ATTITUDE OF MOTHERS AND FEMALE SECONDARY SCHOOL STUDENTS TOWARDS FEMALE GENITAL MUTILATION IN IKA NORTH EAST LOCAL GOVERNMENT AREA OF DELTA STATE, NIGERIA

OZURI RACHAEL
Department of Guidance and Counselling
Delta State University, Abraka, Nigeria.
E_Mail: rachael.britney@yahoo.com

Abstract

The study assessed the attitude of mothers and female secondary school students towards female genital mutilation in Ika North East Local Government Area of Delta State. Three research questions were raised and three hypotheses formulated and were tested at a 0.05 level of significance. This was a descriptive survey design. Two hundred sample size was used for the study with 100 students and 100 female teachers were randomly selected from across secondary schools in Ika North East Local Government Area of Delta State using a multi-stage sampling technique. A validated instrument titled the Female Genital Mutilation Attitude Survey Scale (FGMASS) adapted and modified by the researcher was used to gather information for the study. The instrument was content validated by experts. The reliability of the instrument was determined using the Pearson product-moment correlation coefficient with an alpha value of 0.79. Data collected was analyzed using t-test statistics of independent sample and Analysis of Variance (ANOVA). The analysis yielded the following results: that there is no significant difference in the different ages of mothers and their attitude towards female genital mutilation, that there is no significant difference in the educational attainment of mothers and their attitude towards Female Genital Mutilation was rejected and that there is no significant difference between mothers and female secondary school students in their attitude towards female genital mutilation was rejected. Based on the findings of the study, the following recommendations were made among others: Actions must be taken to prevent and reduce the unacceptable practice of female genital mutilation in our society, women should be given the privilege for proper academic coachings such as the acquisition of *literacy skills or pre-employment training lectures. Women should also be allowed to play a vital role in female genital mutilation and as such programmes of activities should be circulated in all the various groups in the communities to avoid bias, chaos and crisis.*

Keywords: Adolescent Females, Female genital mutilation, Attitudes.
DOI: https://doi.org/10.35386/ser.v20i1&2.438

Introduction

In many societies, an important reason given for female genital mutilation is the belief that it reduces a woman's sexual desire and hence reduces the chance of sex outside marriage. Female genital mutilation has a socio-cultural influence. It influences lifestyle and behaviour. 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 (Rahman &Toubia 2000). Among the Urhobo's and Ketu-Yoruba's of southwestern Nigeria, female genital mutilation is done just before marriage as a fertility rite. The excised part is sacrificed to the ancestors who then give blessings of fertility. When done in the first pregnancy by some Yoruba's and Eastern Ukwuani tribe it is to prevent contact of the baby's head with the clitoris which is believed to cause the death of the baby during childbirth (Mandara, 2004).

Female genital mutilation (FGM) refers to the process involving the partial or the elimination of the female genital organs for natural or non-therapeutic purposes (Okonofua, Larsen, Oronsaye, Snowand&Slanger,2002*).* World Health Organization (2002) defines female genital mutilation to mean the course of action involving fragmentary or the evacuation of the outer female genitalia or any injury to them for religious and non-medical reasons. There are no health well-being for Female Genital Mutilation. It involves eliminating and destroying healthy and usual female genital tissue and obstructs the natural functions of the females' bodily parts. In the olden days, Female Genital Mutilation is performed using different tools like razor blades, daggers and knives, and most times they don't use painkillers. It was approximated that 18% of all Female Genital Mutilation is done by doctors, nurses and other healthcare providers, who use surgical scissors, knives and narcotics. All the different methods of Female Genital Mutilation can result in immediate bleeding and pain which are associated with the risk of infections and other health challenges.

Female genital mutilation is a global phenomenon and its prevalence cut across 28 African countries and few selected communities in different parts of the world. This problem is considered as one of the most dreadful forms of violence against the girl child/woman. Despite the numerous dangerous consequences of female genital mutilation and the fact that this archaic practice has no place in modern civilization, evidence has shown that it is popular in Nigeria, particularly in the rural areas where the population consist mainly of illiterates.

Female genital mutilation lies deep within the tradition and cultural heritage, also it is often wrongly believed that it has a religious origin or to be a requirement of certain religious rites which is not the case. There is a belief that in most societies and cultures, female genital mutilation helps to maintain the virginity of women before marriage and ensures faithfulness during the marriage. Other common beliefs include hygienic factors, aesthetically pleasing and increased fertility. For many women, when it comes to social integration and disfiguring process, it is accepted in return for benefits such as the promise of acceptance in society and the improved prospect of marriage. For instance, the aged women often believe they have gained from Female genital mutilation and that it has been important to their prestige and for that reason they allow it to be performed on their daughters due to the fear of social isolation and stigmatization.

The general policy of Female genital mutilation is carried out by an orthodox circumciser like a chief princess, old women among others, but increasingly trained health providers, such as medical doctors or nurses, are also doing it. This process is referred to as the medicalization of Female genital mutilation, which has become a major concern for the WHO and many anti-Female genital mutilation activists. The WHO warned that under no circumstances should health personnel carry out Female genital mutilation, regarding it as unethical of the medical rules and regulations of "Do no harm". Shell-Duncan (2001) opined that there is also phobia that medicalization might legitimize the practice, giving it the appearance of being beneficial, and hence rolling back the gains made in the elimination of Female genital mutilation.

The World Health Organization (2008) and the United Nations Commission on Human Rights (2010), along with several African and Asian nations and anti-female

genital mutilation groups, have called for an end to the practice of Female genital mutilation. The WHO observes the exercise as a brutal act against a girl that causes her serious lifetime challenges and brings about the traumatic experience. The American Medical Association (2017) also speaks against Female genital mutilation and encourages laws against it. Presently there is increasing global support for criticizing Female genital mutilation and a call for severe punishment given to those who execute it.

World Health Organization (2000), has classified Female genital mutilation into four types.

Type I: Excision of the prepuce with or without excision of part or the entire clitoris.
Type II: Excision of the clitoris with partial or total excision of the labia minora.
Type III: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).
Type IV: Unclassified: Includes pricking, piercing or incision of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissues; scraping of the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding, and any other procedure that falls under the definition of female genital mutilation given above.

One of the familiar types of female genital mutilation is type 2 which reported 80% of all cases while the greatest type is type 3 which comprises about 15% of the total procedures. It was also estimated that Types 1 and 4 of Female genital mutilation account for the remaining 5%. The effects on the general well-being of the individual vary according to the type of Female genital mutilation and the seriousness of the procedure (Onuh *et al*., 2006).

Statement of the Problem

It has been observed by many medical practitioners that female genital mutilation poses a lot of health hazards and health complications to the girl child or woman besides its social and moral effects. The Consequences of Female genital mutilation is a growing health problem in practising communities and western countries.

Female genital mutilation is a potential financial burden to health systems. A study based on data from six African countries found that costs associated with the medical management of obstetric complications resulting from Female genital mutilation were equivalent to0.1–1% of total government spending on women of reproductive age. For some girls and women, the experience of genital mutilation and its effect on them psychologically is comparable to the experience of rape. The experience of genital mutilation has been associated with a range of mental and psychosomatic disorders. For example, girls have reported disturbances in their eating and sleeping habits, and mood and cognition. As they grow older, women may develop feelings of incompleteness, loss of self-esteem, depression, chronic anxiety, phobias, panic or even psychotic disorders. Girls who have not been excised may be socially stigmatized, rejected by their communities, and unable to marry locally, which may also cause psychological trauma. Pain or discomfort during sexual intercourse can trigger memories of the original practice. Some continue to experience profound

emotional and physical pain secondary to coitus which may lead to sexual inhibition and frigidity. (Ibekwe, 2004)

The various forms of female genital mutilation have conveyed so many dangers of destructive health effects. Nearly all the females who have gone through the procedure encounter chronic pains and bleeding (Khosla, Banerjee, Chou, Talle, & Shell-Duncan 2017). Urgent health problems include bleeding, social phobia, trauma, and infection which can also lead to increase mortality rate, premature death, disability, miscarriage, stillbirth, sexually transmitted disease, bacterial infections (tetanus or sepsis) during and after pregnancy, and increased risk of newborn deaths(Khosla *et al* 2017).

Higher incidences of caesarean section and post-partum haemorrhage were found in the women with Type I, II and III genital mutilations compared to those who had not undergone genital mutilation, and the risk increased with the severity of the procedure. The study showed that genital mutilation of mothers has negative effects on their newborn babies. Most seriously, death rates among babies during and immediately after birth were higher for those born to mothers who had undergone genital mutilation compared to those who had not: 15% higher for those whose mothers had Type I, 32% higher for those with Type II and 55% higher for those with Type III genital mutilation. It was estimated that, at the study sites, an additional one to two babies per 100 deliveries die as a result of female genital mutilation. The consequences of genital mutilation for most women who deliver outside the hospital setting are expected to be even more severe (WHO Study Group on Female Genital Mutilation and Obstetric Outcome, 2006).

Despite overwhelming evidence from science that Female genital mutilation causes serious problems to women's health, it is still widely practised in Ika North East Local Government Area. This study is intended to investigate the attitude of mothers and female secondary school students towards female genital mutilation and to find out the attitude of female secondary school students which constitute the rising population of would-be mothers in Ika North East Local Government Area of Delta State.

Objectives of the Study

The main objectives of this study are to:

1. find out the attitude of mothers and that of female secondary school students towards female genital mutilation in Ika North East Local Government Area of Delta State.
2. compare the attitude of both mothers and female secondary school students
3. to find out if there is any difference between the two cross-sectional samples to predict whether this culture is persistent or fading out.

Research Questions

The following research questions were raised to guide the study

1. Is there a relationship between the age of mothers and their attitude towards Female Genital Mutilation?

2. Is there a relationship between the educational attainment of mothers and their attitude towards Female Genital Mutilation?
3. Is there a significant difference between the attitude of mothers and that of female secondary school students towards Female Genital Mutilation?

Hypotheses

The following hypotheses were formulated and tested at 0.05 alpha level of significance

H_{O1} There is no relationship between the age of mothers and their attitude towards Female Genital Mutilation.

Ho_2 There is no relationship between the educational attainment of mothers and their attitude towards Female Genital Mutilation.

H_{O3} There is no significant difference between the attitude of mothers and that of female secondary school students towards Female Genital Mutilation.

Design of the Study, Population of the study and Sample and Sampling Techniques
The design of this study was a cross-sectional descriptive survey research design. This research design was suitable because the researcher intends to compare two groups from which the result will be generalized. The population of this study comprises all parents and female secondary school students in Ika North East L.G.A. of Delta State.

A sample size of 200 (Two hundred) respondents was selected for the study. The multi-stage sampling technique was adopted. Stratified random sampling technique was used to select 5 schools where 100 female students were randomly selected from the 5 sampled public senior secondary schools in Ika North East L.G.A using a simple random sampling technique by balloting with replacement. 20 female students were randomly selected each from the 5 sampled schools used for the study.

The sample of parents was drawn using the stratified random sampling technique. The stratification was based on location in rural or urban areas. A sample size of 100 (one hundred) parents was used. The researcher randomly selected fifty (50) respondents from each group until the required sample size of One hundred (100) was attained.

Method of Data Collection, Instrument and Administration of the Instrument

The instrument that was used to collect data for this study is an adapted Questionnaire titled the Female Genital Mutilation Attitude Survey Scale (FGMASS). The instrument was adapted from the work of Ismail, (2009) and modified by the researcher. The Questionnaire is made of two sections, Section A and Section B. Section A enabled the collection of Bio-data while Section B enabled the collection of the opinion of respondents about the attitude of students and female teachers towards the practice of female genital mutilation. The items on the research instrument were raised on a four (4) Likert scale on the degree of agreement and disagreement with the statement or questions in the questionnaire. The scale on Female Genital Mutilation Attitude Survey Scale (FGMASS) was based on strongly agree 4 points, Agree 3 points, Disagree 2 points and Strongly disagree 1 point, in response to the questions on the questionnaire. Questionnaires were checked against the available options by the respondents as applicable to them. The instrument of data collection which is the

questionnaire was content validated by the researcher and two other experts in the department of educational evaluation and counselling psychology, university of Benin.

The reliability of the instrument was determined using the test-retest method to determine the internal consistency of the instrument. Using this method. Copies of the questionnaire were administered to 20 subjects who were not part of the population of the study to avoid pre-knowledge of items in the final work. After two weeks the instrument was administered to the same sample. Data collected were analyzed using the Pearson Product Moment Correlation Co-efficient with an alpha value of 0.79 was obtained hence, the instrument is considered reliable for the study.

The researcher administered copies of the questionnaires with the help of six (6) research assistants who were specifically trained by the researcher for the purpose. Six research assistants were engaged due to the size of the sample and the number of secondary schools that were covered in Ika North Local Government Area of Delta State. The researcher ensured that the purpose of the exercise was written on the questionnaire to facilitate the exercise. The researcher and her assistants took permission from the principal or heads of then schools thereafter met the respondents in their various classes. the purpose of the research was explained to the students and their cooperation in responding to the copies of the questionnaire solicited. The questionnaire was however administered, and all the copies of the questionnaire were collected the same day. This was to ensure the copies of the questionnaire are properly filled and returned.

Method of Data Analysis

The following statistical tools were used to analyze the data collected: t-test statistics of independent samples and Analysis of Variance (ANOVA) were used to test the hypotheses at 0.05 level of significance.

Findings

The first research hypothesis was interested in finding if there is no significant difference between the age of mothers and their attitude towards female genital mutilation. The table below summarizes the data gotten from the participants on this research hypothesis.

Table 1: ANOVA showing differences between ages of mothers and their attitude towards female genital mutilation.

Sources of variance	Sum of square	df	Mean square	Cal. F. value	p.value
Between	63.049	2	31.125	313	2.21
Within	38113.228	197	100.563		
Total	38176.278	199			

Table 1: shows there is no significant difference between the different ages of mothers and their attitudes towards female genital mutilation. The calculated F value of .313 is less than the P. value of 2.21 at 0.05 level of significance. The null hypothesis which states no significant difference in the different ages of mothers is therefore accepted.

The second research hypothesis was interested in finding if there is no significant difference in the educational attainment of mothers and their attitude towards female genital mutilation.

Table 2: ANOVA showing the difference in the educational attainment of mothers and their attitude towards female genital mutilation.

Sources of variance	Sum of square	df	Mean square	Cal .F. value	P-value
Between	143.02	2	71.15		
Within	8552.20	197	13.64	5.24	3.00
Total	8692.22	199	85.15		

P<0.05

Table 2: shows that F-value (5.24) is significantly higher than the p-value (3.00) at 0.05 level of significance. There is therefore a significant difference in the educational attainment of mothers and their attitude towards female genital mutilation. The null hypothesis which a no significant difference in the educational attainment of mothers and their attitude towards female genital mutilation is therefore rejected.

The third research hypothesis was interested in finding if there is no significant difference between the attitude of mothers and female secondary school students towards female genital mutilation.

Table 3: T-test of the independent sample of the difference between the attitude of mothers and female secondary school students towards female genital mutilation.

Attitude	N	Mean	SD	df	P	t-cal	t-tab
Mothers	68	13.79	6.11	166	0.05	3.75	1.96
Secondary school students	100	21.11	7.31				

Significant at 0.05

Table 3: shows the mean difference between the attitude of mothers and female genital mutilation. The table reveals mothers mean score of 13.79 and female secondary school students mean score of 21.11 with a degree of 166. It shows a t-cal value of 3.75 higher than the t-tab value of 1.96. therefore, the null hypothesis which states that there is no significant difference in the attitude of mothers and female secondary school students towards female genital mutilation was rejected this implies that there is a significant difference in the attitude of mothers and female secondary school students towards female genital mutilation.

Discussion of Findings

Hypothesis one revealed that there is no significant difference in the different ages of mothers and their attitude towards female genital mutilation. This finding is in line with the findings of WHO (2000) who opined that female genital mutilation is usually performed before or after fifteen (15) years of age and considers it a form of violence against women especially as it is often done without their consent and results in many

complications. As age increased, the proportion of respondents and their daughters who had undergone Female Genital Mutilation increased.

Hypothesis two, which states that there is no significant difference in the educational attainment of mothers and their attitude towards Female Genital Mutilation was rejected this may be because civilization, orientation and awareness has helped to influence mothers' attitude towards Female Genital Mutilation. This finding is however supported by Rahman and Toubia (2000) that many people continue female genital mutilation because it is part of the societal norm handed down by their mothers and grandmothers and any attempt to discontinue the practice met with societal pressure and risk of isolation.

Hypothesis three, which states that there is no significant difference between mothers and female secondary school students in their attitude towards female genital mutilation was rejected. This could be because both mothers and female secondary school students have a different attitude towards Female Genital Mutilation. This finding is however in line with the findings of Klouman, Manogi and Klepp (2005) that female genital mutilation affects the relationship between the girl and her parents and may also affect her ability to form intimate relationships in the future even perhaps with her children.

Conclusion

This study has been able to x-ray the comparative attitudes of mothers and female secondary school students towards female genital mutilation in Ika North-East Local Government Area of Delta State. It was however concluded that there is no significant difference in the different ages of mothers and their attitude towards female genital mutilation, that there is a significant difference in the educational attainment of mothers and their attitude towards Female Genital Mutilation and that there is a significant difference between mothers and female secondary school students in their attitude towards female genital mutilation

Recommendations

Actions must be taken to prevent and reduce the unacceptable practice of female genital mutilation in our society.

Professionals in schools including teachers and school nurses have the most regular and ongoing interaction with young people outside of their homes. They are in the best position to detect the warning signs that a girl may be at risk of female genital mutilation or has already undergone the procedure. School staff must have an awareness of these indicators and know when to refer the matter to children's social care and the police. Headteachers and child protection officers, where they have not already done so, undergo compulsory safeguarding training which specifically deals with female genital mutilation. Teachers and students must have an opportunity to discuss issues such as female genital mutilation, especially where a proportion of the school population may come from a practising committee.

Empowering activities for women include, for instance, proper educational sessions such as literacy training or pre-employment training sessions. Even though women

play a central role in the practice of female genital mutilation, activities must reach all groups in the communities to avoid misunderstanding and to lead to intra-group dialogue.

Traditional, religious and Government leaders, Parliamentarians and civil society organizations must be engaged in the campaign against female genital mutilation. Promoting the decision to abandon female genital mutilation includes national activities that bring the practice into public discussion and debate. The media can play a crucial role both in bringing correct information to households and people about positive social change to stop the practice of female genital mutilation.

References

American Medical Association. Expansion of AMA policy on female genital mutilation H-525.980. Chicago (IL): AMA; 2017. Available at: https://policysearch.amaassn.org/policyfinder/detail/female%20genital%20mutilation?uri=%2FAMADoc%2FHOD.xml-0-4716.xml.RetrievedMarch 29, 2019.

Ibekwe P. (2004). Physical and Psychological consequences of female genital mutilation: A case report. Niger. J. Med., **13** (3): 293-294

Ismail, E. (2009). *Female Genital Mutilation Surveying Somaliland*. The Edna Adan Maternity and Teaching Hospital, Hargeisa, Somaliland

Khosla R., Banerjee J., Chou D. Talle A. Hernlund Y., & Shell-Duncan, B. (2017). *Reproductive Health. Transcultural bodies:* Female genital cutting in global context. **1** (14). New Brunswick: Rutgers University Press; 2017. 2007. "Gender equality and human rights approaches to female genital mutilation: A review of international human rights norms and standards," p. 59."Female circumcision in Africa and beyond: The anthropology of a difficult issue," et al., p. (eds), pp. 91−106; World Health Organization (2008, see note 5. [PMC free article] [PubMed] [Google Scholar]

Klouman E, Manongi R. and Klepp, K. I. (2005). Self-reported and observed female genital Cutting in rural Tanzania: associated demographic factors, HIV and Sexually Transmitted infections. Trop. *Med. Intl. Health*, **10** (1): 105-115

Mandara, M. (2004).Female in Nigeria. *International Journal Gynaecology Obstetrics*. **84** (3): 291-298

Okonofua, F.E., Larsen, U., Oronsaye, F., Snow, R.C, & Slanger, T.E. (2002). The association between female genital cutting and correlatives of sexual and gynaecological morbidity in Edo State, Nigeria. *Br. J. Obstet. Gynaecol*., **109**: 1089–1096

Onuh, S. O., Igbarese, G.O, Umeora, O.U.J., Okogbenin, S.A., Ofoide, V.O. & Agariki, E.P.(2006). Female genital mutilation: Knowledge, Attitude and Practice Among Nurses. *J. Natl. Medscape*, **98** (3): 409–414

Rahman, A. & Toubia, N. (2000). Female Genital Mutilation: A Guide to Laws and Policies Worldwide. London: Zed Books

Shell-Dunca, B. (2000). Becoming a Muslim, becoming a person: Female circumcision, religious identity, and person-hood in Guinea-Bissau. *In female circumcision in Africa: Culture, Controversy and Change*. Eds. Shell-Dunca, Bettina & Yiva Hemlund. Boulder, CO. Lynne Rienner Publishers.

Shell-Duncan, B. (2008). From health to human rights: Female genital cutting and the politics of intervention. *American Anthropologist*, **110** (2): 225-236.

United Nations, Commission on the Status of Women, Ending Female Genital Mutilation, E/CN.6.2010/L.8 (54th Session, 1-12 March 2010). http://www.un.org/womenwatch/daw/beijing15/outcomes/L%208_FGM_Advance%20unedited.pdf. Accessed Feb/11th/2016.

WHO (2000).Female genital mutilation. Fact Sheet No 241, June 2000. Geneva, World Health Organization. At: http://www.who.int/mediacentre/factsheets/fs241/en/ (accessed 3 October 2007).

WHO Study Group on Female Genital Mutilation and Obstetric Outcome, "Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries", *The Lancet*, **367** (9525): 1835–1841, 2006.

WHO (2008). Eliminating female genital mutilation: An Interagency statement. (WHO, UNFPA, UNICEF, UNIFEM, UNHCHR, UNHCR, UNECA, UNESCO, UNDP, UNAIDS). Geneva: World Health Organization.

WHO/FCH/WMH/00.5. Report of the Special Rapporteur of the United Nations Sub-commission on Traditional Practices Affecting the Health of Women and the Children: E/CN.4/1986/42; E/CN.4/Sub.2/1989/42 and Add.1, and E/CN.4/Sub.2/1991/6