Journal of Capital Development in Behavioural Sciences Vol. 2. Nos 1 & 2 (October, 2014)
Faculty of Arts & Education, Lead City University, Ibadan, Nigeria
***ISSN Online:** 2449-0679 **ISSN Print:** 2354-3981*

Parental Attitude on Eradication of the Practice of Female Genital Mutilation: The Role of a Counsellor

Oyetade, Monilola D. (Ph.D)
Department of Guidance and Counselling
University of Ibadan, Ibadan.
08027282068
Monioyetade2013@gmail.com

Abstract

Female Genital Mutilation (FGM) is a harmful traditional Practice prevalent among many ethnic groups in Nigeria and is fraught with many complications. In spite of the intervention campaigns by the Government and Non-governmental Organisations, the National Demographic and Health Surveys of 2003 and 2008 reported that the percentage of Nigerian women circumcised had increased from 19 to 30 percent within five years. This study therefore, examines the parents' perception on eradication of the practice of FGM in Ogun and Osun States, Nigeria. A total of 756 respondents comprising 378 male and female adults and 378 male and female adolescents participated in the study. Female Genital Mutilation Awareness Questionnaire (FGMAQ) was administered on the respondents to collect data on their level of awareness on FGM as well as their attitude towards eradicating FGM practice. Results from percentages and chi-square statistical analysis of data revealed that more than half (54.9%) of the respondents favoured the practice of FGM as they believed it upholds tradition and reduces sexual immorality, an attitude that is completely oblivious of its harmful effect and complications arising from it. Therefore, there is need for a well-coordinated professional counselling intervention to eradicate the practice of FGM.

Introduction

Every social grouping in the world has specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group, such as women (Hersh, 1998). In many societies women and girls are very often victims of barbaric harmful traditional customs, attitudes and male prejudices in order to assure male dominance. The origin of such practices may be found in the family, society or religion (Alan, 1994). One of such practices is female genital mutilation (FGM).

The practice of FGM has been going on for centuries, especially in Africa. In other words, female genital mutilation otherwise known as female circumcision (FC), is an age-long practice that cuts across nations, ethnic groups and socio-economic status (Dirrie and Lind, 1991). Other terms in use, apart from female circumcision, include female genital cutting (FGC), female genital surgeries (FGS), female genital alteration (FGA), female genital excision (FGE), and female genital modification (Denniston and Gallo, 2006; Momoh, 2005). The ritual is performed exclusively for cultural and traditional reasons on girls or young women often without their approval or full understanding of the consequences of the procedures. It is because of the severity and irreversibility of the damage inflicted on the female's body that the procedure has been termed "female genital mutilation", often abbreviated to FGM (WHO, 1998).

Female genital mutilation/female circumcision refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons (Anika and Toubia, 2000:2005). According to World Health Organisation (WHO, 2013), it is described as "procedures that involves partial or total removal of the external female genitalia, or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

The procedures are generally performed, with or without anesthesia, by a traditional circumciser (a cutter or *exciseuse*), usually an older woman who also acts as the local midwife, or *daya* in Egypt (El Hadi and

Amal, 2000; UNICEF, 2006). They are often conducted inside the girl's family home (UNICEF, 2013). They may also be performed by the local male barber, who assumes the role of health worker in some areas (El Hadi and Amal, 2000; UNICEF, 2006). Medical personnel are usually not involved, although a large percentage of FGM procedures in Egypt, Sudan and Kenya are carried out by health professionals, and in Egypt most are performed by physicians, often in people's homes (UNICEF, 2013). When traditional circumcisers are involved, non-sterile cutting devices are likely to be used, including knives, razors, scissors, cut glass sharpened rocks and fingernails. Cauterization is used in part of Ethiopia (Kelley, E; Hilliard, P.J.A. 2005; WHO, 2005). A nurse in Uganda, quoted in 2007 in The Lancet, said a circumciser would use one knife to cut up to 30 girls at a time (Wakabi, 2007). With Type III the wound may be sutured with surgical thread, or held together with agave or acacia thorns. Depending on the involvement of health care professionals, any of the procedures may be conducted with local or general anesthetic, or with neither (UNICEF, 2013).

The age at which FGM is performed depends on the country; it ranges from shortly after birth to teenage years (Toubia, 1994, UNICEF, 2013). It could be carried out at times shortly before marriage, during first pregnancy or shortly before delivery because it is believed that if the baby's head touches the clitoris, they will die, especially the male children. The variation in ages signals that the practice is usually not regarded as a rite of passage between children and adulthood (Mackie, 2000). In half of the countries where there is data, most girls are cut before five, including over 80 percent in Eritrea, Ghana, Mali, Mauritania and Nigeria. FGM is so deeply rooted that in extreme cases where a woman who had escaped the practice had died, relatives may insist on the performance of FGM before burial could take place (WHO/UNICEF/ UNFPA, 1995). The Ijaws usually do not regard FGM as a rite of passage between childhood and adulthood (Mackie, G. 2000). In half of the countries where there is data, most girls are cut before five, including over 80 percent in Eritrea, Ghana, Mali, Mauritania and Nigeria. FGM is

so deeply rooted that in extreme cases where a woman who had escaped the practice had died, relatives may insist on the performance of FGM before burial could take place (WHO, 1995). The Ijaws, apart from sharing many traditions with other ethnic groups in Edo and Delta States stand out as a group because they also perform circumcision after death. Myers (1985) made this assertion on the basis of the work of Penawou (1980).

WHO/UNICEF/UNFPA, (2008) reports that an estimated 100 to 140 million girls and women in the world today have undergone some form of FGM, and 3 million female infants and children are at risk from the practice each year. Information about the prevalence of FGM has been collected since 1989 in a series of Demographic and Health Surveys and Multiple indicator cluster surveys funded by the United States Agency for International Development (USAID) and the United Nations Children's Fund (UNICEF). In 2013 UNICEF published a report based on 70 of these surveys, indicating that FGM is concentrated in 27 African countries, as well as in Yemen and Iraq, Kurdistan, and that 125 million women and girls in those countries have been affected (UNICEF, 2013; Yasin Berivan *et al.* 2013).

According to UNICEF, the top rates are in Somalia (98%), Guinea (96%), Djibouti (93%), Egypt (91%), Eritrea (89%), Mali (96%), Sierra Leone (88%), Sudan (88%), Gambia (76%), Burkina Faso (76%) Ethiopia (74%), Mauritania (69%), Liberia (66%) and Guinea-Bissau (50%), Chad (44%), Kenya (27%), Nigeria (27%) (UNICEF, 2013; Julie, 2006). Forty-five million women over the age of 15 who had experienced FGM were living in Egypt, Ethiopia and Northern Sudan as of 2008, and Nine million were in Nigeria (Okeke, Anyaehie, and Ezenyeaku, 2012). Most of the women experience Types I and II. Type III is predominant in Djibouti, Somalia and Sudan, and in areas of Eritrea and Ethiopia near those countries. According to the 2008 National Demographic Health Survey (NDHS) findings, 30 percent of Nigerian women are circumcised compared with the prevalence of FC reported in the 2003 NDHS which

was 19 percent, this suggests that within the space of five years FGM/FC practice has increased by 11 percent. FGM is an unnecessary and illegal practice that causes significant physical, mental and emotional harm.

There are four main types of FGM

- Type 1: Clitoridectomy (removing part or all of the clitoris.
- Type 2: Excision (removing part of all of the clitoris and inner labia lips that surround the vagina — with or without removal of the labia majora larger outer lips)
- Type 3: Infibulation (narrowing of the vaginal opening by creating a seal, formed by cutting and repositioning the labia
- Type 4: Other harmful procedures to the female genitals, which include pricking, piercing, cutting, scrapping and burning the area (cauterization)

All types of FGM are practiced in Nigeria, however, the prevalence of the different types varies by state and regions (IAC, 1997; Okonofua, Snow and Oronseye, 1999).

The World Health Organization has recognized that the genital mutilation of girls and women represents a serious health condition for them, most especially; women undergoing the most severe forms of FGM such as "infibulation" are particularly likely to suffer from health complications requiring medical attention throughout their lives. FGM, to many that practise it, is believed to preserve a girl's virginity, widely regarded as a pre-requisite for marriage, and helps to preserve her morality and fidelity so that parents may demand a high bride price.

In addition, social acceptance is the most frequently cited reason for supporting the continuation of the practice. Therefore, in a socio-economic context, circumcised women have an advantage over uncircumcised. FGM is deeply entrenched in the Nigerian society (IAC, 2000). The advocates of this practice are grandmothers, mothers, women opinion leaders, men and some religious leaders. Others with

vested interest in FGM are those who perform the operation for their daily living. It is also performed based on religious basis (Black and Debelle, 1995). However, the consequences of FGM are highly enormous; the circumcision is fraught with many complications which are hazardous to the female health. The type and severity of the complication(s) depend on the skill and competence of the operators. There are no health benefits to FGM. Removing the damaging healthy and normal female genital tissue interferes with the natural functions of girls' and women's bodies.

The immediate effects which are short-term include severe pain, shock, bleeding, wound infections, including tetanus and gangrene, as well as blood-borne viruses such as HIV, Hepatitis B and Hepatitis C, inability to urinate, injury to vulva tissues surrounding the entrance to the vagina, damage to other organs nearby, such as the urethra (where urine passes) and the bowel (NHS Choices, 2013). FGM can sometimes cause death due to hemorrhage, overdose of anesthesia, etc. Recently, it was reported that a 12 year-old Egyptian girl, Bandaour Shaker, died in June, 2007 during or soon after a circumcision, she died from an over-dose of anesthesia. The girl's mother, Zeinab Abdel Ghani, paid 9 dollars (or 5 British pounds) to a female doctor, in an illegal clinic in the southern town of maghagh, for the operation (The Associated Press, June 29, 2007). In addition, on March 12, 2014 at 12.20 a.m. a 14-year old, Egyptian girl died from FGM operation. The procedure was performed by a doctor. Both the father and doctor are facing criminal charges (NHS Choices, 2014).

Long-term effects include: Chronic vaginal and pelvic infections, abnormal period, difficulties in passing urine and persistent urine infections, damage to the reproductive system, including infertility, kidney impairment and possible kidney failure, complications in pregnancy and newborn deaths, cysts and the formation of scar tissues, pain during sex and lack of pleasurable sensation, psychological damage, low libido, depression and anxiety, flash-back during pregnancy and childbirth, The

need for later surgery to re-open the lower vagina for sexual intercourse and childbirth (in the case of infibulations).

Psychological and Mental Health Problems

Case histories and personal accounts taken from women indicate that FGM is an extremely traumatic experience for girls and women, which stays with them for the rest of their lives. Young women receiving psychological counselling in the UK report feeling of betrayal by parents, regret and anger (NHS Choices, 2013).

Despite its clear health ramification, the involvement of the African medical and research communities on the issue has been hesitant and patchy. Documentation of the prevalence was primarily taken by the advocacy group, who lacked the research training that would produce reliable data (Toubia, 1998). In the last decade, several organizations have sought to know more about female circumcision and its present status in Africa, and various attempts are being made to educate the general public about its dangers. Women activists, both African and International, have made FGM one of the more prominent issues of women's and children's rights, particularly within the United Nations System.

In the campaign to eradicate FGM, developments at the inter-governmental levels have been encouraging. Despite this considerable efforts, research has proved that many people still engage in the practice of female genital mutilation. A human rights perspective affirms that the rights of women and girls to physical and mental integrity, to freedom from discrimination and to the highest standards of health are universal. Cultural claims cannot be invoked to justify their violations. The fact that FGM is a cultural tradition should not deter the international community from asserting that it violates universally recognized rights (WHO, UNICEF, UNFPA, 1996). Therefore, the international bodies, three United Nations, World Health Organizations (WHO), United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA), unveiled a joint plan to bring about a major decline in FGM within 10 years, and to completely eradicate the practice within three

generations in April, 1997 (Amnesty International, 2004). The plan emphasizes the need for a multidisciplinary approach, and the importance of team work at the national, regional and global levels. The eradication strategies will be through Information, Education and Communication (IEC) medium. These strategies by the FGM working groups to sensitize and educate the public about the dangers of FGM include; working with religious bodies and influential community leaders, traditional rulers, school programmes, house-to-house campaigns, training of trainers, mass information campaign through group work, workshops and seminars for health workers, school counselors, researchers and the entire populace including adequate supervision. These measures among others are to be put in place for successful eradication of the practice (IAC, 2000; WHO, 2000). Since FGM/FC is not a disease, but a human practice based on belief and social structures, efforts to stop it must focus on social change. By and large, attitude towards FGM is changing because of the health and social implication it has on the female body. Since an attitude is different from a belief, beliefs do not necessarily involve positive or negative feelings but your disposition towards something. Attitude also differ from behaviour, since how individuals feel about something and how they react toward it are not always the same, so people's attitude about the practice of FGM cannot be the same. It is therefore necessary to find out in a work of this nature the parental attitude towards the eradication of female genital mutilation.

Concept of Attitude

An attitude is an organized predisposition to think, feel, perceive and behave toward a referent or cognitive object. A referent is a category, class or set of phenomena: physical objects, events, behaviours, and even constructs (Kerlinger and Lee, 2000). Attitude comprise three components: the cognitive – what the person thinks of the object; the affective – what the person feels about the object; the behavioural – how the person behaves towards the object in the light of his or her thoughts and feelings (Kerlinger, 1973). In other words, an attitude is a

learnt concept which guides thoughts, feelings and behaviour toward a particular object (a person, a group of people, a policy, an event, or an inanimate object). Attitudes are hypothetical constructs which are acquired rather than being inborn, they are usually inferred from verbal statements and overt behaviour (Davidoff, 1976)

Attitude may be acquired by learning from one's family and culture. Peer group pressure and environmental conditions may also affect their formation and/or intensity. People are not born with particular attitudes; attitudes are acquired. They are outcome of a person's psychological past. Furthermore, attitude is a compost of two components, beliefs and values (Shapnas and Yutchman, 1975). Attitude at times could be evaluative, that is, it reflects a value judgment. It can be relatively permanent and enduring. Attitude change is typically slow. Kelman (1974) observed that once attitude is established, it can help to shape the experiences the person has with the attitude object. It can affect the kind of information to which the person will be exposed, the way in which he or she will organize that information, and often (as in interpersonal attitude) the way in which the attitude object itself will behave. He further argued that 'although attitude change is generally slow, people do continually form new attitudes and modify old attitudes —as they are exposed to new information and new experiences'. When people are confronted by new information which is at odds with their current attitudes, their attitudes sometimes change. Attitude concentrated efforts and education are needed (Akinwusi, 2004). Though information, education and communication strategies are employed for behaviour change towards the practice of FGM, often, these sensitization and enlightenment campaigns are not enough, due to the attitudinal disposition of people.

The impact of the negative attitude of people towards the eradication of FGM cannot be over-emphasized. Thus, it is observed that interpersonal relationship that exists among the family members, culture and the society at large suggest that people are biased towards primary

effects. This could be attributed to the poor effort of public enlightenment campaigns that are supposed to bring about behavioural change towards FGM practice. It is therefore necessary to find out in a work of this nature the attitude of parents towards the eradication of female genital mutilation in Ogun and Osun States.

Attitude towards Female Genital Mutilation

A project coordinator for Women's Right Watch Nigeria, a women lawyer organization that advocates for women's rights and gender equality in Nigeria (Global Fund For Women n. d.), considered that while, "with increasing enlightenment, attitudes are changing towards female genital mutilation (FGM), attitude in rural Nigeria remains unchanged (Women's Rights Watch Nigeria, 7th Nov. 2012). Sources indicate that advocates of FGM present it as a cultural practice that discourages "sexual promiscuity" (CWSI, 5th Nov. 2012; Women's Rights Watch Nigeria, 19th July, 2004) and promotes "chastity in women" (ibid). In correspondence with the Research Directorate, a representative of the Centre for Women Studies and Intervention (CWSI), an NGO that does research on gender issues and advocates for elimination of traditional harmful practices indicated that parents subject their daughters to FGM based on the social belief that a "young woman who refuses to undergo FGM will have difficult labour or will be unfaithful to her husband" or is not considered as a "woman". The CWSI representative stressed that, even though parents can refuse FGM from being performed on their daughters, nobody wants to be an exception.

Research Directorate, Uju Peace Okeke, a lawyer and sexual and reproductive rights advocate in Nigeria on 26th October, 2012, indicated that parents can refuse FGM "sometimes at huge costs" (7th Nov. 2012). Also, the former Executive Director of the Women Empowerment and Reproductive Health Centre (WERHC), cited in the Daily Trust, 6th Dec. 2011, that "it is the pride of every parent to ensure that their daughter goes through it, and any daughter that refuses to co-operate is held down usually by hefty men while FGM is performed" (ibid. 14th Feb. 2012).

Statement of the Problem

The practice of FGM is still high most especially in Osun state. In spite of change in attitude towards the practice in some localities, National Bureau of Statistics (2006), put the prevalent rate of FGM in Ogun State as 25.4 per cent.

Successful eradication of this harmful practice (FGM) does not only depend on the few adults in the society, who might accept it presently, but also on the younger ones who are witnessing and accepting the prevalent situation. The youths would in years to come become parents and decision makers in the society. It is also the belief of people that tradition dies hard because people attach much value to it especially the older generation. The interpersonal relationship that exists among the family members, culture and the society at large towards the views about FGM suggests that value is attached to it and there is no other justification besides blind adherence, hence there is need for behaviour change if eradication goal is to be achieved. Therefore, it is pertinent to investigate the attitude of the parents towards the eradication of female genital mutilation and the attitude of younger generations who are the prime target for the continuous practice in Ogun and Osun States.

Research Question

On the basis of the problem stated above, the study provided answer to this research question: What is the attitude of the respondents towards the eradication of FGM?

Methodology

This study is a survey type. The target population for the study comprised 378 male and female adults within the ages of 20-40 years and above and 378 male and female adolescents with the age range of 10 and 19 years from Ogun and Osun States participated in this study, making a total number of 756 respondents. The choice of these two states was motivated by the report of National Bureau of Statistics (2006) which revealed that the prevalent rate of FGM type I in Osun State was 88.4% and 25.4% practised it in Ogun State in spite of the fact that out of

twenty LGAs only seven LGAs practised FGM. In addition, all the thirty LGAs including Ife-North Area headquarters practised FGM. Therefore, six local government areas were purposively selected from each state of study for the purpose of reliable and valid result. Three urban and three rural were also selected from each state of study.

The instrument, Female Genital Mutilation Awareness Questionnaire (FGMAQ) which is made up of six sections with reliability coefficient of 0.82 was used to elicit information from the respondents, most especially the section F which consisted of 14 items. All the 14 items were designed to elicit information on the attitude of respondents towards eradication of female genital mutilation practice. The scale was structured along the Likert-type response format scoring ranging from Strongly Agree (4 points) to Strongly Disagree (1 point).

Findings

Research Question

What is the attitude of the respondents toward the eradication of FGM? Table 1 Presents the results of the analysis of the respondents on their attitude towards FGM.

Table 1: Attitude of Respondents (Adults and Adolescents) towards Female Genital Mutilation Practice

		Responses							
Statements	**Age Group**	**SA**	**A**	**D**	**SD**	**NA**	**Chi sq**	**Df**	**P**
Reduces sexual immorality	Adolescents	132 (34.9)	77(20.4)	69 (18.3)	100(26.5)				
	Adult	71(18.8)	135(35.7)	90(23.8)	82(21.7)		38.75	3	.000*
Is culturally accepted in my community	Adolescents	109(28.8)	77(20.4)	95(25.1)	97(25.7)				
	Adult	47(12.4)	82(21.7)	169(44.7)	80(21.2)		47.17	3	.000*
Can continue as long as something is done to reduce the pain felt by the victims.	Adolescents	100(26.5)	116(30.7)	75(19.8)	87(23.0)				
	Adult	66(17.5)	119(31.5)	130(34.4)	63(16.7)		25.60	3	.000*
Enhances female acceptance among the people and the girl's age group.	Adolescents	145(38.4)	126(33.3)	55(14.6)	52(13.8)				
	Adult	66(17.5)	164(43.4)	123(32.5)	25(6.6)		70.00	3	.000*
Enhances strong and productive society	Adolescents	166(43.9)	112(29.6)	44(11.6)	56(14.8)				
	Adult	73(19.3)	178(47.1)	102(27.0)	25(6.6)		86.11	3	.000*
Boosts the husband's confidence in his spouse.	Adolescents	137(36.3)	119(31.6)	47(12.5)	74(19.6)				
	Adult	76(20.1)	186(49.2)	96(25.4)	20(5.3)		79.99	3	.000*
Is enforced in my society.	Adolescents	177(46.8)	115(30.4)	41(10.8)	45(11.9)				
	Adult	80(21.2)	217(57.4)	66(17.5)	15(4.0)		88.79	3	.000*
Is animalistic in nature.	Adolescents	157(41.5)	108(28.6)	57(15.1)	56(14.8)				
	Adult	80(21.2)	192(50.9)	77(20.4)	28(7.4)		60.85	3	.000*
Should not be legalized.	Adolescents	120(31.7)	103(27.2)	81(21.4)	74(19.6)				
	Adult	69(18.3)	102(27.0)	158(41.8)	49(13.0)		43.66	3	.000*
Practitioners should be prosecuted	Adolescents	119(31.5)	126(33.0)	75(19.8)	58(15.3)				
	Adult	94(24.9)	172(45.5)	80(21.2)	31(8.2)	5 (1.3)	19.39	4	.001*
If enforced is likely to reduce prostitution in the society.	Adolescents	131(34.7)	81(21.4)	69(18.3)	97(25.7)				
	Adult	87(23.0)	123(33.9)	88(23.3)	75(19.8)	1 (0.3)	24.56	4	.000*
Is a violence against the female child	Adolescents	138(36.5)	105(27.8)	62(16.4)	73(19.8)				
	Adult	74(19.6)	181(47.9)	88(23.3)	35(9.3)		57.39	3	.000*
Is a cultural injustice on the girl-child	Adolescents	124(32.8)	110(29.1)	81(21.4)	63(16.7)				
	Adult	77(20.4)	185(48.9)	79(20.9)	37(9.8)		36.84	3	.000*
Should be stopped	Adolescents	95(25.1)	94(24.9)	78(20.9)	111(29.4)				
	Adult	88(23.3)	105(27.8)	107(28.3)	78(20.6)		11.18	3	.011*

***Number in parentheses represents percentages**
*S = significant at 0.05 alpha level.
SA represents Strongly Agree
A represents Agree
D represents Disagree
SD represents Strongly Disagree

From Table I, $X^2_{(3)} = 38.75$; $p < 0.05$., In item I, there is a significant difference in the attitude of adults and adolescents in their opinion that FGM reduces sexual immorality. Also for item 2 in the same Table I $X^2_{(3)} = 47.17$; $P<0.05$. There is a significant difference in the attitude of adults and adolescents in their opinion that FGM is culturally accepted in their community.

In item 3, $X^2_{(3)} = 25.60$; $P<0.05$, therefore there is a significant difference in the attitude of adults and adolescents in their opinions towards continuation of FGM if something can be done to reduce the pain felt by the victims. Also in item 4, $X^2_{(3)} = 70.00$; $P<0.05$. There is significant difference in the attitude of adults and adolescents in their opinions that FGM enhances female acceptance among the people and the girl's age group. Item 5 shows that $X^2_{(3)} = 86.11$; $P<0.05$. Therefore, there is a significant difference in the attitude of adults and adolescents in their opinion that FGM enhances strong and productive society. Item 6 also shows that $X^2_{(3)} = 79.99$; $P<0.05$. There is a significant difference in the attitude of adults and adolescents in their opinion that FGM boosts the husband's confidence in his spouse.

In item 7 $X^2_{(3)} = 88.79$; $P<0.05$. There is also a significant difference in the attitude of adults and adolescents in their perception that FGM is enforced in their society. Item 8 reveals that $X^2_{(3)} = 60.85$; $P<0.05$. Therefore, there is a significant difference in the attitude of adults and adolescents in their opinion that FGM is animalistic in nature.

Item 9 shows that $X^2_{(3)} = 43.66$; $P<0.05$. Therefore, there is a significant difference in the attitude of adults and adolescents towards legalization of FGM. In item 10 $X^2_{(4)} = 19.39$; $P<0.05$. Therefore, there is a significant

difference in the attitude of adolescents and adults that FGM's practitioners should be prosecuted. Furthermore, in item 11 $X^2_{(3)} = 24.56$; $P<0.05$. Therefore, there is a significant difference in the attitude of adults and adolescents that if FGM is enforced it is likely to reduce prostitution in the society. Item 12 shows that $X^2_{(3)} = 57.39$; $P<0.05$. Therefore, there is a significant difference in the attitude of adults and adolescents that FGM is a violent act against the female child. Item 13 also shows that $X^2_{(3)} = 36.84$; $P<0.05$. Therefore, there is a significant difference in the attitude of adults and adolescents that FGM is a cultural injustice on girl-child. Also, in item 14 $X^2_{(3)} = 11.18$; $P<0.05$ this also shows that there is a significant difference.

Discussion

The findings reveal that both adolescents and adults believed that FGM practice reduces sexual immorality. The amazing thing is that adolescents' response (55.5%) is even slightly higher than that of the adults (54.5%). Therefore, there is a need for intensive sensitization and enlightenment campaigns. Adolescents need to be properly educated on sexuality and be informed of several reasons that accounted for sexual immoralities or promiscuity. Definitely FGM is not the answer to this problem. This attitude must be discouraged and adults also need to be properly educated on eradication of FGM practice. It was also discovered that a higher percentage of adolescents (49.2%) believe that FGM is culturally accepted in their community compared to adults (34.1%) response. They also indicated that if something could be done to the pains associated with FGM, they would love it to continue whereas the adults even disagreed with this.

Furthermore, adolescents and adults believed that FGM enhances female acceptance among the girl's age group. And that it also enhances strong and productive society, it is very obvious that adolescents have little or no knowledge about FGM. In addition, adolescents and adults were of opinion that FGM is compulsory in their society. The finding of this work corroborates the work of Shapnas and Yutchman, (1975) that attitude

may be acquired by learning from one's family and culture. Peer group pressure and environmental conditions may also affect their formation and/or intensity. It also confirms the work of Heather *et. al.*, (2012) that the continued FGC practices of older women may be a result of past societal norms, including pressure from family members or spouses, even if they do not support the practice. They argued further that even the younger ages were more likely to believe the practice should continue just as it is in this present study. Herbert Kelman (1974) observed that once attitude is established, it affects the kind of information the person will be exposed to, the way in which he or she will organize that information and often the way he or she behaves.

PATH (2005) found that education had a major impact on the level of reasoning and acceptability of the practice of FGM among women in most African society for which it was reported that among the illiterates FGM, is often described as a means to safeguard against premarital sexual activity and, as such, prevent female promiscuity and preserve virginity. Based on this, in Kenya, 30% of women supporting continuation of the practice agreed that FGM helped to preserve virginity and avoid immorality. In Nigeria, similar rates (36%) were reported by women, while 45% of men supporting continuation of the practice agreed with this statement. FGM was believed to be proof of a girl's virginity, thereby improving the marriage prospects of unmarried girls who have undergone the procedure. In Côte d'Ivoire, "improved marriage prospects" was cited by 36% of women favoring continuation of the practice once married. FGM is also believed by some communities to ensure that a woman is faithful and loyal to her husband. For example, 51% of women in Egypt believe that FGM prevents adultery. This implies that for the campaign on FGM eradication to be a success, education would serve as the pivot.

Recommendation/Conclusion

Based on the findings of this study, the following are recommended:

1) Attitudes, traditions, customs and beliefs need to change.

2) Government need to show more commitment to ending FGM.
3) Laws prohibiting FGM must be enforced.
4) Non-governmental organizations should be focused and more committed. They should not see these societal problems (HIV/AIDS, harmful traditional practices, etc.) as avenue for money making.
5) Aggressive enlightenment programmes through mass media, public places like hospitals, markets, schools should be taken seriously.
6) Parents should be enlightened and encouraged for behavioural change.
7) Children and adolescents need to be adequately informed and reject FGM.
8) Medical services should be accessed to respond to the consequences of female genital mutilation.
9) Educational system should be able to contribute to preventing and eradicating FGM.
10) There is need to promote the role of men as partners against the practice.
11) Women should be properly educated and enlightened about the dangers of FGM and the need to clamour for its eradication.

The Role of a Counsellor in Eradicating FGM

Nwokolo (2009) sees counselling, as a service-oriented activity, has a role to play in reducing the psychological implications of FC. Counselling is one of the veritable tools that is used for creating awareness and problems solving (e.g. through T.V., radio jingles, dramas, debates, counselling, peer education and choral dances). Students may be given a range of roles to play.

There is need for Government to recruit qualified counsellors in the community whereby the community has a counselling centre because counsellors are in a position to guide the parents, modify and change societal practices that are considered harmful to society.

(a) Small group discussions – studies may be divide into group of six or eight to discuss an issue and come up with common view points and present it to the entire class.
(b) Buzz group – (between two or three students, designed mainly to encourage participation) students are to discuss with neighbours before sharing their thoughts and ideas with the class.
(c) Plenary or large group discussions – the teacher engages the entire class in brainstorming on the issue, or in discussion and feedback from the small group work.
(d) The summary – at the end of each session, the classes will be asked to summarize what has been learnt, to see how this matches with the original objective. This gives students the opportunity to seek clarification on anything they have not understood.
(e) Case studies – students may be given the opportunity to share real-life case studies from the community or clinic with others in the classrooms.
(f) Role Play and Drama – students may be given a range of roles to play in mini dramas to give people the insights into different peoples situations and points of view regarding FGM. The roles may be allocated by teachers, students may work together with the teacher or translate stories or actual case studies into dramas that they can act out.
(g) Story telling – this activity will be used to explore attitudes and values. The module include stories that illustrate different aspects of FGM, which the teacher or student can tell to the class.

Ada *et al*. (2012) emphasise in their study that the counselors should be more involved in the campaign against eradication of FGM. Therefore, suggesting strategies that the counselors would use in eradicating FGM.

The following are suggested:

1) Creation of interpersonal communication between members of the community.
2) Encouraging women to be part of the advocacy that speaks against FGM.

3) Creation of awareness through enlightenment campaign.
4) Promotion of women participation in decision making process in the community.
5) Presenting meaningful education value to people.
6) Campaigning against FGM.
7) Render information service through the media.
8) Publishing best practices.
9) Organizing seminars and workshops where women will be enough to be fully integrated into society.
10) Helping the community as much as possible to maintain the positive cherished traditional and cultural values that are not against women.
11) Organize visits to parents, guardian and significant others.
12) Counselling jingles and witty messages against FGM.
13) Advocating for education of the women.

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