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Perception and Practice of Female Genital Cutting Among Mothers in Ibadan, Nigeria

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Abstract

Female Genital Cutting (FGC) is the practice of altering the structure of the female external genitalia and this has the potential of causing of medical complications and harm to reproductive health. This practice has gone on over many years with no proven health and social benefits. Persistent calls have been made for the practice to stop, yet it still continues primarily in Africa and among certain communities in the Middle East and Asia, of which Nigeria is not an exception. This study sought to determine the perception and practice of FGC among mothers in Ibadan, Nigeria. This cross-sectional study used structured, interviewer-administered questionnaire to elicit data on the perception and practice of Female Genital Cutting from the 106 mothers sampled by convenience from three primary health centres in Ibadan North Local Government Area (INLG). The data was coded and analysed using descriptive statistics and chi-square at a 5% (0.05) level of significance. More than half of the respondents (63.2%) had undergone FGC. Almost 19% of the respondents had circumcised their daughters at an average age of 30.8 days, while another 28.3% had plans to do so in future, probably at a later date. The major practitioners of FGC are traditional circumcisers (54.7%). The mothers' level of education influenced their practice of FGC ($p<0.03$) and there was also a significant association between having undergone FGM and the experience of dyspareunia ($p<0.03$). The most expressed benefit of FGC by the mothers is that, it conserves virginity till marriage and the negative effect mostly expressed was infection. More than half of the women declared that, their mother/mother-in-law's insistence was their reason for performing FGC. Although, the views expressed by the mothers on FGC, including its eradication, were somewhat impressive, this study shows that, FGC is still being practiced and many women are living with its negative effects. There is therefore, the need to intensify and consolidate educative and advocacy efforts to ensure that the practice is completely eradicated.

Keywords

Experience, Female Genital Cutting, Mothers, Perception, Practice

1. Introduction

Alteration of the female external genitalia, referred to as Female Genital Mutilation or Female Genital Cutting (FGM/FGC), has been practiced for ages [1]. It comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons [2]. The United Nations Children Fund [2] defined it as comprising all surgical procedures involving partial or total removal of the external genitalia or other injuries to the female genital organs for cultural or other non-therapeutic reasons.

Female genital cutting has been classified by the World Health Organization (WHO) [2] into 4 major types: Clitoridectomy (partial or total removal of the clitoris and, in very rare cases, only the prepuce; Excision (partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora; Infibulation (narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris; and Others (all

other harmful procedures to the female genitalia for non-medical purposes but do not include tissue removal e.g. pricking, piercing, incising, scraping and cauterizing the genital area).

FGC is a violation of girls' and women's human rights. While the exact number of girls and women worldwide who have undergone FGM/C remains unknown, at least 200 million girls and women have been cut in 30 countries with representative data on prevalence [1]. The practice persists primarily in Africa and among certain communities in the Middle East and Asia [3]. In Nigeria, 68% of women and 62% of men have heard of FGC, Knowledge of FGC was higher among Yoruba women than among women in any other ethnic groups in Nigeria while the practice was more prevalent in the southern zones than in the northern zones. Infibulation is more prevalent in Nasarawa, Kaduna, and Bayelsa than in other states [4].

The proportion of female circumcision among girls aged 0-14years was higher among those whose mothers have also been circumcised. Of those who have heard of FGC, 68% of women and 57% of men believe that the practice is not required by their religion [4]

The practice of FGC has persisted due to cultural and traditional beliefs. FGM is generally practiced as a matter of social convention, and is interlinked with social acceptance, peer pressure, the fear of not having access to resources and opportunities as a young woman and to secure prospects of marriage [5]. It is often seen as an act of love, a rite of passage or preservation of cultural identity. FGC has also been linked to premarital virginity and marital fidelity [6]. Also, illiteracy, lower status of women, their lack of access to money, limited knowledge and power all help to perpetuate FGC. Despite the supposed benefits of FGC, 64% of women and 62% of men think that, the practice should not continue [4]. Female genital cutting may be performed on a newborn, adolescent, at the time of marriage, or during the first pregnancy, but in Nigeria, female circumcision occurs mostly during infancy [7]. The procedure is usually carried out by highly respected women in the community, including traditional birth attendants (TBAs), local barbers, medical doctors and other health workers [8]. According to NPC and ICP Macro[4] traditional agents perform the majority of FGC in Nigeria; 87% of girls age 0-14 and 80% of women age 15-49 were circumcised by a traditional agent while another 12% of girls and 13% of women were circumcised by a medical professional.

Despite its cultural importance in many Nigerian cultures, FGC has been identified as a potential cause of both short and long term medical complications; as well as harm to reproductive health. The procedure is often carried out without obtaining an expressed consent from the individual, infringing on the person's reproductive rights [2]. The potential immediate complications of FGC includes severe pain, shock, haemorrhage, tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue, cellulitis, and urinary dysfunction [7]. Women who have had FGC most often have to live with its consequences for the rest of their lives, encumbering their reproductive health and well-being. Such long-term consequences generally includes dyspareunia, psychosexual problems, an increased risk for postpartum haemorrhage, a potential source of spread of HIV and other infections, recurrent bladder and urinary tract infections, cysts, infertility, increased risk of childbirth complications, newborn deaths, the need for later surgeries [7].

There have been a lot of efforts in counteracting FGC internationally. In most countries, the prevalence of FGC has decreased and an increasing number of women and men in practicing communities support ending its practice [9]. In Nigeria, there are no federal laws banning the practice of FGC, although the government has publicly opposed its practice [8]. According to a United Nations expert report on traditional practices affecting the health of women and children, some states have enacted laws banning its practice. Of the 36 states and the Federal Capital Territory, eight states were said to have enacted laws prohibiting FGM. These states are Abia, Bayelsa, Cross-River, Delta, Edo, Ogun, Osun and Rivers State [10]. Up to, 21 countries in Africa, and several states of two additional countries, have laws against FGC [2]. Legal measures are important to make explicit the government's disapproval of FGC, to support those who have abandoned the practice or wish to do so, and to act as a deterrent [5].

On February 6, 2003, Stella Obasanjo, the First Lady of Nigeria and spokesperson for the Campaign Against Female Genital Mutilation, made the official declaration on "Zero Tolerance to FGM" in Africa during a conference organized by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC), Likewise in 2004, the United Nations Sub-Commission on Human Rights adopted February 6 as an International Awareness Day in an effort to increase awareness about FGC and promote its eradication [11]. Also in December 2012, the UN General Assembly accepted a resolution on the elimination of female genital mutilation [9].

Overall, the practice of FGM/C has been declining over the last three decades. Around 1 in 3 girls aged 15 to 19 today have undergone the practice versus 1 in 2 in the mid-1980s. However, not all countries have made progress and the pace of decline has been uneven. Fast decline among girls aged 15 to 19 has occurred across countries with varying levels of FGM/C prevalence including Burkina Faso, Egypt, Kenya, Liberia and Togo [1].

Most of the previously conducted studies on FGC were focused mainly on the reasons for the practice and its consequences. The results of most of these studies are too generalized and broad-based, neglecting local specificities and circumstances, and thus very difficult to be applied in all areas the tradition is being practiced [12]. There is also need for more researches in order to establish a more accurate prevalence on the practice of FGC in Nigeria [4]. This study was therefore proposed to evaluate the perception and practice of FGC among mothers using Ibadan North Local Government Area (INLG) in Oyo State, Nigeria. A related goal was to determine whether there was a relationship

between mothers' level of education and the practice of FGC.

2. Methods

2.1. Study Design and Setting

This descriptive, cross-sectional survey was conducted at Ibadan North Local Government Area, one of the 33 Local Government Areas (LGA) of Oyo-state. The LGA encompasses Beere round-about, Oke-Are, Mokola, Oke-Itunnu, Ijokodo, Bashorun, Bodija, and Agbowo areas of Ibadan –the capital of Oyo state and the largest indigenous city in Africa, south of the Sahara. This LGA was chosen because it is the largest of all the LGAs in Ibadan with an estimated population of 300,937 people, 149,100 of which are females. It is multi-ethnic, but predominantly Yorubas. There are 7 Primary Health Care (PHC) centres within the LGA namely: Bodija, Barika, Agbowo, Yemetu, Abadina, Sango, and Idi-Ogungun health centres. Of these, 3 centres were randomly selected namely Agbowo, Bodija and Idi-Ogungun PHC centres.

2.2. Study Population and Sampling

The study population comprised mothers who have had at least one female child and attended post-natal and infant welfare clinic at any of the selected PHC centres. Mothers who had at least one female child were purposively selected in order to assess their practice of FGC. One Hundred and six women were sampled from a total of 340 women at the post-natal clinic, in the Health centres.

2.3. Data Collection

Data was collected after obtaining ethical approval and institutional permission. Information was provided on the purpose of the study in order to obtain informed consent and gain the women's cooperation. The questionnaire was administered during the interval between registration and general health talk sessions from mothers who identified themselves as having at least one female child, and were willing to participate in the study. The interview was conducted using a semi-structured questionnaire which was divided into 5 sections to elicit information on the respondents' demographic data, perception and practice of FGC, and mother's experience of FGC, with a total of 27 items.

2.4. Data Analysis

The 106 collected questionnaires were satisfactorily completed and suitable for analysis. The data obtained was coded and analyzed using descriptive statistics and chi-square at a 5% (0.05) level of significance. The findings were presented using simple percentages, tables and charts.

2.5. Ethical Considerations

Ethical approval for the research was obtained from the Ethics Committee, Institute for Advanced Medical Research and Training, College of Medicine, University of Ibadan. Permission was obtained from the matrons in charge of each of the three PHC centres used. Informed consent was obtained from the participants. The respondents' autonomy was respected and anonymity was ensured. As the instrument would be interviewer-administered, the questionnaire was translated to Yoruba language as the inhabitants of the study setting are predominantly Yorubas. There was no event in which the any of the respondents did not understand either of the two languages in which the researcher is proficient. The information gathered was also treated with utmost confidentiality.

3. Findings

3.1. Respondents' Socio-demographic Characteristics

Table 1. *Demographic Data of Respondents (N=106).*

Characteristics	Frequency (n=106)	%
Age (in years)		
19-23	27	25.47
24 – 28	25	23.58
29-33	35	33.01
34-38	14	13.20
39-43	5	4.71
Tribe		
Yoruba	84	79.2
Igbo	20	18.9
Edo	2	1.9
Religion		
Christianity	61	57.5
Islam	45	42.5
Marital Status		
Married	90	84.9
Single mother	16	15.1
Level of Education		
no formal education	2	1.9
primary education	11	10.4
secondary education	57	53.8
tertiary education	36	34.0
Number of Female Children		
1	70	66.0
2	26	24.5
3	8	7.5
4	2	1.9
Age of Child's FGM (in days)	Frequency	Percentage
8	2	10%
10	2	10%
30	6	30%
40	10	50%

From Table 1, majority of the respondents (33.01%) were aged 29-33years, 79.2% of the respondents were of the Yoruba tribe and more than half of the respondents (57.5%) practiced Christianity. Most (84.9%) of the respondents were married while only 15.1% were single mothers. Majority (43.4%) of the respondents attended Idi Ogungun PHC, 27.4% attended Agbowo PHC while the remaining 29.2% attended Barika PHC centre. Age of Female Child (in days) at FGC showed that out of the 20 mothers that circumcised their female children, 10 (50%) of them did so on the child's 40th

day of life, constituting the mode of the distribution. This was followed by those who circumcised their female children on day 30 (30%) and then those who did so on days 10 (10%) and 8 (10%). The average age at which FGC was done was 30.

Table 2. *Respondents who have heard of FGC and their Source of Information on FGM.*

Have heard of FGC	Frequency (n=106)	Percentage
Yes	106	100.0
Source of Information		
Traditional Birth Attendant	10	9.4
Community Health Extension Worker	12	11.3
Doctor	5	4.7
Nurse	19	17.9
Books	6	5.7
Friends and Relatives	54	50.9

Table 2 represents the findings relating to awareness of FGC. All the respondents claimed to have heard of FGC. Friends/Relatives and Health Workers were the most recurrent sources of information while very few read about it in books.

Table 3 shows respondents' perceived meaning of FGC and its benefits. Majority (46.2%) of the respondents perceived FGC to be removal of the clitoris while 10.4% said it was removal of female private parts. On the perceived benefits of FGC, about one-third of the respondents opined that FGC helps to conserve virginity (34.9%) and promotes cleanliness (30.2%); while only a few (15.1%) perceived it as a religious obligation. Just some (9.4%) of the respondents perceived it as making a woman complete. About respondents' perception of the effects of FGC, more than half of the respondents (52.8%) agreed that, FGC could result in infection; another 44.3% said it could result in excessive bleeding. Only about a quarter each perceived incontinence and infertility as effects of FGC.

Table 3. *Perceptions about FGC.*

Definition of FGC	Frequency (n=106)		Percentage
Removal of female private parts	11		10.4
Removal of female fore skin	43		40.6
Removal of clitoris	50		47.2
Tightening of the vagina	2		1.9
Perceived Benefits	*Yes*	*No*	*Don't Know*
Conserve Virginity till Marriage	37 (34.9%)	56 (52.8%)	13 (12.3%)
Promotes Cleanliness	32 (30.2%)	55 (51.9%)	19 (17.9%)
Makes a woman complete	10 (9.4%)	72 (68%)	24 (22.6%)
A Part of Religious Obligations	16 (15.1%)	71 (67%)	19 (17.9%)
Perceived Effects of FGC	*Agree*	*Disagree*	*Undecided*
Dyspareunia	33 (31.1%)	50 (47.2%)	23 (21.7%)
Excessive bleeding	47 (44.3%)	39 (36.8%)	20 (18.9%)
Incontinence	28 (26.4%)	39 (36.8%)	39 (36.8%)
Infection	56 (52.8%)	33 (31.1%)	17 (16.1%)
Infertility	27 (25.5%)	47 (44.3%)	32 (30.2%)

3.2. Perceptions About FGC

Table 4 showed that, almost all the respondents (92.5%) reasserted that, FGC was still being practiced while only 7.5% said otherwise. About 19% of the mothers affirmed that, they have circumcised their daughters while majority (81.1%) have not. Also, less than a third (28.3%) of the mothers still plan to circumcise their daughters while the remaining 71.7% do not plan to. Most of the mothers (61.3%) declared that, FGC was usually performed for their daughters after naming, which is likely from 7 days old considering the predominant Yoruba culture in the study setting and that of most of the respondents.

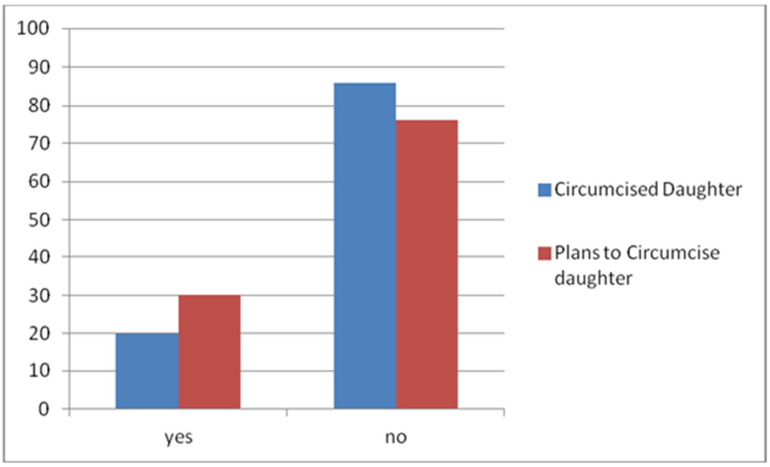

Figure 1. *Bar Chart Showing Respondents' Practice of FGC.*

3.3. The Practice of FGC

Table 4. Respondents' Practice of FGC.

Practice of FGC	Yes n=106	No
Agrees that FGC is still being practiced	98 (92.5%)	8 (7.5%)
Circumcised daughter	20 (18.9%)	86 (81.1%)
Plans to circumcise daughter	30 (28.3%)	76 (71.7%)
Age at which procedure is done		
At birth	15	14.2
Few days after birth	16	15.1
After naming	65	61.3
Onset of menstruation	1	.9
During first pregnancy	1	.9
Does not know	8	7.5

3.4. Respondents' Practice of FGC

Figure 1 shows that only 18.9% of the respondents had circumcised their female children while a little more (28.3%) planned to do so. Majority (81.1%) did not circumcise their female children however, while a little less (71.1%) had no plan to do so.

3.5. The Practitioners of FGC

Figure 2 depicts that, majority of the respondents (88%) identified Traditional Circumcisers and TBAs as the practitioners of FGC; just 2% identified nurses, 1% identified doctors while the remaining 7% claimed they did not know the practitioners of FGC.

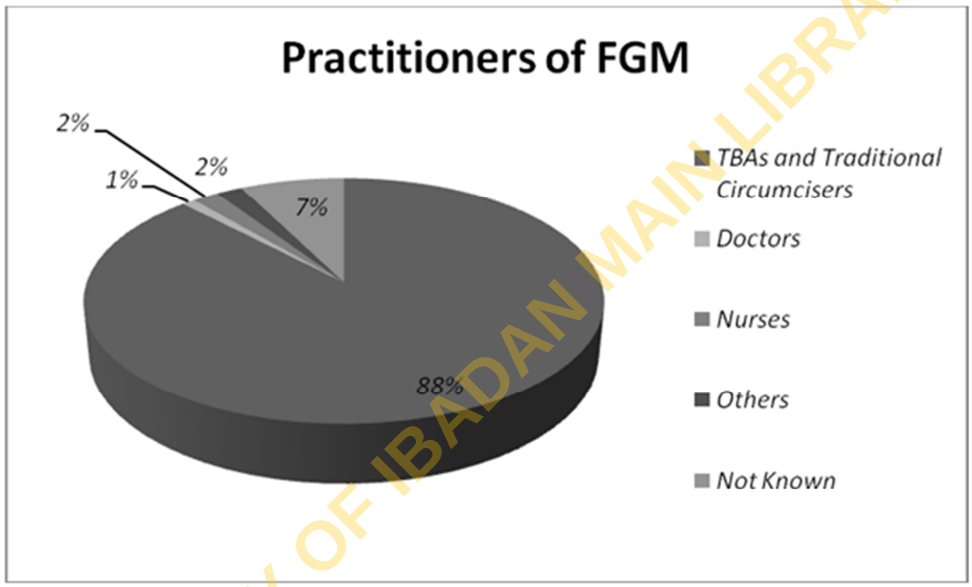

Figure 2. *Pie Chart Showing the Practitioners of FGC.*

3.6. Respondents' Reasons for Performing FGC

Table 5. Respondents' Reasons for Performing FGC.

Reasons for performing FGC	Frequency	Percentage
Husband would insist	1	3.3%
Female not complete without it	2	6.7%
Cultural heritage	6	20%
If males have it, female should have it too	1	3.3%
Mother/mother-in-law could insist	17	56.7%
Cultural heritage and mother/mother-in-law's insistence	3	10%
Total	30	100.0

Table 5 showed that, out of the 30 (28.3%) respondents that planned to circumcise their female children, majority (56.7%) would do so due to their mother or mother-in-law's insistence; 20% would do so because it is a cultural heritage that needed to be promoted; another 10% would do so because it is both a cultural heritage that needs to be promoted and because their mothers/mothers-in-law would insist. Only 1 (3.3%) of the respondents each said they would circumcise their female children because of their husband's insistence and because if males are circumcised, females should too. The rest (6.7%) would perform FGC because a woman is incomplete without it.

3.7. Mothers' Experience of FGC

Table 6. Mothers' Experience of FGC.

Had FGC done	Frequency (n=106)	Percentage
Yes	67	63.2
No	21	19.8
Does not know	18	17.0
Age of Mother when FGC was done		
At birth	4	3.8
Few days after birth	12	11.3
Onset of menstruation	1	0.9
Does not know	68	64.2
Did not have FGC	21	19.8
Total	106	100.0

Table 6 depicted that, majority of the respondents 67 (63.2%) had undergone FGC while none of them said the

procedure was carried out with her permission. Another 17.0% claimed not to know whether or not they had FGC; while the remaining 19.8% claimed not to have undergone FGC. With regards to undergoing FGC, 3.8% said the procedure was carried out on them at birth, 11.3% claimed a few days after birth. Majority (64.2%) claimed not to know when it was carried out, while only one respondent (0.9%) declared that the procedure was performed on her at the onset of menstruation.

3.8. Mothers' Experience of the Effects of FGC

Figure 3 illustrates that, more than half of the respondents (51.9%) experienced dyspareunia while only 48.1% did not. Another 30.2% reported that, they experienced difficult childbirth while 69.8% claimed not to; just 5.7% of them said they experienced incontinence while majority (94.3%) claimed not to. Most of them also did not experience infertility while only 9.4% did.

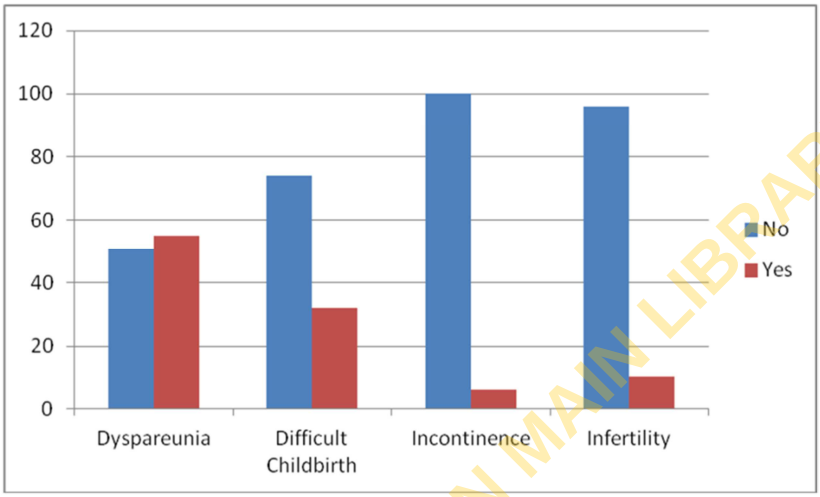

Figure 3. *Mother's experience of the Possible Effects of FGC.*

3.9. Hypotheses Testing for Associations

H_o1: There is no significant association between mothers' level of education and the practice of FGC in INLG.

Table 7 showed that, there is a significant association between the mother's level of education ($p<0.03$) and the practice of FGC in INLG, which implies that mothers' practice of FGC is influenced by their level of education. Consequently, the null hypothesis is rejected.

H_o2: There is no significant association between mothers' who have had FGC and their experience of dyspareunia.

Table 7 also showed that there is a significant association between experience of FGC and experience of dyspareunia ($p<0.03$). This implies that, the experience of dyspareunia among mothers in INLG can be linked with the FGC they had undergone thereby rejecting the null hypothesis.

Table 7. *Associations between variables.*

	Circumcised Daughter					
Level of Education	**Yes**	**No**	**Total**	**Df**	**X^2**	**P-value**
Primary and below	6	7	13			
Secondary	11	46	57	3	8.062	0.030
Tertiary	3	33	36			
Total	20	86	106			
H_o2	*Experiences Dyspareunia*					
Had FGC	Yes	No	Total	Df	X^2	P-value
Yes	40	27	67			
No	4	17	21	2	11.324	0.03
Does not know	11	7	18			
Total	55	51	106			

4. Discussion of Findings

This study has shown a full awareness of FGC among mothers in Ibadan North LGA as all the respondents in the current study were aware of FGC but their source of information was mainly from family and friends. This is in contrast with the source of information documented by Dattijo, Nyango and Osagie [14] where majority of the expectant mothers' source of information was the mass media. This implies that the mothers in the current study would not have had an accurate and updated view of FGC as information from family and friends would have been biased and sentimental compared to that coming from the mass media.

4.1. Perception About FGC

On respondents' perception of the definition of FGC, almost half (47.2%) described it to be simply the removal of clitoris. This finding is expected because the mothers do not have complete and correct information/picture of FGC entails, since their major source of information about the practice was from family and friends.

On the perceived benefits of FGC, about one-third of the respondents opined that FGC helps to conserve virginity (34.9%) and promotes cleanliness (30.2%); while only a few (15.1%) perceived it as a religious obligation. This was in contrast with the findings of Ahanonu and Victor [14] in which majority (56.8%) of the mothers disagreed that, FGC promotes a woman's faithfulness to her husband and also disagreed that FGC is beneficial for the female. Although expected, the belief pattern expressed by mothers in the study have been declared by WHO to be a social convention which is connected to different concrete sociocultural perceptions, most of which are linked to local perceptions of gender, sexuality and religion [9].

About respondents' perception of the effects of FGC, more than half of the respondents (52.8%) agreed that, FGC could result in infection; another 44.3% said it could result in excessive bleeding. Only about a quarter each perceived incontinence and infertility as effects of FGC. This finding corresponds with that of other studies ([4], [14], [9]). The afore-mentioned physical consequences are only one part of what the girl/woman has to live with; she is also left to suffer a myriad of psychological effects such as post-traumatic stress disorder, sleep disorders, recurrent flashbacks, nightmares and panic attacks.

4.2. Practice of FGC

On respondents' practice of FGC, less than a fifth (19%) of the mothers affirmed they have circumcised their daughters while majority (81.1%) have not. These implies that even though the mothers in this study explicitly stated their awareness of the practice of FGC, their practice was not fully synonymous with their awareness of the practice. This might be due some reluctance in going ahead with FGC given their awareness of some of its negative health consequences. Also, less than a third (28.3%) of the mothers still plans to circumcise their daughters. This was also comparable to some other studies where 14.6%, 13% and 21.5% of the mothers had plans to still circumcise their daughters ([13], [15], [16]). In contrast, study conducted by Dike et al [6], all the participants expressed unwillingness to have their daughter circumcised.

The procedure of FGC in this study was performed mainly by traditional circumcisers and TBAs as they were identified by most (88%) of the participants, 2% identified nurses, 1% identified doctors. This is consistent with study of Iranian women by Bigluet al [17] in which almost all operations were performed by traditional circumcisers. Also, Tamire et al [18], study of southern Ethiopia women on belief in FGC where about 60% of the circumcisions were performed by traditional circumcisers while health professionals had performed 30% of them. It is of concern that few registered qualified health practitioners still indulge in this practice as this may lead to of Medicalization of FGC. This refers to situations in which the procedure (including re-infibulation) is practiced by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere, at any point in time in a woman's life [9]. This findings underpins the medical risks and negative impact associated with FGC including short-term and long-term consequences including death to its victims whether during infancy, childhood, adolescence and adulthood; during pregnancy, labour or post-delivery, as similar reports were also documented ([15], [4], [13]). Apart from the fact that, there has not been any associated benefits to the procedure, these traditional practitioners of FGC do not follow universal standard precautions exposing the girls/women to infections including Hepatitis and Human Immunodeficiency Virus [19].

About respondents' reasons for practicing FGC, 56.7% of the mothers would circumcise their daughters due to their mother or mother-in-law's insistence; another 20% would do so because it is a cultural heritage that should to be promoted. This was corroborated by another study which also found that, tradition/culture was the commonest reason for FGC among mothers of female infants [15]. Only one mother affirmed that, she would circumcise her daughter due to the husband's insistence. This result depicted a strong indication of the effects of the mix of interlinked sociocultural factors which evidently influenced the practice of FGC among these women in the study setting. This social convention is connected to different concrete sociocultural perceptions, most of which are linked to local perceptions of gender, sexuality and religion [9]; Gebremariam et al [20] heighted various factors determining FGC which include Religion, residence, respondents' educational level, maternal education, attitude, and belief in religious requirement were the most significant predictors of FGC. Ashimi [21] study on predictors of female genital mutilation among infants in a semi urban community in northern Nigeria also showed that, Maternal occupation, education and religion and type of facility accessed were significantly associated with occurrence of FGM in infants. Study of mothers and daughters in Southern Iran by Dehghankhalili [22] Ancient traditions in the area (57.1%) were mentioned as the most important factor leading to FGC. Religious belief seems to be a consistent and an important variable predicting this practice as seen in various studies [17], [20], [21], [23].

4.3. Experience of FGC

With regards to the mothers' experience of FGC, many (63.2%) had undergone FGC at one time or the other, but none said the procedure was carried out with her permission. Another 17.0% claimed not to know whether or not they had FGC; while less than one-fifth (19.8%) claimed not to have undergone FGC. These figures yet exceeds those documented in NDHS, 2013 of the percentage of women circumcised

with respect to age, tribe, level of education and religion [4]. This also paints a vivid picture of how much the women have endured pain and how they dealt with it in silence, considering the act of FGC and then accepting it as part of their reality. On public perception of female genital cutting among internet users in the Middle East, Shaeer [23] reported that, 31.6% of 992 participants experienced FGC at an average age of 9.6 ± 3.5 years. At that age, they did not have the power to give consent as parents had the final authority over them and they feel it is a normal thing to do and go on with the tradition. Having the experience at an early age goes a long way in forming their perceptions about FGC. Most of the women (64.2%) even claimed not to know when it was carried out, denoting the violative and intrusive nature of FGC. Concerning the consequences of undergoing FGC, more than half of the respondents (51.9%) experienced dyspareunia, 30.2% reported that they experienced dystocia, only 5.7% of them admitted that, they experienced incontinence and 9.4%, infertility. Dehghankhalili [22] reported that, Urinary tract infection was the most commonly reported complication (60.4%) of FGC. This result is akin to the findings documented by Dike et al [6] in south-eastern Nigeria on Female genital mutilation: awareness and attitude of nursing and midwifery students in Afikpo, Nigeria where they identified bleeding, transmission of HIV and painful coitus as complications FGC. These statistics are a snapshot of how much these women have endured the act of FGC and yet living with the horrible outcomes that spans through their physical, psychological and sexual lives.

4.4. Relationship Between Mothers' Level of Education and the Practice of FGC

This study found a significant association between the mother's level of education and the practice of FGC in INLG (P=0.03), which implies that mothers' practice of FGC is influenced by their level of education. This was substantiated in a study which supports that education plays an important role in the eradication of FGC as it broadens one's outlook and increases one's ability to understand more complex information, and question attitudes, beliefs and practices [6]. Another study by Ahanonu and Victor [14] affirmed that mothers with a tertiary education were least likely to agree that an uncircumcised female will be promiscuous (25.9%), compared with about half of the mothers with a secondary education or less (P<0.003). This present study showed that the practice of FGC declined with academic advancement of the respondents. Contrary to the findings, it is worth noting that, Kandala, Nwakeze, and Kandala [24] posited that modernization (education and high socioeconomic status) had minimal impact on the likelihood of FGC, but education plays an important role in the mother's decision not to circumcise her daughter.

Ashimi et al [21] after controlling for confounders, having a mother without formal education were 6 times more likely to circumcise their female infants than those with formal education. In a Study Examining the Determinants of Mothers' Intentions to Allow their Daughters to Undergo Female Genital Mutilation among women in Ravansar, Kermanshah Province in Iran, Pashaei et al [25] noted that, less educated mothers and mothers living in rural areas were more inclined toward FGM and experienced more social pressure to allow FGM. Tamire and Molla [18] Southern Ethiopia School girls' study shows that, girls whose fathers and mothers had educational status under high school level were 2 times more likely to have FGC when compared to those whose parents had attended high school and above.

4.5. Relationship Between Mother Having Had FGC and Her Experience of Dyspareunia

The study found a significant association between a woman who have undergone FGC (p<0.03) and her experience of dyspareunia which establishes that the experience of dyspareunia among mothers in INLG can be linked with the FGC they had undergone. However, a study in Ismailia among 250 women revealed that psychosexual problems, such as loss of interest in foreplay and dyspareunia, did not reach statistical significance, contrasting the findings from the current study [19]. Abdel-Aleem et al [27] study among newly married couples at Assiut and Sohag, Egypt, the main presenting feature of honeymoon distress was superficial dyspareunia, which affected 291 (77.4%) women with FGC versus 16 (29.6%) of 54 without FGC (hazard ratio 8.13, 95% confidence interval 4.32-15.30). Biglu et al [17] also reported that, non-circumcised women had significantly higher Persian-translated version of the Female Sexual Function Index score (25.3 ± 4.34) compared to the circumcised women (17.9 ± 5.39). This implies that, Eradication of FGC will help in improving reproductive health, marriage relationships and quality of life.

4.6. Implication for Nursing Practice, Education and Research

The Sustainable Development Goals (SDGs) 3 and 5 which aim to ensure healthy lives and promote wellbeing for all at all ages and achieve gender equality and empower all women and girls for all by the year 2030. However, the persistence of FGC will hinder, directly or indirectly, the achievement of the SDGs in INLG which was reflected by the high percentage of the mothers who had undergone FGC and experiencing complications as a result of this. It is also disheartening to find that some mothers still had plans to circumcise their female children despite the widespread information on the hazards of FGC and advocacy for its eradication. The implication of this to nursing is that regardless of the impression that the issue of FGC has been accorded attention, more efforts, than ever before, needs to be geared up to ensure that the practice of FGC is abolished. The decrease in percentage of those who practice and/or plan to practice FGC with increasing education serves as a pointer to the importance of the education of the girl-child in order to empower them for decision making regarding their health and that of their children.

4.7. Suggestions for Further Studies

Literature search for this study showed that, there is a dearth of recent studies on this topic; probably because of the illusion that, FGM is now obsolete. This study has however documented that the practice of FGC is still prevalent; there is therefore a need for further intervention studies to improve the overall knowledge base of the populace. In addition, it is suggested that, future studies should focus on the effects of FGC on the quality of life of women, and further explore the perception of mothers on the complete eradication of FGC including the perception of the major practitioners of FGC as identified in this study.

5. Conclusion

This study on the perception and practice of female genital cutting has shown that, all the mothers were aware of female genital cutting showing that practice is still prevalent. The findings from their perception showed that, many of the mothers had some understanding about the procedure but they did not fully perceive the extent of anatomical damage and its negative consequences. Many of the respondents experienced female genital cutting, a few carried it out on their children and some still intend to practice it.

The study has shown that the practice of FGC is however still taking place in INLG of Oyo State mainly due to the influence of the significant others especially, their mothers or mothers-in-law's insistence. Many women in INLG are also living with the horrible effects of Female genital cutting. There is therefore, the need to intensify and consolidate educative and advocacy efforts in order to ensure that the practice is completely eradicated so as to promote the reproductive health of women.

Recommendations

1. More still needs to be done in terms of public campaigns and enlightenment on the harmful effects of FGC in order for the practice to be totally eradicated.
2. Encouraging and facilitating early girl-child education and female empowerment would go a long way in enhancing mothers' decision-making ability regarding their health and that of their children, including their female children
3. FGC eradication strategies should be targeted not only at the mothers but also at those with a great influence on the mothers' decision to, or not to, circumcise their girl-child; especially the elderly women.
4. There is a need for male involvement in FGC eradication strategies, as men also influence the mothers' decision to, or not to, circumcises their girl-child.
5. Integration of efforts with the practitioners of FGC to facilitate its abolishment is imperative, including the deterrence of medicalization of FGC.
6. Establishment of a federal law banning the practice of FGC in Nigeria may also facilitate its eradication

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