ISSN: 3281-3721
Volume 10, Number 2, 2023
International Journal of Education and Sustainable Development

PARENTAL ATTITUDE AND FEMALE GENITAL MUTILATION IN RIVERS STATE: IMPLICATIONS FOR COUNSELLING.

Dr. Konye Nwachukwu
Department of Educational Psychology, Guidance and Counselling
Faculty of Education, Ignatius Ajuru University of Education
Rumuolumeni, Port Harcourt, Rivers State, Nigeria

E-mail: konye.nwachukwu@yahoo.com

ABSTRACT

It is for the most part accepted that singular mentalities of guardians and other relatives affect choices connected with female genital mutilation, such perspectives are impacted by normal practices in the general public. This study examines parental attitude and female genital mutilation in Rivers State, implication for counseling. A survey design was adopted for the study. The sample consisted of four hundred (400) women, drawn from four (4) local government areas namely; Port Harcourt City, Obio/Akpor, (Urban) Khana and Ahoada East (Rural) respectively. The respondents to the study were chosen through a straightforward method of random sampling. An instrument named; The self-designed Parental Attitude and Female Genital Mutilation Questionnaire (PAFGMQ) was utilized for data collection. The instrument was approved by specialists from the Division of Brain science, Ignatius Ajuru College of Training, Streams State. Cronbach alpha insights was utilized to decide the dependability under of 0.81 for the instrument, the information gathered were examined involving mean scores for the exploration inquiries while the invalid speculations were tried with individual item second relationship coefficient. The major findings of the study reveal that, female genital mutilation heightens the risk of psychological problems and emotional trauma among women. The study recommends among others that Rivers State Government should enforce the existing laws on female genital mutilation and ensure strict compliance by those concerned.

Keywords: Parental Attitude, Female Genital Mutilation, Implications for Counselling.

INTRODUCTION

For non-medical reasons, female genital mutilation (FGM/C), also known as female circumcision, is the practice of removing the external genital organs partially or completely. It is a collection of procedures categorized into four main categories based on their precise anatomical extent and increasing severity: The expression "clitoridectomy" (type I) depicts the fractional or complete evacuation of the clitoris or its prepuce; type II (excison) is the fragmented or complete ejection of the clitoris and the labia minora, paying little mind to extraction of the labia majora; type III (infibulation) incorporates the limiting of the vaginal opening through the development of a covering "seal" molded by cutting and repositioning it.

FGM is a harmful practise that is recognised to violate human rights. Various deep rooted basic freedoms ideas, standards, and norms are broken by the act of female genital mutilation (FGM). The freedoms of kids, the preclusion against torment and other awful, brutal, or embarrassing treatment or discipline, the guidelines against segregation in light of sex, the right to life (in situations when the activity brings about death), and the right to life are among them. It is restricted by regulation in a few African and Western nations.

Joined Countries Youngsters Asset in 2016 assessed that somewhere around 200 million ladies and young ladies in 30 nations have been exposed to FGM/C, with Nigeria among four nations where 66% of all ladies who have gone through FGM/C live and the other three nations are Egypt, Ethiopia, and Sudan. Notwithstanding the hopefulness that the law (Kid's Freedoms Regulation, 2004) will save more than 40 million Nigerian ladies and young ladies from the unexpected issues of FGM/C, its implementation and conviction for wrongdoers for causing substantial mischief, mental injury, and advancing wellbeing perils among Nigerian ladies, for the sake of circumcision or other conventional and social practices destructive

to ladies' wellbeing, is not yet clear (Ifijeh, 2015). According to UNICEF (2013), it is estimated that 20 million Nigerian women and girls have undergone FGM, or 10% of the global 2016); in numerous Nigerian people group FGM/C is still till date constrained upon ladies and young ladies by ladies, essentially moms and 'aunts' (Akosile 2016) and marked as 'ladies againstwomen' (Edukugho, 2015). It causes serious, and in some instances, life-threatening, health complications and violates the human rights of women and girls. It is an unsafe practice that is a significant danger to the strength of ladies and young ladies, including their mental, sexual and conceptive wellbeing, which can expand their weakness to HIV and may have unfriendly obstetric and pre-birth results as well as lethal ramifications for the mother and the new conceived. It is also widely acknowledged as an outrageous type of oppression ladies and a major infringement of the common freedoms of young ladies and ladies (Okeke, Anyaehie, & Ezenyeaku). It also reflects deeply rooted inequalities between the sexes. 2012). The experience of genital mutilation has been related with a scope of mental and psychosomatic issues. For instance, young ladies have announced aggravations in their eating and dozing propensities, and in temperament and perception. Ladies might encounter sensations of inadequacy, low confidence, misery, constant nervousness, fears, fits of anxiety, or even crazy issues as they age. Girls who have not been circumcised may experience psychological trauma as well as social stigma, community rejection, and inability to marry locally.

Experiencing sexual pain or discomfort can bring back memories of the original act. With or without the clitoris being removed, some continue to experience severe emotional and physical pain as a result of coitus, which may result in sexual inhibition and frigidity in the inner or outer labia.

Age of mothers, religion, place of residence (urban vs rural), family wealth index, maternal education, and ethnicity were shown to be related in a 2016 research by Setegn, Lakew, and Deribe with the experiences of mothers and/or daughters with female genital mutilation (FGM/C). When compared to urban areas, it was discovered that the prevalence of FGM/C was higher in rural areas. In a similar vein, Muchene, Mageto, and Cheptum (2018) conducted an assessment of Maasai women's knowledge and mentalities in regards to the obstetric impacts of female genital mutilation in the maternity ward of a Kenyan hospital in the Loitokitok Sub-County. 64 mothers admitted to the maternity ward were questioned about their knowledge of and attitude toward FGM/C and its effects on obstetrics. 78% (n=50) of respondents were from rural areas, while 22% (n=14) were from urban areas. Discoveries laid out that greater part of the respondents, 81% (n = 51), had negative demeanor towards FGM/C. The review laid out that greater part of the ladies felt that FGM/C didn't cause a lady to feel more satisfactory as a decent lady or feel more joyful. The majority of people who responded to this study thought that the practice was outdated, had outlived its usefulness, didn't provide any real benefits, or promoted useless pride in the initiates. This suggested that women's attitudes toward FGM/C were shifting, and they were supportive of the new behavior.

In Nigeria, it is assumed that rural areas, where social norms and community ties are stronger, are more likely to see FGM/C occur. Nonetheless, According to the Nigeria Segment and Wellbeing Overview (DHS, 2013), FGM/C is almost equally prevalent among young women under 14 residing in metropolitan (16.8%) and provincial (17%) districts. The aforementioned figures show that the number of girls and women having FGM/C has increased, despite the need to account for the potential of older women moving between rural and urban regions in urban areas has significantly decreased, whereas the situation for rural women has remained virtually unchanged. Demographic and Health Survey of Nigeria (DHS, 2013: According to its survey, FGM has been performed on 32.3% of Nigerian women between the ages of 15 and 49 who live in urban areas vs 19.3% of women in rural regions. Because a woman may have relocated after having FGM/C, especially if she had the procedure when she was young, prevalence by current address may not be a reliable indicator. Therefore, it is more beneficial to examine prevalence among young females in relation to where they live (UNICEF, 2013:37).

Statement of problem

Female genital Mutilation (FGM) has been a pervasive problem all over the world. Female genital mutilation (FGMC) is projected to affect more than 200 million girls and women worldwide across 30 nations, with an average of 3 million girls at risk, despite the global promise to stop FMG by 2030.

Maintaining good health and allowing men to have sexual pleasure are two factors associated with the development of a form of female genital mutilation. The most explanation is social practice. According

to some studies, female genital mutilation (FGMC) has the potential to influence a woman's health care seeking behavior and experience with certain health services. Ken and Roberts-Holmes (2013) show how ladies with FGM take on casualties' ways of life because of the profiling during the assylum method, which compels them to reveal and hold horrible and personal accounts of savagery which typify then as casualties.

Minister Bravo et al (2018), Berggren et al (2006), portray how ladies felt gazed at wellbeing proficient and once in a while they saw a loathing or an absence of regard displayed to them, which caused them to feel embarrassed. However, research suggests that men's ambivalence toward the practice is growing. For instance, according to the study (Fahmy, EL- Mouethy, & Regas, 2010), Egyptian men want their wives to have the procedure because they believe it will improve women's sexual morality. However, the men also believe it will hurt their sexual pleasure. According to research from Sudan, the loss of sexual pleasure for both the wife and the husband as well as the husbands' empathy for the pain and suffering that penetration can inflict on re-infibulation spouses after childbirth may be detrimental to the husbands' manhood (Berggren etal, 2006).

Rates of female genital Mutilation have risen in Nigeria to 4.3 million in 2023. Female genital Mutilation remains wide spread in Nigeria. Despite all the researches carried out in finale genital Mutilation across the globe, there is none known to the researcher that tried to find out the relationship between female parental attitude and female genital Mutilation in Rivers State, Nigeria which is the gap that the researcher intends to fill.

Purpose of the study

The main purpose of this study was to determine the relationship between parental attitude and female genital Mutilation in Rivers State. Specifically, the study sought to do the following.

1. To find out the relationship between the attitude of parents in Urban areas and female genital Mutilation in Rivers State.
2. To find out the relationship between the attitude of parents in rural areas and female genital Mutilation in Rivers State.

Research Questions

The following research questions were used to guide the study.

1. What is the relationship between the attitude of parents in Urban areas and female genital Mutilation in Rivers State?
2. What is the relationship between the attitude of parents in rural areas and female genital Mutilation in Rivers State?

Hypotheses

The following null hypotheses were tested in the study.

1. There is no significant relationship between the attitude of parents in Urban areas and female genital Mutilation in Rivers State.
2. There is no significant relationship between the attitude of parents in Rural areas and female genital Mutilation in Rivers State.

LITERATURE REVIEW

Concept of FGM/C

According to WHO (2008), “the expulsion of the female genital organs in entire or to some extent, or other damage to them, for non-clinical designs, is known as female genital mutilation (FGM/C).”

There are currently four categories of FGM/C as described by the WHO (1997): Type 1 (clitoridectomy) entails partial or complete ejection of the prepuce as well as the clitoris. The clitoris and labia minora are either entirely or partially removed, together with the labia majora, during type 2 (excision). To constrict the vaginal entrance and make a covering seal, Type 3 (infibulations) entails cutting and appointing the labia minora or majora, with or without clitoris excision. Defibulation, or opening of the covering seal, is frequently required prior to childbirth, making it the most invasive form of FGM/C. Reinfibulation alludes

to the diversion of an infibulation after defibulation. Type 4 (other) encompasses any non-medical practises, such as stinging, piercing, cutting, scraping, and knife usage, that injure the female genitalia (WHO, 1997).

Consequences of FGM/C

Girls who have FGM/C incur the immediate danger of suffering from excruciating pain, bleeding, shock, difficulties passing urine and faeces, and infections. Chronic suffering and illnesses may be long-term effects (WHO, 2008). Numerous obstetrical problems were identified in a study of the health impacts of FGM/C (WHO, 2000), with postpartum haemorrhage, mother and foetus deaths, protracted labour and/or blockage, episiotomies, and perineal tears being the most frequent. A new report examining 28,393 ladies going to obstetric focuses in a few African nations (WHO study bunch, 2006) presumed that ladies with FGM/C were essentially more probable than those without to have unfavorable obstetric results, for example, a cesarean, post pregnancy blood misfortune ≥500 ML, broadened maternal emergency clinic stay, birth weight <2500 g, baby revival, and ongoing perinatal passing. The creators additionally presumed that the dangers appeared to be more noteworthy with greater FGM/C. All the more as of late, a methodical survey on the sexual results of FGM/C discovered that ladies with FGM/C were two times as reasonable not to encounter sexual longing, 1.5 times bound to have torment during intercourse, and they experience less sexual fulfillment (Berg and Denison, 2011).

For some young ladies and ladies, going through FGM/C is a horrible encounter that may unfavorably influence their emotional well-being. In point of fact, FGM/C has been linked to a number of mental and physical conditions, including eating and sleeping disorders (HRP, 2006). There are likewise reports of posttraumatic stress turmoil, tension, and gloom related with FGM/C (WHO, 2008). Information from a methodical survey of the mental results following FGM/C showed that ladies with FGM/C might be bound to encounter mental unsettling influences, including uneasiness, somatisation, low confidence, and to have a mental determination (Berg et al., 2010a).

Ultimately, given FGM/C is a profoundly dug in custom among a few ethnic gatherings it conveys results both when it is and when it isn't drilled. Girls and families gain social status, respect, and community membership when they follow the practice (UNICEF, 2005b). In certain social orders, the connection between FGM/C and worth is express: The lady of the hour cost of a young lady who has gone through FGM/C is fundamentally higher than that of a young lady who has not (Wheeler, 2003). Young ladies who have gone through FGM/C every now and again get prizes as festivities and gifts. Conversely, neglecting to adjust can result in the young lady's family's social prohibition from the local area, as well as troubles in tracking down a spouse for her, disgrace, and disparagement (UNICEF, 2005b).

Impact at Society and Community Level

Ahlberg and partners (Ahlberg et al., 2001) offer the viewpoints of sources who believed that they routinely expected to lie about their status as circumcised people in order to escape criticism or social avoidance in Sweden. The way that "Swedish persons" spoke about the training, in their opinion, was detrimental and made the participants feel inferior (i.e., Here the uncircumcised are the bigger portion... Because "they see us as a big thing and you feel inferior," they were forbidden from talking about the matter.

Numerous studies (Johansen, 2002; Jordal and others, 2018; Kahn, 2016; Parikh and others, 2018; Vloeberghs et al., 2011) examining the psychological and social well-being of cut women in the diaspora talk about the reported experience of "feeling different" and shame. In order to avoid being judged and stigmatised, those who desired clitoral reconstructive surgery denied having had FGM in public. The majority of the women in this research intended to use the activity to get "ordinary looking" genitalia (Jordal et al., 2018). Parikh et al. (2018) examine how women react to stigma, revealing a similar sensation of "feeling unique" and a desire for culmination: Some attempt to deflect the topic with humour, while others simply shun it (Parikh et al., 2018).

Johansen depicts school-young ladies' feeling of shock and harshness about their condition. "as if the fact that I was different down there was written on my forehead" (Johansen, 2002). According to Johansen (2002), sense of difference affected interactions with guys and engagement in sports as well as

socialisation with peers. Ahlberg and colleagues (2004) explain how schoolgirls of Somali heritage in Sweden engage in stigmatising behaviour such as "checking each other" and listening to the sound of urination in the lavatory in order to put social pressure on one another. The connections between those who underwent FGM and others who did not, according to some girls, were impacted by negative discourses regarding the practice, which in turn affected their sense of belonging. These discourses had a negative impact on the mental health of females who have experienced FGM in some way. For instance, one of the girls said, "Our teacher dramatises as if circumcision were a disease when she talks about it." understudies feel sorry for you and think you are unique. A few guardians had misled the young lady as well as to the family about her FGM status to safeguard her. This prompted vulnerability and instability among the young ladies (Ahlberg et al., 2001) and had an effect on their confidence in family members.
Alhassan et al., a number of other studies, have looked at how worried migrants are about family members in their home countries pressuring them to perform FGM on their daughters. 2016; Isman et al., 2013; Koukoui et al., 2017; Owojuyigbe et al., 2017; Vloeberghs et al., 2011), which is reflected in their and their daughters' reputations. In a concentrate on African travelers in Portugal, Spain, and Italy, transients felt tension from their mothers by marriage back in their nation of origin with respect to the extraction of their girls. In the nation of beginning, ladies who had not gone through FGM would be minimized and wouldn't have the option to partake in local area exercises, functions, and navigation. " Uncircumcised" ladies in Guinea Bissau were named "solima" (discourteous, juvenile, unseemly) and blufo (moronic, unbridled). Similarly, uncut women are referred to as prostitutes in Eritrea. Parents were concerned about their daughters' and their own reputations when they returned home, despite the fact that such labels were not used as frequently in diaspora. According to Alhassan et al., those who did not have their daughters shaved were said to be stigmatized back home and accused of undervaluing their culture. 2016).
Alhassan et al., a few studies address parents' concerns about their daughters' sexual appetite control and reputation (Alhassan et al., 2016; Koukoui and other, 2017). Taking a gander at travelers from FGM rehearsing networks in Canada and in Ivory Coast, Koukoui et al. (2017) parents' worries that their uncut daughters' sexual behaviour would make them uncomfortable were discovered, their parents, and the rest of the family, as well as the neighbors, feel shame. As a result, they would be avoided and left out (Koukoui et al., 2017). Kahn (2016) describes, derived on conversations with migrants living in the United States who practice FGM, how social norm-breaking was connected to being punished and expelled by community members. The people who followed up on intrusive convictions were removed from the local area in a demonstration of social hushing

So in any event, when you need to conflict with [circumcision], you would rather not open your mouth and say it. You'll feel frightened. You don't want to be alone in society, do you? You shouldn't say it, even if you don't like it (Kahn, 2016).

O'Neill et al. (2017) found that older Somali male migrants in Europe were particularly vocal about this form of women's marriage exclusion when discussing their home country. According to O'Neill et al., younger Somali males and migrants from countries where FGM is common said that despite the significance of the practise, they preferred wives who had not undergone the procedure.
In a couple of the surveys, it was shown that women who had not undergone FGM were being disparaged and their suitability for marriage was being questioned. In contrast, individuals who had not undergone FGM were viewed as being unfit for marriage and were excluded; cut women were regarded to be more mature, responsible, trustworthy, and (sexually) loyal, and shamed in public (Abathun et al., 2016; Brown et al., 2016; Isman and other, 2013; O'Neill and others, 2017). Women were given examples of when they had not undergone the operation and were sent back to their parents after the wedding (Abathun et al., 2016; O'Neill and others, 2017).
Shell-Duncan and coworkers 2018) found that the acceptance of interethnic marriages in Senegambia increased the likelihood of uncut women marrying into families that practice it. Whole ladies, notwithstanding, revealed their female family's dissatisfaction, which was communicated through boisterous attack, provocation, and prohibition. Whole ladies are normally derisively marked "solema" (meaning discourteous, oblivious, graceless, over-sexed, and messy), and relatives refused to consume the meals they prepared and forbade them from attending family events like weddings and family gatherings. Parents who don't consider a girl's beauty make assumptions about their daughters' morals

and whether or not they are being properly raised, which reflects the family's overall social status in the neighbourhood (Shell-Duncan et al., 2018). Furthermore, Abdelshahid and Campbell (2015) demonstrated that Egyptian parents were afraid about their daughters' social acceptance. The idea behind not cutting girls' hair was that they would humiliate themselves by their sexual behaviour and needed to be "protected" from "wrong-doing" and the embarrassment they would bring upon themselves. Uncut girls were believed to "astray," or become too thrilled by anything that was around them (Abdelshahid & Campbell, 2015).

Relationships with family

Ladies' recollections of feeling deserted on the day they were cut, three examinations embraced in Sweden, the US, and the Netherlands (Berggren et al., 2006; Kahn, 2016; Vloeberghs et al., 2011) illustrate the abuse of children, mainly by their mothers who did not help them. They lamented that the elders had chosen to cut instead of them and several exhibited feelings of betrayal, hatred, and irritation (Berggren et al., 2006; Kahn, 2016; Vloeberghs et al., 2011). Studies in the Netherlands, Canada, Sweden, the United States, and the Netherlands found that mothers who had experienced some sort of damage were motivated to protect their daughters from being cut (Berggren et al., 2006; Isman and other, 2013; Kahn, 2016; Koukoui and other, 2017; Vloeberghs et al., 2011). Leaving their own nation, where it was impossible to avoid the practise, and relocating to a safe area for their daughters, several people expressed relief (Kahn, 2016; Koukoui and others, 2017; Vloeberghs et al., 2011). Not leaving the young girls with their grandmothers, who may cut them without permission from the guardians, was one way to keep them safe (Isman et al., 2013; Johnsdotter et al., 2009; Kahn, 2016; Koukoui and others, 2017; Vloeberghs et al., 2011).

Schultz and Lien (2014) investigate how FGM impacted mother-daughter relationships in a high-prevalence community where it is the societal norm. This is done in the context of a ceremonial initiation. Negative feelings included varying degrees of pain, worry, shock, feeling betrayed, and wrath against the mother. Albeit the impacts on the mother-little girl relationship appeared to be for the most part present moment, as Schulz and Lien recommend, a few ladies experienced personal difficulties in their associations with their moms once they lived someplace far off, banished for good and were presented to contentions against FGM. Different ladies detailed pride and depicted commencement as a holding experience enriching them with status inside the local area (Schultz & Lien, 2014).

Sexual intimacy and Impact on Intimate Relationships/marital relationships

Diaspora in big league salary setting Different examinations reported the troubles presented by FGM on personal connections and sexual wellbeing. Studies carried out in the United States, Belgium, the Netherlands, the United Kingdom, and Belgium have recorded “the experiences of women and men whose sexuality and personal relationships are altered by FGM” (Johansen, 2002; Kahn, 2016; O'Neill and others, 2017; Vloeberghs et al., 2011). Women's accounts of difficult sex due to FGM are presented by Vloeberghs and others (2011) and Johansen (2002), along with women's complaints about the lack of pleasure they had or the effort it took to have sex. No matter how painful it was, having sex while married was seen as a wife's obligation, according to Johansen (Johansen, 2002). Vloeberghs and others 2011) describe how some individuals claimed they made it seem like they enjoyed themselves in order to please their husband, or that they devised justifications for not having “sex when their partners showed interest.” In a review taking a gander at African travelers from FGM rehearsing networks in Belgium, the Netherlands, and the Unified Realm, O'Neill et al. (2017) viewed that as albeit a few ladies revealed no sexual issues connected to FGM, different ladies grumbled that they didn't appreciate sex without question however did it to satisfy their accomplices or on the grounds that they saw it to be an obligation (O'Neill et al. 2017). Be that as it may, others felt sincerely impacted by their accomplices' absence of joy and trouble in having climaxes. Some respondents stated that the ways in which FGM affected their intimate relationships contributed to their divorces. Many of the older Somali and Ethiopian participants in the survey claimed that while casual relationships with uncut women were nice, they would not persist because uncut women were unfit for marriage. The younger European participants in the study thought

that love was a higher priority than FGM status when it came to marriage. According to a Norwegian study (Gele et al., 2012), Norwegian Somali men preferred to marry uncut women.
Ahlberg and others (2004) discuss the divergent perspectives of Swedish Somalis regarding trust, virginity, and various forms of female genital mutilation (FGM). According to reports, uninfibulated virgin brides have been sent back to their parents after the groom and in-laws reportedly questioned the girl's virginity (Ahlberg et al., 2001). According to two studies (Kahn, 2016; Vloeberghs et al., 2011), encounters when looking for a significant accomplice were negatively impacted by sexual agony. Kahn (2016) depicts women who despise sex and experience anguish through sexual activity, which prompted a chain of momentary associations with men as opposed to enduring committed and steady connections. According to additional research conducted in Sweden, women's diminished enjoyment of sex may be attributable to cultural discourses that assert that sex should not be enjoyable for women because it is dirty. As a result, the embodiment of such cultural discourses may also be associated with their diminished pleasure (Johnsdotter et al., 2009).

High-prevalence setting where FGM is a social norm
Taking a gander at the impacts of FGM on sexuality in southern Ethiopia, Fight et al. (2017) report on how male and female newlyweds express their delight and anguish. Women who underwent type III FGM spoke of horrific first sex encounters that included intense pain, bleeding, anxiety, fainting, being sick, and running away. The spouses of infibulated ladies likewise detailed feeling uneasiness and scraped areas on their penis after rehashed fruitless endeavors at infiltration. This difficult and awful interaction was, nonetheless, socially supported and decidedly connected with manliness. Men portrayed this involvement in delight and pride, which was especially connected to a feeling of feeling consoled that no one else had at any point entered their better half. In this review, this cycle is consequently accepted to make an obligation of trust and certainty among man and spouse — a consolation that she would stay devoted to him (Fight et al., 2017).
Fight et al. (2017) also attribute women's aversion to sex, pain, and trauma to the breakdown of relationships between men and women. Their study in southern Ethiopia revealed three major sex-avoiding strategies: These included the promotion of additional sex partners, physical and psychological distance, and a direct refusal of sex. Among the suggestions made for keeping away from sexual contact with one's husband were, for instance, sleeping with children, leaving one's husband's bed in the middle of the night, and acting sick. Fight depicts that viciousness toward a spouse was a socially embraced reaction to protection from sex among her Somali review members in Ethiopia.
In order to avoid having sex with their wives while they were married, men also employed a variety of techniques, such as extramarital relationships, polygamy, or divorce. Usually referenced purposes behind leaving a spouse were connected with her "terrible way of behaving" —, for example, battling, being excessively intense, and fruitlessness. The particular marriage examples of polygamy and separation recommend disappointment and strains in union with infibulated ladies (Fight et al., 2017). A review set in Southern Nigeria likewise shows that in spite of the fact that FGM adds to a lady's decency and notoriety as a spouse, practically all men with extracted wives conceded to routinely engaging in sexual relations outside marriage with numerous accomplices. In any case, sex with their extracted spouses was seen as an obligation, and they kept on interacting sexually with their spouses (Owojuyigbe et al., 2017).
Men's perspectives on their wives' FGM status have been the subject of research conducted in Egypt, Kenya, Nigeria, and Ethiopia. According to Abdelshahid & Campbell (2015), a study conducted in Egypt investigated the ways in which a lack of sexual satisfaction and pain lead to conflict between men and women. Due to the private nature of the situation, some women stated that they were unable to discuss their physical discomfort during sexual activity, their emotions of rejection, or their disagreements with one another or with community members. Women were forbidden to discuss their sexuality. Albeit wedded men lamented their spouses' absence of sexual reaction and want, they felt consoled that their wives didn't appreciate sex to the point of proceeding to look for it somewhere else. That is, The point at which I lay down with my significant other, I'd like her to want me . . . absence of reaction, obviously, requests to no man . . . It does not please any man. in any case, when I feel that my better half has no

sexual drives, I feel consoled, at the same time, when we rest together I feel terrible in light of the fact that she doesn't truly want me. (Abdelshahid and Campbell, 2015)

Different examinations show that men's sentiments about the impact of the FGM on ladies' sexuality are conflicted (Abathun et al., 2016; Campbell and Abdelshahid, 2015; Brown et al., 2016). Concentrates on set in Ethiopia and in Kenya depict how young men faced a great deal of societal pressure to avoid being social outcasts and to avoid having a political or economic effect on local government institutions by marrying women who had undergone FGM. These young men refused to marry cut women despite what their families expected of them because they were aware of the health concerns involved and believed that they should object to the practise; nevertheless, negotiating this was not always easy (Abathun et al., 2016; Brown et al., 2016).

Graamans, others (2018) concentrate on Maasai and Samburu in Kenya recommends that negative originations of ladies' sexuality have given way to positive affiliations in regards to ladies' craving of needing to cherish their spouses, their extravagance in joy, and the "pleasantness of adoration," which were believed to be missing in ladies with FGM. It was suggested that this could have an impact on the intimacy that unites husband and wife and keeps the family together. As a result, having undergone female genital mutilation (FGM) caused worries and uncertainties regarding a husband looking for new wives and couples (Graamans et al. 2018).

Impact at Individual Level: Self-esteem, anxiety, trauma, and other psychological consequences

In a review among ladies who were looking for clitoral re-useful medical procedure in Sweden, Jordal et al. (2018) looked at how women saw FGM affecting their sex lives and intimate relationships. They found that they saw their failure to appreciate sex as an impediment since they were living inside a setting in which ladies' sexual joy and to be sure common delight was seen as significant for closeness and closeness. Albeit some of them had the option to appreciate sex and arrive at climax with the right accomplice or while jerking off alone, the sources generally lacked confidence because they felt ashamed of and uncomfortable in their sexual interactions with their genitalia, which had a negative impact on their self-esteem.

Vloeberghs and others (2011) explain the feelings that women had when they were forced to deal with certain scenarios or reminders, such as having sex, particularly on their wedding night, or giving birth (Kahn, 2016; Vloeberghs et al., 2011).

According to studies (Parikh et al., 2018; Vloeberghs et al., 2011), women avoid and deflect in reaction to “negative discourses about FGM or personal experiences” in which they felt stigmatised, as well as indignation at media representations of the procedure as barbaric and pitying. (Johnsdotter et al., 2009). Vloeberghs and others 2011) describe the outrage and frustration felt by their responders when they learn that not all women had FGM and that it was not a religious obligation. A suspicion of unfairness that they had been slashed while others hadn't sparked outrage and once in a while outrage with family members who permitted the training to occur. Others expressed general resentment toward what they referred to as the "backward" customs and "ignorance" that compelled women to perform the ritual (Vloeberghs et al., 2011).

High-prevalence setting where FGM is a social norm

In high-prevalence settings, there is a dearth of qualitative research that describes the psychological effects of FGM, “such as post-traumatic stress disorder” (PTSD), anxiety, and low self-esteem. Numerous examinations contrasting ladies and without FGM on clinical results have found that ladies with FGM have higher paces of these mental difficulties, like sorrow, nervousness, and posttraumatic stress jumble, when contrasted with ladies without FGM (M. R. Ahmed et al., 2017; Moritz & Behrendt, 2005; Kizilhan and other, 2017; Köbach and others, 2018).

These articles were excluded from this review because they did not match the inclusion criteria since it summarises the qualitative research in this area and supports these clinical results.

Health Care Settings

According to some studies, a woman's status as a victim of female genital mutilation (FGM) may have an impact on how she seeks medical care and how she interacts with various health services. Stigma in health care settings, particularly during pregnancy and postpartum, was the focus of three European studies. In one review, ladies announced feeling humiliated during assessments performed by wellbeing experts (Minister Bravo et al., 2018). Prior examinations portray Somalis' encounters of wellbeing experts' ineptitude during work and how to deinfibulate them, which led to pointless issues during work and conveyance (Ahlberg et al., 2001; Berggren and other, 2006). At the point when medical care suppliers didn't talk about FGM status during pre-birth conferences, ladies some of the time believed that the wellbeing experts knew about how to lead deinfibulation (Berggren et al., 2006). According to Ahlberg et al., women were unable to discuss the deinfibulation procedure with their health care provider because of language difficulties that were reportedly present during delivery. 2001). It has been demonstrated that health seeking is negatively impacted by health care providers' stigmatizing attitudes and a lack of awareness regarding the issue.

Asylum Procedures and Safeguarding Agencies

According to Kea & Roberts-Holmes (2013), two studies conducted in the United Kingdom investigated the manner in which the issue of female genital mutilation (FGM) was addressed in asylum procedures and the manner in which governmental agencies dealt with women who were from nations that practice FGM. Parikh and others 2018) portray how ladies from FGM rehearsing nations in the Assembled Realm feel derided by friendly administrations and shielding offices regardless of whether they are actually against the training.

Kea and Roberts-Holmes (2013) show how ladies with FGM take on "casualty characters" because of the profiling during the shelter methodology, which compels them to unveil and retell horrendous and cozy accounts of savagery which generalize them as casualties. It may be perplexing and mentally hurtful to reproduce stories of one's home, ethnic identity, and family members as archaic and barbarous in conformity with the social norms and cultural environment of the nation from which refuge is sought.

Types of FGM

Type 1, A clitoridectomy involves partially or completely expelling the clitoris as well as the prepuce.

Type 2, regardless of the extraction of the labia majora, extraction also involves partial or full evacuation of the clitoris and the labia minora.

Type 3, regardless of clitoris excision, infibulation includes limiting the vaginal opening and making a covering seal by cutting and designating the labia minora and majora.

Type 4, "other," encompasses any residual painful techniques used on the “female genitalia for non-medical reasons, such as pricking, piercing, etching, scraping, and burning.”

FGM of any kind has the potential to be harmful. The more severe the cutting, the greater the magnitude of both short-term and long-term risks (Berg et al. 2014).

Prevalence and trends

Although “the exact number of young ladies and ladies who have encountered FGM is hazy, UNICEF accepts that somewhere around 200 million have been cut, frequently before the age of 15. In certain settings where type 3 is unmistakable, grown-up ladies are additionally consistently reinfibulated following conveyance” (UNICEF, 2020a).

FGM is basically practised across Africa, as well as in some regions of the Middle East and Asia, but the prevalence and kind of FGM vary widely among states. The north of Africa's countries with the highest frequency are Sudan and Egypt, the east's are Somalia, Eritrea, and Djibouti, and the west's are Sierra Leone, Mali, and Guinea. Additionally, there are differences in the kind of procedures used across and occasionally even within nations. Types 1 (essentially clitoridectomy), 2 (extraction), or 4 (especially "scratching" without tissue evacuation) account for approximately 90% of FGM cases. Infibulation (type 3)—the most severe form of female genital mutilation (FGM)—is performed primarily in the northeastern countries of Africa (Djibouti, Eritrea, Ethiopia, Somalia, and Sudan) and accounts for approximately 10% of cases.

Large-scale national surveys like the Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS) provide UNICEF with representative data on FGM prevalence. Self-reporting forms the basis of the data: Women between the ages of 15 and 49 are inquired as to whether they or their girls have been cut. The information gathered additionally differs between nations, as in certain settings just ladies who have at any point been hitched are incorporated (Yoder and Khan 2008).
These kinds of data have a number of obvious flaws, as Elmusharaf, Elhadi, and Almroth (2006) demonstrate. The genuine numbers may be higher on the grounds that (a) ladies are not generally mindful that they have gone through FGM, particularly assuming the sort of FGM is in the less extreme class of, for instance, emblematic "scratching" of the clitoral hood and (b) in nations where the training is prohibited, respondents are probably going to give the "PC" reply, as they might fear criminal indictment. The 31 countries where FGM is most common, most of which are in Africa, are included in UNICEF's database, which does not include all of these countries. UNICEF's gauge took a major leap from 125 million to 200 million when Indonesia was remembered for the data set after 2013. As per UNICEF, almost 50% of the young ladies younger than 12 have gone through FGM in Indonesia, which has a populace of 267 million.
Last but not least, it's critical to remember that the prevalence of FGM is only an estimate. The numbers change enormously, as the accessible information has extended and techniques for computation of appraisals have become more refined (Yoder and Khan 2008).
In any case, the expanded accessibility of broadly delegate information on FGM, remembering rehash reviews for a few nations, considers basically an overall examination of certain patterns in the predominance of and perspectives towards the training.

Decline in prevalence

There has been a huge generally speaking decrease in the commonness of the act of FGM throughout the course of recent many years, however progress has been unevenly circulated (UNICEF, 2020b; see likewise Koski and Heymann 2017).
The UNICEF-UNFPA Joint Program on Female Genital Mutilation/Cutting targets girls aged 15 to 19 worldwide, and overall, there is a decline in FGM: Speeding up Change (Speeding up Change). For instance, analyzing the most recent data by age group in Ethiopia reveals that the prevalence of women between the ages of 45 and 49 decreased from 75.3% in 2005 to 65.2% in 2016. In any case, the general commonness alone may not completely mirror the advancement among the most youthful age partners. According to the most recent data from 2016, the prevalence for women between the ages of 45 and 49 is 75.3%, while it has decreased to 47.1% for the youngest age group (28 Too Many, Ethiopia). Although some women may have their hair cut after the age of 15, the lower prevalence of the procedure among younger women suggests that it is becoming less common. However, “we also observe this trend in countries that have not been targeted by Accelerating Change, like Liberia, where the incidence of female genital mutilation (FGM) among teenage girls has decreased by half in the past three decades” (UNICEF, 2020b).
For young ladies beneath the age of 15 the image looks considerably seriously reassuring, with critical decrease in FGM predominance in east, north, and west African nations. “Taking a gander at the period 1990-2017, we track down a decrease in predominance in east Africa from 71.4% in 1995 to 8.0% in 2016; for north Africa, predominance has plunged from 57.7% in 1995 to 14.1% in 2015; furthermore, for west Africa, the pervasiveness diminished from 73.6% to 25.4% in 2017” (Kandala et al. 2018).

Shift to less severe types of FGM

One more pattern recognized in the writing is a shift to less extreme kinds of FGM As per Koski and Heymann's review in light of DHS information from 22 African and center eastern nations (2017), there is little proof of a significant change in the seriousness of the systems performed. However, non-infibulating forms of FGM have replaced infibulation in some countries that were not included in the study by Koski and Heymann. For instance, in some regions of Sudan and among various ethnic groups, there has been a shift from "pharaonic" FGM (type 3, infibulation) to Sunna FGM (type 1, clitoridectomy). Sunna cuts are thought to reduce the “health risks associated with more severe forms of

the practice because they are less severe" (Bedri et al.). 2019). It is accepted that the focal point of hostile to FGM crusades on the wellbeing dangers of FGM might play had a vital impact in driving this change, joined with strict talks (counting from state establishments) and empower the relinquishment of pharaonic and the transformation of Sunna as a strict commitment (on the same page.; Al-Nagar and Tennessen will follow).

Medicalization

Even though traditional midwives still cut the majority of girls, some countries are moving toward the "medicalization" of FGM. The practice's medicalization may result in more girls and women being cut in medical facilities with sterile blades, possibly lowering the risk of sepsis or death. Factors propelling medicalization incorporate, yet are not restricted to, somewhere safe.

According to Kimani and Shell-Duncan (2018), 93% of women who have been subjected to medicalized FGM reside in just three countries: Egypt, Nigeria, and Sudan. Strikingly, UNICEF's figures do exclude Indonesia, where medicalized FGM is proceeded as a component of the bundle of administrations for babies in wellbeing offices.

The wellbeing risk approach (remembering training for the negative wellbeing impacts of unsterile instruments, which was normal of the main influx of mediations to forestall FGM) may have unintendedly added to this pattern. Now and again, medicalized cutting has been driven by approaches confining customary birthing assistants yet permitting wellbeing experts to do as such (Egypt during the 1990s and all the more as of late Indonesia). A few investigations recommend that monetary benefit likewise is a variable, albeit occasional the essential persuading factor (Doucet, Pallitto, and Groleau 2017). The literature also highlights factors such as health professionals' attitudes in favor of FGM and their ignorance of laws and professional guidelines that either prohibit or criticize the practice (ibid.). The fact that there is a growing consensus that FGM should be defined as a human rights violation demonstrates that concerns about the practice go beyond minimizing the risks to health.

Drivers of FGM

According to Berg and Denison (2013)a, "cultural tradition," which serves as both a form of social control and an identity for women, is the most frequently cited justification for FGM. A few general themes emerge when examining the underlying norms and beliefs that keep this tradition alive. Nevertheless, it is essential to keep in mind that the factors that lead to female genital mutilation (FGM) vary from location to location and occasionally even within a country among different ethnic and religious groups. Thusly, there is no widespread recipe as far as changing what are thinking about to be "tacky" accepted practices. Rather mediations ought to be painstakingly intended to oblige nearby drivers of FGM.

Specifically, three interrelated standardizing subjects support the act of FGM: (a) the belief that the practice is required by religion, b) the significance of the practice to a shared group identity, and c) the connection between the practice and ideals about femininity and women's sexuality. This part examines every one of these topics thus.

Constructing the ideal girl and woman

FGM is associated with cultural norms and traditions regarding femininity and women's sexuality. For instance, the connection among FGM and sexual profound quality is the most repeating subject in examinations distinguishing causes and drivers of FGM (see the efficient survey of Berg and Denison 2013a, see likewise the writing audit of Alcaraz, Siles González, and C. Solano Ruiz 2013, and the Precise Audit and Meta-Ethnography by Elamin and Artisan Jones 2020). According to Johnsdotter et al., FGM, particularly infibulation, is thought to reduce sexual desire and assist women in resisting "illicit" sexual acts, such as those performed to preserve a young woman's virginity and her wife's faithfulness. 2009; 2016 Philips; Ahlberg and team 2004).

This view is especially unmistakable in societies where early virginity is viewed as a proof of ethical quality and where ladies are viewed as wanton and hypersexual in the event that they are left uncontrolled (Fahmy, El-Mouelhy, and Ragab 2010; Johansen 2017). According to a study conducted in Kersa District,

East Hararge, Oromia Region, Ethiopia, the continuation of FGM was justified by the need to reduce female hypersexuality and prevent premarital sex (Yirga et al.). 2012).
A study on female genital mutilation in Nigeria was conducted by Sanni and Bishwajit (2018): An Enduring Test for Ladies' Privileges Nigeria Segment and Wellbeing Overviews directed in 2003, 2008 and 2013 gave the information to this review. The members were hitched ladies matured somewhere in the range of 15 and 49 years. A complicated survey plan was made to take into account cluster effects and sampling weights because the data were clustered. Both bivariate and multivariate regression methods were used to analyze the data. Results: The overall prevalence of FGM was 38.9 percent (95 percent CI = 36.4–40.1), and it was 17.4 percent (95 percent CI = 15.3–19.7) among their daughters. There has been a significant expansion in the predominance of FGM in 2013 contrasted with its 2003 level. Respondents who had gone through circumcision were bound to have their girls circumcised. Traditional practitioners performed almost all of the circumcisions in all three surveys. In the relapse examination, respondent's age, region and district of residency, strict alliance, instructive status, and family abundance gave off an impression of being critical indicators of FGM. Conclusion: In Nigeria, FGM stays a broadly common peculiarity with a rising number of ladies encountering this training. The prevalence was characterized by significant regional and socioeconomic disparities that call for immediate policy intervention.
The significance of ensuring one's health and allowing one's partner to have sexual relations are two additional factors that are connected to concepts of femininity. FGM is related with "tidiness" and "immaculateness," while the clitoris is viewed as messy, male organ. According to Izette and Toubia (2000), Although “the precise number of girls and women who have experienced FGM is unclear, UNICEF believes that at least 200 million have been cut, often before the age of 15. In some settings where type 3 is prominent, adult women are also regularly reinfibulated following delivery” (UNICEF 2020a).
The north of Africa's countries with the highest frequency are Sudan and Egypt, the east's are Somalia, Eritrea, and Djibouti, and the west's are Sierra Leone, Mali, and Guinea. Additionally, there are differences in the kind of procedures used across and occasionally even within nations (Izette and Toubia, 2000).
However, a number of studies show that men's attitudes toward the practice are shifting (for a general overview, see Varol et al., 2015). For instance, that's what one investigation discovers, while Egyptian men believe their spouses should have the methodology for its apparent gainful consequences for ladies' sexual ethical quality, the men likewise see and mourn an adverse consequence on sexual joy (Fahmy, El-Mouelhy, and Ragab 2010). “Studies from Sudan suggest that husbands sympathise with the irritation and suffering infiltration can bring on re-infibrated women during labour, the loss of sexual pleasure, and the possibility that the absence of the wife's sexual pleasure is harmful to their manliness” (Berggren et al. 2006).

FGM and shared group identity

The practice of female genital mutilation (FGM) is regarded as a social convention that contributes to a shared group identity by securing kinship, ethnic, and communal ties. FGM fosters social cohesion on a societal level. Public declarations and other community-based interventions frequently address this social part of the training by recommending that local area individuals can accomplish social union in alternate ways or lay out new accepted practices in regards to the meaning of safeguarding young ladies and ladies from the practice's harmful effects. Tostan, a non-governmental organization founded in Senegal in the early 1990s, is the most well-known and widely acknowledged initiative of this kind. Tostan's work has been repeated by various NGOs working in Africa.

Mental sex and outcome

Despite the global pledge to stop FGM/C by 2030, the projected number of girls at risk of receiving the surgery each year is 3 million, with over 200 million girls and women worldwide believed to be affected. The instruction is delivered all over the world, starting in “West, North, East, and Focal Africa, the Middle East, Asia, and South America. with the highest prevalence and concentration of FGM/C in Africa.” 1 Additionally, the training has been expected to have a global impact by influencing the relocation of

individuals "from cutting networks who move with the training to their new host nations, making FGM/C pervasive in Europe, North America, Australia, and New Zealand." Lower maternal training and a family history of FGM/C were revealed to be risk factors in a recent systematic study of public, local, and local area studies focusing on variables connected to FGM/C.

It has been found that FGM/C has detrimental physical and psychological repercussions on women and girls that commonly damage their wellbeing, including their ability to engage in sexual activity. FGM has caused substantial physical, psychological, social, and sexual harm to women and young girls. Some of these detrimental impacts on a person's physical, mental, and sexual health can endure a lifetime and can be either short-term or long-term. It is also understudied how sexual and gender-based violence affects coercive FGM/C, family violence, intimate partner violence, and the abuse and neglect of young girls in FGM/C communities. The gendered power elements in families where ladies have minimal financial office, no dynamic power as guardians, and no free access or assets to look for medical care further tradeoffs long haul results. In a review did as of late in Kenya utilizing the 2014 Segment Wellbeing Overview found that ladies who had encountered FGM/C legitimate actual personal accomplice viciousness fundamentally more than the people who had not gone through this training.

The most common mental health consequences are persistent disability and low psychosocial functioning. "Post-Traumatic Stress Disorder (PTSD), anxiety, depression, and memory loss related to the experience of FGM/C" are all potential manifestations of these psychological issues. A third of the 66 immigrant ladies who had gone through FGM/C were found to have scores over the end for emotional and additionally uneasiness problems, PTSD, and substance use. Risk factors like low monetary strengthening were additionally fundamentally connected with the improvement of psychopathology, according to a study of their mental health. Ladies with FGM/C might encounter pessimistic feelings towards the cutting experience and this possibly deteriorates during obstetric and gynecological assessments and labor when the physical and mental unfriendly impacts of the methodology become unmistakable and are a wellspring of extraordinary distress to ladies being referred to. Women have been divided into adaptives, disempowered, and traumatized groups based on how they deal with the negative effects of FGM/C. This classification indicates some efforts to categorize the mental health burden that women who have experienced FGM/C experience in their lives. Sensations of inadequacy, dread, ongoing touchiness, bad dreams, a feeling of mediocrity, and the concealment of feelings and feelings are linked to an increased risk of psychiatric and psychosomatic diseases, among other reported mental consequences of FGM/C. Other explores brought up that there is colossal close to home and actual agony related with the training as well as reconstituted measures that occur. Even after the reconstitute surgical procedure, the psychological impairment caused by FGM/C and the subsequent trauma suggests low self-esteem, low self-efficacy, and uncertainty about one's gender and sexual identity. However, there are studies that show that sensate labial flaps used in clitoral reconstruction after FGM significantly improve "sexual function, clitoral sensation, genital aesthetics, and self-esteem."

Problems with one's sexual health are also linked to FGM/C. A few investigations have looked at "the sexual working of ladies living with and those without FGM for the most part showing clear qualifications of sexual working between the two gatherings." On the actual level, the evacuation of the clitoris cuts off the joy point and cutting of different pieces of the vulva apparently influences sexual awareness in this way unfavorably influencing the encounters among cut ladies and the in general sexual personal satisfaction is likewise affected. The review continues to show that different spaces of sexual working eminently sexual craving, excitement, oil, climax and fulfillment areas explicitly were accounted for to be lower among slice ladies in contrast with whole ladies while furthermore they may likewise encounter sexual agony.

INTERVENTIONS TO REDUCE THE PREVALENCE OF FGM/C

In Africa, efforts to end FGM/C have taken a variety of different approaches. These methodologies incorporate those in view of basic liberties systems, legitimate components, wellbeing gambles, elective ceremonies, positive abnormality, preparing wellbeing laborers as change specialists, preparing and changing over circumcisers, and the utilization of far reaching social advancement processes. Individual,

interpersonal, community, and national stakeholders have been the focus of these approaches-based interventions (Muteshi & Sass, 2005).
According to Feldman-Jacobs and Ryniak (2007), In 2007, the Population Reference Bureau (PRB) published the findings of a thorough investigation of ongoing intervention programmes in African countries. The review identified 92 distinct tasks, 27 of which were evaluated, often by observational plans. Only four of the 27 projects that were evaluated (15%) made use of a controlled when plan. Since this was not a systematic evaluation, no judgements regarding the effectiveness of the therapies were made, despite providing valuable insight into the variety of initiatives taken to reduce FGM/C prevalence.

Contextual factors related to the continuance or discontinuance of FGM/C
According to UNICEF (2005b), FGM/C is a long-standing custom that many groups have made an integral part of their ethnic and social identities. According to Yoder et al., (2004) data from the Demographic and Health Surveys (DHS), the prevalence of FGM/C varies greatly depending on factors including age, place of residence (urban or rural), area or province, degree of education, ethnicity, and religion. Further examination of DHS information by UNICEF (2005a) proposes that instructive fulfillment, a lady's own circumcision status, and nationality have the best impact in clarifying help or resistance for the training. In this way, Projects intended to diminish the predominance of FGM/C ought to be nation explicit and adjusted to reflect provincial, ethnic, and financial fluctuations while likewise considering the different justifications for why FGM/C is rehearsed among a given ethnic or social gathering.

Creating awareness with anti-FGM campaigns
The Value Female Network provides "survival kits" to victims of gender-based abuse and FGM as well as educating local communities in Osun State. These groups are attempting to put a stop to the practise throughout Nigeria, especially in areas where it is well-known to be actively practised. By teaching communities about the need to stop the practise, the Society for the Improvement of Rural People aims to prevent female genital mutilation (FGM) in the states of Enugu and Ebonyi. A campaign against FGM was started in 2011 in Agwagune and many other areas in Cross River State by Gift and Augustine Abu, a married couple. Their objective was to increase public awareness of the harmful effects of FGM and convince local authorities and cutters to put a stop to the practise.
Prior to Gift and her significant other, the two locals of Agwagune, took their mission to the local area, no one considered opposing female circumcision as that could draw in a vicious reaction from the local area individuals who once accepted that the training should be safeguarded and given over from one age to another. However, individuals like Inah are protesting it right now.

A common practice
The couple's assurance to battle FGM began when Gift, a prepared medical caretaker, saw some FGM-related scars on ladies while functioning as an attendant in the family arranging unit of a public emergency clinic in Keffi, Nasarawa State. Additionally, she saw that deadly complications during childbirth commonly happened to circumcised women. It seemed like every female who visited the family planning centre had a scar, she said, and I was able to learn that the scars had something to do with a tradition and a ritual that every woman in the community had to go through.
Roused by this disclosure, Gift did a few examination into the predominance of the training and her discoveries drove her to activity, "I found the story fascinating, began discussing the training, and began battling female genital mutilation," she said. Gift was surprised when her husband agreed to work with her after she shared her discoveries with him. She then, at that point, left her nursing position and together, they established the Middle for Social Worth and Youth Improvement (CESVED), a non-benefit, to battle destructive conventional practices.

Theoretical review
This work is moored on the hypothesis of Moral Relationship Believed by Michael Foucault and Derida in 1930. The doctrine of this theory asserts the existence of universal, objective moral codes and principles

that must be followed at all times. Instead, the theory argues that culture and individual choice determine morality. According to ethical relationships, moral principles are truly valuable; They may or may not be true. The ethical relationship can take one of two forms: traditionalism and subjectivism. Conventionalism holds that moral guidelines are culturally or socially specific.
Subjectivism holds that the legitimacy of moral not set in stone by individual decision. The distinctive individual comes to moral conclusion about what is ethically great and terrible and is mindful to set up his/her own standards. The theory of ethical relativism was adopted for this study because female genital Mutilation is practised in most countries as a result of cultural norms. However, parents have the right to choose whether to circumcise their female children or not. It is not a practice that is forced on parents to adhere to.

METHODOLOGY

The methods in which the research was carried out include:
Research design
This study adopted survey research design.

Population of the study

The population of this study consists of all the women in Rivers State. As at the time of the study, the total population of married men and women in Rivers State was 93000. (Source: National Bureau of Statistics)

Sample/Sampling Technique

Considering the population of the study, the Krejcie and Morgan sample Determination size table was used to select a sample consisted of four hundred (400) women, drawn from four (4) local government areas namely; Port Harcourt City, Obio/Akpor, (Urban) Khana and Ahoada East (Rural) respectively. A simple random sampling technique was used to select 100 married men and women from Port Harcourt City Local Government Area. 100 men and women from Obio/Akpor Local Government Area, 100 men and women from Khana Local Government Area and 100 men and women from Ahoada Local Government Area, making it a total of 400 men and women selected in Rivers State using Simple Random Sampling Technique.

Instrument for Data Collection

The instrument used for data connection is a questionnaire tittled "parental attitude and female genital Mutilation questionnaire" (PAFQ), which was constructed on a four point Likert scale of strongly Agree (SA), Agree (A), Strongly Disagree (SD), and Disagree (D).

Validity of the Instrument

The instrument was face and content validated by the researcher.

Reliability of the Instrument

The reliability of the instrument was determined using test-retest method. In doing this, 40 copies of questionnaire were distributed to parents who were not part of the study. The Cronbach alpha reliability coefficient was used to test for reliability and it yielded a coefficient level of 0.80 reliability.

Administration of the Instrument

A total of 400 copies of questionnaire were distributed to all the parents who were used for the study. The 400 copies of questionnaire were distributed by the researcher.

Method of Data Analysis

All the hypotheses were tested “using Pearson Product Moment Correlation Coefficient. While research questions were answered using mean and standard deviation.”

RESULTS

Research Question I: what is the relationship between the attitude of parents and female genital mutilation Rivers State?

Table 1.1: Mean scores on the relationship between the attitude of parents and female genital mutilation.

S/N	Item Statement	Urban Parents X	Rural Parents X	Mean Set X_1 X_2	Remarks
1.	Parents believe that FGM could cause a lot of bleeding and danger to young girls who underwent the procedure.	2.81	2.74	2.77	Agreed
2.	Parents believe that FGM is a compulsory cultural ritual.	2.72	2.31	2.62	Agreed
3.	Girls who experience FGM reported a lot of genital infections.	2.96	2.61	2.8	Agreed
4.	Female genital mutilation preserve girl's chastity until marriage.	2.36	2.71	2.54	Agreed
5.	Parents receive it as a role that they should perform so that they are not blamed by the society.	2.45	2.62	2.53	Agreed
6.	Parents view FGM as being primitive and barbaric.	2.93	2.85	2.89	Agreed
	Aggregate mean (X)	2.71	2.64		

Data analysis on table 1.1 reveals that both urban (2.81) and rural (2.74) parents agree that FGM could cause a lot of bleeding and danger to young girl who underwent the procedure, on the belief that FGM is a compulsory cultural ritual, urban parents had 2.71 while rural parents had 2.31. The item on girls who experience FGM reported a lot of genital infections scored a mean of 2.96 and 2.01, for urban and rural parents respectively.

Research Question 2: what is the relationship between the attitude of parents and the effect of female genital mutilation in Rivers State?

Table1.2: Mean scores on the relationship between the attitude of parents and the effect of female genital mutilation.

S/N	Item Statement	Urban Parents X	Rural Parents X	Mean Set X_1 X_2	Remarks
7.	The FGM Practice has a harmful and negative health consequences on young girls.	2.86	2.91	2.88	Agreed
8.	Parents whose girl child engages in FGM experiences low self-esteem and anxiety.	2.78	2.85	2.82	Agreed
9.	FGM leads to heightened risk of psychological problems and emotional trauma.	2.96	2.69	2.83	Agreed

10.	FGM creates negative self -image among women	2.81	2.89	2.85	Agreed
11.	Many parents whose girl child are involved are stigmatized in the society.	2.93	2.78	2.86	Agreed
	Aggregate mean (X)	2.71	2.64		

Table 1.2 Data analysis shows that both urban and rural parent agree that FGM Practice has a harmful and negative health consequence on young girls with a mean score of 2.16 and 2.91 respectively, on FGM leads to heightened risk of psychological problems and emotional trauma, urban parents had 2.96 while rural parents had 2.69, while FGM creates negative self- image among women had 2.81 for urban parents while 2.89 for rural women among others.

Hypothesis 1: There is no significant relationship between the attitude of urban and rural parents on female genital mutilation in Rivers State.

Table 1.3: Test of relationship between attitude of urban and rural parents on Female genital mutilation.

Variables	N	X	SD	X	P	Remarks
Urban parents	200	2.71	1.63	0.78	0.057	Significant
Rural parents	200	2.64	1.59			

Table 1.3 showed that the calculated value of person correlation coefficient was 0.78, while the table value is 0.057. (X= 0.78; R < 0.05). Thus, meaning that the null hypothesis was accepted, indicating that, there is a significant relationship between the attitude of urban and rural parents on female genital mutilations in Rivers State.

Hypothesis 2: There is no significant relationship between the attitude of urban and rural parents on the effect of female genital mutilation in Rivers State.

Table 1.4: Test of relationship between urban and rural parents on the effect of female genital mutilations.

Variables	N	X	SD	X	P	Remarks
Urban parents	200	2.87	1.69	0.78	0.057	Ho_2
				0.69		Significant
Rural parents	200	2.82	1.67			

Analysis of data in table 1.4 revealed that the calculated value of Pearson Correlation Coefficient was 0.69 (r=0.69, P < 0.05). Thus the null hypothesis was accepted, showing that there is a significant relationship between urban and rural parents on the effect of female genital mutilation in Rivers State.

Discussion of Results:
The findings on the relationship between parents attitude and female genital mutilation reveals that, parents believe that FGM could cause a lot of bleeding and danger to the lives of young girls, the girls who experienced FGM reported cases of genital infections, parents view FGM as been primitive and barbaric in nature among others. These findings are affirmed by WHO (2008), and Berg & Denison (2011) who stated that young ladies introduced to FGM are at risk for fast genuine outcomes like outrageous miseries, depleting and shock.

The findings on the effect of female genital mutilations reveal that the FGM practice has a harmful and negative, health consequences on young girls, it leads to a harmful and negative, health consequences on young girls, it leads to a heightened risk of psychological problems and emotional trauma on women,

many parents whose female children are involved in FGM are stigmatized. This finding is at variance with several studies by Brown et al (2016), woman et al (2013) and O'Neil et al (2017) who showed that there is stigmatization of women who have not taken part in FGM in the community.

Implications for Counseling

The findings of the study revealed that parental attitude has a significant relationship with FGM in Rivers State. Therefore, it is expedient for counselors to do the following:

1. Ensure that there is a periodic sensitization programme on the negative effects of FGM in various communities in Rivers State.
2. Ensure that they create room for counseling procedures to be held in their offices for parents who have various cases of FGM and other family related issues.
3. Counselors should also ensure that they carry out thorough investigations on girls who are suffering from various health challenges resulting from FGM and collaborate with the government and NGOs to put a stop to the menace.

CONCLUSIONS:

The study examined parental attitude and female genital mutilation in Rivers State: implication for counseling. The traditional practice of female genital mutilation is harmful and infringes on a girl's right to health and well-being as a whole. The study concluded that female genital mutilation could cause bleeding and severe danger to girls who underwent the procedure and it heightens the risk of psychological problems and emotional trauma among women. On its effects the study affirms that female genital mutilation has a harmful and negative health consequences on young girls. The null hypotheses indicated that there is a significant relationship between the attitude of urban and rural parents on female genital mutilations in Rivers State.

RECOMMENDATIONS:

Based on the findings of the study, the following recommendations are put forward:

(1) To change the existing belief that support the practice of FGM, community leaders should organize weekly sessions to educate parents on the dangers associated with female genital mutilation.

(2) Communities should liase with health professionals to carry out workshops or seminars on FGM related complications during pregnancy and child delivery.

(3) To foster negative attitude against FGM, the communities should set up law enforcement agencies who should implement the law on the practice and prosecute those who lure girls into it.

(4) The Rivers State government should enforce the existing laws on FGM and ensure strict compliance to the laws.

REFERENCES

Achia, N. O. (2014). Spatial modelling and mapping of female genital mutilation in Kenya. BMC Public Health 14: 276.

Ahmady K. (2015) A comprehensive research study on female genital mutilation/cutting (FGM/C) in Iran. *Swift Journal of Social Sciences and Humanity*.:28–42.

Ashimi, A., Labaran A., Muhammad S., & Taiwo A.. (2014). A Multicentre study on knowledge and attitude of nurses in northern Nigeria concerning female genital mutilation. *The European Journal of Contraception & Reproductive Health Care 19*: 134–40.

Ashimi, O., & Taiwo G. (2015). Perception and attitude of pregnant women in a rural community North-West Nigeria to female Genital Mutilation. Archives of Gynecology and Obstetrics 291: 695–700.

Awodele, O., Akinwumi A., Oladunni A. A., & Deborah F. A., (2011). Pharmacovigilance amongst Doctors in private hospitals in Lagos West senatorial district, Nigeria. *The International Journal of Risk and Safety in Medicine 23*: 217–26.

Berg R. C., U. V, Odgaard-Jensen J, Fretheim A, & Vist G. E. Effects of female genital cutting on physical health outcomes: a systematic re

Berg, R. C., & Vigdis U., (2013). The obstetric consequences of female Genital mutilation/Cutting: A systematic review and meta-analysis. obstetrics and gynecology International 2013.

Bishwajit, G., Daniel P. O., Sharmistha G., Sanni Y., Tang S., & Zhanchun F., (2017). Physical inactivity and self-reported depression among middle- and older-aged population in South Asia: World health survey.

Bjälkander, O., Laurel B., Bailah L., Vanja B., Staffan B., & Lars A., (2012). Health complications of female genital mutilation in Sierra Leone. *International Journal of Women's Health 4*: 321–31.

Bowen, N. K., & Joelle. D. P., (2005). Knowledge gaps among school staff and the role of high quality ecological assessments in schools. *Research on Social Work Practice 15*: 491–500.

Dare, F. O., V. O. Oboro, S. O. Fadiora, E. O. Orji, A. O. Sule-Odu, & Olabode T. O., (2004). Female Genital Mutilation: An Analysis of 522 Cases in South-Western Nigeria. Journal of Obstetrics and Gynaecology: *The Journal of the Institute of Obstetrics and Gynaecology 24*: 281–83

Dawson, Angela, Sabera Turkmani, Shairon Fray, Susie Nanayakkara, Nesrin Varol, and Caroline Homer. 2015. Evidence to Inform Education, Training and Supportive Work Environments for Midwives Involved in the Care of Women with Female Genital Mutilation: A Review of Global Experience. Midwifery 31: 229–38.

Dehghankhalili M, Fallahi S, Mahmudi F, Ghaffarpasand F, Shahrzad ME, Taghavi M, et al. Epidemiology, Regional Characteristics, Knowledge, and Attitude Toward Female Genital Mutilation/Cutting in

Development Impact Guest Blogger. 2016. Why Do Harmful Norms Persist? Female Genital Cutting in Burkina Faso: Guest Post by Lindsey Novak. Available online: http://blogs.worldbank.org/impactevaluations/why-do-harmful-norms-persist-female-genital-cutting-burkina-faso-guest-post-lindsey-novak (accessed on 7 November 2018).

Diejomaoh, F. M., and M. K. Faal. (1981). Adhesion of the labia minora complicating circumcision in the neonatal period in a Nigerian community. Tropical and Geographical Medicine 33: 135–38.

Egwuatu, V. E., & Agugua N. E., (1981). Complications of female circumcision in Nigerian Igbos. *British Journal of Obstetrics and Gynaecology 88*: 1090–93.

Ekwueme O. C, Ezegwui H. U, Ezeoke U., (2010) Dispelling the myths and beliefs toward female genital cutting of woman: assessing general outpatient services at a tertiary health institution in Enugu State, Nigeria. *East African Journal Public Health 7*: 64-67.

Federal Ministry of Health (FMOH)/World Health Organization (WHO) (2007) Elimination of Female Genital Circumcision in Nigeria. Abuja: Federal Ministry of Health 2007: 1-8.

Female Genital Mutilation. 2018. Available online: http://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation, accessed on 6 November 2018.

Hernandez, L. M., Dan G. B., & Behavioral Institute of Medicine (US) Committee on Assessing Interactions among Social. 2006. The impact of social and cultural environment on health. Washington, DC: National Academies Press.

Hodges, T., Nigeria National Planning Commission, & UNICEF Nigeria Country Office. 2001. Children's and women's rights in Nigeria: A wake-up call: situation assessment and analysis, 2001. Kathmandu: National Planning Commission.

Kaplan, A., Mary F., Isabelle B., Mireia U., Miguel M., Malick M., & Haruna C.. (2013). Female genital mutilation/cutting in the gambia: long-term health consequences and complications during delivery and for the Newborn. *International Journal of Women's Health 5*: 323–31.

Khalesi ZB, Beiranvand SP, Ebtekar F. Iranian midwives' knowledgeof and attitudes toward female genital mutilation/cutting (FGM/C).

Macro, I. C. F., & National Population Commission. (2014). Nigeria demographic and health survey 2013. abuja: national population commission, http://dhsprogram.com/publications/publication-fr293-dhs-final-reports.cfm accessed on 7 November 2018.

Mpinga, E. K., Aurélie M., Jennifer H., Ngianga-Bakwin K., Tshimungu K. F., Henk V., Ngoyi K. Z. B., & Philippe C., (2016). Female genital mutilation: A systematic review of research on its economic and social impacts across four decades. Global Health Action 9.

Okeke, T. C., USB Anyaehie, & Ezenyeaku C. C. K., (2012). An overview of female genital mutilation in Nigeria. *Annals of Medical and Health Sciences Research 2*: 70–73.

Pashaei T, Ponnet K, Moeeni M, Khazaee-pool M, & Majlessi F., (2016) Daughters at risk of female genital mutilation: examining the determinants of mothers' intentions to allow their daughters to undergo female genital mutilation. PLoS 1: 11(3). e0151630. doi:1371/journal.pone.0151630.

perspectives of female genital cutting among the local religiousleaders in Erbil governorate, Iraqi Kurdistan region. Reprod Health. 2018;15(1):44. doi: 10.1186/s12978-018-0459-x.

Sanni & Bishwajit (2018). Female Genital Mutilation in Nigeria: A Persisting Challenge for Women's Rights Nigeria Demographic and Health Surveys.

World Health Organization. Eliminating female genital mutilation. An interagency statement-OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. 2008. Available at: http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagen.

Yirga, W. S., Nega A. K., Mengistu W. G., & Arja R. A., (2012). Female genital mutilation: prevalence, perceptions and effect on women's health in Kersa district of Ethiopia. *International Journal of Women's Health 4*: 45–54.