THE PERCEIVED IMPACT OF ADULT LITERACY EDUCATION IN THE REDUCTION OF FEMALE GENITAL MUTILATION IN EGOR LOCAL GOVERNMENT AREA OF EDO STATE

BY

EKUISUE JOANNA CHIOMA

DEPARTMENT OF ADULT AND NON FORMAL EDUCATION, FACULTY OF EDUCATION, UNIVERSITY OF BENIN, BENIN CITY.

AUGUST 2016.

DEDICATION

This research work is dedicated first and foremost to God Almighty without whom these four years would have been impossible. To my father, Mr. Lucky Eni Ekuisue (of blessed memory), my mother, Mrs. Patricia Nwakaego Ekuisue, to my siblings, humanity and all lovers of knowledge.

THE PERCEIVED ROLE OF ADULT LITERACY EDUCATION IN THE REDUCTION OF FEMALE GENITAL MUTILATION IN EGOR LOCAL GOVERNMENT AREA OF EDO STATE

BY

EKUISUE JOANNA CHIOMA

EDU1201779

BEING A RESEARCH PROJECT PRESENTED TO THE

DEPARTMENT OF ADULT AND NON FORMAL EDUCATION, FACULTY OF EDUCATION, UNIVERSITY OF BENIN, BENIN CITY

IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF BACHELOR OF EDUCATION (B.Ed) IN ADULT EDUCATION (ENGLISH AND LITERATURE)

AUGUST, 2016.

CERTIFICATION

We certify that this project was carried out by **EKUISUE JOANNA CHIOMA of** Faculty of Education, University of Benin, Benin city, in partial fulfilment for the award of Bachelor of Arts (Education) degree in English and Literature.

_____	_____
Dr. Mabel Oyitso	**Dr. (Mrs). C. O. Olomukoro**
Project Supervisor	Project Coordinator
Date_____	**Date**_____

_____

Prof. (Mrs) Lilian I. SALAMI

Dean, Faculty of Education

_____

ACKNOWLEDGEMENTS

I thank the Almighty God for his grace and love that has kept me till this day and for the good health, strength, peace and knowledge he gave to me during my course of study and for the successful completion of this project work.

I wish to express my profound gratitude to Ven. S.O Makun for his spiritual, moral and financial support. You were a father indeed.

My gratitude also goes to my amiable supervisor, Dr. Mabel Oyitso who left no stone unturned in seeing that this project met required standard and became a huge success and all my lecturers for four years of expanding my knowledge

My thanks also go to my beloved dad, Mr. Lucky Eni Ekuisue (of blessed memory) and my mum Mrs P.N Ekuisue for their unflinching moral, spiritual and financial support may God Almighty bless them beyond measures.

Also, I sincerely acknowledge my sisters-Ekuisue Nkechi Cynthia & Ekuisue Onyekachukwu Violet, my brother Ekuisue Prosper-who endured greater inconveniencies for their co-operation during the course of my study, my aunts Joy and Peace Ekuisue, my uncle (Emeka Ekuisue) Madam Hadiza Adole and the entire Ekuisue family for their immense encouragement and financial support throughout the last phase of this programme. I pray the Almighty God bless you richly.

My gratitude also goes to all members of All Saints Youth Fellowship especially Praise temple and publicity units for their fervent love and support throughout the duration of this program.

Finally I want to thank all the wonderful people I've met in the course of this programme, the likes of Enwemnwa Uchebudike Prosper-the Bishop (you're the definition of reliable), Ogunojuwo Damilola Oluwaseyi (because of you I didn't give up), Peace Akpoyibo,Ugwute Emmanuel Rooney(for always coming to my rescue), Ehizogie Iyeomoan Emmanuel (osemen) for always believing in me, loving me and typing my project, Ndudi Prosper Ogechukwu (bestie of life) Ifeanyichukwu Stephen Onyeidu (your love inspires me), Ada Chukwudi Christian, Ochonogor Justice Nwabueze, Nwose Smile Kelvin Idogun Princess Charity,Loveth, Miss Ella, Sade, Alonso for making my stay beautiful for always believing in me and typing my project, Isaac Spartan Onisofe(you saw only the best in me)Okoh Austin Moon(being with you made all the difference)and Christopher Mena for reading through my scribbles. My coursemates Toju Esther, Iruoghene Bosin Lovina, Amusan Dare(the Taylor)greatest boss ever, Ehinome, UK Sidi, Nwaghodo Oge Catherine, Cynthia, Sophia, Oluchukwu,Okiemute Desmond,(okemutiny) Nosa Obayuwana (Nosumba),Miss lovable, Omoruyi David Aisosa(Didi) for making these years eventful. Time will constrain me from mentioning everyone who directly or indirectly saw to the success of this journey. I want to say I am grateful and God bless you all richly.

ABSTRACT

The study was conducted to examine the perceived impact of Adult literacy education in the reduction of Female Genital Mutilation. Attempt was made to know what adult education has done and can do to stop the inhuman practice of Female Genital Mutilation that is deeply entrenched in the culture of the people. It employed the survey research design and oral interview as well as open and closed questionnaire items.100 respondents were randomly selected in the area under investigation.

Data collected was analysed using simple percentages and frequency counts. Results from the study showed that a large percentage of the people have been mutilated. It further showed that awareness about the practice is high due to literacy and media sensitization although a large percentage are equally unaware of the legal implications of mutilating their children. Furthermore acquisition of literacy skills has helped in the reduction of female genital mutilation and provided access to information about the health implications of the procedure as well as help to forestall future occurrences. Based on the findings, it was recommended that girl child education be encouraged and subsidized, non-formal education should be encouraged. Mass mobilization should be used to enhance participation in literacy education programme. The male folk should be educated and encouraged to join anti-FGM campaign. Mass media campaigns should be made a continuous exercise so as to strengthen the campaigns and spread the awareness of the ills.

TABLE OF CONTENT

Title page	i
Certification	ii
Dedication	iii
Acknowledgement	IV
Table of content	V
Abstract	VI

CHAPTER ONE: INTRODUCTION

Background of Study	
Statement of Problems	
Purpose of the Study	7
Research Questions	7
Significance of the Study	8
Scope and Delimitation	13
Definitions of Terms	14

CHAPTER TWO: REVIEW OF RELATED LITERATURE

The Concept of FGM	11
Cultural practices of FGM	12
Modern practices of FGM in Nigeria	24
Reasons for the continued practices of FGM in Nigeria	28
Prevalence and attitude towards FGM	32
Awareness of the ills of FGM	36
Role of adult literacy in the reduction of FGM	39
Summary	43
Conclusion	44

CHAPTER THREE: RESEARCH METHODOLOGY

Research Design 45

Population of Study 45

Sample and Sampling Technique 51

Reliability of the Instrument 45

Validity of the Instrument 46

Method of Data Collection 47

Method of Data Analysis 54

Administration of the Instrument 54

CHAPTER FOUR: DATA ANALYSIS AND DISCUSSION OF RESULT 54

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATION

Summary 65

Conclusion 68

Recommendations 66

Suggestions 69

Reference 72

APPENDICE 1 74

Chapter one: Introduction

Background to the study

The traditional practice of Female Genital Mutilation (FGM) is regrettably persistent in many parts of the world. This occurs commonly in developing countries where it is firmly anchored on culture and tradition regardless of the many decades of campaigns and legislation against the practice (Onuh et al, 2006; World Health Organisation (WHO), 2008). It has therefore become pertinent to ask how a practice which carries substantial risks to the patients and offers little benefits became so widely accepted by parents and practitioners.

Female Genital Mutilation also known as circumcision is any procedure which involves partial or total removal (cutting) of the outer genitalia or any injury to the female organs for cultural, religious or other non-medical/therapeutic reasons (WHO, 2008).

Female Genital Mutilation is believed to have originated in Africa (Egypt) though some American, Asian and Middle-Eastern countries have been known to practice it. According of Agatharcluides of Gidus, a geographer, Female Genital Mutilation originated in Egypt. In his book about female circumcision in the second century, he wrote that it occurred among tribes resident on the Western coast of the Red Sea. They believed that Female Genital Mutilation was rooted in the bi-sexuality of gods. In the same vein, mortals reflect the traits of gods, possessing both male and female souls. The feminine soul of man was believed to be located in the prepuce of the penis, and the masculine soul of the female located at the clitoris. For individuals to live healthy and have healthy gender development, the female soul had to be excised from the man, and the male soul from the woman. This belief birthed circumcision which later became very important and essential for boys and girls to become men and women respectively. By the nineteenth century, Female Genital Mutilation became widely accepted as

a medical procedure for preventing ailments ranging from bedwetting to paralysis. It then evolved over time in various cultures for various reasons according to time, space and place.

According to Population Action International (PAI, 2003) Female Genital Mutilation is done usually on girls aged 4 – 6, and so is considered as one of the worst violations of the rights of the girl child. The period of cutting varies from place to place, ranging from a week after delivery to the period just before a woman is to be married. For example, the Urhobo people of southern Nigeria. In Egypt, about 90% of the girls are cut before ages 5 and 14; in Yemen, more than 75% are cut before they are two weeks old. Female Genital Mutilation is rooted in culture, tradition beliefs and religion. In some communities, it is a prerequisite for marriage. In some other communities, it is a ritual of passage or transition to womanhood. Others value it as a way of preserving their daughters' virginity until marriage, e.g. in Sudan, Egypt and some parts of Nigeria.

This traditional practice which has existed for over two decades has attracted increasing global attention with the United Nations (UN) alongside other Non-Governmental Organisations (NGO) establishing a strong global consensus against the practice. In many countries, WHO and other NGOs have been developing projects to educate rural communities on the adverse effects of the practice in a bid to changing their behaviour or attitude against the practice. Several countries have passed laws against the practice, including Nigeria on May 5th 2015 because of the long and short term consequences of the practice.

It is however recognised that laws alone are not effective, hence the need to create and support preventive education programmes within the communities directly involved, through adult literacy programmes.

Literacy in its simplest form connotes the ability to read and write. Adult literacy therefore entails equipping adults with the skills needed to read, write, carry out basic computations and

contribute meaningfully to the society in which they belong. However, because what it means to be literate differs from one social milieu to another, a functional literacy programme aimed at social reconstruction and social change is best suited for rural dwellers in the fight against Female Genital Mutilation.

Brown and Tomori (1979) defined adult literacy—citing UNESCO 1976, as the entire body of educational processes whatever the content, level and method, formal or otherwise whereby persons regarded as adults develop their abilities, enrich their knowledge, improve their technical or professional qualities and effect changes in their attitude or behaviour in the two-fold perspective of personal development and participation in balance and independent social, economic and cultural development.

Adult literacy programmes that seek to prevent, eradicate or create awareness on the ills of Female Genital Mutilation are based on community education that emphasizes the harmful effect of the practice. It employs such methods as classroom, media, rallies, market jingles, group dynamics, etc. the programme would enable circumcised patients and parents as well as the general public get information on specific ways to prevent the health problems associated with the procedure and provide counselling services to affected girls and women. This is done by giving open talks in market places, in the clinic waiting rooms (ante and post-natal clinics) using pictures and projections to show the damaging effect of excision on the girl child, employing the language of the people.

Adult literacy opens the eye of the adult to the immediate dangers of Female Genital Mutilation like shock, tetanus, injuries, haemorrhage, painful menstruation, etc, as well as the long-term effect like scarring, difficulty in urination, infertility, recurrent urinary infections, etc., in a bid to stem the practice among rural people in the 21st century.

Sadly, based on observation women and girl children are still being forced to go through the traditional demands of Female Genital Mutilation with no reason to change their views or belief on the traumatic traditional way of life even with the recent bill against Female Genital Mutilation in Nigeria. It is the intention of this study to help discontinue this practice by bringing adults to the knowledge of disadvantages and health complications associated with Female Genital Mutilation through functional adult literacy programmes/community education in Egor Local Government Area of Edo State.

Statement of the problem

As a universal issue, the process and degree of devastation vary from country to country. This is the function of the level of awareness and literacy. Despite numerous health campaigns against Female Genital Mutilation, it is still being practiced in rural areas especially as a result of their accepted and social definition of feminity and attitude towards female sexuality. A common feature is the social condition of women who have been groomed to accept Female Genital Mutilation as a means of becoming or attaining womanhood and getting social identity and acceptance. In recent times, many of these communities have started to acknowledge the dampening effects of Female Genital Mutilation on women's sexual pleasure; preservation of chastity is not always the goal.

Based on the foregoing, this study intends to investigate the issue of Female Genital Mutilation in Edo State. It seeks to investigate the perceived impact of adult literacy education in the reduction of the practice of Female Genital Mutilation in Egor Local Government Area.

Purpose of the Study

From the foregoing, Female Genital Mutilation no doubt is prevalent in the locality especially the rural communities. This study therefore seeks to:

1. Examine the rate at which this practice is being carried out among the populace in Egor Local Government Area.
2. Determine the level of information/awareness the people have on the subject of Female Genital Mutilation.
3. Determine the role of literacy in the reduction of Female Genital Mutilation in the communities.
4. Ascertain the level of social and economic damage caused by Female Genital Mutilation.
5. Prescribe some preventive measures which will—in league with existing measures form a formidable barrier against the continued practice of Female Genital Mutilation.

Research Questions

It will answer the following research questions:

1. What percentage of the populace still indulges in Female Genital Mutilation in Egor Local Government Area?
2. What is the level of awareness of the ills of the practice in Egor Local Government Area?
3. What is the role of literacy in the reduction of Female Genital Mutilation in the various communities in Egor Local Government?
4. What are the socio-economic damages caused by Female Genital Mutilation?
5. What preventive measures have been put in place to curb the practice in Egor Local Government Area?

Significance of the Study

This study is intended to bring to awareness the perceived impact of adult literacy education in the reduction of Female Genital Mutilation (FGM) as well as bring to awareness the disadvantages of Female Genital Mutilation and its attendant long and short term consequences on the women folk and girl child alike.

Furthermore, this study will increase existing literature on Female Genital Mutilation as a social issue. It is hoped that this study would be looked upon as one of such works aimed at mapping out further a common but complex and uncharted territory and pen it to further investigation by other results. It is hoped therefore that the findings of the study will provide some insight and guidance to patients, parents, NGOs and adult literacy facilitators who deal with the problem of Female Genital Mutilation in rural communities. Practically, it is hoped that this study will assist government in re-evaluating existing policies so as to come up with a more realistic programmes and policies towards the eradication of Female Genital Mutilation in Edo State and Nigeria in general.

Scope of Study

The study is on Female Genital Mutilation. The focus of the research is Egor Local Government Area which has an area of 93Km^2 and a population of 339,899 people as at the 2006 census. The research seeks to find out the perceived impact of adult literacy in the remediation of Female Genital Mutilation in the local government under review. The entire women and girls in Egor LGA will constitute the study population.

Limitation of the study

Limitations encountered in the course of the study included the constraints of finance to go round the entire Egor local government. Also getting some elderly women to grant oral interviews and fill out their questionnaire items was another limitation because of the language barrier especially those with a formal education. There was also the issue of selective reasoning because FGM is a sensitive issue some people prefer not to talk about it and when they do their real FGM status may be altered due to self-reporting. Getting the same set of people for the test retest procedure is another challenge encountered in the course of the study. In addition the parts of the local government with really bad roads like Okhoro were for the most part inaccessible and could not be sampled.

Definition of Terms

Adult Literacy Education: Any educational activity or chain of activities carried out of classroom situation which aim at equipping adults with skills, knowledge and attitude which can be used to combat day to day life situation with literacy skill: reading, writing and computing.

Female Genital Mutilation: constitute all procedures that constitute the partial or total removal of the external genitalia of young girls and women whether for cultural, medical or personal reasons.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

Introduction

There have been mixed opinions over the practice of Female Genital Mutilation (FGM) across West African countries. Female circumcision has been observed to be a cultural rather than a religious practice (Toubia, 1994; Caldwell, 2000). However the economic and social consequences caused by Female Genital Mutilation have remained indelible in the affected families as some of them have either lost a loved one in the process or are still suffering the long term effect of Female Genital Mutilation.

The purpose of this chapter therefore is to review literature on the following areas: the concept of Female Genital Mutilation- definitions, practices, types, reasons and instruments used the effects and consequences of Female Genital Mutilation and the perceived role or impact of Adult literacy in stemming Female Genital Mutilation in the local government area.

- The concept of Female Genital Mutilation
- Cultural Practices of Female Genital Mutilation
- Modern practice of Female Genital Mutilation in Nigeria
- Reasons for the continued practice of Female Genital Mutilation
- Prevalence and attitude towards Female Genital Mutilation

- The level of awareness of the ills of the practice among the populace.
- The role of Adult literacy in the reduction of Female Genital Mutilation

The concept of female genital mutilation:

Definitions and Types of Female Genital Mutilation

Many authors have expressed their views on the concept of Female Genital Mutilation and were of the opinion that the procedure does more bodily and psychological harm than good. Proctor (2000) defined females as the sea which produces or gives birth to the young. Oxford English Dictionary defined mutilation as the act of injuring or damaging very severely by breaking or tearing off a necessary part.

Female Genital Mutilation (FGM) which is sometimes referred to as female circumcision is described as a traditional practice in which a person sometimes unskilled or a health worker cuts off parts or whole organ of the female external genitalia. Female Genital Mutilation has also been defined as a group of traditional practices that involves partial or total removal of the external female genital or other injury to female organs for cultural, religious or other non-therapeutic (medical) reasons.(WHO, 2010).

According to World Health Organisation (WHO, 2002), Female Genital Mutilation constitutes all procedures that involve the partial or total removal of the external female genitalia of young girls and women or it is the injury to the female genital organs whether for cultural or any other reason. In 1995, WHO stressed that Female Genital Mutilation was one of the deeply rooted harmful traditional practices in Africa.

Traditionally, Female Genital Mutilation is called ‘Female Circumcision’ (FC) but the realisation of its harmful physical, psychological and human rights consequences has led to the use of the terms, ‘Female Genital Mutilation’ or ‘Female Genital Cutting’ (FGC) to describe more accurately the consequences of the procedure and distinguishes it from the much milder ‘male circumcision’ (Kiragu, 1995).

Female Genital Mutilation, FC or FGC as it is variously called refer to the cutting or alteration of the female genitalia for social rather than medical reasons (Rahman and Toubia, 2000). It has also been referred to as any practice which includes the removal or the alteration of the female genitalia (Sarkis, 2003). It also comprises all methods involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons (WHO, 2001:1). Inter-African Committee (IAC) (Nigeria) defined it as 'any interference with the natural appearance of the female external genitalia using a blade, knife or any sharp instrument in order to bring about either a reduction in size of the clitoris or a complete removal of the vulva'. From the foregoing definitions, Female Genital Mutilation can be defined as any act (deliberate or not) to partially or wholly tamper with the female external reproductive organ under the guise of culture, religion or any other belief.

Cultural practices of female genital mutilation

The traditional practices of a society are closely linked with the living conditions of the people and with belief systems. Communities that practise Female Genital Mutilation report a variety of social and religious reasons for continuing with it. Seen from a human rights perspective, the practice reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against women.

Female Genital Mutilation is nearly always carried out on minors and is therefore a violation of the rights of the child. The practice also violates the rights to health, security and physical integrity of the person; the right to be free from torture and cruelty, inhuman or degrading treatment, and the right to life when the procedure results in death.

Female Genital Mutilation is mostly carried out on girls between the ages of 0 and 15 years.

However, occasionally, adult and married women are also subjected to the procedure. The age at which Female Genital Mutilation is performed varies with local traditions and circumstances, but is decreasing in some countries (UNICEF, 2005).

Globally it has been estimated that between 100 and 140 million girls and women worldwide have been subjected to one of the first three types of Female Genital Mutilation (WHO, 2000). Estimates based on the most recent prevalence data indicate that 91.5 million girls and women above 9 years in Africa are currently living with the consequences of Female Genital Mutilation (Yoder and Khan, 2007). There are an estimated 3 million girls in Africa at risk of undergoing Female Genital Mutilation every year (Yoder, 2004). Types I, II and III Female Genital Mutilation have been documented in 28 countries in Africa and in a few countries in Asia and the Middle East. Some forms of Female Genital Mutilation have also been reported from other countries, including among certain ethnic groups in Central and South America.

Growing migration has increased the number of girls and women living outside their country of origin who have undergone Female Genital Mutilation or who may be at risk of being subjected to the practice (Yoder, 2004).

In many communities, the practice may also be upheld by beliefs associated with religion (Budiharsana, 2004; Dellenborg, 2004; Gruenbaum, 2006; Clarence-Smith, 2007; Abdi, 2007; Johnson, 2007). Even though the practice can be found among Christians, Jews and Muslims, none of the holy texts of any of these religions prescribes Female Genital Mutilation and the practice pre-dates both Christianity and Islam (WHO and UNFPA, 2006). The role of religious leaders varies. Those who support the practice tend either to consider it a religious act, or see efforts aimed at eliminating the practice a threat to culture and religion. Other religious leaders support and participate in efforts to eliminate the practice. When religious leaders are unclear or avoid the issue, they may be perceived as being in favour of Female Genital Mutilation.

The practice of Female Genital Mutilation is often upheld by local structures of power and authority such as traditional leaders, religious leaders, circumcisers, elders, and even some medical personnel. Speculations abound of an increase in the performance of Female Genital Mutilation by medical personnel. In many societies, older women who have themselves been mutilated often become gatekeepers of the practice, seeing it as essential to the identity of women and girls. This is probably one reason why women, and more often older women, are more likely to support the practice, and tend to see efforts to combat the practice as an attack on their identity and culture, it should be noted that some of these actors also play a key role in efforts to eliminate the practice (Toubia and Sharief, 2003; Draege, 2007; Johnson, 2007). Female Genital Mutilation is sometimes adopted by new groups and in new areas after migration and displacement (Abusharaf, 2005, 2007). Other communities have been influenced to adopt the practice by neighbouring groups (Leonard, 2000; Dellenborg, 2004) and sometimes in religious or traditional revival movements (Nypan, 1991).

Preservation of ethnic identity to mark a distinction from other, non-practising groups might also be important, particularly in periods of intensive social change. For example, Female Genital Mutilation is practised by immigrant communities living in countries that have no tradition of the practice (Dembour, 2001; Johansen, 2002, 2007; Johnson, 2007). Female Genital Mutilation is also occasionally performed on women and their children from non-practising groups when they marry into groups in which Female Genital Mutilation is widely practised (Shell-Duncan and Hernlund, 2006).

In Nigeria, generally, about 40% of women from the Hausa, Yoruba and Ibo, Efik, Shuwa, and most population groups except the Itsekiri of Cross Rivers State practice and undergo Female Genital Mutilation (FGM) (Female Genital Mutilation Network, 2000). The Nigerian Population Commission (NPC) [2000], conducted a study using a total population of 8,206 women aged between 10—49 years who were interviewed from different regions in the

country. Women aged 10—14 years were included in the survey because the pre-test conducted before the survey revealed teenage pregnancy, motherhood and early age at commencement of sexual activities. However, analysis was restricted to women aged 15—49 because most of the variables were not relevant to women of younger ages. When broken down by age groups, the rate of circumcision increased with increase in age. This could be understood to mean that most women within 30—49 age category may have been circumcised before the awareness campaign on its harmful effects became apparent. The research also reveals that more urban than rural dwellers were circumcised and circumcision is more prevalent in the southwest, southeast and central region than in the northwest and northeast. This goes to explain that the practice is more of a cultural than religious phenomenon. Surprisingly, respondents with no education were the least circumcised followed by those with secondary education. Primary educated respondents had the highest percentage of circumcised respondents followed closely by those with higher education. This may mean that educated respondents may have been circumcised at a very tender age when they had no say in the matter. On the type of circumcision practiced and performed on them, 82 percent of the total respondents claimed to have undergone clitoridectomy, 7 percent mentioned excision while 4 percent indicated infibulation. When analyzed by background characteristics the study revealed that older females aged 45 – 49 years performed more infibulation (87 percent) than any other age group and infibulation is more prevalent in the Northeast (50 percent) than excision (21 percent) and clitoridectomy (14 percent). In the other regions, clitoridectomy is more prevalent although excision and infibulation were slightly high in the Northwest. Central region recorded the least in both excision and infibulation with less than 1 percent prevalence rate. Those without education recorded the highest percent in clitoridectomy (85 percent) and infibulation (5 percent) but had the least in excision but primary educated respondents had the highest in excision. The result shows that the higher the education of respondents the less likely she is to

be infibulated though primary educated respondents were excised more than infibulated. When diagnosed by regions, most south easterners (49 percent) and South westerners (41 percent) performed circumcision at birth-contrary to their northern counterparts who performed it mostly at age 5 and above. The higher the education, the higher the tendency for circumcision to be performed at birth and the lower the education the higher the possibility of performing infibulation after 5 years. Most excision and clitoridectomy are performed at birth and while more urban than rural dwellers perform circumcision at birth the reverse is the case at age 6 and above. In addition, the rural-urban differential may not give the true picture because most urban dwellers may have performed the rite in the rural area before moving to the urban centres. The study also attempted to relate the opinion of all respondents (whether circumcised or not) on whether Female Genital Mutilation should be continued by their characteristics and circumcision status. The results showed that most urban and rural dwellers are of the opinion that the practice should be discontinued although 17 percent and 15 percent respectively want the practice to continue. However, respondents from the Southwest top the list of those who want the practice to continue followed by the southeast. Most respondents from all the regions approve of its discontinuation with northeast having the greatest share (63 percent) and Southwest with the least percentage (39 percent). What informed this response from the Northern region might not be unconnected with infibulation, which is a more severe form, and which is found to be more prevalent in those regions than in the southern part. On the other hand, more of those with primary education want the practice to continue while the highest percentage that feels the practice should be discontinued came from those with higher education. This response by the higher educated respondents shows that the higher the education the more likely one is aware of the health implications of the practice. Circumcised respondents are most likely to want the practice continued than their uncircumcised counterparts. On circumcision status, those who are circumcised are more likely to circumcise

their daughters and plan to circumcise those not yet circumcised than their non-circumcised counterparts. This may mean that those circumcised are more likely to believe in the reasons for circumcision than those not circumcised.

Demographic and Health Survey (DHS), (2000) reported that a survey conducted by Principal International Incorporated; revealed that Female Genital Mutilation originated some 2000 years ago in Southern Egypt or Northern Sudan but the practice began in earnest in the 19th and 20th century in many parts of West Africa. The practice was also believed to have been carried out in ancient Rome and Arabia.

According to Population Action International (PAI) (2003), Female Genital Mutilation is inflicted on girls aged 4—12 years and so it's considered one of the worst violations of the contentious rights of the girl child.

There are various variants of the term (FGM) in different countries where it is practiced. These variants are a reflection of what and how the procedure is practiced. Among the Bambara speaking group of Mali, Female Genital Mutilation is known as *bolokoli*—washing your hand. This means that the practiced is carried out for purification. In Eastern Nigeria among the Igbos it is called *isa aru*—having your bath. According to them, a woman must have her bath before she has a baby. This implies that like the Urhobos, circumcision is carried out before delivery. In Somalia, the clitoral gland is removed and shown to the girls senior relatives who decides whether enough has been amputated before the labia is removed. A single hole of about 2—3 millimetres is left for passage of urine and menstrual fluid by inserting something such as a twig into the wound. After which the vulva is closed with surgical thread, agave or acacia thorns, or covered with a poultice such as raw egg, herbs and sugar. In some cases the parts that have been removed are placed in a pouch for the girl to wear. The girl's legs are tied from hip to ankle for up to six weeks to help the wound heal and tissue bind faster. If the remaining

hole is too large in the view of the girl's family after the binding of tissues, the procedure is repeated (Swiss Medical Weekly, 2011).

In Igboland, a hard metal carving knife known as 'aguba' is usually used in cutting the clitoris, whereupon local herbal concoctions are used to stop blood flow and ameliorate the excruciating pains. The girl child /woman is taken to a fast flowing river where she is given a bathe to wash off all her ties to the spirit husband who is believed to have sexual relations with uncircumcised women in their sleep, hence the local name for Female Genital Mutilation 'isa aru' which literarily means taking a bath. To further speed up the healing process, palm oil is applied to the wound intermittently using a feather to spread the oil along cut edges of the former position occupied by the clitoris. As the child cries the mother takes solace in the fact that she has produce a woman made ready for her husband's ecstasy and sexual satisfaction. She also believes that she has paved the way for her daughter to have easy passage during delivery and boycott birth pangs (Clement, 2004).

In some tribes, the woman is sewn back each time her husband goes travelling and is opened again each time he comes back. In cases of divorce, the woman is sewn up to forbid any possibility of intercourse (saadwai, 2000) and so also when a woman is widowed. This practice is known as infibulations or pharoic circumcision. It is mostly carried out among the Muslims. In addition, a study published in the African Journal of Reproductive Health (AJRH) an international journal published by a Nigerian NGO called the Women's Health and Action Research Center(WHARC) reports that Female Genital Mutilation is common among the Edo people of Edo state for various religious and cultural beliefs that have been difficult to eradicate despite western education. The types and extent of genital mutilation is a spectrum from clitoridal excision with labia minora/inner layer of majora excision.

In Egor local government area the practice of Female Genital Mutilation used to be considered a traditional ritual that prepares every young female child for transition to womanhood. It is

asserted that the practice of Female Genital Mutilation does not comprise minor forms of genital rituals like washing the tip of the clitoris, pricking it with a pin or needle or separating and cleaning the prepuce or foreskin but in essence refers to a ritualistic practice where actual cutting and removal of the sexual organs take place.

There are conventionally three known types of Female Genital Mutilation, the fourth been unclassified namely:

Type 1 (Sunna): This is the least severe form of the practice constituting of the removal of the prepuce (retractable fold of the skin) and tip of the clitoris.

Type II (Excision or Clitoridectomy): This is a severe form and consists of the removal of the entire clitoris (Prepuce and glands) and the removal of the adjacent labia.

Type III (Infibulations-Pharoic circumcision): This is the most severe form of the practice and consists of the removal of all the labia minora and the labia majora i.e. the excision and infibulation of the vulva. This is the commonest form in Nigeria.

Type IV is sometimes called unclasssified: It is practice in Nigeria, Ethiopia and other parts of Africa and consists of "other mutilation" such as pricking, piercing, incising, ripping, tearing, burning, scraping and cauterization.

In Egor local government area like other parts of Nigeria, type III is most commonly practiced. The operation is performed on girls whose ages range from 3 days to puberty as a rite of passage to true femininity and sometimes is justified as an embellishment required for securing a husband. While some other very traditional people do it on the 7^{th} or the 8^{th} day to safeguard the life of the child from evil. In some parts of Africa, Female Genital Mutilation is delayed until during pregnancy or until two months before a woman is due for delivery (Owunmi, 1993; Akpabio, 1995). This is based on the assumption that the baby may die if he/she comes into contact with the mother's clitoris during birth although there is no medical evidence to support this. Some cultures also perform circumcision after death (Penawou, 1980), where the woman

was not circumcised when she was alive. Female Genital Mutilation is practiced as a cultural ritual by ethnic groups. Nnorom (2000). It is typically carried out with or without anaesthesia by a circumciser using knife or razor. The practice involves one or more of several procedures which vary according to ethnic group. In some parts of Egor local government area a tip of the clitoris is cut off while some cut all the outer part leaving a small hole for urine and menstrual blood and the vagina is open up for intercourse and childbirth. For the most part, the procedure was carried out by a medically untrained woman designated for that assignment by the community. She is often the most elderly woman in the community at that time. Female Genital Mutilation has no health benefit while the health effects depend on the procedure. In the old practice the methods used to stop bleeding after the procedure include; packing the wound with gauzes or other herbal substances, applying pressure and bandaging the wound. The instruments used were often unsterilized ranging from razor blades, scissors, sharp flints and stones, shades of cut glasses etc. increasing the risk of injuries and more serious infections like tetanus, HIV/AIDS, etc.

Modern Female Genital Mutilation Practice in Nigeria

Female Genital Mutilation is widespread in Nigeria. Some socio-cultural determinants have been identified as supporting this avoidable practice. Female Genital Mutilation is still deeply entrenched in the Nigerian society where critical decision makers are grandmothers, mothers, women opinion leaders, men and age groups. The new Female Genital Mutilation practice is targeted at curbing promiscuity among female inhabitants of communities where it still holds sway. It is used as a way of controlling women's sexuality.

Modern practices have evolved, the more recent practice is termed 'nursling' derived from the word nurse. The procedure involves circumcising the girl child from day two to five with seven days as the maximum length of time. The clitoris is excised, and herbs, and in most cases orthodox medicine is applied to facilitate healing and prevent infections. More enlightened

women visit hospitals and clinics to get their female children circumcised. Unlike the old practice, trained medical and modern practitioners insert one or two stitches around the clitoral artery to stop the bleeding after the procedure. While many reasons are advanced for this deeply entrenched cultural practice, the basic intention is to diminish sexual pleasure in order to achieve chastity before marriage and fidelity after marriage. There are however no proofs that circumcised women are less promiscuous.

Another recent Female Genital Mutilation practice is termed *medicalisation* of Female Genital Mutilation. The medicalisation of Female Genital Mutilation refers to the performance of the act by doctors or other members of the health profession. The practice is asserted to be less painful, cut a lesser amount of tissue and make use of local anaesthesia and infection prevention pills. The procedure is often performed in health facilities. It involves pricking or making just a slight cut in the clitoris. The act is also known as 'psychological circumcision' by some nurses. The practice according to Fadela Novak in a report from a journal published by the Forced Migration Review (2003) is neither new nor emerging in East African Countries primarily Egypt, Sudan, Eritrea and Somalia. However it is more recent and emerging in West Africa where an increasing number of medical and paramedical personnel are the chief perpetrators of the act. Such clinics have been identified in Kenya and Guinea. The practice has been found to be more expensive than the traditional practices; reasons being that it is considered safer and of better quality. With medicalisation of Female Genital Mutilation, the procedure has become a business avenue for a number of health care workers and so a means of economic gain (WHO, 2015). In some parts of Europe for instance, some practitioners have offered 'safe' forms of Female Genital Mutilation with minimal cutting to comply with tradition. In another report by the Obstetrics, Gynaecology and Reproductive Medicine Home (2014), the procedure is increasingly being performed by health care providers to reduce the incidence of complications. However, Serour (2013) in the African Journal of Urology (2013)

is of the opinion that medicalisation of Female Genital Mutilation will and does not reduce the long term complications of Female Genital Mutilation and so violates the codes of medical ethics. Furthermore its medicalisation according to them would result in a setback in the global efforts to eradicate the practice and provide a platform for non-health care providers to start experimenting with the idea, resulting in increased incidence of complications.

In the words of Oduro & Onuh, 2006, Female Genital Mutilation has been found to have physical, psychological, psychosexual and health implications on victims. The immediate complications include fatal bleeding, acute urinary retention, wound infections, tetanus, recurrent infection and death (Oduro & Onuh, 2006). Late complications could include inability to get pregnant, complications during childbirth—including the need to have caesarean section and transmission of HIV if instruments are not sterile or reused (Ibekwe, 2012; WHO, 2006). Findings from these various studies have continued to show the unflinching attitudes of the practitioners. In addition, the practice is sustained because of the supposed pleasure the husband will derive at the expense of the woman. Despite the implications and the effort being made by individuals and the world body to eradicate this practice, many countries in Africa (Nigeria inclusive) and other continents still continue to subject their women folks to the traditional practice of Female Genital Mutilation. Female Genital Mutilation is widespread in Nigeria. Some socio-cultural determinants have been identified as supporting this avoidable practice as Female Genital Mutilation is still deeply rooted in Nigeria. Most women and girls in Egor local government area of Edo State, Nigeria still face the ritual annually irrespective of their religious inclinations.

Literature reviewed by Okhiai, Idonije & Asika (2011)revealed that while some people see female circumcision as an ugly practice that needs to be eradicated on grounds of risk of contracting infectious diseases such as HIV/AIDS, Hepatitis and some other adverse health consequences such as heavy bleeding, severe pains and complication during childbirth which

often result in caesarean operation, others see it as a practice that should be embraced for reasons which include cleanliness, social acceptance, better marriage prospects, preservation of virginity and prevention of premarital sex.

Reasons for the continued practice of female genital mutilation

There are many reasons for the retention of this practice in not only Egor local government area but Nigeria at large. Some of which are highlighted below:

- **Preservation of culture and tradition:** Female Genital Mutilation is regarded as a tribal traditional practice (our custom is a good tradition and has to be protected), as a superstitious belief practiced for preservation of chastity and purification. Female Genital Mutilation is a cultural rather than a religious affair. It is carried out as a way of preserving the culture of the people which is to instil pride and grace in the female child. Many people continue Female Genital Mutilation because it is part of the societal norms handed down by their mothers and grandmothers and any attempt to discontinue the practice is met with societal pressure and risk of isolation.
- **Preservation of virtue amongst female children:** Female Genital Mutilation is carried out to terminate or reduce to the barest minimum feelings of sexual arousal in the girl child. So as to prevent promiscuity or early involvement in pre-marital sex and so foster the preservation of virtue and self-worth.
- **Cleanliness:** Some culturally inclined and superstitious people still believe that the clitoris and environs emit bad odour which can make a woman unpleasant to her husband hence the removal of the clitoris and labia minora to eliminate the odour and make a woman sexually clean and appealing to her husband. Others feel the milk of the mother will become poisonous if her clitoris touches the baby.

- **Social acceptance/identity:** Mothers chose to subject their daughters to the practice to protect them from being ostracized, beaten, shunned, or disgraced (Yoder & Khan. 2007; UNICEF. 2003). It is culturally believed that Female Genital Mutilation makes a woman stand out. It is a yard stick for cultural identity and acceptance. Some also believe that the clitoris has male traits and so could make a girl child exhibit some male traits like stubbornness and aggression. It therefore becomes penitent to circumcise the girl child so as to make her a complete woman.
- **Better marriage prospect:** One of the reasons for Female Genital Mutilation is to ensure respectability of a woman, thus enhancing her chances of marriage and getting a better 'bride price' (Rahman, 2000; Chege, 2001). It is believed that a woman who has gone through the process of Female Genital Mutilation has better marriage prospect in comparison to those who did not go through the process of Female Genital Mutilation. This is because she is deemed clean and safe for her husband. The assertion is that, the prepuce can make a man impotent if it comes in contact with the penis and in worse cases can result to the eventual death of the man.
- **Fertility:** It is also believed that Female Genital Mutilation increases a woman's fertility as anything that would have been a barrier has been cut off in the process of the circumcision. Many people who have gone through the process or have had their daughters subjected to the process, do so because they believe that the clitoris is poisonous and can harm the child if it comes in contact with it during childbirth.
- **Focus:** Many women who still indulge in Female Genital Mutilation do it on the ground that it will help them or their girl children remain focused. Since Female Genital Mutilation eliminates the chances of sexual arousal there will be less chances of falling into temptations associated with puberty and help them maintain focus on studies and life career by channelling all the teenage energy on other productive ventures.

- **Virginity:** Female Genital Mutilation is still practiced as a way of preserving virginity till marriage. In some parts of Nigeria the cut edges of the external genitalia are smeared with secretions from the snail footpad with the belief that the snail being a slow animal would influence the circumcised girl to 'go slow' with sexual activities in future.
- **Legal Reasons**: In some places it is believed that circumcision puts a woman in the right position to inherit properties from her husband and father in places where female children have rights to inheritance. It is believed that one cannot inherit properties if one is uncircumcised.
- **Preservation of Marriage:** It is believed that a woman who has been subjected to Female Genital Mutilation can give her husband increased sexual pleasure and so eliminate the chances of her husband cheating. That way she can satisfy her husband and preserve her marriage.
- Clement Okoh Nnachi in his article published by the Nigerian Tribune in 2007 asserted that in Eastern Nigeria among the Igbos, it is believed that uncircumcised women make love to spirits in their sleep who in turn cause their unhealthy appetite for sexual intercourse; it is also said that such women give birth to *ogbanje* children. With such unwholesome tales, out of fear and possible stigmatization most mothers subject their daughters to Female Genital Mutilation.

Prevalence and attitude towards female genital mutilation

Female Genital Mutilation varies from country to country, tribes, religion, and from one state and cultural setting to another and no continent in the world has been exempted (Odoi, 2005). The term prevalence is used to describe the proportion of women and girls now living in a country that have undergone Female Genital Mutilation at some points in their lives.

According to a 2013 UNICEF report based on surveys completed by select countries, Female Genital Mutilation is known to be prevalent in 27 African countries, Yemen and Iraqi Kurdistan where 125 million women and girls have undergone Female Genital Mutilation. The prevalence of Female Genital Mutilation has been estimated from large-scale, national surveys asking women aged 15—49 years if they have themselves been cut. The prevalence varies considerably, both between and within regions and countries with ethnicity as the most decisive factor. In every countries the national prevalence is almost universal, (more than 85%); four countries have high prevalence (60-85%); medium prevalence (30-40%) is found in seven countries, and low prevalence, ranging from 0.6% to 28.2%, is found in the remaining nine countries. However, national averages hide the often marked variation in prevalence in different parts of most countries. In Sierra Leone, Gambia, Burkina Faso and Mauritania, prevalence rates for Female Genital Mutilation were 94%, 79%, 74% and 72% respectively. In contrast, fewer than 6% of women had been circumcised in Ghana, Niger, and Togo. Gambia and Mauritania had the highest percentage of daughters circumcised (64%), Togo, Ghana and Niger had the lowest (1%) (Bulletin of the World Health Organization, 2012).

Although estimates of the prevalence of Female Genital Mutilation may vary, sources have consistently found the practice to be undergone by the majority of women in the 'horn of Africa', in the West African countries of Guinea, Sierra Leone, Gambia, Mauritania, Mali, Burkina Faso, Sudan and Egypt. Of these countries all have laws or decrees against the practice except Sierra Leone, Mali and some states of Sudan.

In most parts of North-Eastern African countries, type III also known as infibulations is the most prevalent practice, e.g. Algeria. In Benin Republic, a 2006 survey revealed that prevalence varied with religion as it is prevalent in 49% of Muslim women, 15% of Protestants, 12% of traditional religions and 7% of Roman Catholic women. The same goes for Chad, Cameroon, Burkina-Faso and Cote d'Ivoire where religion is the major determinant. After

Nigeria, Guinea has the highest prevalence rate in the world. According to a 2005 survey 96% of women aged between 15 and 49 have been cut. Like the others, religion is the major determinant. Being a predominantly Muslim country, a prevalence rate of 99% was recorded among the Muslims, 94% for Catholics and Protestants, 93%of Animist women. In Kenya, the Kenya Demographic and Health Survey (DHS) in 2014 reported a prevalence rate of 21% among women aged 15-49. In Kenya prevalence varies widely by age, location, ethnic group and religion. Prevalence according to the report increases with age. It is lowest among women ages 15- 19 at 11.4%, and highest among women aged 45-49 at 40.9%. By region, prevalence is highest in the former provinces of north eastern (97.5%), Nyanza (32.4%), Rift valley, (26.0%), Eastern (26.4%), and Nairobi (8%). It is more common in rural than urban areas. By ethnic groups, it is more prevalent among women in Somali (93.6%), Samburu (86%), Kisii (84.4%), and Maasai (77.9%). By religion, it is more prevalent in Muslim women (51.1%) and women listing no religion (32.9%). It is less prevalent in Roman Catholic (21.5%) and protestant or other Christian women (17.9%)

A 2008 demographic survey found that 30% of all Nigerian women used in the study have been subjected to Female Genital Mutilation. According to them, a possible explanation for the prevalence rate is the definition of Female Genital Mutilation used. From prior research conducted by the NDHS in 2003 types II and IV are the more common forms of circumcision in Nigeria but while type II is common in the south-eastern and south-western states, type IV is found mostly among the Northern states. Benue and Ondo states have a nearly 100 percent prevalence rate of type II, while type IV and type I are more prevalent in Kebbi and Osun states respectively. Except in Rivers and Plateau states, practitioners of type I reside in the western states of the country. It is only Borno state where type III is practised. The state with the least prevalence is Kogi State with 1 percent prevalence rate; only the Fulani do not practice any

form. Altogether, the prevalence rate of Female Genital Mutilation in Nigeria varies from 1 percent to a nearly 100 percent indicating that the practice is still deeply rooted in the country. The prevalence rate in Nigeria like in the other countries varies with religion. Female Genital Mutilation is prevalent in 31% of Catholics, 27% of Protestants, and 7% of Muslim women. The practice of Female Genital Mutilation was banned throughout the country in 2015. In another survey carried out by the National Baseline Survey of Positive and Harmful Traditional Practices Affecting Women and Girls in Nigeria (Egunjobi: 2000) reports that the highest rates of Female Genital Mutilation were found in Osun state (98.7%), Oyo state (96.8%), Ondo state (91.6%) Edo state (74%). In the south-East, the highest rate was found in Imo (95.4%), Abia (82.4%), Anambra (75.5%). In the south-south, Cross River (93%), Delta state (91.4%), Akwa -Ibom state (65%). In Kano state, the rate is 55.5%, in Kaduna, it is 36.5% and in Jigawa, 32%. Earlier studies conducted in Egor local government area, showed that many of the women have either been circumcised or have had their daughters circumcised. Even with the new laws in place about 70% of the populace still believe in Female Genital Mutilation and fully indulge in it because of varied reasons like culture, ignorance and tradition. 82% of the respondents did not support Female Genital Mutilation yet 50% of them were circumcised, thus it may be assumed that most Female Genital Mutilation would not have been performed if they were given options of making a choice by themselves (Osifo & Evbuomwan, 2009; Anufore et al, 2004; Odimegwu et al, 1978). Snow et al, (2002) reported a prevalence rate of 46% in and around Egor local government area. In a cross sectional study involving five clinics in the local government area. The practice of Female Genital Mutilation is undergoing some changes in different parts of Egor local government area. There is a marked decrease of the practice in the younger age groups compared to the older age groups. This change is clearly evident in Egor local government area with less prevalence in the younger generations than the older ones. The practice is also more prevalent in the rural communities like Ogida, some part of Edaiken,

Eweka, Okhoro etc. than in the urban communities of the local government. People's attitudes towards Female Genital Mutilation are changing owing to the influence of the younger generation which appears to be the more vibrant force in these communities. Many of these youngsters, haven acquired education, are armed with the knowledge of the ills of Female Genital Mutilation and so go to lengths to effect change in their immediate circles in the communities.

Awareness of the ills of female genital mutilation

An estimated 100-140 million girls and women worldwide are currently living with the consequences of Female Genital Mutilation. In Africa about 3million girls are living with the effects of Female Genital Mutilation. Despite the increased international and national attention given at community levels, the prevalence of Female Genital Mutilation overall has declined very little (Okeke, Anyaehie & Ezenyeaku, 2012). In 2008, WHO together with nine other United Nations Partners issued a statement on the elimination of Female Genital Mutilation to support increased advocacy for its abandonment by fuelling increased awareness campaigns on the damages of the process. There is a lack of high quality studies on strategies for inducing an awareness of the ills of the procedure. Community leadership involvement is key in increasing awareness and reducing prevalence (Reproductive Health Library, 2016).

In like manner, the people of Egor socio-political milieu are not totally unaware of the ills of Female Genital Mutilation as there has been series of awareness campaigns on the issue through the efforts of the women's group including the Centre for Development and Population Activities (CEDPA) funding to mobilize women to fight against the practice of Female Genital Mutilation yet the practice still persists howbeit on a much lower rate because it is deeply rooted in the customs and traditions of the people. A baseline survey revealed that 67% of those who did nothing to stop the practice even with the awareness campaigns did so because

they accepted the status quo as God-given and so resigned to their fate. It also revealed that 56.5% accepted Female Genital Mutilation as a way of life especially among the elderly. These results show that awareness has not totally eradicated the practice because those who still indulge in the practice do it out of regard for the custom and tradition. The awareness level of the people on the ills of the practice have been facilitated by some factors like culture contact (socialization), literacy, Tv and Radio programmes, the activities of the National Youth Service Corps (NYSC) members posted to the local government over the years, activities of governmental and non-governmental organisations like the International Federation of Women Lawyers (FIDA) Edo state branch. Some of their successful interventions towards raising awareness on the ills of the practice among the local populace as reported by the ENGENDERING LEGISLATIVE ISSUES (ELI) PROJECT, DECEMBER 2002 include**:** Workshops, advocacy visits to traditional, political and opinion leaders, especially community leadership and local government council officials, targeted radio and television discussion programmes , baby tracking was also carried out by the trained paralegals as part of their regular schedule of duties. In the course of raising awareness about Female Genital Mutilation and other harmful practices in the communities, paralegals would visit the homes of women who recently gave birth to baby girls to inform them of the health and psychological problems they may cause their daughters if they put them through the circumcision rites. While offering useful advice, they would also remind community members that it was illegal to circumcise a girl-child in Edo State and what the consequences were of flouting the laws of the state.

Although, all of these activities have helped to raise the awareness level of these indigenes to a considerably high level, more work needs to be done to them on the ills and dangers associated with the practice. This could be achieved by increased support for adult literacy by endorsing more literacy centers in the state.

The role of adult literacy in the reduction of female genital mutilation

The history of adult literacy in Nigeria is as old as the advent of Western formal education. The European Christian missionaries and their Muslim counterparts pioneered its introduction. Defining literacy is problematic. Historically and culturally relative, the term is impossible to define in isolation from a specific time, place, and culture. Illiteracy can only be understood in relation to a culture's definition of literacy because it is a lack of a certain set of characteristics.

.

In the simplest sense, literacy means "the ability to read and write" in a given language, but this definition appears very inadequate because it does not give a clear picture of the level of one's "ability to read and write. Akinpelu (2002) opined that literacy meant more than the skills or the ability to read and write alphabets, words and simple statements. Obanya (2004), views literacy as a developmental concept, which recognises the UNESCO's definition of literacy as the ability to read and write with understanding of a simple statement (in one's own language) related to one's daily life". Later, this definition was complemented by the "ability to count and do simple calculations (or basic arithmetic).

According to Programme for the International Assessment of Adult Competencies (2006) "Literacy is the ability to identify, understand, interpret, create, communicate and compute, using printed and written materials associated with varying contexts". Literacy involves a continuum of learning which enables individuals to actualize their goals, to develop their knowledge and potential, and to take full and active part in their community and the larger society. This ultimately leads to *functional literacy*; i.e., the ability to adapt to new and changing circumstances and requirements.

From the foregoing we can therefore conclude that adult literacy in simple terms should be seen as a tool that can equip the individual to improve himself intellectually, empower himself economically, and make himself socially and politically relevant.

According to Mohamud (2008) there is a correlation between a woman's attitude towards Female Genital Mutilation and her place of residence, educational background and work station. Demography and Heath Survey indicate that urban women are less likely to support Female Genital Mutilation than their rural counterparts. The same goes for employed women. However, women with little or no education are more likely to support the practice then those with a secondary or university education.

In Egor local government area, many programs that are aimed at eradicating Female Genital Mutilation have been put in place over the years basically through community action aided by community education which placed emphasis on the dangers associated with the process. Like in other places around the globe, with increase in educational levels Female Genital Mutilation has taken a downward dive. Adult literacy has been able to reduce the rate of Female Genital Mutilation in the locality by giving women and men public talks in hospitals, market places, churches etc. using the language of the people to ensure penetration. Youths have also helped to reduce the unhealthy phenomenon by giving their parents enlightenment on the evils associated with the practice through household conversation and posting posters in public places. These youths having acquired knowledge on the ills of Female Genital Mutilation revolt against the act as it directly affects them.

Media houses have been co-opted into the adult literacy programmes to reach those at the grassroots. The use of drama and radio discussions to drive home the reality of Female Genital Mutilation have been a major breakthrough receiving sponsorship from Non-Governmental Organisations (NGOs), Ministry of health, state government as well as individuals.

Through adult literacy, the rites of passage have been carried out by some inhabitants without the mutilation, giving a sense of fulfilment to the participants and community.

Practitioners who get their livelihood from performing Female Genital Mutilation are being encouraged to take part in vocational adult literacy to make them relevant in their society without necessarily carrying out Female Genital Mutilation.

Furthermore, institutions, private and government owned corporations have to a large extent also helped to carry out a mass sensitization of the ills of Female Genital Mutilation among adult inhabitants of Egor social milieu. Some of these bodies include; radio stations, tv houses, churches, human rights activities, NGOs like the Women Health Action Research (WHARC), National Youth Service Corps (NYSC) etc. this they have done by broadcasting programmes that feature talks on the subject of Female Genital Mutilation which has provided adults with the platform to gain knowledge about the disadvantages of the practice of Female Genital Mutilation.

This literacy programmes have been able to bring about a change in their attitude and orientation towards and about the practice of Female Genital Mutilation; hence helping them to balance traditional values with knowledge. Most of the programmes are tilted towards health education and community health extension programmes. The health education programmes helped to give the adults knowledge about the immediate and long term consequences of the procedure as well as the steps to take in preventing these problems from arising for those who are yet to go through the procedure and practical steps to take in remediating the situation for those who had already gone through the procedure. However for those who were still suffering the long term consequences of the procedure, counselling ser4vices were either made available or an education as to where to go for counselling was offered. These programmes are oriented towards changing the attitudes and erroneous believe that have held sway about Female Genital Mutilation in the various communities of the local government area. They have held in various places like markets, town halls, school fields, clinics, churches, etc. Members of the National Youth Service Corps have also taken it upon themselves to educate the rural populace on the

dangers of the practice and other harmful traditional practices as well as good practices they could embrace as part of their community development services.

This enlightenment has in no small measure reduced the communal practices of Female Genital Mutilation. This is manifested by the fact that those who still indulge in the practice do so clandestinely and some because of the literacy acquired have resorted to taking their female children to hospitals and clinics and midwives as opposed to the former practice of subjecting the girl child to the whims of a medically untrained woman.

Summary

The practice of Female Genital Mutilation has been shown to cause more bodily and psychological harm than good. The economic cost associated with recurrent health problems caused by the practice of Female Genital Mutilation in a way causes more emotional trauma than envisioned. This is because so much time and money is spent trying to cure the long term consequences of Female Genital Mutilation. It could be inferred from reviewed literature that awareness of the ills of Female Genital Mutilation is on the increase in not just Egor local government area but in Nigeria at large. This means that as awareness, literacy and social status increases, Female Genital Mutilation reduces.

Conclusion

It is said that knowledge is power and wisdom is profitable to direct; in the light of this, we can conclude that adult literacy has helped to checkmate the UGLY PRACTICE of Female Genital Mutilation. It has equipped the adults with better attitude, skills and values via the efforts of corporations, governmental and non-governmental bodies. Education has thus helped to refine archaic and barbaric aspects of the customs and practices in Egor local government area.

CHAPTER THREE

METHODOLOGY

This chapter attempts to describe the methods used by the researcher in gathering, recording and analysing the data used in the study. To this end, the following sub-titles have been highlighted:

1. Research Design
2. Population of the Study
3. Sample and Sampling Technique
4. Instrument of the study
5. Validity of the Instrument
6. Reliability of the Instrument
7. Method of Data Collection
8. Method of Data Analysis

Research Design

This study employed the survey research design. This was considered most appropriate for the research as it enables the researcher to get the opinions of the respondents.

Population of the Study

The target population is the entire Egor local government area of Edo state including women, youths and men.

Sample and Sampling Technique

The sample for the study consists of 80 girls and women and 20 men from Egor local Government Area. The sampling technique adopted for this study was the stratified random

sampling technique. This helps for adequate representation of the opinions and attitude of both sexes on the issue of Female Genital Mutilation and the perceived role of Adult literacy in the reduction of the procedure.

Instrument of the study

A number of instruments were employed in gathering information for this study thereto, the researcher made use of both primary and secondary sources. The primary sources comprised a self-developed questionnaire which comprised close and open ended questions as well as personal information from respondents and relevant questions based on the research questions through series of oral interviews while the secondary sources comprised printed materials, written documents and online sources two separate sets of questionnaires were developed for male and female opinions respectively. Section A for both questionnaires featured bio-data while section B included question items raised to help answer the research questions raised for the study.

Validity of the Instrument

The instrument used for this study employed the content method. A draft of this study was presented to an expert (the project supervisor) in the department of Adult and Non- formal Education who helped to evaluate the strength of the questionnaire in measuring the variables of interest involved in the study. Corrections and suggestions were made which were later incorporated in improving the content and face validity of the instrument in compliance with the supervisor's advice.

Reliability of the instrument

The two instruments used in this study were found very reliable in collecting relevant data relating to the project topic. To establish reliability, the test retest procedure was used,

consequently, the constructed questionnaire was administered to a group of 50 men and women twice within the interval of two weeks. The correlation coefficient of the two responses was determined using the Pearson product moment correlation coefficient statistics formula.

Method of Data Collection

The questionnaire and oral interviews were administered by the researcher and retrieved by her. Questionnaires were administered in five secondary schools and at the town hall. Clarifications were given to questions that arose in the course of administration.

Method of Data analysis

The data collected were analysed using frequency counts, tables and percentages, the highest percentage was favoured and synthesized into highly objective and descriptive statements of fact while the low percentage was concluded to be unfavourable to the result.

Chapter four

Analysis and discussion of results

This chapter analyses the data collected for the study through the administration of questionnaires to 100 respondents comprising of 80 females and 20 males of Egor Local Government Area of Edo State.

It discusses other major findings of the study. The results were analysed based on the five research questions raised in the study. Tables were drawn for responses from the questionnaires. The following research questions were tested one after the other.

Female respondents' questionnaire

Section A

Research Question 1

What percentage of the populace still indulges in Female Genital Mutilation?

Table 4.1: distribution of the percentage of people still involved in FGM.

S/N	Questions	Responses/percentages		
		Yes	No	Total
1.	Have you been circumcised?	68 (85%)	12 (15%)	80(100%)

From table 4.1 above, we see that 85% of the respondents have undergone mutilation at different point while 15% have not been circumcised. This infers that 85% of the population still indulge in the practice. This indicates that a high population of the people still indulge in the practice of FGM

Research Question 2

What is the level of awareness of the practise in Egor local government area?

Table 4.2- distribution of responses according to the level of awareness

S/N	Questions	Response /percentages		
		Yes	No	Total
2	Have you heard of the term FGM?	39 (48.7%)	41(51.3%)	80(100%)
3	Do you know anyone who has been circumcised?	55(68.7%)	25 (31.3%)	80(100%)

The table above shows that 51.3% of the respondents have not heard of the term "Female Genital Mutilation", but may be aware of the procedure which is traditionally known as "Female Circumcision", while 48.7% have heard about the term: Female Genital Mutilation. As can be seen from table, the respondents have knowledge of the practise. They are aware of when the procedure was carried out on them, and also know others who have gone through the procedure as can be seen in the table.66% of the respondents were circumcised at infancy,12.5% at childhood, 3% before/after their first pregnancy, while 15% have so far never been mutilated. It shows also that the respondents have more than a basic knowledge of the practice. 68.7% know other apart from themselves who have also been circumcised while 31.3% do not know anyone who has been circumcised. This means that awareness about the practice is high in the area.

Research Question 3

What is the role of literacy education in the reduction of Female Genital Mutilation in the communities?

Table 4.3distribution of responses on the role of literacy in reducing the practice of FGM

S/N	Questions	SA	A	SD	D
4	Literacy has made people aware that FGM has no bodily / social benefit to the child.	26 (32.5%)	45 (56.3%)	6 (7.5%)	3 (3.7%)
5	Literacy has made ardent supporters of FGM to embrace medical alternatives.	19(23.7%)	48 (60%)	6 (7.5%)	7 (8.8%)
6	Literacy has provided an avenue for people to balance traditional values with knowledge.	24 (30%)	40 (50%)	0	16(20%)

From table, 56.3% of the respondents are of the opinion that literacy has raised awareness in the people that FGM has no bodily or social benefit to the girl child while 32.5% strongly agree. 7.5% of the respondents disagree with the fact that literacy has made people realise FGM has no benefit for the girl child while 3.7% strongly disagree. From the study, it is also evident that 60% of the respondents agree that literacy has made ardent supporters of FGM seek medical alternatives to the practise, while 23.7% strongly agree with it. On the contrary, 8.8% disagree and 7.5% are strongly opposed to the notion as shown in table above. The results also indicate that 50% of the respondents agree that literacy education provides an avenue for people to balance traditional values with knowledge while 30% strongly agree, but 20% disagree with the idea. This means that literacy can be used as a tool to create awareness about the disadvantages of the procedure and help in the reduction of the practice.

Research Question 4

What are the socio-economic damages caused by female genital mutilation?

Table 4.4: distribution of responses on the socio-economic damages of FGM.

S/N	Questions	SA	A	SD	D
7	FGM has done more bodily harm than good.	38(47.5%)	16(20%)	11(13.8%)	15(18.7%)
8	FGM increases the chances of complications during childbirth.	25(31.3%)	16(20%)	27(33.7%)	12(15%)
9	HIV and other blood related diseases can be contracted through FGM.	33(41.3%)	24(30%)	12(15%)	11(13.7%)
10	Treatment of the effects of FGM is expensive.	23(28.7%)	29(36.3%)	16(20%)	12(15%)

From the responses in table above, 20% agree that FGM has done more bodily damages than good, 47.5% strongly agreed, but 18% disagreed with the idea that FGM has done more bodily harm than good and 13.8% strongly disagreed. The table also reveals that 20% agreed with the notion that Female Genital Mutilation increases the risks of complications during childbirth, 31.3% strongly agreed, while 15% and 33.7% disagreed and strongly disagreed respectively. From table, 30% of the respondents agree that HIV and other blood related infections can be contracted through FGM, 41.3% strongly agreed while 13.7% disagreed and 15% strongly disagreed. The table shows that 36.3 of the respondents agreed that treating the effects of FGM is expensive, 28.7% strongly agreed while 15% disagreed and 20% strongly disagreed. This indicates that the procedure embodies so much economic and social consequences that are detrimental to the physical and psychological well-being of the girl child as it not only increases the risk of infections but financial burdens of curing the contracted diseases.

Research Question 5

What preventive measures can be put in place?

Table 4.5: table of distribution on the preventive measures applicable in reducing the incidence of FGM.

S/N	Question	SA	A	SD	D
11	Imprisonment and other legal sanctions have been effectively implemented.	11(13.7%)	10 (12.5%)	27 (33.8%)	32 (40%)
12	Media sensitization and other non-governmental campaigns help in preventing FGM	25(31.3%)	39(48.7%)	9(11.3%)	7(8.7%)

From the table: 48.7% agreed that media sensitization and other non-governmental campaigns help in preventing FGM,31.3% strongly agreed but 8.7% disagreed while 11.3% strongly disagreed. The table also showed that 13.5% of the respondents agreed that there have been legal sanctions in a bid to prevent the continued practice of FGM which have been effectively implemented and 12.5% strongly agreed while 33.8% disagreed and 40% strongly disagreed, implying that the legal sanctions have not been fully implemented effectively. This means that media sensitization play a huge role in preventing incidences of FGM and also legal sanctions if effectively implemented can forestall incidences of FGM.

Discussion of Findings

The study reveals that a greater proportion of the populace have not heard of the term female genital mutilation but they are aware of the procedure. This agrees with what Yoder(2004) cited in Innocenti Digest Journal(2006) which says that ‘the use of the word “mutilation” reinforces the idea that this practice is a violation of girls’ and woman human rights and thereby helps promote national and international advocacy towards its abandonment. At community level, however, the term can be problematic as local languages generally use the less judgemental “cutting” to describe the practice.

Furthermore, the study also revealed that awareness about the practice is high as seen in table 6&7 which reveals not just a knowledge of when the procedure was carried out but a knowledge of those who have also been circumcised.

The study also found that literacy plays a major role in raising the awareness of the people towards the dangers of the procedure and the need for its abandonment. These findings corroborate those of Oman and Ladur (2004) who stated that "FGM is the most harmful practice from a medical perspective and whatever the reason, whether religious, aesthetic, hygienic or moral, the justification given for FGM are all mechanisms that maintain social conventions of cutting girls and women and contribute to the perpetration of the practice. Information regarding the validity of these justifications help to change attitude towards FGM but real and lasting change in behaviour is most likely to result from transforming the social conventions itself through literacy". This is evident from the responses got from the male category questionnaires distributed, where the decision not to circumcise their daughters have been influenced by education.

The study also revealed that the procedure engenders many socio-economic damages which range from serious bodily harms that could result in abscesses, loss of sexual urge, scars as well as the economic and financial cost required to manage more serious issues like HIV, Tetanus, recurrent urinary tract infections as well as re-infibulation (which is a process of surgically reinstating the clitoris so sexual urge can return to the genitalia)This is just as Moneti (2006) said that "infection is another consequence particularly when the procedure is carried out in unhygienic conditions using unsterilized instruments.

Wheeler and Patricia (2004) also concurred that the damage resulting from FGM together with the psychological trauma and pain associated with it can compromise an adult woman's sexual life. Women who have been infibulated may be re-infibulated upon marriage, a process that can be a source of pain and result to further psychological trauma. Marital problems can arise and can eventually lead to divorce which may jeopardize women's social and economic status.

The study also revealed that though there are legal sanctions against FGM, the people are unaware of these sanctions as there have not been so much publicity about these sanctions, while others believe that the sanctions exist but have not been effectively implemented even though prevalence of the practise among the younger generation is on a decline due to education which focuses on the dangers attached to the procedure at the detriment of the possible legal consequences.

The study also found out that media sensitization has done a great deal in raising the level of awareness of the ills associated with the procedure, hence helping in preventing the process. The study also suggested other preventive measures like: increasing advocacy for the girl child, publicly punishing offenders caught in the act, enlightening parents on the dangers of the procedure, rewarding anyone who reports incidences of FGM, re-orientation of the female folks on their rights, privileges and the need to desist from some harmful cultural practices. Some also suggested that media campaigns should be broadcasted and projected to women in market places in pidgin or in their local languages so that older women can see what FGM does to their children.

Other suggestions included actively involving community leaders in the anti-FGM campaigns as community efforts play a major role in taking on or abandoning a practice.

Chapter five

SUMMARY, CONCLUSION AND RECOMMENDATION

Summary

The research study is centred on the perceived role of adult literacy education in the reduction of female genital mutilation. The purpose of the study was to examine the prevalence of the practise among the populace and ascertain the perceived role of literacy in the reduction of the prevalence rate of the practise in these communities.

This it did by raising a number of research questions geared towards finding out not just the what but the role of adult literacy in the anti-FGM campaign. To help guide the study, it reviewed literature under the following sub headings in the chapter two:

The concept of FGM

Cultural practices of FGM

Modern practices of FGM

Reasons for the continued practice of FGM

Level of awareness about the ills of the practice

The role of adult literacy in the reduction of FGM.

The study employed the survey research design and used oral interview as well as open and close-ended questionnaire items in collecting data which was analysed using simple percentage and frequency counts.

From the analysis of the data, the study found that prevalence of female genital mutilation has declined over the years. The younger generations are less circumcised than the older generation which is not unconnected to the rise in adult literacy and awareness programmes over the years. Level of education has been seen as significant factor regarding people's opinions of female circumcision. Results show that as educational level increases, support for the practise decreases.

The study found that:

- FGM is still being carried out though clandestinely among the older generation. It is however on a decline among the younger generation due to the influence of education.
- There is awareness about the practice among the people but little awareness about the ills of the practice as well as the legal implications of mutilating their children.
- Literacy has helped to reduce the incidences of FGM to a large extent. Especially as a result of media sensitization via radio and TV programmes.
- The socio economic damages caused by FGM included HIV, tetanus, infections, urinary tract diseases, low sexual gratifications in marriage, etc. do not just have financial effects but bears lasting psychological effects
- Literacy is key in reducing the procedure and so must be encouraged especially adult and non-formal education.

Conclusion

In conclusion, female genital mutilation is very inimical to the reproductive, social, economic, physical and psychological health of women and should be strictly prohibited not only in Nigeria but throughout the world. In addition, hospitals, government and non-governmental organizations should draw up health programmes of activities targeted at informing, educating and communicating the dangers of female genital mutilations to the rural dwellers. Government and non-governmental organizations should through conferences, seminars and workshops; educate the parents (especially women) of child bearing age on the danger of female genital mutilation and the possible legal sanctions. School authorities should advice women accordingly on the consequences of female genital mutilation. The Federal, state and local governments should set up a body to monitor the enforcement of the laws that will prohibit female genital mutilation in the communities where it is still being practiced. Finally, women leaders should organize interactive sessions during their meeting days, like August meetings and educate women on risks associated with female genital mutilation.

Recommendations

The following suggestions have been recommended for the prevention and possible eradication of the practise;

- Acquisition of non-formal education should be encouraged so as to eliminate the social and cultural beliefs attached to FGM due to ignorance. Combatting FGM should be part of the curriculum.
- Laws prohibiting FGM should be made known and available in local languages for the indigenes to imbibe and internalise as this would make the reality of the violation clearer and more relatable.

- Nigeria is a highly patriarchal nation so involving the men in the campaign against FGM would go a long way in eradicating the procedure as they are the major decision makers. It is therefore recommended that sensitization of the male should become a priority for anti-FGM campaigns.

- Most people who disagreed that FGM bears many bodily harm have a greater probability of circumcising their daughters. They should be encouraged to seek medical counsel.
- The education of the girl child will go a long way in eradicating FGM. Therefore government should make adequate provision for educational equality among the sexes in rural communities by subsidising education at the grassroots and nurturing the progress so as to bridge the gap between the genders.
- Government should liaise with media houses to ensure that campaign against female genital mutilation becomes a continuous exercise in line with the maxim “repetition strengthens memory”. Community leaders should be enjoined to learn as much as possible about the subject of FGM so they can influence members of their community to discard the practice and embrace other healthy practices.

Suggestion for further studies

Egor local government is only one in 18 local government areas in Edo State. It is therefore suggested that this study be expanded to cover all the local government area. And efforts being made to ensure effective implementation of the laws prohibiting FGM in the state should be variable of interest.

DEPARTMENT OF ADULT AND NON-FORMAL EDUCATION

FACULTY OF EDUCATION

UNIVERSITY OF BENIN, BENIN CITY, EDO STATE.

QUESTIONNAIRE

The researcher is a final year student of the above named institution carrying out a research on the role of adult literacy in the reduction of Female Genital Mutilation.

You are please requested to carefully answer the question as you think appropriate.

This questionnaire is purely for academic purpose and any information given will be appreciated and treated in strict confidence.

Please tick in the boxes ( ) or fill in the gaps (__) as appropriate.

SECTION A

1. Age: 15 – 20 ( ), 21 – 25 ( ), 26 – 30 ( ), 31 – 40 ( ), 40 and above ( )
2. Marital status: single ( ), married ( ), divorced ( ), others, specify _____
3. Educational status: no formal education ( ), primary ( ), secondary ( ), tertiary ( )
4. Religion: Islam ( ), Christianity ( ), African Traditional Religion ( ), others_____

SECTION B

5. Have you heard of the term Female Genital Mutilation? Yes ( ), no ( )
6. Have you been circumcised? Yes ( ), no ( )
7. When was it done? Infancy ( ), childhood ( ), teenage years ( ), before or after pregnancy ( ) never ( )
8. Do you know anyone who has been circumcised? Yes ( ), now ( )

	Agreed	Strongly agreed	Disagreed	Strongly disagreed
9. Literacy has made people aware that Female Genital Mutilation has no bodily/social benefit to the child				
10. Literacy has made ardent supporters of Female Genital Mutilation to embrace medical alternatives				

11. Literacy has provided an avenue for people to balance traditional values with knowledge				
12. Female Genital Mutilation has done more bodily damages than good				
13. Female Genital Mutilation increases chances of compilations during childbirth				
14. HIV and other blood related infections can be contracted through Female Genital Mutilation				
15. Treatment of the effects of Female Genital Mutilation is expensive				
16. Media sensitization and other non-governmental campaigns help in preventing Female Genital Mutilation				
17. Imprisonment and other appropriate legal sanctions against Female Genital Mutilation have been effectively implemented				

18. What other preventive measures can be put in place? _____

DEPARTMENT OF ADULT AND NON-FORMAL EDUCATION

FACULTY OF EDUCATION

UNIVERSITY OF BENIN, BENIN CITY, EDO STATE.

QUESTIONNAIRE

The researcher is a final year student of the above named institution carrying out a research on the role of adult literacy in the reduction of Female Genital Mutilation (FGM).

You are please requested to carefully answer the question as you think appropriate.

This questionnaire is purely for academic purpose and any information given will be appreciated and treated in strict confidence.

Please tick in the boxes ( ) or fill in the gaps (__) as appropriate.

SECTION A

1. Age: 15 – 20 ( ), 21 – 25 ( ), 26 – 30 ( ), 31 – 40 ( ), 40 and above ( )
2. Marital status: single ( ), married ( ), divorced ( ), others, specify _____
3. Educational status: no formal education ( ), primary ( ), secondary ( ), tertiary ( )
4. Religion: Islam ( ), Christianity ( ), African Traditional Religion ( ), others_____

SECTION B

5. Do you support Female Genital Mutilation? Yes ( ), no ( )
6. Would you subject your daughter to Female Genital Mutilation? Yes ( ), no ( )
7. What influences your decision? Culture/tradition ( ), religion ( ), fear of stigmatization ( )
8. Do you agree that Female Genital Mutilation has no health/bodily benefit to the girl child? Yes ( ), no ( )
9. Female Genital Mutilation should be legalised in Nigeria. Agree ( ), strongly agree ( ), disagree ( ), strongly disagree

References

Abdi MS (2007). *A religious oriented approach to addressing FGM/C among the Somali community of Wajir*. Nairobi, Population Council

Adeokun LA, Oduwole M, Oronsaye F, Gbogboade AO, Aliyu N, Wumi A, Sadiq G, Sutton I, Taiwo M (2006). In Trends in female circumcision between 1933 and 2003 in Osun and Ogun States, Nigeria (a cohort analysis**).** Afr. J. Reprod. Health. 10(2):48-56.

Adjetey FA (2005). Female Genital Mutilation: Tradition or Torture. In Bond J, ed. Voices of African Women; Women's Rights in Ghana, Uganda and Tanzania. USA: Carolina Academy Press.Ch 2.

Akinpelu, J.A. (2002). *Philosophy and Adult Education*. Ibadan: Sterling-Horden Publishers (Nig.) Ltd.

Almroth L, Almroth-Berggren V, Hassanein OM., Al-Said SSE, Hassan SSA, Anuforo PO, Oyedele L, Pacquiao DF (2004). Comparative study of meanings, beliefs, and practices of female circumcision among three Nigerian tribes in the United States and Nigeria. J. Transcult Nurs15 (2):103-13.

Assembly of the African Union (2003). Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. Adopted by the 2nd Ordinary Session of the Assembly of the Union, Maputo,11 July 2003. Available at: http://www.achpr.

Bosch, X. (2006). Female genital mutilation in developed countries: *Lancet*, 358: 1177-9

Brewer DD, Potterat JJ, Roberts JM, Brody S (2007). Male and female circumcision associated with prevalent HIV infection in virgins and adolescents

Caldwell, J.C., Orubuloye, I.O. and Caldwell, P. (2005). Female genital mutilation: Conditions of decline. *Population Research and Policy Review* 19(3): 233-254.

Chege JN, Askew I, Liku, J (2001).An Assessment of the alternative rites approach for encouraging abandonment of Female Genital Mutilation in Kenya. FRONTIERS in Reproductive

Dare FO, Oboro VO, Fadiora SO, Orji EO, Sule-Odu AO, Olabode TO (2004). Female genital mutilation: an analysis of 522 cases in South- Western Nigeria. J. Obstet. Gynaecol. 24(3):281-283

Egwatu V, and Agusa N. (2004). Complications of female circumcision in Nigerian Igbos. *Br J Obstet. Gynecol.* 88: 1090-1093 (Abstract).

Ezimah, M. O. A. (2004). *Knowing Adult Education: Its Nature, Scope and Processes*. Owerri: Springfield Publishers Ltd.

Fathalla, M.F. (2005). From Obstetrics and Gynecology to women's health: The Road Ahead. New York: Parthenon, 201.

Federal Republic of Nigeria (2004). *National Policy on Education*. Lagos: NEDRC.

Gillis, N., 2004. Genital Mutilation, Which way Out. New Nigeria, pp: 20. Health Organisation (WHO), 2010. Fact sheet Nº241.

Gruenbaum, E. (2004). *The female circumcision controversy. An anthropological perspective.* Philadephia, Pennsylvania; University of Pennsylvania Press. Long, J.

Health.http://www.popcouncil.org/pdfs/frontiers/FR-_final Reports/kenya_FGC.pdf

Hinzen, H. (2006). "*Resourcing for Quality: Adult Literacy Learning".* In Hinzen H. (ed.) Adult Education and Development. 66(45-64).

Holy Bible Genesis 17 9-14 Circumcision, the Sign of the Covenants
http://www.tradingeconomies.com/nigeria/literacy-rate-adult-make-percent-ofmales-ages-15-andabove-webdata. htmol. Retrieved 29/10/2012.
http://www.unesco.org/education/efareport In Association for the Development of Education in African Newsletter, 15(2-3), 10.
in Africa from a regional to a specific Nigerian examination. Soc. Sci. Med. 44(8): 1181-1193
Jalal, F. & Sardjunani, N. (2006). "Increasing Literacy in Indonesia". In Adult Education and Development. 67(131-158).
Nwafor, N.H.A. (2009). *An Introduction to History of Education*. Port Harcourt: Dot Solutionz Printers & Publishers.
Nwafor, N.H.A. (2011). A *Handbook on Policy and Design*. Port Harcourt: Dots Solutionz Printers & Publishers.
Nzeneri, I. S. (2010). *Adults in Battle: Any Hope of Victory?* Inaugural Lecture; University of Port Harcourt.
Obanya, P. (2004). *The Dilemma of Education in Africa*. Ibadan: Heinneman Educational Books (Nig.) Plc.
Obermeyer, C. (2002). Female genital surgeries: The known, the unknown and the unknowable. *Medical Anthropology Quarterly*, 13(1): 79-105.
org/english/_info/women_en.html (accessed on 16 October 2007).
Osokoya, I. O. (2008). *Contemporary Issues in Educational History and Policy in Nigeria.* Ibadan: Laurel Educational Publishers Ltd.
Oyugi, C. (2007). Social cultural factors that promote female circumcision and how this predisposes women to HIV infection. (Abst. 60067) Inter. Conf. On AIDS; 12: 1011. [NLM Gateway].
Programme for the International Assessment of Adult Competencies (2006). http:www.oeed.org/ educationaeconomyandsociety/adultliteracy.htm.
Shell-Duncan, B. and Hernlund. Y. (eds), (2005). Female circumcision in Africa. Boulder, Colorado: Lynne Reinner Publishers, Inc.
UNESCO (2003). Education For All. Retrieved 29/10/2012.
UNESCO (2005). *"Education For All Goals and Millennium Development Goals*". Site internet de l'UNESCO, www.unesco.org/education/efa/fr
World Bank Report (2010).
World Health Organization (WHO). (2011). *Female genital mutilation: Information kit. Geneval*: WHO.