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ORIGINAL ARTICLE

INFLUENCE OF THE LOCATION OF MOTHERS AND FEMALE STUDENTS ON THEIR ATTITUDES TOWARDS FEMALE GENITAL MUTILATION: IMPLICATIONS FOR COUNSELLING

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Abstract

This study assessed the influence of the location of mothers and female students on their attitudes towards female genital mutilation in Delta State, Nigeria, and suggested some implications for counselling. The design was cross sectional descriptive survey research. Two aims were raised, with corresponding partial aims. The study population comprised of mothers and female secondary school students in Ika North East Local Government Area of Delta State. The instrument used for the study was a questionnaire entitled: "Female Genital Mutilation Attitude Survey Scale" (FGMASS), which was adopted and modified by the researchers. Data were analysed using the *t*-test. The results revealed that there was a significant difference in the attitude of mothers towards female genital mutilation in both urban and rural areas. However, there was no significant difference in the attitude of female secondary school students towards female genital mutilation in either urban or rural areas. Based on this, recommendations were made.

Keywords: *Attitude to genital mutilation; Female students; Mothers*

INTRODUCTION

Female genital mutilation/cutting (FGM/C), also known as female circumcision, is the partial or total removal of the external genital organs for non-medical reasons. The procedure is mainly performed as a cultural rite. Typically it includes the partial or total excision of the external genitalia, especially the clitoris and *labia minora* (Merriam-Webster Dictionary, 2019). FGM is a cruel procedure, and a cultural tradition that deprives women of sexual satisfaction, exposing them to psychological and physical complications. It reflects deep rooted inequality and constitutes extreme violation of the reproductive and human rights of women and girls (Azuonwu and Ezekiel, 2020). The set of procedures can be categorised into four major groups, according to their precise anatomical extent and ascending level of seriousness: Type I (clitoridectomy) refers to partial or complete removal of the clitoris or its prepuce; type II (excision) is the partial or complete removal of the clitoris and the *labia minora*, with or without excision of the *labia majora*; type III (infibulation) involves the narrowing of the vaginal opening through the creation of a covering "seal" formed by cutting and repositioning the inner or outer *labia*, with or without removal of the clitoris. Type IV includes all other damaging procedures to the female genitalia for non-medical reasons, including pricking, piercing, incising, scraping, and cauterization. The World Health Organization (2008) have stressed that the immediate complications of FGM/C include serious pain, haemorrhage (bleeding), urine retention, tetanus or sepsis (bacterial infection), shock, open

sores in the genital region and injury to nearby genital tissue. The future result could be frequent bladder and urinary tract infections, cysts, infertility, incontinence, an upsurge of risk in new-born deaths, and childbirth complications including fistula and the need for later surgeries.

In 2016, UNICEF estimated that about 200 million women and girls from 30 countries have been involved in FGM/C. Nigeria was listed as one of the four countries where two thirds of all women who have gone through FGM/C live. The three other countries were Egypt, Ethiopia, and Sudan. Despite optimism that a new law (Child's Rights Act, 2003) would prevent over 40 million Nigerian girls and women from the health complications of FGM/C, its enforcement and conviction of offenders for inflicting psychological trauma, bodily harm and encouraging health hazards among Nigerian women, in the name of circumcision or other traditional and cultural practices harmful to women's health, remains to be seen (Ifijeh, 2015). In Nigeria, 20 million girls and women are estimated to have undergone FGM, representing 10% of the global total (UNICEF, 2013; 2016). In many Nigerian communities, FGM/C is still forced upon girls and women, primarily by mothers and 'aunties' (Akosile, 2016) – which can be labelled as "women against women" (Edukugho, 2015). The human rights of girls and women are violated, and it causes serious and life-threatening health complications. FGM/C is "a harmful practice that leads to serious threat to the health of women and girls, including their reproductive, psychological and sexual health, which can raise their vulnerability to HIV and may have unfavourable obstetric and prenatal outcomes, as well as serious consequences for the mother and the new born. FGM/C is also acknowledged worldwide as a fundamental violation of the human rights of women and girls, reflecting deep-rooted inequalities between the sexes, and constituting a serious form of discrimination against women" (Okeke et al., 2012).

The effect of genital mutilation has been linked to a range of mental and psychosomatic disorders. These result in disturbances in mood, cognition, eating and sleeping habits. 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 and rejected by their communities, which can lead to their inability to marry locally – and in turn cause psychological trauma. The pain or discomfort experienced during sexual intercourse could also trigger memories of the original practice. Some continually experience sexual inhibition and frigidity because of the profound emotional and physical pain (Ibekwe, 2004). That is, mothers who had access to different kinds of mass media were more likely to have good knowledge, attitudes, and practice than mothers who had no access to any kind of mass media (Belda and Tololu, 2017). Although a federal law was passed in May 2015 banning FGM/C and other harmful traditional practices (HTPs), this Violence Against Persons Prohibition Act (VAPP) only applies to the Federal Capital Territory (FCT) of Abuja. Thirteen federation states already have similar laws in place, but there is variation in the passing and enforcement of laws, the improvement of which depends on state and federal police capacity and willingness.

Setegn et al. (2016) assessed the geographic variation and factors associated with female genital mutilation among reproductive age women in Ethiopia with variables like mother's age, religion, place of residence (urban versus rural), household wealth index, maternal education, and ethnicity, in connection with mothers and/or daughters' FGM/C experience. It was observed that there was a higher prevalence of FGM/C in rural geographical locations compared to urban locations. Similarly, Muchene et al. (2018) assessed knowledge and attitudes on the obstetric effects of female genital mutilation among Maasai women in the maternity ward at Loitokitok Sub-County Hospital, Kenya. 64 persons admitted to the maternity ward were interviewed on their knowledge of obstetric effects of FGM/C and their attitude towards the practice. The majority of them were from rural locations [78% (n = 50)] and urban 22% (n = 14). The findings established that most of the respondents [81% (n = 51)] had a negative attitude towards FGM/C. The study revealed that the majority believed that FGM/C did not make a woman feel more acceptable or happier. Most respondents considered the practice to have no tangible benefits; it was out-dated and had

outlived its usefulness. This showed that the attitude towards FGM/C was changing.

In Nigeria, it is assumed that FGM/C is more likely to occur in rural areas, which have high community ties and social norms having great influence on the people. However, according to the study by Nigeria Demographic and Health Survey (DHS, 2013), its findings revealed that girls under the age of 14 have almost the same prevalence of FGM/C as urban areas (16.8%) and girls in rural areas (17%). Although the possibility for older women to migrate between rural and urban areas must be considered, the aforementioned do suggest a significant decline in FGM/C being carried out on girls and women living in urban areas, while the situation has remained almost unchanged for those living in rural areas. The DHS (2013: 349) survey indicates that 32.3% of Nigerian women aged 15 to 49 living in urban areas have undergone FGM, compared to 19.3% of women living in rural areas. Thus, prevalence by current place of residence may not be a point of reference, as the woman might have moved since undergoing FGM/C, particularly if the cutting was performed at a young age. As such, it is more helpful to look at prevalence among young girls according to their place of residence (UNICEF, 2013: 37).

Rationale for the study

The researchers perceive FGM/C in Nigeria to be a reoccurring challenge for counselling psychologists, largely due to some beliefs that encourage this practice, including the presumption that it protects young women from extramarital relationships, the social influence of circumcision for marriage, that the uncircumcised vulva is perceived as unclean, and to avoid the death of new born infant. Religious reasons and monetary gains from the practice are considered additional factors. Another assumption is that FGM/C is more likely to occur among women in rural areas when compared to those in urban areas. It is presumed that this may be connected to community ties and traditions, which they say are stronger in rural areas and where social norms are more influential. FGM/C generates a tribal identity, especially in a multi-tribal country like Nigeria, where different tribes have different reasons and timing for female genital mutilation. The human rights perspective – which addresses the practice in terms of the right to be free from torture and cruel, inhumane, or degrading treatment, violation of rights of children and other person's right to health, security, and physical integrity – together with the health consequences, remains the dominant argument against FGM/C in Nigeria.

In Nigeria, the debilitating effects of FGM/C are evident and cannot be easily overcome without professional help. Skilled training and psychological assistance to increase awareness is needed, as well as helping victims to heal psychologically, and decreasing FGM/C in Nigeria. Studies on FGM/C exist, as it relates to the location of mothers and female students on their attitudes towards female genital mutilation. However to the knowledge of the researchers, there is a dearth in literature as it relates to the influence of mothers and female student's location on their attitudes towards female genital mutilation in Delta state, Nigeria the very essence for which this study was been carried out. Counselling psychologists and other specialists can use the results of this study as a guide in assisting clients who are victims of FGM/C.

Purpose of the study

To ascertain if there was any difference in the influence of the location of mothers and female students on their attitudes towards female genital mutilation in Delta State, Nigeria.

Limitations of the study

Interpreters were required to assist in translating some parts of the questions to the mothers, especially those from rural locations. This is due to the high prevalence of illiteracy.

Research questions

- Is there any difference in the attitude of mothers in urban and rural areas toward female genital mutilation?
- Is there any difference in the attitude of female secondary school students in urban and rural areas toward female genital mutilation?

Hypotheses

- There is no significant difference between the attitude of mothers in urban and rural areas toward female genital mutilation.
- There is no significant difference between the attitude of female secondary school

students in urban and rural areas toward female genital mutilation.

Ethical considerations

Ethics refers to a body of principles of right and good conduct, and assures the person responding to the questionnaire during a research study of his or her right to give information willingly; to be informed of the results; the right to seclusion and confidentiality; and not to be in a stigmatizing manner (Cohen and Swerdlik, 2010). Ethical clearance for this particular research was obtained as follows: the principals of the selected schools were informed, then teachers of the randomly selected students were instructed by the principals to assist the researchers in explaining the reasons for the consent forms to the students – this was to improve the students confidence with regard to confidentiality, after which consent letters were signed by the recipients and returned to the researcher. The consent letters were sent to their parents too, while the consent letters signed by parents were returned to the researchers through the teachers, providing consent for their wards to participate in the study. Before questionnaires were administered, consent of the mothers involved in the study was also sought.

MATERIALS AND METHODS

We used a cross-sectional descriptive survey design. This was considered suitable because it compares two groups of a sample of the population, i.e., mothers and female secondary school students, from which the results can be generalized. The study population comprised mothers and female secondary school students in Ika North East Local Government Area (L.G.A) of Delta State. Ten public secondary schools in the L.G.A were randomly selected using stratified random sampling technique based on the location, i.e., rural and urban areas. Five public secondary schools from each location and twenty respondents from each school made a total sample size of two hundred female students. The sample of the mothers was drawn using the same stratified random sampling techniques based on location, i.e., rural and urban. Then random sampling was used to select one hundred respondents from each group until the required sample size of two hundred was attained. However, at the point of analysis some of the questionnaires were discarded.

The instrument used for the study was a questionnaire entitled Female Genital Mutilation Attitude Survey Scale (FGMASS), adopted from Ismail (2010) and modified by the researchers. The questionnaire is divided into two sections, A and B. Section A contains personal data and section B twenty-four items to ascertain the respondents' opinion, i.e., the responses of mothers and female secondary school students to the practice of female genital mutilation. The research instrument went through both face and content validation. This was achieved via a series of amendments made by experts in the field of counselling psychology, and one from measurement and evaluation. Pearson's Product Moment Correlation Coefficient (r) was applied in determining the reliability consistency between a set of scores from twenty respondents who were not part of the sample. An r-value of 0.82 was obtained, indicating that the instrument was highly consistent and reliable. A t-test of an independent sample was used in testing.

RESULTS

There is no significant difference between the attitude of mothers in urban and rural areas toward female genital mutilation.

Table 1 shows a calculated t-value of 3.16, and a t-value of 1.96 testing at 0.05, alpha level of significance. As the t-calculated value of 3.16 is greater than the alpha level of 0.05, the partial aim, which states that there is no significant difference between the attitude of mothers in urban and rural areas toward female genital mutilation, was rejected. This implies that there was a significant difference between the attitude of mothers toward female genital mutilation in urban and rural settlements in Ika South Local Government Area of Delta State, Nigeria.

There is no significant difference between the attitude of female secondary school students in urban and rural areas towards female genital mutilation.

Table 1 – *T*-test of independent sample of difference between the attitude of mothers in urban and rural areas towards female genital mutilation

Location	*N*	Mean	SD	Df	*t*-cal	*t*-tab
Mothers in urban areas	75	11.57	5.23	166	3.16	1.96
Mothers in rural areas	93	19.09	6.43			

Note: α – 0.5.

Table 2 shows a calculated *t*-value of 0.35, and a *t*-value of 1.96 testing at 0.05, alpha level of significance. As the *t*-calculated value of 0.35 is lesser than the alpha level of 0.05, the partial aim, which states that there is no significant difference between the attitude of female secondary school students in urban and rural areas toward female genital mutilation, was retained. This implies that there is no significant difference between the attitude of female secondary school students towards female genital mutilation in urban and rural areas in Ika South Local Government Area of Delta State, Nigeria.

Table 2 – *T*-test of independent sample of difference between the attitude of female secondary school students in urban and rural areas towards female genital mutilation

Location	*N*	Mean	SD	Df	*t*-cal	*t*-tab
FSSS Urban	133	19.35	6.31	166	0.35	1.96
FSSS Rural	35	19.41	7.16			

Note: α – 0.5.

The results from this study revealed a significant difference between the attitude of mothers towards female genital mutilation in urban and rural areas (in Ika South Local Government Area of Delta State, Nigeria). This lends credence to the earlier assumptions raised by the researchers that FGM/C was more likely to occur among women in rural areas, where community ties and traditions were stronger and social norms more influential – as revealed in the mean score differences. The study also revealed no significant difference between the attitude of female secondary school students in urban and rural areas towards female genital mutilation (in Ika South Local Government Area of Delta State, Nigeria).

DISCUSSION

The findings showed a significant difference between the attitude of mothers toward female genital mutilation in both urban and rural areas in Ika South Local Government Area of Delta State. This is in agreement with the studies of Setegn et al. (2016), who assessed Geographic Variation and Factors Associated with Female Genital Mutilation among Reproductive Age Women in Ethiopia, and observed a higher prevalence of FGM/C in rural geographical locations when compared with urban locations. The researchers are of the opinion that the reason for the more likely occurrence in rural areas may be connected to the high community ties and social norms which have great influence on the people when compared to those in the urban areas.

The study of Muchene et al. (2018) on the Knowledge and Attitude on Obstetric Effects of Female Genital Mutilation among Maasai Women in a Maternity Ward at Loitokitok Sub-County Hospital, Kenya – showed that the majority of respondents [81% (n = 51)], had a negative attitude towards FGM/C, as majority of the women believed that FGM/C did not make a woman feel more acceptable or happier. However, the researchers are of the opinion that this may be connected to the recent upsurge in exposure to mass media by the women in rural areas, such as the use of mobile phones, television and internet exposure, and an increase in the number of women traveling to urban areas; thus exposing them to the immediate complications of FGM/C, including severe pain, shock, haem-

orrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue, recurrent bladder and urinary tract infections, incontinence, cysts, infertility, and an increased risk of new born deaths – as emphasised by WHO (2008).

The findings also revealed no significant difference between female secondary school students in urban and rural areas in Ika South Local Government Area of Delta State – in relation to their attitude toward female genital mutilation. The finding lends credence to DHS (2013) which showed that girls under 14 have almost equal prevalence of FGM/C with urban areas having (16.8%) and those in rural areas (17%). The researchers are of the opinion that many of the students at this stage have been brainwashed or indoctrinated to believe that going through the process of FGM/C is an act of bravery that marks their entry into womanhood, and that financial rewards await "successful initiates", without telling them the immediate complications of FGM/C, which includes recurrent bladder and urinary tract infections, severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue, incontinence, cysts, infertility, an upsurge in the risk of new-born deaths – as emphasised by WHO (2008). This calls for a proactive approach to health and sexuality counselling on the part of the school counsellors.

Recommendations

- Adequate education and exposure needs to be carried out on the adverse effect of FGM/C, using media like mobile phones, television, and the internet to promote awareness, especially for the recipients within rural areas.
- Counsellors and trainees should therefore be effectively exposed to therapies that could be used in assisting victims of FGM/C.
- More advocacies need to be carried out on FGM/C, because its adverse effects are numerous. That way, timely assistance can be given to clients, and awareness is created among women in religious organizations, social bodies, schools, and marketplaces.
- Although it is now prohibited by law, this is insufficient to eradicate it. As such, our royal fathers, who are the custodians of the people's culture and tradition, civil society groups, faith-based organizations, youth group religious leaders, teachers, women groups, town union executives, and other stakeholders, should be part of the crusade against this menace.

Implications for counselling

In many societies in Nigeria, FGM/C is perceived as one of the major customs a girl must adhere to, to be successfully initiated into womanhood. Unfortunately, it brings potential health hazards – as emphasised by WHO (2008).

From the result of this study:

- The attitude of mothers in urban areas can be galvanized to help the mothers in rural areas to educate their growing children about the dangers of FGM/C.
- Secondary school counsellors need to be aware of the dangerous trend of thought among the female students, and create awareness of the hazards of FGM/C through student group seminars, parent/teacher conferences, and individual counselling.
- Government at all levels should facilitate the awareness of the dangers of FGM/C through funding of seminars and public lectures.
- Finally, advert and other educational programmes should be produced and transmitted via radio, television, and the internet, to educate parents and children on the potential hazards of FGM/C.

CONCLUSIONS

A significant difference existed between the attitude of mothers towards female genital mutilation in urban and rural areas. However, no significant difference existed between the attitude of female secondary school students towards female genital mutilation in urban and rural areas (in Ika South Local Government Area of Delta State).

Ethical aspects and conflict of interests

The authors have no conflict of interests to declare.

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