimum\ required\ sample\ size)$$

To compensate for non-response, taking that 70% of responses is anticipated, the sample size was calculated using the formula

$$nf=n/e$$
$$nf = n/e$$
$$nf=174/0.70$$
$$nf= 248.57$$

For the accuracy of the study, the sample size was rounded up to 250Multistage sampling was used:

Sample technique

A multistage sampling technique was used for this study

Stage 1: Selection of Local Government Area

A local government area was randomly selected out of the three LGA in Ilorin metropolis by rolling a dice

Stage 2: Selection of wards

Simple random sampling by balloting method without replacement was used to select five (5) wards out of the total wards in selected local government areas. Equal allocation was used to distribute the sample size across the selected wards to give at least fifty (50) respondents per ward.

Stage 3: Selection of settlement

Simple random sampling was employed to choose settlements within designated wards by rotating a bottle. This method entails dividing the settlement into quarters and then spinning the bottle. The settlement indicated by the bottle's direction was selected for the survey.

Stage 4: Selection of household and participants

Systematic sampling was utilized to pick households within the chosen settlement. This involves selecting the initial household on the right and then skipping every other household at regular intervals until the designated sample size for the settlement is attained.

Research instrument

A semi-structured interviewer-questionnaire was used for this study. The research instrument comprises of six sections:

Results

The results are based on data collected from 230 respondents. Below is the summary of findings, including relevant tables and figures.

Table 1
Sociodemographic characteristics of respondents

Sociodemographic characteristics		Frequency (N=230)	Percentage (%)
Age group	19-25	31	13.5
	26-30	52	22.6
	31-35	34	14.8
	36-40	64	27.8
	41-45	30	13
	46 and above	19	8.3
	Mean±SD	34.59±7.73	
Ethnicity	Yoruba	217	94.3
	Hausa	11	4.8
	Others	2	0.9

Educational level	None	72	31.3
	Primary	38	16.5
	Secondary	54	23.5
	Tertiary	66	28.7
Marital status	Single	22	9.6
	Married	200	87
	Widowed	8	3.5
Religion	Islam	223	97
	Christianity	6	2.6
	Traditional	1	0.4
Family type	Monogamy	148	64.3
	Polygamy	82	35.7

From the survey of 230 respondents, with an average age of 34.59 and a standard deviation of 7.73, most 72 (31.3%) have no educational background, almost all 200 (87%) are married, and close to two-thirds 148 (64.3%) are from the monogamous type of family

Table 2
Knowledge of FGM among women of reproductive age group in Ilorin metropolis

Knowledge statements		Frequency	Percentage (%)
Have you heard of Female genital mutilation (FGM) before?	Yes	221	96.1
	No	9	3.9
How would you define Female genital mutilation (FGM) (N=221)	A cultural practice without significant health implications	135	58.7
	Removal or alteration of the external female genitalia for non-medical reasons	81	35.2
	Not sure	14	6.1
Can you identify the different types of FGM	Yes	103	44.8
	No	127	55.2
Type of FGM (N=103)	Removal of part of the clitoris	91	88.3
	Removal of part or all of the clitoris and the inner labia	10	9.7
	Other harmful procedures like poking, piercing, mutilation, or scraping	1	1
	Not sure	4	3.9
How prevalent do you think FGM is in your community?	Very common	192	83.5
	Somewhat common	18	7.8
	Not very common	12	5.2
	Not sure	8	3.5
Do you know the problems associated with FGM?	Yes	77	33.5
	No	153	66.5

Problems associated with FGM (N=77)	Bleeding	39	50.6
	Infection	34	44.2
	Death	4	5.2
	Childbirth difficulty	7	9.1
	Others	12	15.6

Almost all 221 (96.1%) have heard about FGM, of whom more than half 135 (58.7%) defined female genital mutilation as a cultural practice without health complications, less than half 103 (44.8%) can identify the different types of FGM, of whom the majority 91 (88.3%) knows the removal of part of the clitoris type of FGM, majority 192 (83.5%) of the respondents believed that FGM is very common in their community, two-thirds 153 (66.5%) do not know the problems associated with FGM.
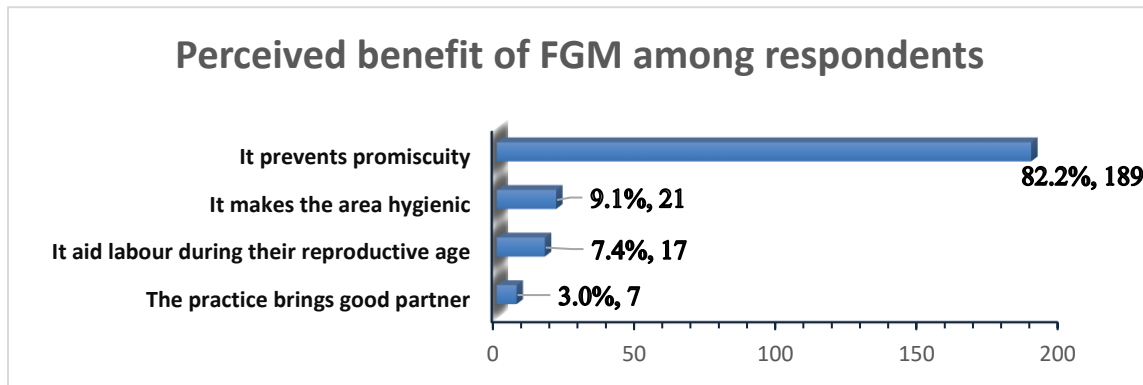

Perceived benefit of FGM among respondents

It prevents promiscuity — 82.2%, 189
It makes the area hygienic — 9.1%, 21
It aid labour during their reproductive age — 7.4%, 17
The practice brings good partner — 3.0%, 7

Figure 1: Bar chart illustration of the perceived benefit of FGM among respondents (N=230)

Table 3
Attitude towards FGM practices among women of reproductive age group in Ilorin metropolis

Attitude statements		Frequency (N=230)	Percentage (%)
Do you support the practice of female genital mutilation?	Yes	146	63.5
	No	84	36.5
Do you think the practice of FGM will prevent a girl child from promiscuity?	Yes	151	65.7
	No	47	20.4
	Not sure	32	13.9
Will you perform FGM on your girl child?	Yes	128	55.7
	Father's decision	26	11.3
	No	76	33
Do you think FGM should be abolished?	Yes	63	27.4
	No	150	65.2
	Not sure	17	7.4
How comfortable are you discussing FGM within your community?	Very comfortable	167	72.6
	Somewhat comfortable	40	17.4
	Not comfortable	8	3.5

	Not sure	15	6.5
How influential do you believe cultural norms are in perpetuating FGM?	Very influential	179	77.8
	Somewhat influential	24	10.4
	Not influential	7	3
	Not sure	20	8.7
How significant do you think the role of education is in reducing the prevalence of FGM?	Very confident	91	39.6
	Somewhat significant	29	12.6
	Not very significant	64	27.8
	Not sure	46	20

Almost all 221 (96.1%) have heard about FGM, of whom more than half 135 (58.7%) defined female genital mutilation as a cultural practice without health complications, less than half 103 (44.8%) can identify the different types of FGM, of whom the majority 91 (88.3%) knows the removal of part of the clitoris type of FGM, majority 192 (83.5%) of the respondents believed that FGM is very common in their community, two-thirds 153 (66.5%) do not know the problems associated with FGM.
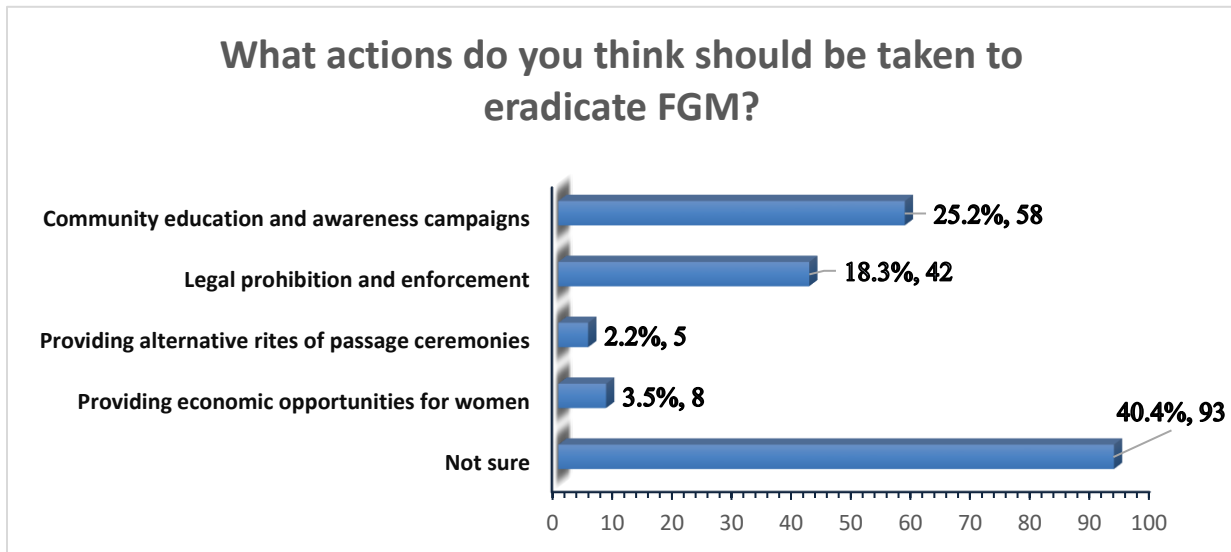

Figure 2: Barchart illustration of perceived action to eradicate FGM

The findings from the figure above show that only a few 42 (18.3%) of the respondents believed that legal prohibition and enforcement are the actions necessary to eradicate FGM.

Table 4
Factors influencing the FGM practices among women of reproductive age group in Ilorin metropolis (N=230)

Factors influencing the practice of FGM		Frequency	Percentage (%)
How influential do you believe cultural norms are in perpetuating FGM?	Very influential	179	77.8
	Somewhat influential	24	10.4
	Not influential	7	3
	Not sure	20	8.7

How significant do you think the role of education is in reducing the prevalence of FGM?	Very confident	91	39.6
	Somewhat significant	29	12.6
	Not very significant	64	27.8
	Not sure	46	20

The majority 179 (77.8%) of the respondents believed that cultural norms are very influential to the practice of FGM and more than one-third 91 (39.6%) of the respondents are very confident that education plays a significant role in reducing female genital mutilation.

What do you think are the main factors influencing the continuation of FGM?

- Social acceptance and marriageability — 17.4%, 40
- Preservation of virginity and sexual purity — 19.6%, 45
- Religious requirement — 5.2%, 12
- Family norms — 9.1%, 21
- Cultural norms — 45.2%, 104
- Hygiene and cleanliness — 2.6%, 6
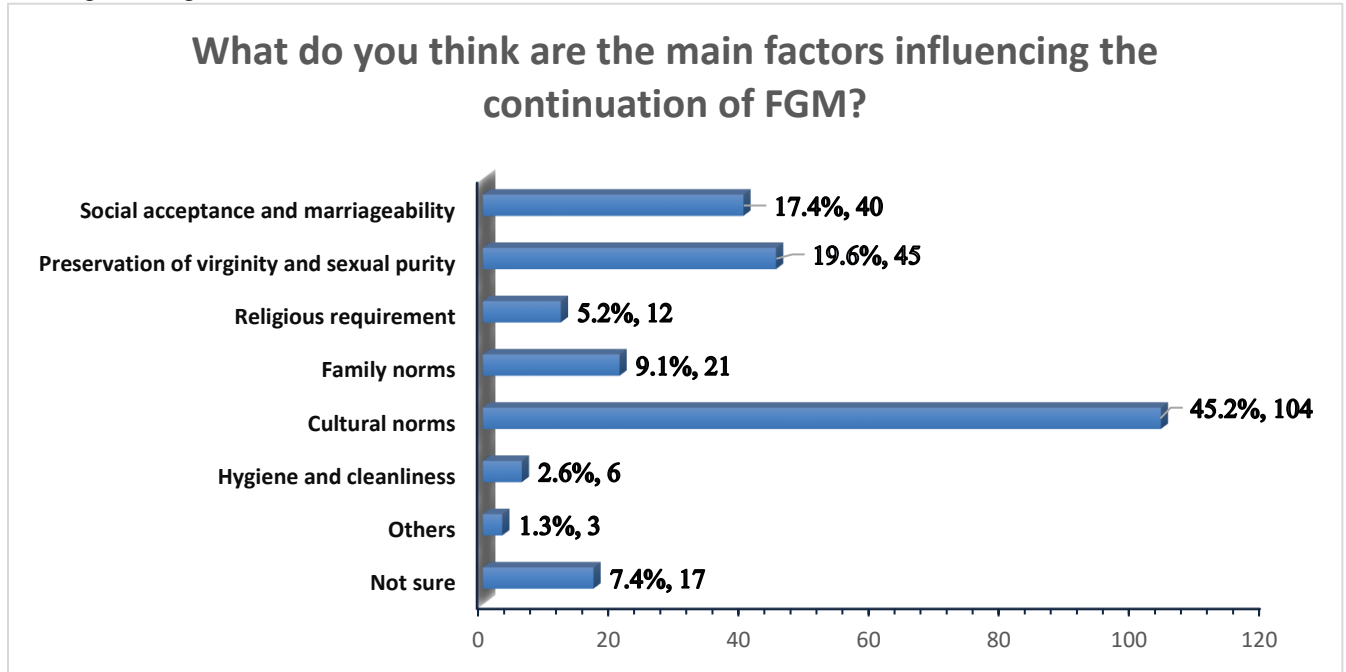- Others — 1.3%, 3
- Not sure — 7.4%, 17

Figure 3: Factors influencing the continuation of FGM

The figure above shows that Cultural norms (104, 45.2%), preservation of virginity and sexual purity (45, 19.6%), and social acceptance and marriageability (40, 17.4%) are the most common factors influencing the continuation of FGM.

Table 5
Associated health problems of FGM among women of reproductive age group in Ilorin metropolis (N=230)

Health problems associated with FGM		Frequency (N=230	Percentage (%)
Are you aware of the health consequences associated with FGM?	Yes	81	35.2
	No	149	64.8
What health issues do you think can arise from FGM?	Pain and psychological trauma	54	23.5
	Infection and hemorrhage	45	19.6
	Sexual dysfunction and complications during childbirth	27	11.7
	Urinary problems and menstrual difficulties	7	3
	Not sure	119	51.7
Have you or someone you know experienced any health complications as a result of FGM?	Yes	65	28.3
	No	133	57.8
	Not sure	32	13.9
What form of health complication was experienced (N=65)	Bleeding after the procedure	49	75.4
	Fever from infection after the procedure	6	9.2
	Loss of sexual desire	3	4.6
	Problem during delivery	2	3.1
	Others	7	10.8

The table above shows that Only one-third 81 (35.2%) are aware of the health consequences associated with FGM, of whom more than two-tenths 54 (23.5%) lead to pain and psychological trauma, and few 65 (28.3%) have experienced health complications as a result of FGM either personal or from close relative, of whom majority 49 (75.4%) experienced bleeding after the procedure.

Table 6
Practice of FGM among women of reproductive age group in Ilorin metropolis.

Practice of FGM		Frequency	Percentage (%)
Have you or someone you know undergone FGM?	Yes	193	83.9
	No	37	16.1
If yes, what type of FGM was performed?	Type I: Clitoridectomy	172	89.1
	Type II: Excision	16	8.3
	Type III: Infibulation	3	1.6
	Type IV: Other harmful procedures like pricking, piercing, incising, scraping	2	1
	Not sure	3	1.6
Did your girl child undergo FGM?	Yes	142	61.7
	No	88	38.3
	Type I: Clitoridectomy	127	89.4

If yes, what type of FGM was performed?	Type II: Excision	12	8.5
	Not sure	3	2.1
If yes, what were the reasons for undergoing FGM?	Culture	127	89.4
	Family norms	10	7.0
	Religious norms	4	2.8
	Others	1	0.8
Were you circumcised?	Yes	179	77.8
	No	21	9.1
	Not sure	30	13
If yes, what problem that you can remember did you experienced from circumcision	Bleeding after the procedure	23	12.8
	Difficulties during delivery	1	0.6
	Fever from infection after the procedure	3	1.7
	Loss of sexual desire	2	1.1
	Others	150	83.8

The result shows that the majority of 193 (83.9%) of the respondents have undergone or know someone who has undergone FGM, of which clitoridectomy (172, 89.1%) is the most common type of FGM performed. Furthermore, close to two-thirds 142 (61.7%) have a girl child that have undergone FGM, of whom the majority 127 (89.4%) had the clitoridectomy type of FGM performed which majority were influenced by culture (127, 89.4%). The majority 179 (77.8%) of the participants have undergone circumcision of whom more than one-tenth 23 (12.8%) experience bleeding complications after the procedure.

Table 7
Association between the sociodemographic characteristics and knowledge of the health consequences associated with FGM among women of reproductive age.

Sociodemographic characteristics	Are you aware of the health consequences associated with FGM? (N=230)			
	Yes (%)	No (%)	X	p-value
Age group				
19-25	12 (38.7)	19 (61.3)	10.48	0.063
26-30	23 (44.2)	29 (55.8)		
31-35	8 (23.5)	26 (76.5)		
36-40	17 (26.6)	47 (73.4)		
41-45	10 (33.3)	20 (66.7)		
46 and above	11 (57.9)	8 (42.1)		
Ethnicity				
Yoruba	79 (36.4)	138 (63.6)	3.62	0.164
Hausa	1 (9.1)	10 (90.9)		
Others	1 (50)	1 (50)		
Educational level				
None	13 (18.1)	59 (81.9)	26.33	<0.001

Primary	12 (31.6)	26 (68.4)		
Secondary	17 (31.5)	37 (68.5)		
Tertiary	39 (59.1)	27 (40.9)		
Marital status				
Single	14 (63.6)	8 (36.4)	12.4	0.002
Married	67 (33.5)	133 (66.5)		
Widowed	0 (0)	8 (100)		
Religion				
Islam	77 (34.5)	146 (65.5)	1.52	0.217
Christianity	4 (57.1)	3 (42.9)		
Family type				
Monogamy	53 (35.8)	95 (64.2)	0.064	0.8
Polygamy	28 (34.1)	54 (65.9)		

Using a chi-square level of significant association threshold of p-value at 0.05, the result shows a significant association between the educational level and marital status on the knowledge of the health consequences associated with FGM among women of reproductive age at a p-value of <0.001 and 0.002 respectively.

Table 8
Predictor of the association between the sociodemographic characteristics and knowledge of the health consequences associated with FGM among women of reproductive age.

Sociodemographic characteristics	p-value	OR	95% C.I. for OR	
			Lower	Upper
Age group				
19-25	0.006	**Ref**		
26-30	0.057	3.261	0.965	11.023
31-35	0.302	2.152	0.503	9.211
36-40	0.194	2.352	0.647	8.548
41-45	0.029	5.259	1.185	23.349
46 and above	<0.001	27.737	4.706	163.5
Ethnicity				
Yoruba	0.556	**Ref**		
Hausa	0.285	0.302	0.034	2.716
Others	0.854	0.757	0.039	14.647
Educational level				
None	<0.001	**Ref**		
Primary	0.054	2.847	0.981	8.262
Secondary	0.022	3.258	1.186	8.952
Tertiary	<0.001	9.034	3.228	25.281
Marital status				
Single	0.258	**Ref**		

Married	0.1	0.328	0.087	1.236
Widowed	0.999	-	-	-
Religion				
Islam		**Ref**		
Christianity	0.215	3.03	0.526	17.454
Family type				
Monogamy		**Ref**		
Polygamy	0.419	1.348	0.653	2.781

The logistics regression shows that age group 26-30, 31-35, 36-40, 41-45 and 45 and above are 3.3, 2.1, 2.4, 5.3 and 27.7 times respectively, more likely to have knowledge of the health consequences associated with FGM than those age group 19-25 years (OR=3.26, p-value=0.057; OR=2.15, p-value=0.302; OR=2.35, p-value=0.194; OR=5.26, p-value=0.029; OR=27.74, p-value<0.001). Furthermore, respondents who are of the Hausa tribe and other tribes are 70% and 24% respectively less likely to have knowledge of the health consequences associated with FGM than those of the Yoruba tribe (OR=0.30, p-value=0.285; OR=0.76, p-value=0.854). Respondents who have primary, secondary and tertiary educational level are 2.8, 3.3 and 9 times respectively, more likely to have knowledge of the health consequences associated with FGM than those who do not have any education (OR=2.85, p-value=0.054; OR=3.26, p-value=0.022; OR=9.03, p-value<0.001) and respondents who are from the polygamous family type are 35% more likely to have knowledge of the health consequences associated with FGM than those from the monogamous family type.

Table 9
Association between the sociodemographic characteristics and the practice of FGM among women of reproductive age

Sociodemographic characteristics	Did your girl child undergo FGM? (N=230)			
	Yes (%)	No (%)	X	p-value
Age group				
19-25	13 (41.9)	18 (58.1)	12.288	0.031
26-30	27 (51.9)	25 (48.1)		
31-35	22 (64.7)	12 (35.3)		
36-40	43 (67.2)	21 (32.8)		
41-45	22 (73.3)	8 (26.7)		
46 and above	15 (78.9)	4 (21.1)		
Ethnicity				
Yoruba	131 (60.4)	86 (39.6)	10.217	0.006
Hausa	11 (100)	0 (0)		
Others	0 (0)	2 (100)		
Educational level				
None	64 (88.9)	8 (11.1)	60.95	<0.001
Primary	28 (73.7)	10 (26.3)		
Secondary	33 (61.1)	21 (38.9)		
Tertiary	17 (25.8)	49 (74.2)		

Marital status				
Single	2 (9.1)	20 (90.9)	32.31	<0.001
Married	132 (66)	68 (34)		
Widowed	8 (100)	0 (0)		
Religion				
Islam	139 (62.3)	84 (37.7)	0.297	0.297
Christianity	3 (42.9)	4 (57.1)		
Family type				
Monogamy	85 (57.4)	63 (42.6)	3.259	0.071
Polygamy	57 (69.5)	25 (30.5)		

Using chi-square level of significant association threshold of p-value at 0.05, the result found a significant association between the age group, ethnicity, educational level and the marital status of respondents on the practice of FGM among respondents at p-value less than 0.05. Therefore, the null hypothesis which posits no association between the sociodemographic characteristics and the practice of FGM is rejected and the alternative hypothesis is accepted.

Table 10
Predictors of the association between the sociodemographic characteristics and the practice of FGM among women of reproductive age

Sociodemographic characteristics	p-value	OR	95% C.I. for OR	
			Lower	Upper
Age group				
19-25	0.385	**Ref**		
26-30	0.096	0.338	0.094	1.215
31-35	0.032	0.199	0.045	0.871
36-40	0.089	0.319	0.085	1.192
41-45	0.059	0.218	0.045	1.057
46 and above	0.419	0.479	0.081	2.85
Educational level				
None	<0.001	**Ref**		
Primary	0.09	0.377	0.122	1.165
Secondary	0.002	0.184	0.064	0.526
Tertiary	<0.001	0.053	0.018	0.16
Marital status				
Single	0.01	**Ref**		
Married	0.003	13.895	2.52	76.61
Religion				
Islam		**Ref**		
Christianity	0.562	0.566	0.083	3.864
Family type				
Monogamy		**Ref**		
Polygamy	0.814	1.098	0.505	2.388

The logistics regression shows that age group 26-30, 31-35, 36-40, 41-45, 46 and above are 66%, 80%, 68%, 78% and 52% less likely respectively, to practice FGM on their girl child than those age group 19-25 (OR=0.34, p-value=0.096; OR=0.20, p-value=0.032; OR=0.32, p-value=0.089; OR=0.22, p-value= 0.059; OR=0.48, p-value=0.419). Respondents who have primary, secondary and tertiary education are 62%, 82% and 95% respectively, less likely to practice FGM on their girl child than those who have no education (OR=0.38, p-value=0.09; OR=0.18, p-value=0.002; OR=0.05, p-value<0.001).

Discussion

The study's findings provide valuable insights into the knowledge, attitudes, and practices surrounding Female Genital Mutilation (FGM) among women of reproductive age in Ilorin, Nigeria. Despite a high awareness of FGM (96.1%), the practice remains prevalent, with 83.9% of respondents having undergone or knowing someone who has undergone FGM. The majority of respondents (58.7%) defined FGM as a cultural practice without significant health implications, highlighting a critical knowledge gap. Only 33.5% of respondents were aware of the health consequences associated with FGM, which is concerning given the established risks of FGM, including bleeding, infection, and childbirth complications.

The study identified cultural norms (77.8%), preservation of virginity and sexual purity (19.6%), and social acceptance and marriageability (17.4%) as key factors influencing the continuation of FGM. These findings underscore the complex interplay between cultural, social, and economic factors that perpetuate FGM.
The logistic regression analysis revealed significant associations between sociodemographic characteristics and knowledge of FGM's health consequences. Specifically, respondents with higher education levels (tertiary education) were more likely to be aware of FGM's health consequences. Additionally, respondents from polygamous families were more likely to have knowledge of FGM's health consequences. Regarding the practice of FGM, the study found significant associations with age group, ethnicity, educational level, and marital status. Respondents with tertiary education were 95% less likely to practice FGM on their girl child compared to those with no education.

Conclusion

This study underscores the complex and deeply entrenched nature of Female Genital Mutilation (FGM) within the targeted communities, highlighting the critical need to address cultural norms and misconceptions driving its persistence. Despite widespread awareness of FGM, a profound knowledge gap regarding its devastating health implications persists. Education emerges as a crucial catalyst for change, with higher educational attainment linked to greater awareness of FGM's health risks and decreased support for the practice. To eradicate FGM, comprehensive interventions must prioritize education, awareness, and community engagement, leveraging targeted programs, intergenerational dialogue, and advocacy efforts promoting women's empowerment and human rights. Ultimately, dismantling FGM's cultural entrenchment requires sustained efforts, innovative strategies, and collective commitment to prioritize women's health, well-being, and human rights.

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