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SOCIO-CULTURAL DETERMINANTS OF FEMALE GENITAL MUTILATION (FGM) PRACTICE IN KWARA SOUTH SENATORIAL DISTRICT, KWARA STATE, NIGERIA

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Abstract
In most societies where female genital mutilation is practiced and perceived as a cultural tradition which is continuous practice had often debated. The objective of this study is to investigate the sociocultural determinants of female genital mutilation among the people of Kwara South Senatorial District, in Kwara State, Nigeria. The study adopted a descriptive research design by employing quantitative method. The study made use of questionnaire to gather information from respondents. One hundred and eighty-eight (188) respondents were selected for this study using multistage sampling techniques. The first stage employed a simple random sampling in which three (3) Local Government Areas (LGAs) were selected out of the seven (7) LGAs in the Districts. The second stage adopted a purposive sampling in selecting one urban and one rural areas from each LGAs. Lastly, the study adopted a quota sampling technique, in which questionnaires was distributed to the areas based on their population, and were analyzed and presented as frequency percentage. Findings from the study revealed that majority with 56.3% respondents disagreed that the female genital mutilation practice was as a result of religious rite of purification. About 56.4% majority of the respondents affirmed that poverty/poor living standard do not determine the practice of female genital mutilation. More than half of the total respondents (56.9%) attest to the fact that the practice does not control sexual desire. Also, 62.7% confirmed that the practice is based on cultural believe and indigenous value system. The study further revealed that 53.7% respondents disagreed that illiteracy/insufficient education background do not contribute to the practice of female genital mutilation. Based on this, the study concluded that female genital mutilation is deeply rooted in the cultural system. Therefore, it is recommended that government should empower women and increase awareness about the complications of female genital mutilation, innovative and culturally adapted strategies policies for re-orientation and changing behavior, and stakeholders should work with and not against cultural and community practices and beliefs.
Keyword: Belief, Customs, Female Genital Mutilation, Sociocultural, and Traditions

Introduction

Female genital mutilation has been a practice believed to be customary in many parts of the world and Nigeria is not exclusive. The practice has generated several debates on the reasons for its perpetration and why it should be abolished. It is based on this that the study examines the sociocultural determinants of female genital mutilation in Kwara South Senatorial Districts, in Kwara State, Nigeria. In most societies where female genital mutilation is practiced, and perceived as a cultural tradition which is continuous practiced had be often debated. However, due to severe consequences associated with Female Genital Mutilation, the World Health Organizations and Governments of many nations especially in Africa, have gathered separate efforts to end the practice (Ahinkorah, John, Ameyaw, Seidu, Budu, Sambah, Yaya, Torgbemu, and Thomas, 2020). Female Genital Mutilation is carried out in various forms in different part of the world. In other words, the rationale for performing female genital mutilation differs from location to location. The World Health Organization (2022) stressed that the reasons for practicing female genital mutilation varies from one region to another, and include a mix of sociocultural factors within families and societies. However, sociocultural factors are remarkable determinants of this practice.

According to World Health Organization (2022), perceived female genital mutilation as the partial or total removal of the external female gentalia for non-medical reasons. The World Health Organization (2022) went further to highlights the types of female genital mutilation being perpetrated across the globe, and they include; type I which involves the partial or total removal of the clitoral glans. That is, the removal of the external and visible part of the clitoris, which is the sensitive part of female genitals. Type II is the partial or total removal of the clitoral glans and labia minora (which is the inner folds of the vulve), with or without removal of the labia majora (which is the outer folds of the skin). Type III on its part is said to be the most extreme part of the practice as the WHO perceived it as lessening of the vaginal hole by creating a covering seal as envisaged by Ahinkorah et al (2020). That is to say the seal formed by cutting and repositioning the libia minora, or libia majora, sometimes through stitching, with or without the removal clitoral glans. Lastly is type IV which include all other harmful procedures to the female genitalia such as pricking, piercing, incising, scraping and cauterizing the genital area.

Statement of the Problem

Several scholars such as Ahmadi (2018), Awolola and Ilupeju (2019), Ahinkorah et al (2020), Kimani et al (2020), and among others have conducted series of researches on female genital mutilation. Female genital mutilation has thrived in Africa nations due to the strong sociocultural practices, which facilitates clandestine perpetration of the act and underreporting as averred by (Odukogbe, Afolabi, Bello, and Adeyanju, 2017). Globally, at least 3 million females are estimated to be at risk of female genital mutilation yearly, while over 200 million females have experienced female genital mutilation which occurs in more than 40 nations (Njue, Karumbi, Esho, Varol and Dawson, 2019). Out of this statistics, about 48.2% Nigeria females had undergone female genital mutilation (WHO, 2022). On the prevalence of female genital mutilation in Africa as posited by the Editoral Board (2019), nations with the highest prevalence are Somalia (98%), Guniea (97%), Djibouti (93%) and Egypt (87%). In Nigeria, female genital mutilation is usually carried out at birth, infancy, puberty, marriageable age and even during pregnancy, and the practice remains a social norm. The prevalence of female genital mutilation in Nigeria from the South-East was 2.9%, 20.7% in the North-West, 9.9% in the North Central, 25.8% in the South-South, 49.0% in the South East and 47.5% in the South-West as stated by TooMany (2018). Also, the prevalence according to State include Osun State with 76.6%, Ebony with 74.0%, Ekiti State was 72.3%, Imo State being 68.0%, Oyo State with 65.6%, and Kwara State with 63.4%.

Awolola and Ilupeju (2019) stressed that several health agencies perceived female genital mutilation practice as a form of violence against female and also an infringement into the rights of the women in the society. Nonetheless, female genital mutilation is often motivated by beliefs and what is considered acceptable sexual behavior. Its objective s is to ensure premarital virginity and marital fidelity. The practice is associated with cultural ideas of femininity and modesty, which include the notion that girls are clean after the removal of the body parts that are considered unclean as stated by WHO (2022). However, because there is no grounded empirical study on the subject matter, especially in Kwara South Senatorial District makes this study germane.

Conceptualization

Concepts of Female Genital Mutilation

The concepts behind female genital mutilation have generated several views from different scholars around the globe. In the view of Klien, Helzner, Shayowitz, Kohlhoff and Smith-Norowitz (2018), they stressed that female genital mutilation is a usual procedure practiced on female in developing nations like Nigeria and it is underreported. In the same vein, Akweongo, Jackson, Appiah-Yeboah, Sakeah and Philip (2021) opined that female genital mutilation is a traditional practice in African societies which is grounded in patriarchy system to subjugate the females. This view stressed that the approach to do away with the practice focus on women's empowerment and changing gender role. The World Health Organization (2022) conceived that female genital mutilation comprises of all procedures involving the removal of female external genital organ for no medical reason. In other words, female genital mutilation is the practices that manipulate, alter or remove the genital organs of females.

Prevalence of Female Genital Mutilation in Nigeria

The practice is founded in traditional beliefs and societal pressure to conform, despite the exposure of the people to the acculturating influence of the western world. Although the Government of Nigeria in the last decade recognized the practice as harmful to children and women and has embarked on corrective measures, aimed at addressing the end of the practice openly and energetically, through the formulation of policies, programmes, legislation and behavioral change not has currently impacted reduction in the prevalence (UNICEF 2016).

According to WHO (2022), female genital mutilation is practiced in 28 countries in Africa. It also takes place in the Southern part of the Arabian Peninsula and some countries in Asia. However, the practice is most widespread in African continent. The prevalent rate varies greater from the region or crunchy to the next. In area where FGM is practiced, it is a socially accepted practice and is generally supported by most of the members of a commonly involving the women themselves. Family who do not want to subjects a girl to genital mutilation run the risk of social exclusion as long as the majority in a community continues to adhere to the practice.

Table 1: Prevalence on the Types of FGM in Nigeria

Zone	% of Women who heard of FGM	% of Women who been cut	Type 1	Type 2	Type 3
North Central	36.0	9.6	1.2	64.6	2.5
North East	40.1	1.3	-	-	-
North West	25.1	0.4	-	-	-
South East	87.1	40.8	1.3	12.2	2.7
South South	82.5	34.7	3.0	66.0	7.5
South West	85.7	56.9	2.2	36.3	1.3

Sources: Nigeria Demographic and Health Survey, 2017

The practice of female genital mutilation is still widespread among tribes and religious groups where the milder forms are done except in south-south region where infibulations, the total closing of the vulva is done but usually after age five. It is done more among the poorly educated, low socio-economic and low socio-status group (NDHS, 2017). Although, UNICEF (2016) gave the national prevalence of 61% among Yoruba, 45% among Ibo and 1.5% among Hausa-Fulani ethnic group. With these figure, female genital mutilation poses a greater problem among the Yoruba ethnic group in Nigeria.

Types of Female Genital Mutilation

Female Genital Mutilation (FGM) is practiced in more than 28 countries in Africa and a few scattered communities worldwide. Its burden is seen in Nigeria, Egypt, Mali, Eritrea, Sudan, Central African Republic and northern part of Ghana where it has been an old traditional and cultural practice of various ethnic groups (UNICEF, 2016; Odoi, 2010). The highest prevalence rates are found in Somalia and Djibouti where Female Genital Mutilation is virtually universal (UNICEF, 2016). According to Okeke, Anyaechi, and Ezenyeaku (2012), in Nigeria, Female Genital Mutilation has the highest prevalence in the south-south (77%) followed by the south-east (68%) and south west (65%), but practiced on a smaller scale in the north. It is a pre-marriage affairs involving the excisim of the clitoris and part of the labia majora.

Nigeria has the population of 150 million people with the women forming 52% (Adegoke, 2005). The national prevalence rate of Female Genital Mutilation is 41% among adult women. Prevalence rates progressively decline in the young age groups and 37% of circumcised women do not want Female Genital Mutilation to continue as cited in UNICEF (2016). 61% of women who do not want Female Genital Mutilation said it was a bad and harmful tradition and 22% said it was against religion. Other reasons cited were medical complications (22%), painful personal experience (10%) and the view that Female Genital Mutilation is against the dignity of women (10%) (UNICEF, 2016). However, there is still considerable support for the practice in areas where it is deeply rooted in local tradition in Nigeria.

Nigeria is the most populous country in Africa with majority of the people living in the rural areas where poverty, ignorance, superstition, lack of basic infrastructure such as good health care, electricity, good roads etc. Diverse cultural beliefs and tradition are the predominant features (Okeke et al, 2012). As a result, Female genital mutilation (FGM) practiced in Nigeria is classified into four (4) types according to WHO/UNICEF/UNFPA (2000). The nature of the practice also varies from one culture to another inclusive of the age at which the traditional genital surgery is performed on the female.

Type I: This is known as Clitoridectomy which is the least severe form of the practice and involved the removal of the prepuce or the hood of the clitoris and all or part of the clitoris. In Nigeria, small proportion of women undergo this type of FGM. It is identical to the male circumcisim.

Type II: This is the Excision which is more severe in practice and involved the removal of the clitoris along with partial or total excision of the labia minora. Sometimes, the labia majora is removed and no stitching is done. It is observed majority of women in Nigeria undergo this form of FGM.

Type III: or infibulation is the most severe form of female genital mutilation. It involves the removal of the clitoris, the labia minora and adjacent medial part of the labia majora and the stitching of the vaginal, leaving an opening of the size of a pin head to allow for menstrual flow or urine. Type III or infibulation is the most prevalent and harmful than type I and II. This is why it is known as pharaonic circumcision. Fifteen percent of FGM in Africa is in this type (Amnesty International Document, 2013). The practice of type III FGM is not that prevalence in Nigeria.

Type IV: This characterised by all operating on the female genital involving recognized by including; introcision and gishiri cuts, pricking, piercing or incision of the clitoris and/ or labia, scraping and/or cutting of the vagina (angrya cuts), stretching the clitoris and/or labia, cauterization, the introduction of corrosive substances and herbs in the vagina and other forms. It also includes the intermediate infibulations where in some kinds of mutilation is carried out with varied degrees of stitching. These are instances where the clitoris is removed and the surface of the labia minora is roughened to permit stitching. In some other, the Clitoris is not removed but the labia minora is removed and stitching within the clitoris. There is also the unclassified form of FGM. This form of FGM involves scarification of the clitoral prepoce, and essential cut into the clitoris and labia minora.

Sociocultural determinants of Female Genital Mutilation

According Ofor and Ofole (2017) different cultures have a variety of reasons for carrying out female genital mutilation. In West Africa, this may be related to different ethnic and tribal cultures, family relations, tribal connections, class, economic and social circumstances, education and among others (Ahamdi, 2018). Amongst the factors that encourage families to circumcise their daughters is the family's concern about the girl's inability to marry if she is not circumcised. La Barbera (2016) states that an important part of female genital mutilation practice goes back to the recognition of women who are not circumcised as indecent. Of a fact, African women do strongly support the action of female genital mutilation in spite of the pain, agony and consider it so vital for their daughters' future, especially for their marriage. Some indigenous Africans believe that circumcised girls might control their sexual desires accordingly after maturity and it protects them from sins and faults. It is believed that uncircumcised women have lower fertility powers compared to circumcised women and are not able to control their sexual desire (Ahamdi, 2018). On the other hand, in West African countries, female circumcision represents their purity and innocence.

In some female genital mutilation practicing societies, unmutilated women are regarded as unclean and are not allowed to handle food and water (AID, 2013). There is the belief that genitalia are unsightly and dirty. There is also the issue of gender based factors, as female genital mutilation is often deemed necessary in order for a girl to be considered a complete women and the practice marks the divergence of the sexes in terms of the future roles in life and marriage. The removal of the clitoris and labia as viewed by some as the "male parts" of a woman's body is thought to enhance the girl's femininity, often synonymous with docility and obedience (AID, 2013). The factor of religion is also not left out as female genital mutilation predates Islam and is not practiced by the majority of the Muslims. Many of those who oppose mutilation denied that there is no link between the practice and religion. Though, Islamic leaders are not unanimous on the subject. Although predominant among Muslims, female genital mutilation also occurs among Christians, animist and Jews (AID, 2013). In certain communities where genital mutilation is carried out as part of the initiation into

adulthood. Female genital mutilation defines who belongs to the community. In such community, a girl cannot be considered an adult in a female genital mutilation practicing society unless she has undergone it (AID, 2013). This is usually done to preserve the cultural identity of the females in the practicing community.

Theoretical Framework

Cultural and Ethical Relativism Theory

Amongst the proponent of this theory are Grnenbaum (1982) and Hosken (1999) stated that in order to achieve more clarity on the issue of relativism, one must consider the difference between cultural and ethical relativism. According to Kelly (2009) opposing ethnocentrism is cultural relativism, the view point that behavior in one culture should not be judged by the standards of another culture. The position present problems, at its most extreme, cultural relativism argues that there is no superior, international or universal morality, that the moral and ethical rules of all cultures deserve equal respect. In today's world, human rights advocates challenge many of the tenents of cultural relativism. For instance, Africa and the Middle East have traditions of female genital mutilation (FGM). This practice reduces female sexual pleasure and it is believed in some cultures, that there will be likelihood of adultery. Such practice has been opposed by human rights advocates, especially women's right groups (Hosken 2008). The idea is that the tradition infringes on a basic human rights-disposition over one's body and one's sexuality. Cultural relativism is an observation that, as a matter of fact, different cultures have different practices, standards and values. Some would argue that the problems with Relativism can be solved by distinguishing between methodological and moral relativism. In anthropology, cultural relativism is not moral position, but a methodological one.

Within this perspective, cultural relativism states that, to understand another culture fully, one must try to see how people in the culture see things like what motivate them? What are they thinking when they do those things? Such an approach does not preclude making moral judgments or taking action. In the case of Female Genital Mutilation, one only can understand the motivations for the practice by looking at the situation from the point of view of those who engage in it. Having done this, one then faces the moral question of whether to intervene to stop it. It should be noted that different people and groups live in the same society. For example, women and men, old and young, the more and less powerful can have widely different views about what is proper, necessary and moral. But the other side, the idea of human rights invokes a realm of justice and morality beyond and superior to the laws and customs of particular countries, cultures and religions (Wilson, 2009). Human rights include the right to speak freely, to hold religious beliefs without persecution and not to be murdered, injured or enslaved or imprisoned without charge. Such rights are seen as inalienable and international. Child labor, breast ironing, divergent sexual practices and female genital mutilation are examples of practices that are customary in some cultures and seen as ethically acceptable in those cultures. In other cultures, however, such practices are not customary and are seen as unethical. When taking time to study different cultures, as anthropologists and other social scientists do, one would see that there is no shortage of examples. For further examples of the practices with varied moral judgment upon them, consider wife and child battering, polygamy or cannibalism or infanticide. There are some cultures that endorse these practices as morally acceptable. Western culture, by contrast, regards these practices as immoral and illegal. It seems to be true, therefore that different cultures have different ethical standards on a least some matters.

Research Methods

This study adopted a descriptive survey research design. The study employed a quantitative method in which questionnaire was used to gather information from the respondents. The study population include both male and female from 18 years and above from Kwara South Senatorial Districts. In selecting the women, multistage sampling techniques was adopted. The first staged employed a simple random sampling in which three (3) Local Government Areas (LGAs) were selected out of the seven (7) LGAs in the Districts, and they include; Irepodun-Omuaran LGA, Offa-Offa LGA, and Oyun-Ilemona LGA. The second stage is adopted a purposive sampling in selecting one urban and one rural areas from each LGAs. And as a result, the following were picked from each LGAs. For Irepodun LGAs, Omu-Aran town and Adigun village were selected; In Offa LGA, Offa town and Igbodun village were also selected and in Oyun LGA, Ilemona town and Aho village were selected. The reason for picking these areas is because the practice of female genital mutilation

is rampant there. Lastly, the study adopted a quota sampling technique, in which questionnaires was distributed to the areas based on their population. One hundred and eighty-eight (188) copies of questionnaires was self-administered to respondents, and data from questionnaire survey were analyzed with the use of statistical package for social science (SPSS version 20) and presented as frequency percentage.

Results

Socio-Demographic Characteristics of Respondents in Kwara South Senatorial District in Kwara State.

Table 2: Percentage Distribution of Respondents on Socio-Demographic attributes.

Variables	IREPODUN-OMUARAN (N=75)	OFFA-OFFA (N= 60)	OYUN-ILEMONA (N=53)	Total (N= 188)
Age	No (%)	No (%)	No (%)	No (%)
Less than 20 years	10 (13.3)	-	8(15.1)	18(9.6)
21-30	20(26.7)	14(23.3)	11(20.8)	45(23.9)
31-40	16(21.3)	25(41.7)	21(39.6)	62(33.0)
41 and above	29(38.7)	21(35.0)	13(24.4)	63(33.5)
Sex				
Male	24 (32.0)	32(53.3)	23(43.4)	79(42.0)
Female	51(68.0)	28(46.7)	30(56.6)	109(58.0)
Marital Status				
Single	22(29.30	17(28.3)	21(39.6)	60(31.9)
Married	35(46.7)	28(46.7)	32(60.4)	95(50.5)
Divorce	10(13.3)	6(10.0)	-	16(8.5)
Separated	8(10.7)	4(6.7)	-	12(6.4)
Widowed	-	5(8.3)	-	5(2.7)
Ethnic group				
Hausa	9(12.0)	18(30.0)	15(28.3)	42(22.3)
Igbo	11(14.4)	5.(8.3)	8(15.1)	24(12.8)
Yoruba	34(45.3)	30(50.0)	24(45.3)	88(46.8)
Others	21(28.0)	7(11.7)	6(11.1)	34(18.1)
Religion				
Traditional Belief	10(13.3)	-	8(15.1)	18(9.6)
Christians	23(30.7)	27(45.0)	15(28.3)	65(34.6)
Islam	42(56.0)	33(55.0)	30(56.6)	105(55.8)
Occupation				
Students	15(20.0)	-	7(133.2)	22(9.6)
Civil Servants	12(16.0)	21(35.0)	13(24.6)	46(24.5)
Self-Employed	26(34.7)	15(25.0)	12(22.6)	53(28.2)
Artisan	22(29.3)	24(40.0)	21(39.6)	67(25.6)
Education				
No Formal Education	23(30.7)	20(33.3)	23(43.4)	66(35.1)
Primary	20(26.7)	11(18.3)	8(15.1)	39(20.7)
Secondary	12(16.0)	15(25.0)	-	27 (14.4)
Tertiary	20(26.7)	14(23.3)	22(41.5)	56(29.8)

Source: Field Survey, 2021

Socio-demographic characteristics of respondents were shown in Table 2. Data on age composition of respondents shows that majority (33.5%) of the respondents from the three selected local government area in Kwara South fell within the ages of 31-40 years, and 41 years and above. However, there is a little significant difference between them. The Table (2) also shows that 23.9% of the respondents were between 21-30 years and 9.6% were less than 20 years. These findings imply that those with the highest percentages are adults and likely to have the knowledge of female genital mutilation (FGM) practice in their various communities. Data presented in Table 2 also shows the gender disparity of respondents in the study. Out of 188 respondents, 58% were females while only 42% were males. The striking disparity in gender composition of participants spread across the three selected local government areas in Kwara South Senatorial which district shows a large percentage distribution of female respondents in the study. This suggests that female counterparts were many in the study and this is because they seemed to have more

knowledge and indulged in the practice of the subject matter than the male, as they have more experience than the males on the FGM issues.
Furthermore, information on marital status of respondents was also presented in Table 2. The data indicate that more than half (50.5%) respondents were married, and of the less than one-third, that is 32% were single. It further explained that 8.5% were divorced, 6.4% were separated and 2.7% were widowed. The inference deduced from this finding is that, there were more married people in the study as female genital mutilation cuts across all categories of people in the study area and also, female genital mutilation is experienced by both male and female. Also, information on the ethnic group of respondents indicates that there was more Yoruba ethnic group in the study. Yoruba ethnic group has the highest percentage (46.8%) of the total respondents. Respondents with 22.3% constitutes the Hausa ethnic group while the Igbo ethnic group represents the lowest percentage with 12.8%. Other ethnic groups in the study include Idoma, Tiv, Edo, Ilaje, Igala, Ebira and Ijaw with 18.1%. The importance of this finding is that the study area is located in Kwara State, and is predominantly occupied by the heterogeneous Yoruba community.

Data presented in Table 2 further shows the dominance of Islamic religion in the three local government area selected for the study. The Table revealed a high percentage of Islamic worshippers with 55.8% as represented in the study. The percentage for Christians showed 34.6% and the lowest percentage (9.6%) were traditional worshipers. What this finding implies, is that there are many Islamic worshippers in the study and this is attributed to the fact that Kwara State is located in the North central geo-political zone of the country which is dominated by the Muslim communities. Furthermore, the data presented in Table (2) showed the occupation of respondents. Finding revealed that 28.2% were self-employed, 25.6% were artisans and 24.5% were civil servants, while, 11.7% of them were students. However, there are significant differences in responses of those who are self-employed, artisan and civil servants. As a result, there were many self-employed in the study. Finally, data presented in Table 2 the educational background of respondents with majority (35.1%) having no formal education, had 29.8% had tertiary education, while 20.7% were with primary education and 14.4% possessed secondary education. The implication of these findings portrayed that majority of the respondents were without formal education, which tends to presume that the practice of FGM still largely looms among the illiterates, webbed in traditional orientation.

Table 3 Comparative Percentage Distribution of Respondents on the Socio-cultural Factor influencing FGM in Kwara South Senatorial Districts

Religious Rite of Purification	**Strongly Agree No (%)**	**Agree No (%)**	**Undecided No (%)**	**Disagree No (%)**	**Strongly Disagree No (%)**
Irepodun-Omuaran (₦ = 75)	7 (9.3)	20 (26.7)	8 (10.7)	29 (38.7)	11 (14.7)
Offa-Offa (₦ = 60)	9 (15.0)	15 (25.0)	-	26 (43.3)	10 (16.7)
Oyun-Ilemona (₦ = 53)	-	18 (34.0)	5 (9.4)	25 (47.2)	5 (9.4)
Total (₦ = 188)	16 (8.5)	53 (28.2)	13 (6.9)	80 (42.5)	26 (13.8)
Poverty/Poor Living Standard					
Irepodun-Omuaran (₦ = 75)	12 (16.0)	18 (24.0)	-	30 (40.0)	15 (20.0)
Offa-Offa (₦ = 60)	5 (8.3)	12 (20.0)	10 (16.7)	25 (41.7)	8 (13.3)
Oyun-Ilemona (₦ = 53)	6 (11.3)	19 (35.9)	-	23 (43.4)	5 (9.4)
Total (₦ = 188)	23 (12.2)	49 (26.1)	10 (5.3)	78 (41.5)	28 (14.9)
Control of Sexual desire					
Irepodun-Omuaran (₦ = 75)	10 (13.3)	31 (41.3)	-	22 (29.3)	12 (16.1)
Offa-Offa (₦ = 60)	8 (13.3)	27 (45.0)	6 (10.0)	19 (31.7)	-
Oyun-Ilemona (₦ = 53)	4 (7.5)	27 (50.9)	-	22 (41.5)	-
Total (₦ = 188)	22 (11.7)	85 (45.2)	6 (3.2)	63 (33.5)	12 (6.4)
Cultural Beliefs/Indigenous value system					
Irepodun-Omuaran (₦ = 75)	18 (24.0)	35 (46.7)	-	22 (29.3)	-
Offa-Offa (₦ = 60)	10 (16.7)	23 (38.3)	6 (10.0)	12 (20.0)	9 (15.0)
Oyun-Ilemona (₦ = 53)	6 (11.3)	26 (49.0)	3 (5.7)	18 (34.0)	-
Total (₦ = 188)	34 (18.1)	84 (44.6)	9 (4.8)	52 (27.6)	9 (4.9)
Illiteracy and Insufficient Educational Background					
Irepodun-Omuaran (₦ = 75)	5 (6.7)	20 (26.7)	11 (14.7)	29 (38.6)	10 (13.3)
Offa-Offa (₦ = 60)	5 (8.3)	16 (26.7)	8 (13.3)	20 (33.4)	11 (18.3)
Oyun-Ilemona (₦ = 53)	5 (9.4)	17 (32.1)	-	31 (58.5)	-
Total (₦ = 188)	15 (8.0)	53 (28.2)	19 (10.1)	80 (42.5)	21 S(11.2)

Source: Field Survey, 2021

Data presented in Table 3 show that more than half of the respondents (56.3%) disagreed in both strong and mild terms that religious rite of purification do not influenced female genital mutilation practice as 36.8% agreed in strong and mild terms, and 6.9% were undecided. Thus, these findings implied that majority of the respondents disagreed that religious rite of purification is not one of the socio-cultural determinants of FGM in Kwara South Senatorial District. Furthermore, respondents were asked to comment on whether poverty and poor living standard encouraged the practice of female genital mutilation. Data in Table 3 indicate that majority (56.4%) of the respondents in both strong and mild terms that poverty and poor living standard does not influenced female genital mutilation practice among the people of Kwara South Senatorial District, while

a little above one-third (38.3%) of the respondents were undecided. The implication of the finding is that a large proportion of the respondents in strong terms affirmed that poverty and poor living standard is not one of the determinants of female genital mutilation practice. In addition to this finding, female genital mutilation practice is viewed as a traditional norm which is still predominant in some societies with high level of poverty, hunger and low status of women as posited by the WHO (2022). The views of respondents on whether female genital mutilation is practiced to control sexual desire especially among females were sought. As a result, data presented in Table 3 revealed that more than half (56.9%) of the respondents disagreed in both strong and mild terms that the practice control sexual desire among females, while 40% of the respondents agreed and 3.2% respondents were undecided. The inference deduced from these findings is that majority of the respondents across the sampled survey believed that female genital mutilation is not practiced to control sexual desire among females.

Also, data presented in Table 3 indicates that majority (62.7%) of the respondents gave cultural belief and indigenous value system as one of the reasons for practicing female genital mutilation in their various communities. More than one quarter (32.5%) of the respondents from the sampled population disagreed while 4.8% were undecided that cultural belief and indigenous value system had nothing to do with the practice of female genital mutilation in the various communities. The implication of this finding is that cultural beliefs and indigenous value system encouraged the practice of female genital mutilation in the various communities, under study as put by AID (2013), in certain communities where mutilation is carried out as part of the initiation into adulthood, female genital mutilation defines who belongs to the community. In such community, a girl cannot be considered an adult in a female genital mutilation practicing society, unless she has undergone female genital mutilation. In addition, data presented in Table 3 revealed that majority (53.7%) of the respondents disagreed in both strong and mild terms that illiteracy and insufficient educational background are part of the factors determining the continued practicing of female genital mutilation in the various communities. However, more than one-third, that is (36.2%) of the respondents agreed in both strong and mild terms, while the rest (10.1%) of the respondents were undecided. These findings are indications that illiteracy and insufficient educational background has no influenced the practice of FGM in Kwara South Senatorial District.

Discussion of Findings

In respect to sociocultural determinants of female genital mutilation, several studies have been conducted on the socioeconomic and demographic dimensions of female genital mutilation. The practice serves as a social stratification mechanism in which circumcised females are perceived to be in higher status and also constitutes prerequisite for inheritance in some practicing societies in Nigeria (Ahinkorah et al, 2020). However, this study presents data on the following sociocultural determinants; religious rite of purification, poverty/poor living standard, control of sexual desire, cultural beliefs/indigenous value system, and illiteracy and insufficient educational background.

Results from the study shows the age composition of respondents that majority of the respondents from the three selected local government area in Kwara South fell within the ages of 31-40 years, and 41 years and above, which imply that those with the highest percentages are adults and have the knowledge of female genital mutilation (FGM) practice in their various communities. This is 20% Nigerian female aged 15-49 have undergone and experience female genital mutilation. Nonetheless, female genital mutilation is prevalent in Nigeria, and the country was ranked third highest accounting to 10% global practice of female genital mutilation (Ahinkorah, et al, 2020). The study also shows the gender disparity of respondents, and therefore revealed that a large percentage distribution of female respondents took active part in the study. This is because they seemed to have more knowledge and experience about the practice than the male counterpart. The study revealed that there were more married people in the study as female genital mutilation cuts across all categories of people in the study area. According to Ahinkorah et al (2020), married women had the highest odds of undergoing female genital mutilation. Though, female genital mutilation is experienced by both male and female. The Study of Awolola and Ilupeju (2019) supported the finding stated that 71% of the female genital mutilation were carried out at marriage. Also, revealing is the that there were

more Yoruba people in the study as the study area is located in Kwara State, which is predominantly occupied by the heterogeneous Yoruba community. This finding was supported by the study conducted by Kandala (2020) that the prevalence of female genital mutilation/cutting was higher among the Yoruba ethnic groups in Southwestern States, Nigeria.

No religion support or condemn the practice, but more than half females in four out of 14 nations where data is available viewed female genital mutilation as a religious requirement. It is assumed that female genital mutilation is often perceived as being connected to Islam. Perhaps, because it is practices among many religious groups, including Christians, Muslim, Ethiopian, Jews and followers of certain traditional African religion (United Nations Fund for Population Activities, 2022). As a result, findings from the study revealed that there are many Islamic worshippers in this study and this is attributed to the fact that Kwara State is located in the North central geo-political zone of the country which has many Muslim communities. Female genital mutilation is found mostly within and adjacent to Muslim communities. Prevalence rates among various Muslim nations depend on the ethnicity and location. However, Muslim religious authorities agree that female genital mutilation is neither required nor prohibited by Islam. The study also revealed that majority of the respondents were without formal education, which tends to presume that the practice of FGM still largely looms among the illiterates, webbed in traditional orientation.
According to World Health Organization (2022), religious leaders take different positions in respect to female genital mutilation. Some promote it, while some considered it irrelevant to religion. However, some people believed that the practice has religious support. Though, there is no religious scripts that prescribed the practice. In most societies, where it is being practiced, it is considered a cultural tradition, which is often used as an argument for its continuation.

Finding from the study revealed that majority (56.3%) of the respondents believed that religious rite of purification is not one of the socio-cultural determinants of FGM in Kwara South Senatorial District. This study is in contrary to the assertion of the WHO (2022) which states that the motive behind the practice of female genital mutilation is as a result of the traditional belief which is aimed at ensuring premarital virginity, and marital fidelity among females. It is also based on the notion that females are clean and beautiful after the removal of the body part which is considered unclean. The study also revealed that a large proportion (56.4%) of the respondents in strong terms affirmed that poverty and poor living standard is not one of the determinants of female genital mutilation practice. However, results from this study corroborated the finding of Ahinkorah et al (2020), that female genital mutilation among the wealthy class are less likely to undergo the practice unlike those in the poverty class. Nevertheless, female genital mutilation practice is viewed as a traditional norm which is still predominant in societies with high level of poverty, hunger and low status of women in which Nigeria is inclusive as averred by the WHO (2022). In respect to this, Kimani, Kabiru, Mutashi and Guyo (2020) stressed that female genital mutilation or cutting is conceived by some as a rite of purification that enabled girls to participate in religious prayer.

According to Alex (2017), societies with low literacy rates, ignorantly say 'it is what others do, and what we have always being doing'. It is necessary to note that social pressure, are a powerful force. The study revealed that illiteracy and insufficient educational background do not influenced the practice of FGM in Kwara South Senatorial District as 53.7% respondents affirmed to it. The study conducted by Ahinkorah et al, (2020) stated that the level of education is factor that determines the practice of female genital mutilation, thereby stating that female undergoing female genital mutilation decreased with increasing in their level of education. Studies shows that women are less likely to have their daughters undergo cut as their level of education rises. That is, a higher level of education will make parents less likely to support female genital mutilation. However, emerging evidence as averred by Brandley (2018) shows basic education can be an effective tool for abolishing the practice of female genital mutilation.

One of the belief of female genital mutilation practice is to prevent promiscuity among females, as it is assumed that uncircumcised females are very active sexually and will not be easily satisfied by one man, since the act reduces female's sexual desire (Editorial Board, 2019). Data from the study shows that more

than half of the respondents across the sampled survey believed that female genital mutilation is not practiced to control sexual desire especially among females. It is also regarded as one the strongest determinants of the FGM as practiced but with no scientific backing. This finding however contradicts the study of Alex (2017) which states that the damage of the genitalia means the chance of a woman having illicit sexual relations is reduced, as her libido is decreased.

Several people supported female genital mutilation and have described it as a functional and socially significant cultural and religious practice that should be practiced continuously. Belief system have been attributed to the practice of female genital mutilation in different cultural settings. This is to say that the belief of female genital mutilation remains strong. Though, it contradicts the modernization theory which suggests that an increase in modernization, economic development, education and communication should reduce the practice of female genital mutilation (Alhassan, Barrett, Brown, and Kwah, 2016). The underlying assumption for the practice of female genital mutilation as posited by the Editorial Board (2019) is the belief system of the people such as if the head of the baby touches the tip of the clitoris, the baby will die. Result from this study shows that cultural beliefs and indigenous value system encouraged the practice of female genital mutilation across Kwara South Senatorial districts.

Conclusion

The prevalence of female genital mutilation depends on certain social factors such as income/occupation, level of education, and religion. However, the practice reflects deeply in customs and tradition. Thus, it is a practice with deep social roots and seen in most communities as a social norm or a religious imperative. Female genital mutilation is always carried out in among minor and young girls and it is a grave violation of their rights against torture. According to this study, it discovered that beliefs which surround the religion, control of sexual desire and cultural value were particularly instrumental in shaping people's orientation towards the persistent practice of female genital mutilation. Based on the findings, it could be concluded that female genital mutilation is rooted in custom and tradition in which the cultural practice is unavoidable in Kwara South Senatorial Districts, and by extension, in the State and Nigeria at large.

Recommendations

Based on the findings from the study, the following recommendations were made;

i. Government should empower women and increase awareness of complications of female genital mutilation.
ii. Innovative and culturally adapted strategies policies for re-orientation and changing behavior and
iii. The main motive should be to work with and not against cultural and community practices and beliefs.

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