PREVENTION OF FEMALE GENITAL MUTILATION (FGM): THE CASE OF FEMALE STUDENTS AND TEACHERS OF NATIONAL TEACHERS INSTITUTE, KWALE, DELTA-STATE

BY

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A THESIS SUBMITTED TO THE POSTGRADUATE SCHOOL, IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MASTERS DEGREE IN PUBLIC HEALTH (M.P.H) OF THE AHMADU BELLO UNIVERSITY, ZARIA.

DECEMBER 2000

.

DECLARATION

This is to declare that this project is an authentic work conducted by me within the regulations of the postgradute School of Ahmadu Bello University, Zaria. All directly quoted materials and secondary sources are duly acknowledged.

Sign .....

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CERTIFICATION

This thesis, entitled prevention of female genital mutilation (FGM): The Case of female student teachers at National Teachers Institute, Kwale, Delta-State meets the regulations governing the award of Masters degree in Public health (MPH) of Ahmadu Bello University, Zaria.

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DEDICATION

Dedicated to:

(1) MY LORD AND SAVIOUR - JESUS CHRIST, FOR DIRECTION AND INFINITE MERCIES AND BY WHOSE GRACE I AM PRIVILEGED TO UNDERTAKE THIS RESEARCH WORK.

2) MY FAMILY FOR UNDERSTANDING AND ENCOURAGEMENT WHILE I WAS AWAY IN SEARCH OF MORE KNOWLEDGE.

3) MY MOTHER AND LATE FATHER (CHIEF J.I. EBINUM) FOR THEIR LOVE AND UPBRINGING.

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ABSTRACT

This is a research work on female genital mutilation among female students and teachers of National Teacher's Institute Kwale, Delta-State. It estimated through proportions the prevalence of FGM among female students and their teachers in National Teacher's Institute Kwale, Delta-State. Recorded complaints of complications were made through in-depth interviews of women who had been subjected to FGM and through focus group discussions regarding approval or disapproval of the practice of FGM in the locality. Promoting and sustaining factors were also sorted out from knowledge, altitude and practices of FGM within the Community.

This study was conducted in a Teacher Training Institute in Kwale, Delta-Slate. Kwale is the head quarters of Ndokwa West Local Government Area of Delta Slate. Nigeria.

Questionnaires were used to collect data from 233 respondents drawn from the entire female student population and focus group discussion was conducted for a selected few respondents randomly picked. Personal interviews were also held .with some community leaders including men and women.

Findings were sorted and analysed, summary of these include :

(1) That, FGM is still being practised in the community with a high prevalent rale of 65%.

(2) No new promoting factors were particularly identified but the commonly identified ones include culture and tradition, ignorance, myths, illiteracy and religion. These were merely confirmed as promoting and sustaining factors.

(3) That, as much as 50% of the circumcision took, place in pregnancy.

(4) That, in the pre-pregnant slate, 60% of victims of genital mutilation arc children under 5 years of age.

(5) That, 1 out of every 5 victims of genital mutilation in the prc-prcgnanl slate, is a neonatal infant.

(6) There is a gradual but slow declining trend in the practice of FGM in the area.

(7) Complications were few.

(8) As much as 17% of respondents indicated disapproval in intervention aimed at discontinuing the practice,

(9) Majority (83%) of respondents are in favour of discountinuing with the practice.

Conclusions and recommendations were then made based on these findings.

TABLE OF CONTENTS

Title Page..... i

Declaration..... ii

Certification..... iii

Dedication..... iv

Acknowledgement..... v

Abstract..... vi

Table of Contents..... viii

List of Tables..... x

List of Figures..... xi

List of Plates..... xii

List of Appendixes..... xiii

CHAPTER ONE

1.1 Introduction..... 1

1.2 Statement of problem..... 2

1.3 Significance of problem..... 3

1.4 Rationale of study..... 3

1.5 Research Questions..... 4

1.6 Aims and objectives..... 4

CHAPTER TWO - LITERATURE REVIEW

2.1 Historical Perspective..... 5

2.2 Basic structure of female external genitalia..... 6

2.3 Types of female genital mutilation (FGM)..... 8

2.4 Complications and consequences..... 10

2.5 Customs, Attitudes, Beliefs in FGM..... 11

2.6 Situational Analysis of intervention and prevention of FGM..... 12

CHAPTER THREE - METHODOLOGY

3.1 Introduction..... 15

3.2 Study Population..... 15

3.3 Sampling Frame..... 15

3.4 Sampling size..... 15

3.5 Sampling Method..... 16

3.6 Field Procedure..... 17

3.7 Ethical Considerations..... 18

3.8 Fund..... 18

CHAPTER FOUR

4.1 Presentation of Data..... 19

4.2 Data Analysis..... 34

4.3 Focus Group Discussion and Interviews..... 37

CHAPTER FIVE

5.0 Summary, Conclusion and Recommendations..... 41

5.1 Summary..... 41

5.2 Conclusion..... 42

5.3 Recommendations..... 42

References..... 45

LIST TABLES

Pilot study showing rate of circumcision in female Secondary School students..... 19

Circumcision in different age groups of female student Teachers.. 19

Circumcision among the teachers and students at various age groups..... 21

Circumcision at pregnancy and before conception..... 25

Circumcision at various stages of child development..... .26

Age in years at first pregnancy when circumcised..... 26

Age in years at circumcision conducted before first pregnancy..... 27

Complications from circumcision..... 28

Response to willingness to stop the practice of FGM..... 30

LIST OF FIGURES

FIGURE 1	Graph showing trend of prevalence between age groups among student teachers.....	20
FIGURE 2	Mean percentage of genital mutilation among student teachers above and below 30 years.....	23
FIGURE 3	Mean percentage of genital mutilation among teachers above and below 30 years.	24
FIGURE 4	Showing percentage of distribution of complications among the circumcised.....	29
FIGURE 5	Response to willingness to stop the practice of FGM.....	31
FIGURE 6	Sectarian and Religious Distribution with the practice of FGM...	32

LIST OF PLATES

PLATE 1 Students Teachers being briefed on completion of questionnaire..... ... 33

PLATE 2 Student teachers completing their questionnaire..... 39

PLATE 3 Focus discussion group showing a teacher speaking..... 42

PLATE 4 Another discussion group with community leaders and community health providers..... 42

LIST OF APPENDICES

Appendix A	-	Map of Nigeria showing Kwale in Ndokwa West Local Government Area of Delta State, South-West of Asaba.
Appendix B	-	Letter of recommendatin from Ministry of Health, Asaba, Delta State of Nigeria.
Appendix C	-	A letter of invitation for a focus group discussion.
Appendix D	-	Approval letter from Ministry of Education, Kwale, Delta State to conduct a research work in Post Primary Institutions.
Appendix E	-	A sample of completed questionnaire.

CHAPTER I

1.1 INTRODUCTION

Female genital mutilation (FGM) is an age long practice that involves a range of harmful procedures with partial or total removal of the female external genitalia and/ or other injury to the female genitals for cultural or any other non-therapeutic reasons(1) . FGM is still practiced widely particularly in many areas of Africa including Nigeria. It is a painful and sometimes fatal procedure carried out on infants, children, adolescents and even pregnant women. The practice of FGM is associated with high morbidity with occasional fatal incidence and a life-long psychosexual trauma. Reasons for this practice from cultural point of view include: the general belief that it is done to reduce the sexual urge of the female and thus protect her from becoming promiscuous (2) . This is documented from a work done in Nigeria in the then old Bendel-state. Though other obscure reasons such as religion, aesthetics among others exist, it appears the general held-belief of mutilation protecting the womenfolk from promiscuity is rather deep rooted. This can be inferred from the fact that high attainment in education has done practically little to change the belief that fidelity is advanced with the practice of FGM. Presently, there has been decades of a world-wide-call for the outright elimination of female genital mutilation and there have been concerted measures in place by governments, international agencies and regional bodies and women advocacy groups. In 1998, World Health Day celebration on 'safe motherhood', the then Nigeria first lady, Mrs Maryam Abacha has this to say "may I, therefore, use this opportunity to send a very strong and powerful appeal to all heads of families to resist all cultural temptation which forces parents to circumcise their children for what ever reason.

This practice is evil, inhumane, and debases the dignity of womanhood and indeed mankind" (3). This statement was followed by a strong call to all including the United Nations (UN) to adopt a resolution banning female genital mutilation and also an appeal to the Federal Government to enact a law, which provides stiff penalties for the perpetrators of FGM. A joint statement by the World Health Organization (WHO), the United Nation Population Fund (UNFPA) confirms the universally unacceptable harm caused by genital mutilation of girls and women.

1.2 STATEMENT OF PROBLEM

1. In the absence of reliable data presumably because of secrecy with which FGM is carried out, World Health Organization (WHO) estimates that about 2 million girls are still at risk of genital mutilation each year and about 100 to 132 million women now living are estimated to have undergone the procedure (4). Most of these are found in Africa and some parts of Asia in spite of spirited efforts worldwide to halt the practice.

In Nigeria, for instance, prevalence from a national baseline survey from 1996 to 1997 covering the thirty states and the Federal Capital Territory showed a rate from very low to very high rate ranging from 0.1-98% (5)

2. Up till this date, the harmful practice lingers on and has shifted underground, shrouded in secrecy as a result of government stance adopted.
3. The practitioners involved are untrained people using crude and unsterile instruments leaving behind a trail of health complications with disabilities and sometimes loss of lives.

1.3 SIGNIFICANCE OF PROBLEM

The continued harmful practice of FGM places life-long physical and reproductive health disabilities that are universally unacceptable on victims. The practice leads to loss of youthful lives in some cases and continues to strain limited and scarce health care resources posed by pregnancy complications. FGM is not only an assault on the reproductive health of pregnant women and girls but also a violation of their human rights. FGM is an obstacle to the realization of the goal of health for all including girls and pregnant women on whom it is practiced.

1.4 RATIONALE OF STUDY

Elimination of this harmful practice will no doubt improve on the sexual and reproductive health of women and thus enable women to achieve the current goal of enjoying socially and economically productive lives. This is in line with the United Nations convention on the elimination of all forms of discrimination against women to which Nigeria is a signatory. It also supports the World Health Assembly Resolution (WHA 47.10) ON TRADITIONAL PRACTICES harmful to the health of women and children and WHO policy on non medicalisation of female genital mutilation.

The rationale for this study is, therefore, on the need for new and additional information on the complexities of deep rooted factors sustaining FGM. Also, there is a felt need to make additional inputs to current strategies and plans to halt FGM and thereby contribute to elimination of this health burden on the population.

1.5 RESEARCH QUESTIONS

Are there other obscure factors sustaining this harmful practice beside ignorance, traditions, religion and low literacy level? Bearing in mind that FGM is still practiced by highly educated elites in the society and the practice cuts across religion and profession. Which factors are not yielding to intervention? In some places FGM has defied laws, which had to be reversed and again repassed with renewed pressure from human rights advocacy groups.

1.6 AIM

To prevent FGM among female population in Kwale, Ndokwa West Local Government Area, Delta State.

1.7 OBJECTIVES

1. To estimate via proportion the prevalence of FGM among female student teachers in TTI, Kwale, Delta state.
2. To conduct an in-depth interview of women who had gone through the process and record complaints of complications during childbirth or difficulty during sexual activity as a result of procedure.
3. To probe through focus group discussions among male and female leaderships in the community their views regarding approval or disapproval of the practice in their area of jurisdiction.
4. To prepare health messages geared toward sensitizing the people on the dangers of FGM.

CHAPTER (II)

LITERATURE REVIEW

2.1 HISTORICAL PERSPECTIVE

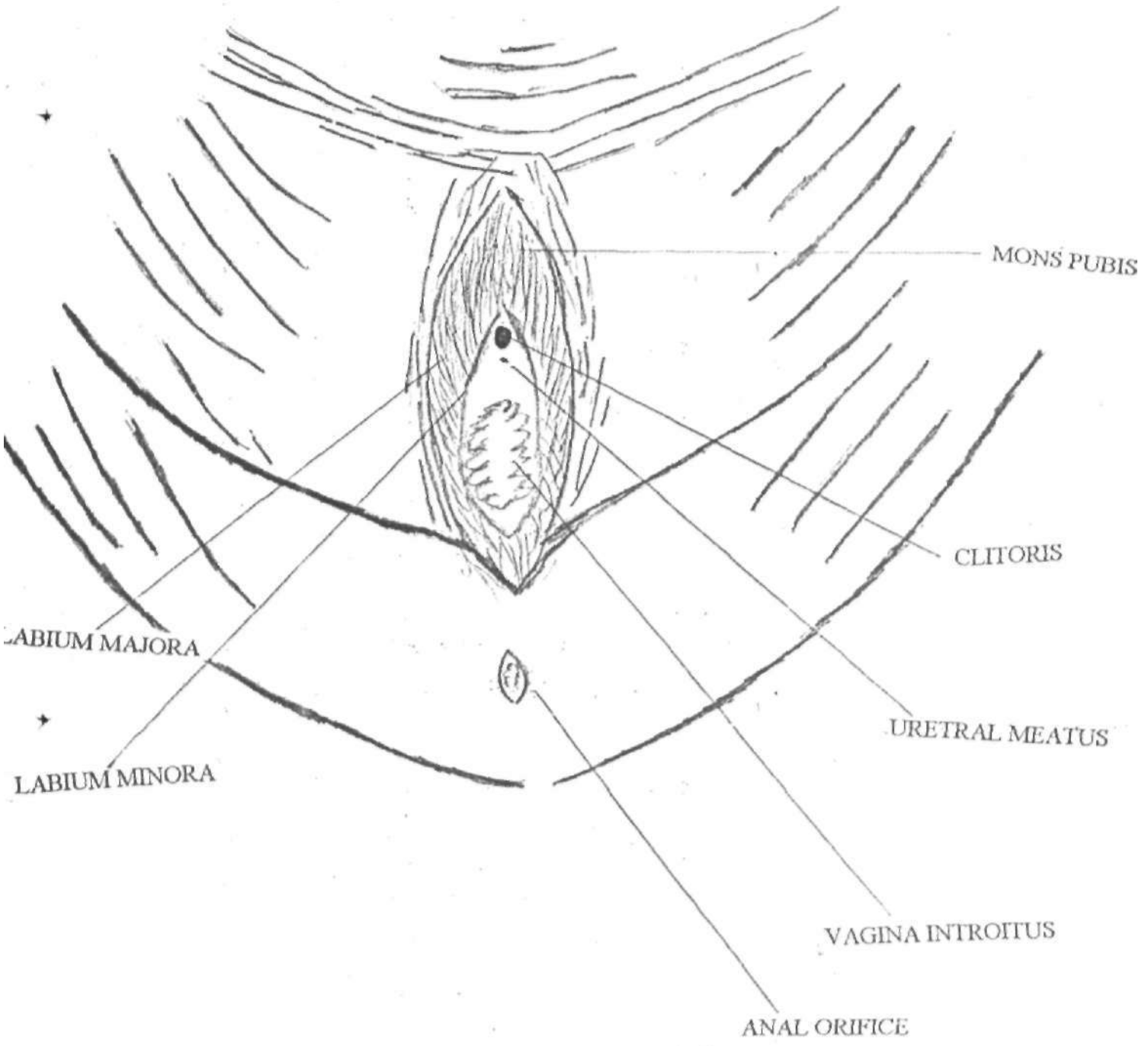
The historical roots of the practice of FGM are obscure, though male circumcision is thought to predate female circumcision. In biblical times about 1250 yrs BC, circumcision was a part of covenant between God and the Israelites. Some historians believed it was a mark of slavery when the Israelites were in Egypt and that this tradition was only transferred over after their release. There was even no indication that female circumcision was then in practice.

While some historians still believed the practice appear to date back 2,000 years to ancient Egypt (4), others believe it sprang up independently in different parts of the world and that it was practiced by West African tribes over 5,000 years ago predating even the practice in Egypt. However, the foremost known documented information about female circumcision was from a famous historian Herodotus (6) who claimed that in the fifth century BC female circumcision was practiced by the Phoenicians, Hittites and Ethiopians as well as by the Egyptians. It is also believed that at one time or the other female circumcision was performed among various communities in all continents of the world, both old and new but today most developed nations have abandoned the practice. It is only in a number of African countries, Arabian Peninsula, Malaysia and Indonesia that, it is still being practiced. In Nigeria, circumcision is practiced by most tribes and religions including pagans. Therefore the claim that circumcision was ushered in by the Muslim faith cannot be substantiated. In the old Bendel State, female circumcision is still practiced among the Binis, the Ishans, the Ika-Ibos and Ukwanis. (2)

2.2 BASIC STRUCTURE OF FEMALE EXT. GENITAL(7)

The female External genitalia is also referred to as the vulva. The most anterior portion of the genitalia is a fatty mound area covered with skin and pubic hair. Just below the mons-pubis in the midline is an erectile structure known as Clitoris. The clitoris terminates in the glans clitoris, which is surrounded by the foreskin or the prepuce. The *female clitoris is the homologous structure to the male penis.* The glandular end is a sensuous structure that plays a vital role in sexual physiology. Other midline structures beneath the clitoris are the urethral openings and the vaginal orifice.

Two pairs of skin fold encircle the midline Structures in the vulva. A medial (inner) thin fold is the labia Minora, which extends to the clitoris splitting on either side of it as the suspensory ligaments. The labia minora are highly vascularized and also very sensuous. Just lateral (that is on the outer side) to the labia minora is a thicker fold known as the labia Majora. It is laden with pubic hair and sweat glands and extends posteriorly to end in an area known as the foutchette.



SCHEMATIC DIAGRAM SHOWING FEMALE EXTERNAL GENITAL (VULVA).

This basic structure of the female external genitalia is essential to the understanding and appreciation of the various physical complications that follow female genital mutilation. For example, in the type III procedure (WHO 1995 classification) or 'pharaonic' type of female genital mutilation, the clitoris, a physiological sensuous organ is entirely removed compromising a vital part of the female sexual response and physiology. Also with the apposition of the raw surfaces of the labia majora in the Type III or 'pharaonic' FGM, the urethral opening can be closed along with the vaginal opening leading to various complications as urinary retention and gynatresia (narrowed vagina) respectively. The accompanied vaginal scarring may lead to difficult coital relations and difficult childbirth and vulva repair by decircumcision may become necessary.

2.3 TYPES OF FEMALE GENITAL MUTILATION (WHO 1995) (8)

TYPE I

Excision of the prepuce with or without excision of part or all of the Clitoris.

TYPE II

Excision of the prepuce and Clitoris together 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)

(i) Pricking, piercing or incision of the clitoris and/ or labia.

(ii) Stretching of the Clitoris and/or labia.

iii) Cauterization by burning of the clitoris and surrounding tissues

(iv) Scraping ("angurya" cuts) of the vaginal orifice or cutting ("gishiri" cuts) of the vagina.

(v) Introduction of corrosive substances or herbs into the vagina to either cause bleeding, tightening or narrowed vagina.

(vi) Any other procedure that falls under the definition of female genital mutilation given above.

In other forms of classification (9), the works of EL Dareer A.A., 1983, the terms `SUNNA', `INTERMEDIATE', `PHARAONIC' were used to describe the various types of female genital mutilation. `SUNNA', a word meaning `following the tradition of Prophet Mohammed' describes a milder form of FGM corresponding closely to the Type I WHO. Classification. However, only the tip of the prepuce here is removed. This is said to be practiced by the educated elites and religious muslim families. Some health workers even smuggle this into practice as a `Placebo' procedure to daring patients at high costs ostensibly explained off as being protective from the operations of quacks. Next to the `Sunna' method is the `Pharaonic' corresponding closely to the WHO Type III. Here at times, instead of using stitches to obliterate the introitus, the legs are bound together for about forty days and some irritating foreign compounds applied to the raw wounds to promote fusion and closure of the introitus leaving a small opening to allow just the size of a match stick. The `Intermediate' circumcision lies between the two described extremes ones, the `Sunna' and the `Pharaonic' but appears to be closer to the latter. It consists of removal of

the clitoris and some parts or the whole of the labia minora. Sometimes slices of the labia Majora are removed and stitched.

2.4 COMPLICATIONS AND CONSEQUENCES

The health consequences of FGM can be described under immediate and late complications.

Immediate complications include an excruciating pain at the time of surgery often performed without anaesthesia. In some cases the painful experience is prolonged as in infibulations when some foreign irritating compounds are used and legs are bound together for weeks. Major bleeding can occur from uncontrollable blood loss and depending on the proficiency of the handler shock and death may follow. There is the risk of Human Immunodeficiency Virus (HIV) transmission with the sharing of equipments for several individuals. Other forms of immediate complications that may arise include wound infection, dysuria and urinary retention.

Late complications particularly with infibulations may include scarring with keloid and inclusion cysts. Infection of the wound can lead to vulva abscess, recurrent urinary tract infections and chronic pelvic infection. Difficult labour from scarring of the introitus can lead to damage of the bladder and adjacent organs, resulting in vesico-vagina-fistula (V.V.F) and recto-vagina fistula (R.V.F). These are tears between the vagina and the bladder, or the vagina and the rectum respectively. Women who suffer from these tears leak urine and/or feaces and are often ostracized by their families and communities.

Among newborn infants, difficult and obstructed labour can lead to various degree of cerebral injury or still birth and where child marriage is practiced as in some parts of Northern Nigeria it compounds and aggravates the risk of obstructed labour from complicated genital mutilation.

The traumatic and psychosexual consequences of FGM remain with many women for years, if not lifetime. Acquired gynatresia with cryptomenorrhoea, dyspareunia or even apareunia and ultimate infertility can result. Thus painful intercourse is common with little or no penetration at all in some cases except following a decircumcision.

2.5 CUSTOMS, ATTITUDES, BELIEFS IN FEMALE GENITAL MUTILATION.

Many reasons have been cited for the practice of this harmful procedure. Reasons range from psychosexual and sociological presumptions, through myths, to beliefs concerning hygiene, aesthetics and religion(10)

Some tribes contend that the practice is part of socialization by initiation into womanhood (11). In Ukwani, Delta-State for instance I am aware of its practice on pre-pubertal girls with some rites or ceremonies referred to as 'ine-Ugu'. Other workers sited claim that the practice is desired to attenuate the sexual urge of the female and thus protect her from conjugal infidelity.

Islam has been alleged as being responsible for the spread of female circumcision but the fact is that this procedure is also being practiced by people that have never been influenced by Islam. It is being practiced by not only muslims but also Christians and pagans. Though the Islamic word 'SUNNA' meaning 'following religious tradition' is used

to describe the Type I of female genital mutilation suggesting a religious inference, leading Islamic Scholars however have refuted this, claiming the practice has no basis from the Koran(6)

Other reasons canvassed for the practice of FGM include the act of making sex more pleasurable for the man by narrowing the introitus while some claim that the ugly site of the genital locality deserves aesthetic modification procedure. Local hygiene and preservation of virginity are also some other vague reasons that have been cited, with reference from the Holy Bible (Mat. 19 vs 12) to back up the latter.

2.6 SITUATIONAL ANALYSIS OF INTERVENTION AND PREVENTION OF FEMALE GENITAL MUTILATION (FGM).

FGM has drawn worldwide attention including those of governments, regional and international organizations. Various international agencies including WHO, United Nations Children's fund (UNICEF), the United Nations Population fund (UNFPA), the United States Agency for International Development (USAID), and International Federation of Gynaecology and Obsterics (FIGO), among others, have condemned the practice. In 1998 World Health Day Celebration on `Safe motherhood', the then Nigeria's first lady, Mrs Maryam Abacha condemned in totality the practice and described the practice as being evil, inhuman and debases the dignity of womanhood and indeed mankind.

Many heads of state including Nigeria, Benin and Senegal have voiced out against the practice. In Nigeria, the elimination of female genital mutilation is already one of the goals of National health Policy and there is currently a draft to that effect. Some State legislative assemblies have also followed suit among which are Balyelsa and Ogun State

assemblies legislating against the practice. Though, edict alone has not been able to eliminate FGM, they demonstrate government preparedness and paves way for possible litigations.

Because, FGM is at the 'heart' of most traditional values, legal decrees and policy statements alone have not been able to impact much success. For example acts passed in Egypt in 1959 and in Sudan in 1946 have not succeeded in stemming the practice to date as in Nigeria. Thus grassroots community education and advocacy has been the main line of action against FGM and programmes as regional conferences, educational workshops, advocacy and research at the national, regional, and community levels are variously on ground.

Public health education is being promoted through various forms of mass media including video-plays, films and other educational materials. In Nigeria anti- FGM activities included training traditional birth attendants (TBA) who in turn train colleagues all over the country at the same time educating them on harmful traditional practices. The Nigerian Nurses and Midwives association, through its members continue to educate the public through plays and live performances.

Alternatives to female genital mutilation has been advocated in some places for example in Kenya. This involves allowing the rite of passage for adolescent girls, including the ceremonies, gift presentations by in-laws and automatic recognition into womanhood, while skipping the actual mutilating procedure (4).

Also FGM practitioners are retrained as traditional birth attendants (TBAS) or to some other trade or skill to occupy them and reduce opposition against anti-FGM activities.

Lastly, researchers into FGM are being encouraged from various interest groups and Non-Governmental Organizations to identify what determines success or failure of anti-FGM measures so that subsequent efforts can be modified and made more effective.

CHAPTER III

METHODOLOGY

3.1 INTRODUCTION

The study is a descriptive one using quantitative statistical methods.

3.2 Study Population

Female students and female staff of National Teachers Institute, Kwale Delta-State.

3.3 Sampling frame

The entire school registers for students and staff list was used.

3.4 Sampling size

The sample size N, for a qualitative data is expressed as a proportion and it is given by

$$N = \frac{P \times q \times 3^2}{SE^2}$$

where P = % of those affected in population.

q = 100 - P, the population proportion unaffected.

Z = Standard normal deviate

SE = Sampling error tolerated (%)

P, estimated from a previous published report as obtained in the National draft policy on female genital mutilation is between 0.1% - 98%. Thus let P be 50, q = 100 - 50.

At 95% confidence level, sampling error tolerated is 5%. and standard normal deviate Z = 1.96

$$\therefore N = \frac{50 \times 50}{5^2} \times 1.96^2$$

$$= \frac{50 \times 50}{25} \times 3.84$$

$$= \frac{9604}{25} = 384$$

Minimum sample size thus required = 384

However, a sample size of 233, which is the total sample frame available, was used.

3.5 Sampling Method

Multistage sampling was intended with one school selected randomly from each of the three Senatorial District of Delta-State. In the second stage, from the 3 schools selected 80 students would have been selected at random from each school to make up the sample size.

However, due to time constraints and disruption in school Calendar occasioned by teacher's industrial action, a convenient sampling method was undertaken. In this case, a National Teachers Training Institute that was operating was used with its entire student/staff population of 233. The school population is fairly representative of the general population in Delta-State as students and staff from the major ethnic groups are in attendance.

3.6 Field Procedure

Consent and authority to undertake the study was obtained from the following Ministries.

1. Ministry of Health, Asaba
2. Ministry of Education, Kwale.

Letters of notification were sent to prominent male and female leadership in the community on the proposed focus group discussion.

A pilot study was conducted at St. Mary Magdalene Girls Grammar School, Ashaka involving 50 respondents randomly selected. This was followed by a sampling of opinion leader's comment on the result and analysis of the pilot study.

The main group of study involved a population of 233 female students and teachers of National Teacher Training Institute, Kwale. They were served with structured and self administered questionnaire which included baseline background questions on demography, knowledge, attitude and practices of female genital mutilation, the attendant complications experienced if any, and their responses morally and/or actively to the eradication policy of the government.

Several pretest questionnaires were prepared, restructured on the field before the final one used.

A focus group interview was finally arranged with a group of student teachers and teachers randomly picked.

3.7 Ethical considerations

Permission was obtained from the school authorities concerned following a written consent and authority from the Education Board.

Consent was sought and received from the respondents and confidentiality was assured.

3.8 Fund

Fund was mobilized privately prior to approval and release of a research grant. The fund was used to cater for transportation, recordings, photographs, stationary, word processing, data-analysis, binding and also to remunerate facilitators.

3.9 SCOPE AND LIMITATION.

Due mainly to time constraints, and disruption in school calendar by teacher's industrial action, the study has been restricted to the determination of the prevalence and practice of FGM among female students and teachers of National Teachers' Institute (NTI), Kwale in Ndokwa local government area of Delta State. It was originally intended by a multistage sampling technique to cover secondary schools in the 3 senatorial district of Delta-State.

CHAPTER IV

4.1 PRESENTATION OF DATA

Table I

Pilot study showing rate of Circumcision in female secondary school students.

Age group in years	No. of cases	No. Circumcised	%	No. not circumcised	%
15 - 19	39	1	2.6	38	97.4

2.6% of respondents have been subjected to female genital mutilation, while vast majority (97.4%) of respondents have not been subjected to the practice within 15-19 age group.

TABLE II

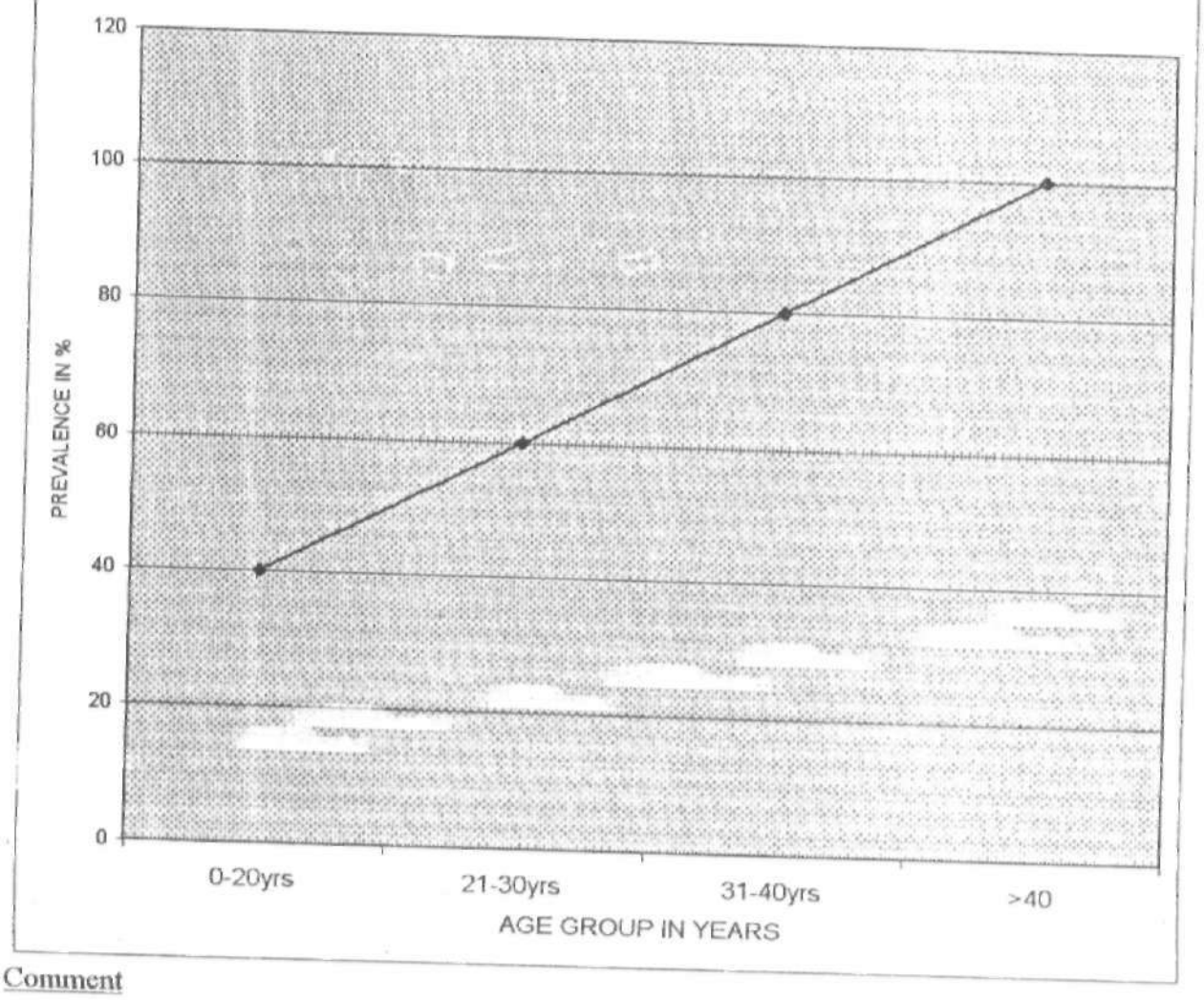
Circumcision in different age groups of female student Teachers.

Age group in years	No. of cases	No. Circumcised	% of Total	No. Not Circumcised	% of Total
<20	35	14	6	21	9.0
21-30	137	86	36.8	52	22.2
31-40	58	49	20.9	9	3.9
>40	3	3	1.3	0	0.0
234	233	152	65.0%	82	35.1%

Comments

Majority of the students sampled, (137 = 58.9%) fall under the age group 21-30 years. This was followed by the age group 31 - 40 years with 12% distribution. In all, 152 females (65.0%) were subjected to FGM in the Institution.

FIG I: TREND OF PREVALENCE BETWEEN AGE GROUPS AMONG STUDENT TEACHERS



Comment

Gradient = 60/3 = 20

There is approximately, 20% declining rate of prevalence between each generation gap of 10 yrs.

TABLE III

Circumcision among the teachers and students at various age groups.

Age group in years	STUDENTS			TEACHERS		
	Total No.	No. Circumcised	%/age group	Total No.	No. Circume-Ised	%/age group
<20	35	14	40	1	1	100
21 - 30	137	86	62.8	20	8	40
31 - 40	58	49	84.5	38	33	86.8
>40	3	3	100.0	24	21	87.5
Total	233	152	287.3	83	63	314.3

Table III shows that among the students, majority (58.8%) fall under the age group 21 - 30 years. Among the teachers, majority (45.8%) fall under the age group 31 - 40 years. While 73.8% of the students are under 30 years of age, 74.7% of the teachers are above 30 years of age.

The table shows percentage prevalence within each age group rising steadily with older age groups. This is more striking with student teachers. See fig. I on graphic representation.

Chi-Square Test of Association between FGM and advancing age groups among (Student Teachers) is as follows.

Calculated chi-Square (X^2) = 21.2

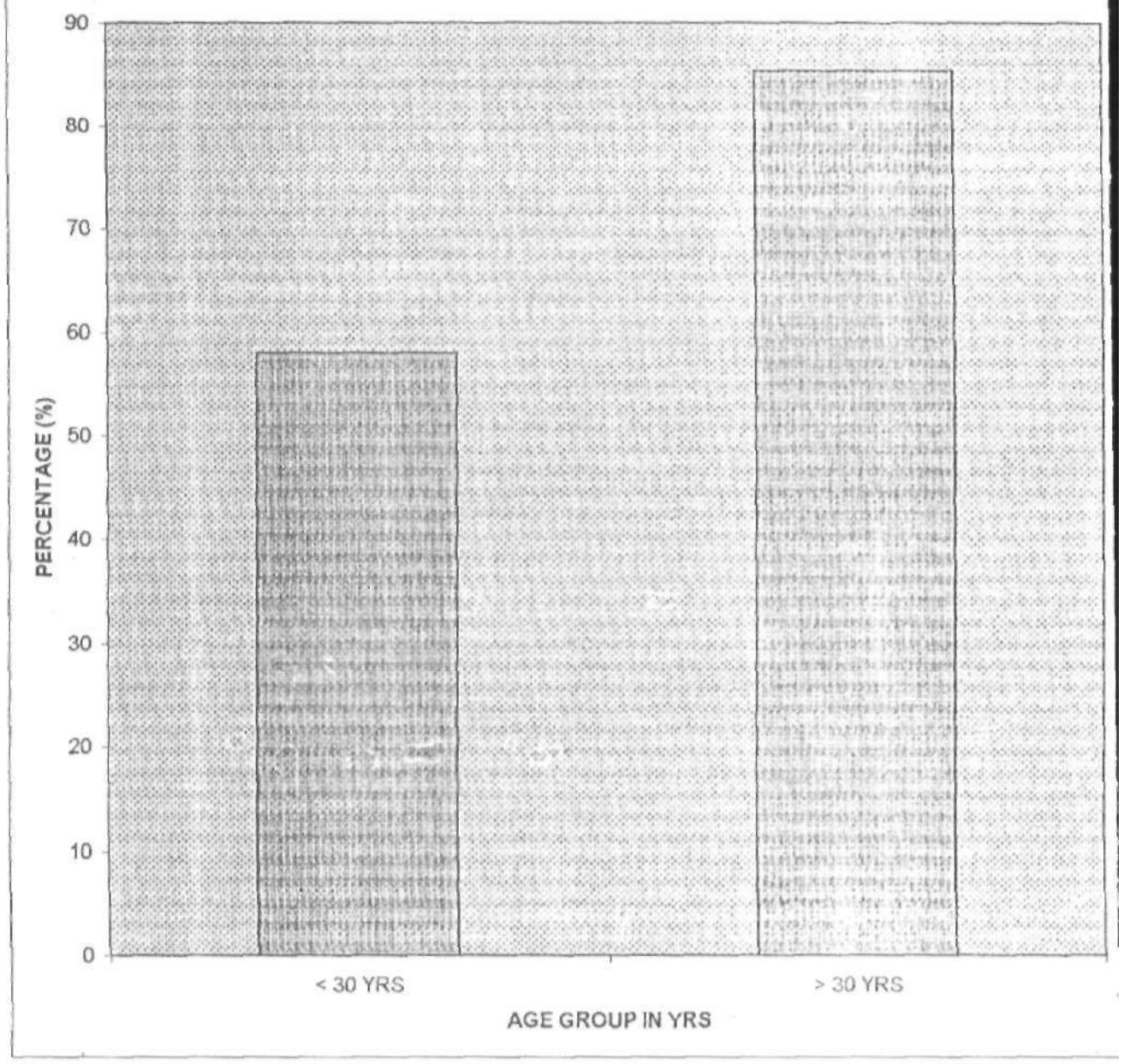
degree of freedom (df) = 3

At 1% and 5% level of significance, with df = 3, X^2 from table = 7.81 and 11.34 respectively.

Obtained X^2, 21.2 is significantly higher.

Null hypothesis is therefore rejected at both 1% and 5% level of significance. The author concludes that FGM in this community is associated with advancing age group by the alternate hypothesis being upheld.

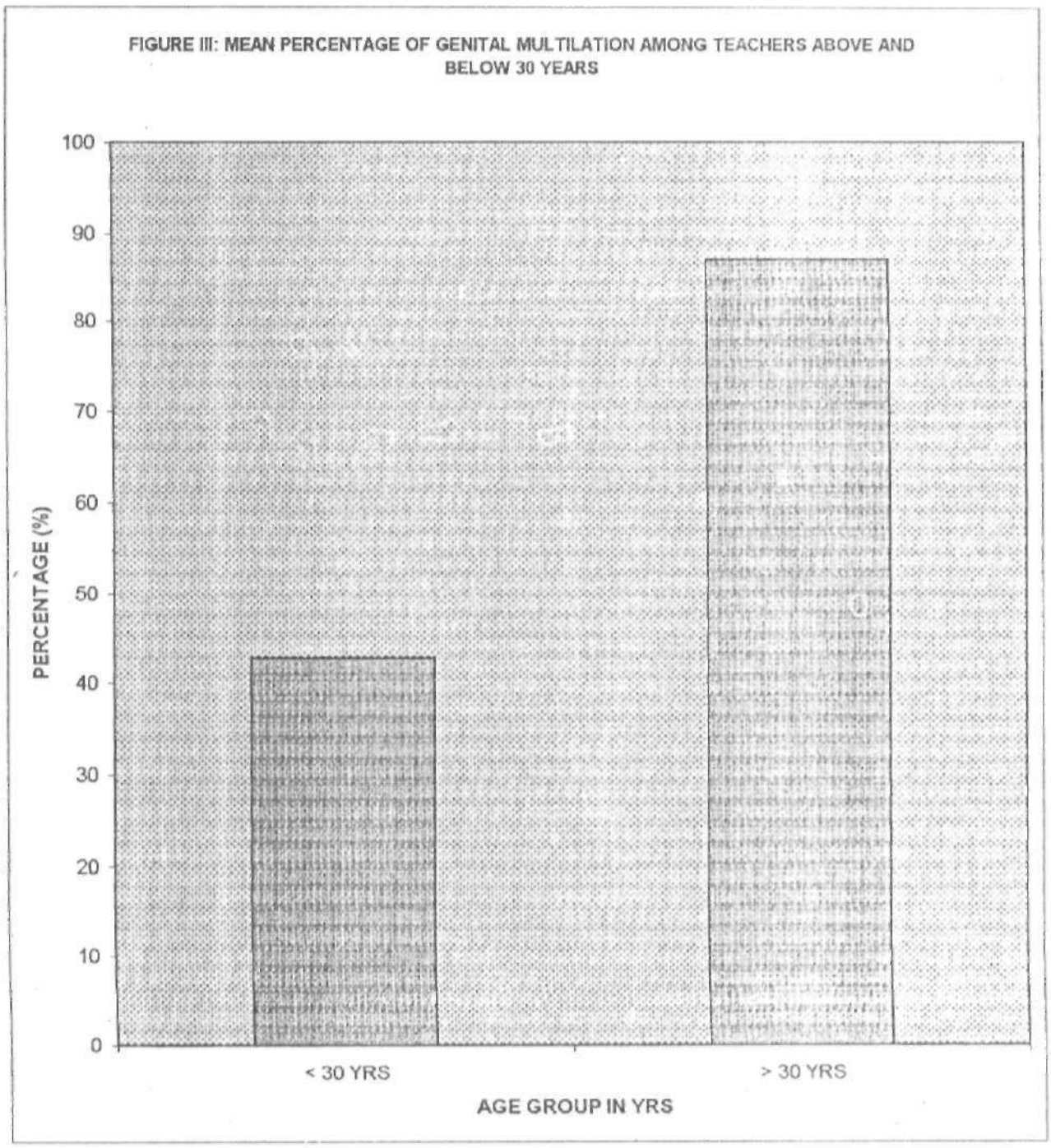
FIGURE II: MEAN PERCENTAGE OF GENITAL MULTILATION AMONG STUDENT TEACHERS ABOVE AND BELOW 30 YEARS



COMMENT

Students above 30 years show a higher prevalence (85.3%) than students under 30 years (58%)

FIGURE III: MEAN PERCENTAGE OF GENITAL MULTILATION AMONG TEACHERS ABOVE AND BELOW 30 YEARS



COMMENT

Teachers above 30 years show a higher prevalence (87%) than teachers under 30 years (42.8%)

TABLE IV

Circumcision at pregnancy and before conception

		At pregnancy		Outside pregnancy		
	No.	No. Circumcised	%	No. Circumcised	%	Total
Student	154	75	48.7%	79	51.2%	100%
Teacher	62	38	61.3%	24	38.7%	100%
Total	216	113	110.0%	103	89.9%	200%

In this study group, over half of those circumcised (110%) took place during pregnancy, while (90.0%) of those circumcised took place before any conception.

Chi-Square Test of Association

Calculated $X^2 = 3.87$ (corrected).

df = 1

At 5% level of significance

Table $X^2 = 3.84$.

Calculated Chi-Square is significantly higher

Therefore probability for Null hypothesis to be true for a non association between FGM and pregnancy is 0.05. This is highly unlikely and therefore null hypothesis is rejected. Based on this the author concludes that FGM is associated with pregnant state in this community.

Table V

➤ Circumcision at various stages of child development.

	Neonatal period		Infancy		Childhood	
	No.Circume-ised	%	No,Circume-ised	%	No,Circume-ised	%
Student Teachers	21	15.4	30	22.0	50	36.8
Teachers	10	7.4	12	8.8	44	32.4
Total	31	22.8	42	30.8	94	69.2

Comment

Among those who circumcised before the reproductive age, 30.8% took place within one year of birth, while 69.25 took place later in childhood. Also, among those circumcised at infancy, majority (74%) were done at neonatal period.

Table VI

Age in years at first pregnancy when circumcised

Age group in years	Frequency distribution (F)	%	Cumulative frequency
10 -15	2	2.6	2
15 - 20	29	38	31
20 - 25	38	50	69
25 - 30	7	9.2	76

Mean = 20.8 years

Mode = 20.85 years

Median = 19.7 years

Standard Deviation = 3.42 years

Comment

Average age of respondent who were subjected to genital mutilation at first pregnancy is 21 years. Also, 50% of respondents subjected to the procedure during pregnancy fall within the age group 20 - 25 years.

Table VII

Age in years at Circumcision conducted before first pregnancy.

Age group in years	Frequency distribution		Cumulative frequency
	(F)	%	
0 - 5	35	60	35
5 - 10	3	5	38
10 – 15	4	6.9	42
15 – 20	15	25.9	57
20 – 25	1	1.7	58

Mean = 16.5

Mode = 20

Median = 4

Standard Deviation 8.2

Comment

Majority of subjects (60%) subjected to genital mutilation at pregnancy state are under 5 years of age.

Table VIII

Complications from circumcision

Types	Nos of cases	%
Post Operative Bleeding	5	3.3
Post Operative pain	3	2.0
Post Operative Wound	1	0.7
Total	9	6%

Total complications was 6% of those subjected to genital mutilation, Post operative bleeding accounting for the largest with 3.3%.

FIGURE IV: SHOWING PERCENTAGE DISTRIBUTION OF COMPLICATIONS AMONG THE CIRCUMCISED

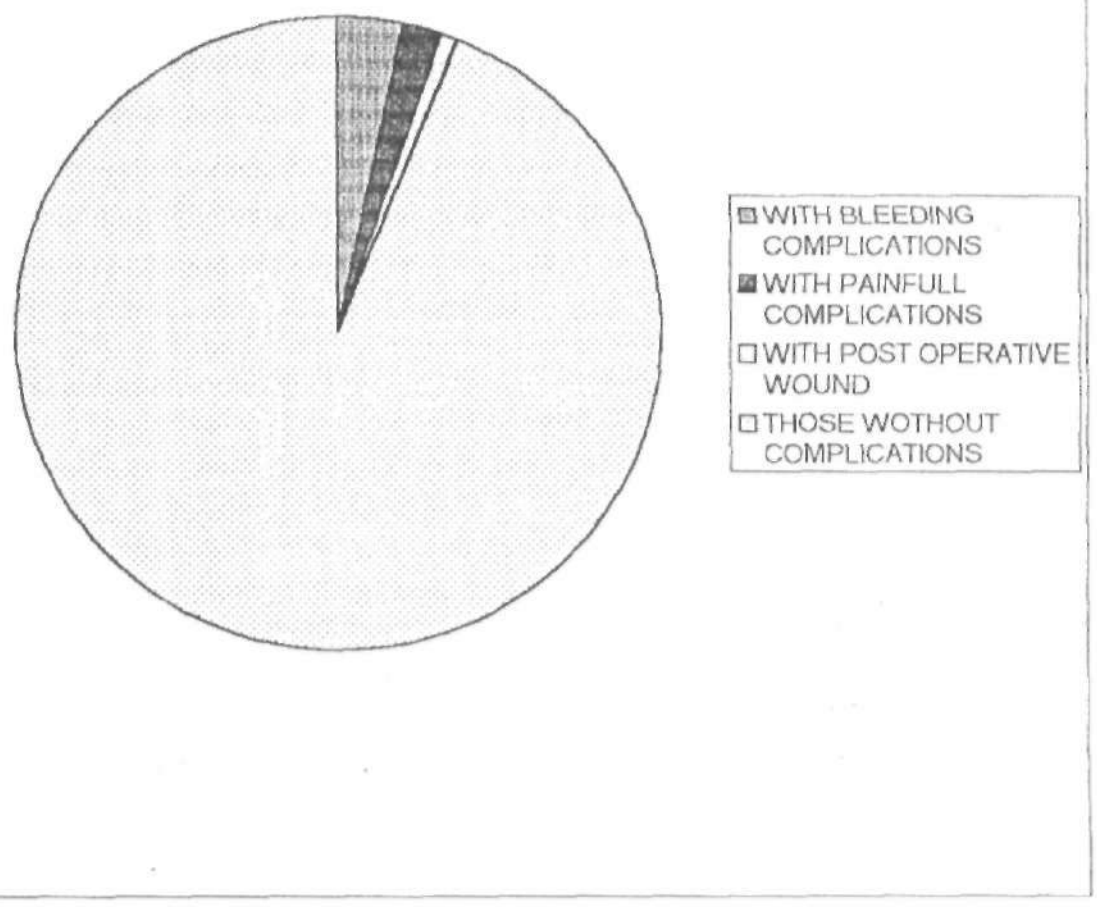


Table IX

Response to willingness to stop the practice of FGM

	No of No	%	No of Yes	%
Students	38	12.3	178	58
Teachers	15	4.9	76	24.8
Total	53	17.2	254	82.8

Comment

Table IX shows that 17.2% of respondents are still not in favour of stopping the practice of FGM, while the majority of respondents (82.8%) indicate readiness to stop the practice.

FIGURE V: RESPONSE TO WILLINGNESS TO STOP THE PRACTICE OF FGM

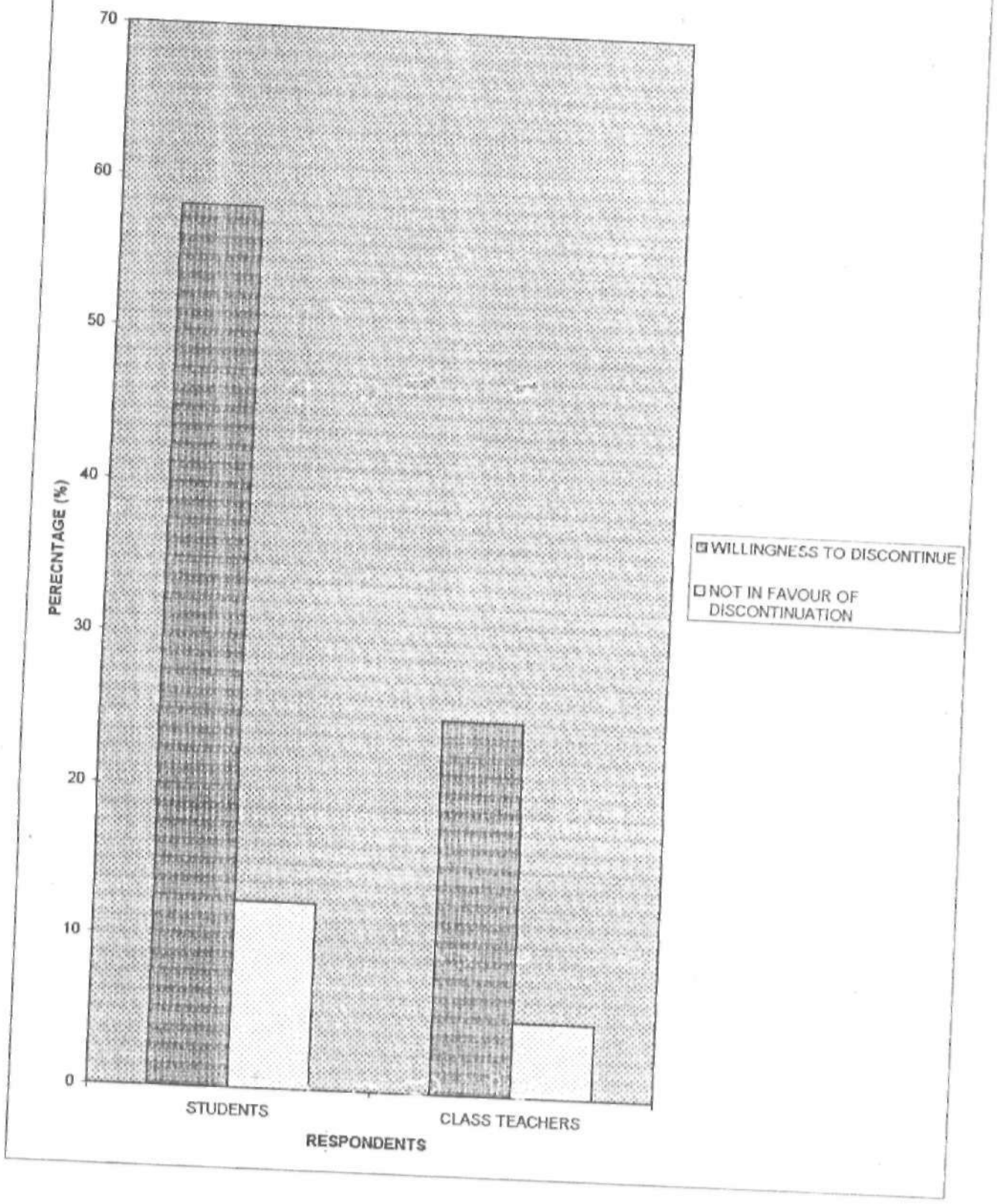
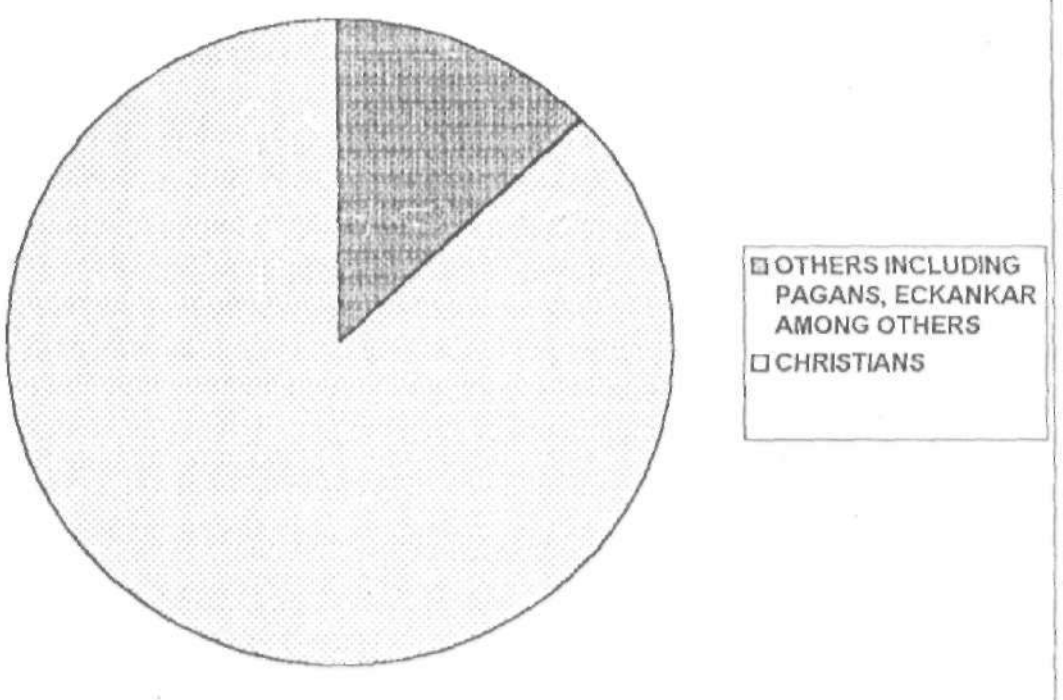


FIGURE VI: SECTARIAN AND RELIGIOUS DISTRIBUTION WITH THE PRACTICE OF FGM



COMMENT

Majority (87%) of circumcised respondents are Christians while the remaining proportion (13%) are made up of other sects and groups.



PLATE: 1 STUDENT TEACHERS BEING BRIEFED ON COMPLETION OF QUESTIONAIRE



PLATE: 2 STUDENT TEACHERS COMPLETING THEIR QUESTIONAIRE

DISCUSSION

4.2 DATA ANALYSIS

The pilot study revealed a very low prevalent rate (2.6%) of FGM among the female students studied in the locality in a secondary institution, (Table I). The age group of the study sample was between 15 to 19 years. When this low prevalence of FGM was evaluated with assistance from Local Community leaders and women in the community, it was found that the figure does not reflect the true prevalence of FGM practice in the community; because by tradition, circumcision is generally done at first pregnancy. Thus, it was concluded that the main target group is the reproductive age group. It therefore, became necessary to select a sample with the reproductive age group adequately represented.

The female student teachers sampled presented such a group as majority of the students sampled (58.8%) fell under the age group 21 - 30 years which included the main reproductive age group, the target age group mostly subjected to FGM. Other age groups are adequately represented in this sample and it is believed the sample is representative of the general female population. With the reselection of the sample from student teachers, the prevalence of FGM was found to be as high as 65% in the community (Table II). A nationwide baseline survey from 1996 to 1977 estimated a prevalent rate of 0.1 to 98% (5). However, in this study, it was found that the prevalence of FGM could be as high as 85% to 100% among those over 30 years of age and as low as 43% among those below. The lower rate among the younger age group is possibly due to the level of health awareness of the relatively more enlightened age group (Table III). The calculated, significant Chi-Square (X^2) value, (21.2) and the Null hypothesis applied infer that with advancing age group, a

female respondent is most likely to have been subjected to FGM. Though no causal relationship can be inferred between FGM and age group, it can be said that indirect factors play some role in promoting and sustaining FGM; thereby bearing a direct relationship with age groups of generations of parents involved in the practice of FGM by influencing their attitudes. Thus while children of older parents suffer more as victims, children of younger generation of parents are steadily being spared. The latter result could be the effect of health awareness campaigns and education steadily eroding promoting factors like ignorance and false beliefs with succeeding generations of parents. In fact, from Table III and Fig.I, it could be seen how the prevalent rate of FGM shows a declining trend from the older age group at the rate of 20% per 10 year generation gap. This drops to a declining rate of 2.0% per year generation gap.

Table IV reveals the fact that half of all those circumcised actually took place in pregnancy, 50% of whom fall within the age group 20-25 years of age (Table III). Average age of subjects at circumcision during pregnancy was found to be 21 years, which falls within the active reproductive age group.

The association between pregnancy and FGM when subjected to Chi-Square Test reveals a calculated significant value of $X^2 = 3.87$ (Table IV; Standard X^2 from table = 3.84 at df = 1 and 5% level of significance). Thus probability for Null hypothesis to be true for non-association between pregnancy and FGM is 0.05. This is highly unlikely and therefore Null hypothesis is rejected, while the alternate hypothesis for an association is upheld. The inference from here is that a woman with a past history of pregnancy state up to 7 months is most likely to have been subjected to FGM in this community.

Circumcision at various stages of child development before reproductive age (See Table V) reveals that a significant number (30.8%) took place at infancy, majority of which (74%) was at neonatal period. Among those circumcised before the reproductive age, (see Table IV), about 70% of them took place in childhood (See Tables IV and V), majority of whom (83%) are children under 5 years (See table VII). This suggests a high level of child abuse and violence against children besides those of women. The prevalence in children is thought to be rising as more people in an attempt to evade being apprehended as a result of government recent position on the practice now perform the procedure on their wards at very tender ages in childhood.

The rate of complication obtained from this study is shown in Table VIII and Fig IV. Complication was seen to be as low as 6% among the circumcised. Those with complications presented mostly with postoperative bleeding, pains and wound infections. The low rate of health awareness, fear of apprehension for practicing FGM, coupled with few and inaccessible health facilities could undermine accurate information on this subject. Secondly, restrictions on the part of the women in communicating freely on subjects of sexuality and reproductive complications hinders obtaining accurate information in this area. In particular, freedom from complications of pregnancy and delivery is used traditionally as a mark of reproductive capability in womanhood in the community. Nonetheless, it is the belief that the low rate of complication could be the result of the type of FGM in practice, probably, type I (WHO classification 1995). The type I FGM is devoid of much tissue invasion and destruction. On the other hand, it is believed that with the attempt

to revert to childhood circumcision, a significant rise in neonatal and infant mortality rates in the community could be registered. Further analysis of this study reveals that as much as 17% of respondents still indicated unwillingness to do away with the practice of FGM, while as much as 83% approves its discontinuation (See Table IX and Fig. V). The high level of disapproval could reflect persisting level of ignorance and traditional values which cut across both male and female respondents alike particularly the elderly ones in the area.

4.3 **Focus group Discussion and Interviews**

Over 70% of interviewers affirm FGM as a cultural and traditional practice among their people and as evidence from the ceremonial display and dances often accompanying some of them with gift presentation from in-laws of celebrants. The festive display is the rite of passage into womanhood and favourites of this festivity claim that not only does this rite accords instant recognition into womanhood for all to see, but it is a sort of socialization which mother-in-laws love to witness if for anything, but for the series of gifts and attention drawn to the family. In fact, it is said that, to remain uncircumcised is not only to miss out of these funs but rather to be compelled to wear a social stigma, denied appropriate status and a 'voice' in the community as a woman. A discussant claimed that during some festivals, the uncircumcised woman is made fun of, and jeered at, by a group of 'light hearted' teenagers and kids with unprintable and obscene vulgar remarks.

One of the women-discussants held high to containment of sexual urge of women as one of the reasons for practicing FGM. It is believed a wife may become unfaithful or sexually intimidating with uncontrollable libido. The traditional males also see the

uncircumcised woman nudely repulsive and therefore unacceptable. It is believed that the female organ (Clitoris) with time overgrows and present like a male organ with similar feature of a propulsive sexual drive. A woman interviewed who had only daughters about 6 in all, claims her first 3 daughters who were not circumcised were rather loose and wayward. She attributed this possibly to the circumcision which was denied those daughters. In other words, infidelity and prostitution is thought of as the penalty for uncircumcised women. This assertion is seen to be presumptuous, as no work has been done to relate promiscuity with FGM. In fact, by the extent of the practice of genital mutilation in this subregion, it would have been expected that prostitution will be a rare profession.

Safe Confinement and delivery is another factor among the long list of beliefs by proponents of FGM in this study. Some men interviewed among the community leaders argued that the tradition is for the woman to be circumcised immediately she conceives the first pregnancy usually at 7 months. The long wait into pregnancy is to be sure the woman proves and merits the new status of being a woman by conceiving and carrying the baby up till 7 months, an age they believe, the fear of miscarriage no longer exists. Having thus proved her new status, she is now circumcised to clear the way for safe delivery. It is believed ignorantly that the Clitoris obstructs safe confinement. While many of the women and student teachers interviewed also held onto this view, some even believe the unborn child could be harmed on his passage over the uncircumcised female organ. Some others see it as a cultural taboo for the unborn child to pass over the uncircumcised female organ without incurring a `bad omen' in later life or a serious affliction of ill-health in childhood.



PLATE 3 FOCUS DISCUSSION GROUP SHOWING A TEACHER SPEAKING



PLATE: 4 ANOTHER DISCUSSION GROUP WITH COMMUNITY LEADERS AND COMMUNITY HEALTH PROVIDERS

One male discussant questioned the use of episiotomy scissors at delivery of first pregnancy. He wonders what the midwife or doctor is cutting, while at the same time disapproving of their traditional circumcision aimed at the same purpose for safe delivery. However, he was properly educated on the role of episiotomy at routine delivery of first pregnancy.

It is noted that while most of these beliefs, attitude and practices hold very little scientific ground to justify FGM, they are however deep rooted in tradition and culture of the people concerned. A proper understanding of their complexities, on how they are sustaining the harmful practice really needed to be unravelled to check the practice.

In summary, the following factors have been identified as promoting and sustaining female genital mutilation in the community. These include:

(1) Culture and tradition.
(2) Ignorance.
(3) Myths.
(4) Aesthetics .
(5) Religion.
(6) illiteracy.

Nothing new in particular among these factors except for the fact that they are yielding very slowly, if not disappointingly, to measures of intervention.

Also, parents of most present victims of FGM are illiterates and pagans, factors which literally will complement ignorance and myths respectively in promoting and sustaining FGM. Thus, future generation of more enlightened parents may see a more declining trend in FGM prevalence as it was noted in our study involving the younger and older age groups of students and teachers respectively.

CHAPTER V

5.0 SUMMARY, CONCLUSION AND RECOMMENDATIONS

This research work focuses on female genital mutilation among female students and teachers of a Teacher Training Institute in Kwale, Delta-State. The results of the findings as presented in chapter four is hereby summarized. In other words, this chapter presents the summary of the findings, conclusions drawn from the findings, and recommendations.

5.1 SUMMARY

Based on the data collected and analyzed in chapter four, the findings of this research work is summarized as follows:

(1) That, FGM is still being practiced in the community with a high prevalent rate of 65%.

(2) No new promoting factors were particularly identified but the commonly identified ones include culture and tradition, ignorance; myths, illiteracy and religion. These were merely confirmed as promoting and sustaining factors.

(3) That, as much as 50% of the circumcision took place in pregnancy.

(4) That, in the pre-pregnant state, 60% of victims of genital mutilation is children under 5 years of age

(5) That, 1 out of every 5 victims of genital mutilation in the pre-pregnant state, is a neonatal infant.

(6) There is a gradual but slow declining trend in the practice of FGM.

(7) Complications were few.

(8) As much as 17% of respondents indicated disapproval in measure of intervention aimed at discontinuing the practice.

(9) Majority (83%) of respondents is in favour of discountinuing with the practice.

5.2 CONCLUSION.

Based on the Summary of these findings the following conclusion is obtained:

For now, FGM is still widely practiced in this community and the impact of preventive and interventionary measures are yet to be adequately felt, though there is a declining trend in the practice.

5.3 RECOMMENDATIONS

(1) Health Education/enlightenment programmes.

Except for enlightenment programmes through the electronic media and state television, there is little on ground to sustain the eradication programme on FGM in the community. Most people don't listen to broadcast and power supply is so irregular that the average community individual in the locality hardly watches the state television programmes. In the light of these constraints, women-advocacy-groups at the local government level need to be established and coordinated. Local government health workers can identify opinion leaders in the community through social clubs, cooperatives among others to form and coordinate this group. Thus, when organized, they can seek assistance from similar state and National Women's Advocacy group and also from NGO's groups. The local women's advocacy groups can organise public enlightenment programmes through video-plays, films and other educational materials. Members can be mobilized to

educate the community through plays, and other life performances.

(2) LEGISLATION

This alone will not end FGM. However, they demonstrate government political will and preparedness to eradicate the harmful practice. Thus, intensive lobbying of policy makers by influential members of advocacy-groups against FGM activities can help to bring about the enactment of appropriate laws against the harmful practice in states where this is still not yet in place. Also, in view of the trend to revert to child circumcision, appropriate child protection law may be deemed necessary against child abuse and violence.

(3) OUTREACH PROGRAMMES

Working with health providers, appropriate task force against FGM can institute programmes in nursing schools, high schools, health care facilities and women organization groups.

(4) SUGGESTED ALTERNATIVES TO FGM

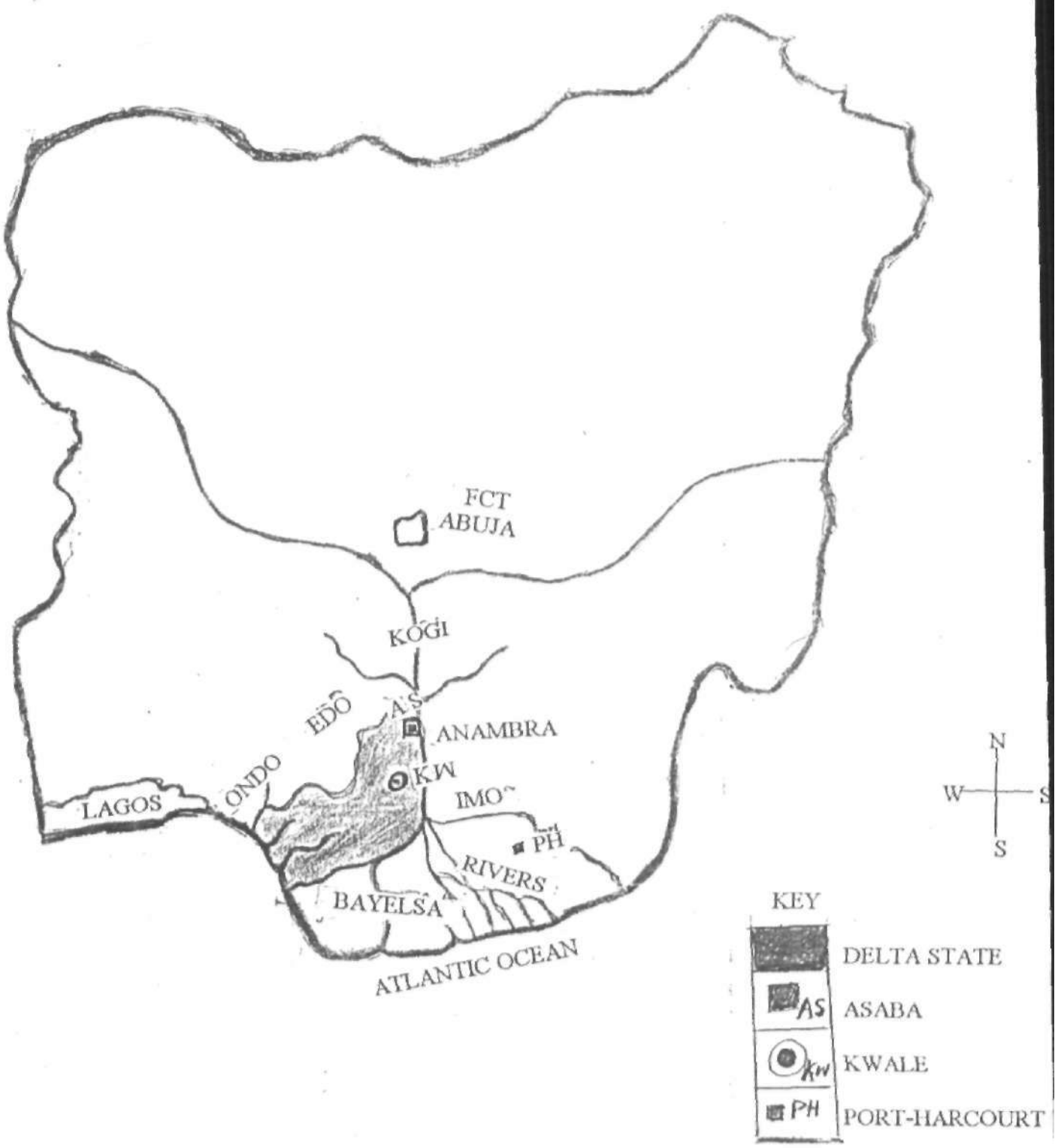
This can be adopted by encouraging some community groups to find healthy alternatives to genital mutilation without giving up its social and cultural aspects. Thus activities like rite of passage for adolescent girls, including the ceremony, gift presentation and automatic rite of passage into womanhood can still be upheld while skipping the actual harmful procedure. This project could also encourage young men to pledge that they will not insist on marrying only circumcised women and young men to pledge that they will not circumcise their daughters. This can be done after much enlightenment and expected change in attitude.

Alternative employment or a retraining of local traditional circumcisers as TBAS for instance, or shoemakers could be instituted to check opposition from this group to various anti-FGM measures. At this point, it is also necessary to advise that associated health workers will need to be well remunerated to check medicalizations of FGM, besides, meting out appropriate disciplinary measures against unscrupulous ones.

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MAP OF NIGERIA SHOWING KWALE IN NDOKWA-WEST LOCAL GOVERNMENT AREA OF DELTA STATE, SOUTH-WEST OF ASABA.



Telegram PERMHEALTH

Telephone

DELTA STATE

MINISTRY OF HEALTH

P.M.B 5012
ASABA
DELTA STATE OF NIGERIA

Your Ref:

Our Ref: NO.HA.109/5/T2/37

15th Sept. 2000

TO WHOM IT MAY CONCERN

The bearer, DR. M.A. EBINUM, a staff of Hospitals Management Board who is currently undergoing a post graduate training in EPIDEMIOLOGY at the Ahmado Bello University, Zaria is currently carrying out a research programme in Reproductive and Family Health in the State.

I would be very grateful if you can give him the necessary assistance he deserves, please.

DR. TABS. O. TABOWEI
Permanent Secretary
Ministry of Health

HEALTH RESEARCH PROJECT ON FEMALE GENITAL MUTILATION AMONG FEMALE SCHOOL TEACHERS IN KWALE & ASHAKA COMMUNITIES, DELTA-STATE.

DEAR MR/MRS./DR./CHIEF/..... Mahn Kaizer .....

.....

RE- FOCUS GROUP INTERVIEW ON ABOVE PROECT.

You are cordially invited to participate in the above named project on female circumcision in the community among female school teachers. Your contribution will be highly appreciated.

Time:..... 11 · A·M ·.....

Venue:..... 030 Mixed Boys School, Ashaka. .....

DR. M. EBINUM.

APPENDIX D

Telegrams: Education-Kwale

Telephone 053/801025

DELTA STATE

MINISTRY OF EDUCATION OFFICE

(NDOKWA WEST LOCAL GOVERNMENT AREA)

P. M. B. 9
KWALE
DELTA STATE

Your Ref.....

Our Ref No. MEK.16/102

12th Oct. 2000

Dr. M. Ebinum
Department of Community Health,
Abu - Zaria

Re - Application to Conduct a Ressarch On Female Students and Teachers in Ndokwa West L.G.A. Post - Primary Institutions

With reference to the above subject matter, I am directed to inform you, that you have been granted approval to carry conduct your research in Ndokwa West Local Government Area, Post Primary Institutions.

(J. K. Otutu)
for Chief Inspector of Education,
Ministry of Education,
Kwale.

HEALTH RESEARCH PROJECT,
FEMALE GENITAL MUTILATION AMONG FEMALE TEACHERS IN KWALE / ASHAKA, DELTA STATE.

Strictly confidential. No name. No Address.
Please read carefully and be blessed as you complete.

SECTION A-DEMOGRAPHY

(1) Age 37 (2) Married / Single..... (3) No of Children N/A

(4) Religion
(i) ✓ Xtian (ii) Muslim (iii) Pagan (iv) Atheism

(5) Highest class(educational level) attended N.C.E (6) Ethnic Origin(tribe).....

(7) Highest class attended by
Mother Nursing Father Dispenser

(8) Profession (Trade) of:
Mother Nursing Father Dispenser

SECTION B (Tick box appropriately)

(9) Are you circumcised? Yes ☑ No ☐

(10) Age at circumcision? 7 day (11) Any initiation rite or ceremony done? Yes ☐ No ☑

(12) Any reason or reasons why you're circumcised? according to traditional r

(13) Was circumcision at first pregnancy, before or after? before

(14) Any medical problem following? Yes ☒ No ☑

(15) Please describe or explain any of the problem. There was no Problem after Circumcision

(16) If you have not been circumcised, will you like to be circumcised later? Yes No

(17) If yes, or no State reasons. is to reduce the sexual urge

(18) Will you circumcise any of your daughters? Yes ☑ No ☐ Tick one

If yes, or no state reasons. Uncircumcised female always indulge in sexual acts.

SECTION C

(20) Are you aware that female circumcision can cause problem sooner or later in life? Yes ☐ I am aware. No ☑ I don't know.

(21) Are you aware of existing efforts to stop the practice world-wide?

Yes [✓] I am aware No [ ] I don't know

(22) Are you in favour of stopping the practice? Yes [ ] No [✓]

(23) If yes or no to 22 above, state reasons. females who are not circumcised always indulge in sexual acts

(24) If yes to 22 above, what measure if any have you ever done personally, or jointly in any formal group to check the practice?.....

.....

(25) Will you like to be personally interviewd by the research worker? Please indicate by ticking Yes [✓] No [ ]

(26) If yes to 25 above, give name and address of yourself below.

Miss Stella Egwuru

NO 142 Umusadege road

Kwale or Iyiashili Pls ulogbe