EVALUATION OF AFRICAN WOMEN'S DEVELOPMENT FUND AND THE JUSTICE, DEVELOPMENT AND PEACE COMMISSION FEMALE GENITAL CUTTING INTERVENTION PROGRAMME IN OYO STATE, NIGERIA

By

CHRISTINE EKOJOKA UDOH-EMOKHARE

MATRIC NO: 66856

B.Ed (Guidance & Counselling/Communication & Language Arts) (IBADAN)

M.Ed (Counselling Psychology (IBADAN)

MPhil/Ph.D (Educational Evaluation) (IBADAN)

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ABSTRACT

Female genital cutting (FGC) has been identified as one of the most harmful traditional practices that affect females' psychological well-being in Nigeria. Based on reports of psychological problems and increased incidences of maternal mortality caused by FGC in some Local Government Areas (LGAs) in Oyo State, the African Women's Development Fund (AWDF) and the Justice, Development and Peace Commission's (JDPC) female genital cutting intervention programme was executed. Although monitoring and evaluation activities have been carried out intermittently by JDPC, there has been no known independent-external evaluation of the programme. This study, therefore, evaluated the AWDF-JDPC intervention programme to determine its effectiveness in relation to knowledge of the dangers of FGC and attitudes towards the practice.

Survey design was adopted and the Input-Process-Outcome evaluation model was used. Purposive sampling technique was used to select four LGAs; two intervention (Ibadan North-East and Lagelu) and two non-intervention (Ibadan South-West and Atiba) from which 800 participants each were selected. The proportionate to size sampling technique was used to select 934 in-school and 666 out-of-school participants making a total of 1,600. Twenty nine in-depth interviews were conducted for Healthcare Providers (HCPs); and 52 females with participated in the five Focus Group Discussions (FGDs) from the intervention LGAs. Knowledge on dangers of FGC (r=0.71), attitude towards FGC (r=0.68), psychological perception of FGC (r=0.78), intervention activities assessment (r=0.87), victims' counselling assessment (r=0.80) and update training assessment (r=0.87) scales were used. Data were analysed using t-test, Analysis of variance and Multiple regression at 0.05 level of significance, while qualitative data were content analysed.

There were significant differences in the intervention and non-intervention participants' knowledge (t=43.83) and attitude (t=9.67). Their mean scores in knowledge and attitude were 35.63; 39.50 for intervention and 24.10; 37.29 for non-intervention groups respectively. There were significant differences among the three (3) stages of adolescence in relation to knowledge ($F_{(2,797)}$=12.00) and attitude ($F_{(2,797)}$=5.22). Intervention programme, psychological experience, age range, present educational level/status, parents' educational status, FGC status, marital status, work status and location of residence jointly contributed to knowledge on dangers of FGC (R=.32); while educational level and work status had relative contribution values of β=-.21 and

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β=.16 respectively. All the interviewees attested to no prior intervention programme, while majority of the participants in the FGDs reported experiencing fear of pain during sex.

The beneficiaries of the African Women's Development Fund and Justice, Development and Peace Commission female genital cutting intervention programme acquired more knowledge on the dangers of female genital cutting which also influenced their attitude towards the practice. Continued education and dissemination of appropriate information on female genital cutting are necessary to facilitate the sustenance of current knowledge of the dangers inherent in the practice and influence the attitude of females towards the practice.

Keywords: Female genital cutting, JDPC Intervention programme, Psychological experience, Oyo State, African Women's Development Fund.

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DEDICATION

This work is dedicated to God Almighty, the Author of my life, the Beginner and Finisher of all that is in me; to my loving and ever supportive parents and first academic mentors: Prof. Christopher Ofuonye and Mrs. Rose Emengini Udoh (KSJI).

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CERTIFICATION

I certify that this study was carried out by CHRISTINE EKOJOKA UDOH-EMOKHARE in the International Centre for Educational Evaluation (ICEE), Institute of Education, University of Ibadan, Nigeria.

Supervisor

Professor Ifeoma M. Isiugo-Abanihe
B.Sc.Ed (Temple, U.S.A), M.Ed (Temple, U.S.A)
Ph.D (Ibadan)
Professor, Institute of Education,
University of Ibadan, Ibadan, Nigeria
Ibadan, Nigeria

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ABBREVATIONS AND ACRONYMS

AWDF: African Women's Development Fund

CHEWs: Community health workers

DHS: Demographic Health Survey

FGC: Female genital cutting

HCPs: Health care providers

IEC: Information, education and communication materials

JDPC: Justice, Development and Peace Commission

LGAs: Local government areas

MHCCS: Maternal health counselling centres

NDHS: National Demographic Health Survey

PHEWs: Public health workers

C/TBAs: Traditional/community birth attendants

IPO: Input, Process, Output/Outcome

HCDT: Hofstede's Cultural Dimension Theory

IDV: Individualism versus Collectivism

UAI: Uncertainty Avoidance Index

PDI: Power Distance Index

MAS: Masculinity versus Femininity

LTO vs STO: Long Term Orientation versus Short Term Orientation

SCT: Sociocultural Theory

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CHAPTER ONE

INTRODUCTION

1.1. Background to the Problem

Many ethnic groups, religions and cultures in many parts of the world, have diverse and institutionalised practices which are detrimental to human health, and specifically to women's health. Such practices which are socio-cultural include male child preference, patterns of inheritance, cultural demand of unlimited child bearing, and child betrothal among others (Utulu, 2000 and Callaghan, 2010). Health challenges associated with these socio-cultural practices include physiological dysfunctions, physical deformities, obesity, emotional stress and mental illness. Some of the more serious consequences include bleeding and excessive blood loss, severe pain, difficulty at child birth, and even death. According to documentations by health practitioners and human rights activists (Noah, 2009; WHO, 2010; Okeke, Anyachie, and Ezenyeaku, 2012), many cultural and traditional practices are unhealthy to the physical, physiological and or emotional well-being of individuals, and also infringe on their human rights (Kumi, 2010 and Althaus, 1997), hence the term 'harmful traditional practices'.

In Nigeria, there is a conglomeration and vast number of ethnic groups with diverse religious affiliations, and various cultural practices. Many of the practices targeted at women are considered harmful, unhygienic and dehumanising, because of the trauma they cause (Human Rights and Conflict Resolution Centre - HRCRC, 2010; Nowak, 2008; UNICEF, 2001). Some of such practices include widowhood rites, rites of passage involving traumatic processes, certain food restrictions during pregnancy, early/forced marriage, wife entertainment and wife dis-inheritance and inheritance (Grabman and Eckman, 2010; Frances, 1997). In addition to these practices, the Federal Ministry of Health in Nigeria as cited by Noah (2009) and some other international health and human rights organisations have identified Female Genital Cutting (FGC) as one of the many prominent harmful traditional practices that is traumatic in nature and is commonly used as a puberty initiation rite in African countries including Nigeria.

Based on several descriptions of the process of cutting or altering the female genitalia, various terms have been attributed to the practice. Hence, terms such as 'Female Genital Mutilation – FGM, Female Genital Cutting – FGC, Female Circumcision – FC' and Female Genital Mutilation/Cutting – FGM/C, have been used to describe the removal of parts or the

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alteration of the female genitalia for cultural reasons. According to the World Health Organisation (2008), the use of the word mutilation reinforces the fact that the practice is a violation of girls' and women's right and therefore promotes advocacy for abandonment of the practice; hence, the synonymous use of other terms such as female genital cutting (FGC), female circumcision (FC) and Female genital cutting/mutilation (FGM/C) with FGM is not unusual. In order to reduce the negative connotation attached to the term 'mutilation', and the recall of the traumatising experience for victims of the practice as well as to avoid the offensive feelings of practicing communities, these terms especially FC have been used. Therefore, according to WHO (2008), FGC is defined as a traditional practice that involves "the partial or total removal of the female external genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons."

In recent times, there has been a constant focus on female genital cutting (FGC) practice. The practice which has its foundation in African and Nigerian traditions is performed on females within and outside the shores of Nigeria (Frances, 1997; Nour, 2008; and Moges, 2011). Usually, the practice is executed shortly after birth, during adolescence as a rite of passage into adult or woman hood, or just before first delivery of a married woman (Adeniran, 2011; WHO Factsheet, 2014). Several reports have attested to the unfavourable outcomes of the practice; these have been labelled as complications and consequences (Akinsanya, 2011; WHO, 2012; Oyetade, 2012; Iliyasu, Abubakar, Galandanci, Haruna and Aliyu 2012).

Due to the medical, emotional and mental health risks which are also referred to as post FGC complications (Tag-Eldin, Gadallah, Al-Tayeb, Abdel-Aty, Mansour and Sallem, 2008), various FGC intervention programmes have been carried out within Nigeria as well as many other African countries. The aim of such projects is to reduce to the barest minimum and hopefully eradicate the practice, which it is assumed will eventually checkmate the occurrence of consequences associated with FGC. Legislations at international levels, workshops and trainings at national and local levels, as well as community based activities at the grassroots level, are some of the approaches that have been utilised in order to achieve intended outcomes of such projects and initiatives. Despite continuous efforts through these intervention programmes to ensure that FGC is eradicated, the practice remains unabated.

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Reports of FGC practice remaining unabated can be said to be questionable. This is because majority of FGC initiatives (legislations, workshops, trainings amongst others) programmes and projects do not put in place mechanisms to monitor the implementation of activities involved in reducing the rate of the practice. Such mechanism(s) involve a comprehensive evaluation where indicators such as prevalence rates, programme/project inputs, processes and outcomes and other indictors as may be considered necessary, can be used to determine if the practice of FGC is really unabated. Evaluation activities are therefore aimed at determining the worth of programmes/projects, using available indicators to directly or indirectly provide information on how effective an initiative or programme/project has been, via achievement of stated objectives.

According to some national surveys (Multiple Indicator Cluster Survey - MICS 2011; Demographic Health Surveys – DHS 2003 and 2008; and Nigeria Demographic and Health Survey, 2013), prevalence rates of the practice within the six geo-political zones of Nigeria has been reported as ranging between 2.7% and 49.2%, with the South East (49.2%) and South West (46.4%) respectively, having the highest prevalence rates. Furthermore, these reports have reported Nigeria as having a high prevalence rate among African countries. According to the DHS reports, the prevalence rate of the practice was 22% and 30% respectively, with an increase of 8% between 2003 and 2008; while the MICS reports of 2007 and 2011 respectively, indicated a prevalence of the practice as 27% and 22.10% among other African countries, thus recording a decrease of 4.9% of the practice within this period.

Nigeria has been identified as a signatory to several international human rights instruments that have provisions against the practice of FC/FGM which include: The Universal Declaration of Human Rights(UDHR),1948; the International Covenant on Civil and Political Rights(ICCPR) 1966; the International Covenant on Economic, Social and Cultural Rights,(ICESCR) 1966; Convention on the Elimination of all forms of Discrimination against Women (CEDAW), 1979, and Convention against Torture, (CAT), 1984. At the regional level also, the country is a party to similar instruments such as the African Charter on Human and Peoples' Rights; the African Charter on the Rights and Welfare of the Child, 1990; as well as the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2003.

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Based on these instruments, the 1999 Constitution of the Federal Republic of Nigeria, though without an explicit expression on the rights of women in Nigeria, provides for the right against discrimination. The Child Rights Act of 2004 and its equivalent, adopted by various states in Nigeria, also provides for the rights of women, including girl-children. With the country acceding to these human rights instruments as well as using them as basis for protecting the rights of women, the girl child and children in general, it is therefore disheartening to note that for Nigeria, the percentage increase and or decrease in prevalence rate of the practice among other African countries, as reported by the health surveys, is quite high and it is not commensurate to the amount of work that appears to have been put into eradicating the practice.

Several study reports have corroborated the findings of health surveys that indicate the high prevalence of FGC in Nigeria, especially in the South West and South East zones, can be adduced to cultural dictates (Abiodun, Oyejola and Job, 2011; Ibekwe, Onoh, Onyebuchi, Ezeonu and Ibekwe 2012). In addition to the cultural aspects which have made the practice a norm, the practice of all FGC types (Types I, II, III and IV) which range from slight to extensive cuttings, could be regarded as contributory to the high prevalence rate attributed to Nigeria (Lescure, 2006; Gbadamosi, 2008; and Grabman and Eckman, 2010). Furthermore, with the Nigerian government's opposition to the practice, by her being a part of a resolution calling for eradication of harmful traditional practices including FC/FGM, at the 46th World Health Assembly (U.S. Dept. of State, 2001), the non-availability of any Federal Law criminalizing the practice can also be considered as a facilitating factor for the continuation of FGC in Nigeria.

In the South Western region of Nigeria which has a prevalence rate of 46.4% (MICS, 2011), intervention programmes such as that funded by the African Women's Development Fund (AWDF), and implemented by the Justice, Development and Peace Commission (JDPC), Ibadan was carried out in Oyo State, in 2012. AWDF is an international organisation that targets social justice and women's rights issues, hence its thematic focus areas are: Women Human Rights; Economic Empowerment; Governance, Peace and Security; Reproductive Health Rights; HIV AIDS and Arts, Culture and Sports; while JDPC is a non-governmental and faith based organisation. JDPC like the AWDF has the following as its main focus groups: the under-served located in rural areas; people living with HIV AIDS; women associations and community based organisations; inmates and ex-inmates of prisons and their families; farmers' groups; children and youths.

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Although no actual data had been recorded, pre-existing conditions of psychological experience reported by females with FGC, as well as increased incidences of maternal mortality due to the practice were major reasons for the AWDF-JDPC intervention programme being carried out in specific local government areas (LGAs) in Oyo State. Also, reports of high prevalence rates of FGC and its different types (Inter African Committee – IAC report, 1997 and Committee for the Elimination of all forms of Discrimination against Women – CEDAW report, 2008) in the South West region of Nigeria and other reports such as those listed in Table 1.1 formed the background reasons for the execution of the programme.

The AWDF-JDPC intervention programme thus started in 2012 with the aim of educating community members in the LGAs of intervention on the dangers of female genital cutting, via facilitating of update- training for health care providers/programme trainees on Female Genital Mutilation counselling procedures, anti-natal care and other maternal health related issues.

Table 1.1: FGC Prevalence Rates of South West Zone of Nigeria and Oyo State

Report	Year	South West Region	Oyo State
National Demographic Health Survey (NDHS)	1999	48.4	-
National Demographic Health Survey (NDHS)	2003	56.9	-
Multiple Indicator Cluster Survey (MICS)	2007	51.3	72.9
Demographic Health Survey (DHS)	2008	53.4	83.9
Multiple Indicator Cluster Survey (MICS)	2011	48.4	71.0
National Demographic Health Survey (DHS)	2013	47.5	65.6

Source: NPC 1999, 2003, 2008 and 2013; MICS, 2007 and 2011.

Though the programme officially ended in 2013, as originally planned, some of the programme activities are still being executed up to date. Some of such activities include psychosocial support (counselling) for females with FGC, step down trainings for different groups of opinion leaders in the community and enlightenment talks during various clinic sessions within primary/maternal health centres as well as during other group sessions within the communities. Based on reported pre-existing conditions, the AWDF-JDPC intervention programme's objectives are as follows:

1. To create enlightenment on the dangers of FGM through gender based workshops, enlightenment talks, media campaigns and development/ distribution of Information, Education and Communication (IEC) materials.
2. To effectively facilitate update trainings for C/TBAs, PHEWs, CHEWs and Midwives implementation of maternal health counselling in their LGAs in Oyo and Osun States.
3. To facilitate opportunities and access to expert counselling for females with FGC.
4. To monitor the project on ground and evaluate the impact of previous interventions on knowledge of dangers of FGC.
5. To carry out routine follow up for on-going intervention activities.

Some studies such as child betrothal, early marriage, FGC, forced marriage and their effect on the psychosocial and educational development of the girl child (Utulu, 2000), as well as assessment of various activities by governmental and non-governmental organizations, to reduce the practice of FGC (Oyetade, 2012) have focused on harmful traditional practices (HTPs). The thrust of these studies was to establish the fact that the HTPs of interest affect psychosocial and educational development; and that increased activities against the practice of FGC will facilitate a reduction of the practice. These studies in their assessment of outcomes of HTPs of interest and governmental and non-governmental organizations' anti-FGC activities therefore engaged majorly, victims of HTPs of interest and participants on some of the governmental and non-governmental organizations' FGC activities, not including other significant stakeholders that may have influence on the intended outcomes of such studies.

According to the Population Reference Bureau – PRB (2013), based on their monitoring of intervention programmes a holistic, integrated and multisectoral approach involving interrelated factors and significant stake holders in relation to an area of interest, facilitates achievement of intervention objectives. Hence, the use of this approach by the AWDF-JDPC intervention programme was done with the intention that outcomes of reduction in the practice of harmful traditional practices such as FGC will be achieved, preventive measures against continued cutting of females irrespective of their age would be facilitated thus resulting in attitude change, as well as cater for the general well-being of females with FGC or otherwise in practicing communities. Therefore, multisectoral approach activities were targeted at recognised leaders in the communities, health care providers, community/traditional birth attendants (C/TBAs), as well as community members.

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In order to achieve objectives set out in the intervention programme, and to be able to determine the programme's outcomes, activities such as advocacy visits, awareness creation/enlightenment talks/social mobilisation, update training, provision of information, education and communication (IEC) materials and media activities such as publications in notable newspapers and radio jingles were embarked upon to increase knowledge on the dangers of FGC and to change attitude towards the practice. Also, maternal health counselling centres (MHCCs) were established based on reports of health and psychological issues experienced by cut females. The establishment of the centres was aimed at providing psycho-social counselling for females with FGC, through health care providers/programme trainees and C/TBAs, who attended the update training. These centres based on their accessibility for FGC victims who are referred by C/TBAs for comprehensive counseling and medical attention, were selected from existing Primary/Maternal Health Centres. Hence, comprehensive FGC activities were mainstreamed into such health centres' routine activities.

According to studies such as Nowak (2008), Kandla, Nwakeze and Kandala (2009) amongst others, there is a constant reiteration that FGC has negative impact on cut females. One of such impacts is on the psychological well-being of females with FGC and otherwise. Psychological consequences have therefore been identified as one of the major problems of FGC practice, which affects the social and sexual aspects of females who have been cut. Hence, psychological experience for the cut female is a consequence of FGC which is characterised by anticipated pain, fear, violence, mockery, ostracizing and uncertainty of outcome(s) of the practice. These experiences are often times caused by feelings of betrayal, bitterness and anger; and these may subsequently result in posttraumatic stress disorders involving recall of the process, emotional stress and mental illness, especially for females who experience the practice at an age of awareness; or who face stigmatisation for not undergoing the practice as a cultural dictate.

In this wise, negative feelings or thoughts as a result of being cut are connected and this is corroborated by Nowak's statement that: 'The pain inflicted by FGC does not stop with the initial procedure, but often continues as an on-going torture throughout a woman's life' (Nowak p. 61). Also, in a study by Njue and Askew (2004), fear of penetration during intercourse was found to be a facilitating factor resulting in lack of sexual satisfaction. Confirming the psychological trauma caused by the practice, as well as stigmatisation for refusing to be cut,

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Nour (2008) reports that feelings of fear exist for both females and parents of females who are not cut because of uncertainty of outcomes of their decision(s) such as ostracising.

For growth and development of an individual to take place, constructs of knowledge and attitude are very important. This is because they are major constructs by which an individual is able to learn, integrate into the society and interact with those in the society. Therefore, with the main aim of FGC intervention programmes geared towards facilitating knowledge on effects of FGC as a traditional practice, and alleviating problems such as psychological experience caused by FGC, it can be inferred that intervention programmes are meant to have influence on knowledge acquisition in relation to FGC and its dangers, and help form attitudes towards the practice. Also, with psychological experience which is a resultant of psychological consequences caused by FGC, it is assumed that it will be a facilitating factor in combination with intervention programmes in modifying and changing attitudes towards its continuation especially within practicing communities.

The constructs of knowledge and attitudes are significantly influenced by several variables that abound within an individual's environment. Some of such variables include race, ethnicity, age, gender, income, educational attainment, location, employment status and family size. Goldberg, Sweeney, Merenda and Hughes (1998) and Power and Elliot (2006) have also observed that some levels of influence on these constructs help to explain and prove facts in a particular area of interest. The influence of age range, adolescents' or young adults' educational level, schooling status, parents educational status, work status, FGC status, marital status and location of residence will be considered in relation to knowledge of FGC and attitude towards the practice. The common aim of most FGC intervention programmes is to create awareness on the dangers of female genital cutting as a traditional practice. The programmes also help in sensitising people on the need to change their attitude towards the continuation of the practice due to its attendant complications and consequences (Norwegian Knowledge Centre for the Health Services - NKCHS (2009). According to Iliyasu, Abubakar, Galadanci, Haruna and Aliyu (2012) and Anderson, Rymer, Joyce, Momoh and Gayle (2012), interventions which use strategies of awareness creation and dissemination of information through various activities, facilitate acquisition of knowledge and modification of or change in attitude and behaviour.

Age has been found to exert a certain level of influence on constructs that relate to human life or processes. Some of such constructs include knowledge, attitudes, perception and

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experiences. According to some studies (Snow, Slanger, Okonofua, Oronsanye and Wacker 2002; Masho and Mathews, 2009), age at which a female experiences FGC is a significant factor that facilitates knowledge on dangers of FGC and influences the attitude of females towards the practice. But it has also been observed as reported by Masho and Mathews (2009) that other variables such as demographic and socio-demographic factors (location, religious affiliation, education, FGC and marital status and level of exposure to mass media) can moderate the influence of age; hence certain age levels can contravene assumed norms in relation to attitude.

Several studies and reports, (Owolabi, Laurel, Bailah, Vanja, Staffan and Lars, 2012; Exchange, 2008 and WHO, 2013) have also reported that age at which FGC is experienced is a decisive factor for level of vulnerability to the various consequences and complications that are attributed to the practice as well as attitude towards the practice. According to their reports, most common complications such as excessive bleeding, delay in or incomplete healing, tenderness and fever are significantly more often reported by girls who have undergone FGC before 10 years of age. Also, child marriages which involve girls less than 18 years and have FGC as a prerequisite for marriage have recorded higher risks during pregnancies. This has resulted in common complications as well as vesico-vegina fistula (VVF), infection, anemia, and eclampsia which contribute to higher mortality rates of both mother and child (Forward, 2014). It is thus assumed that such girls experienced FGC between the ages of 10 -14 considering the age at which they may have been married coupled with the prerequisite of having a cut status.

Factors relating to education, exposure to interventions and contextual issues have also been found to influence human knowledge and attitude. Therefore, schooling status, educational status and attainment, access to intervention programmes and mode of acquiring information are some of the variables that are of significant importance in facilitating knowledge acquisition on dangers of FGC and influencing attitude towards the practice. Several studies have found significant relationships between knowledge and attitude; educational status and educational attainment (Iliyasu, Abubakar, Galadanci, Haruna and Aliyu, 2012; and Morgan, Ferkas, Hillemeier and Maczuga, 2009). These showed that a minimum level of education with additional educational qualifications, were commensurate to a higher exhibition of knowledge and expected attitude formation, modification or change which were obtained. Also, mode of acquiring information on the practice of FGC has been reported to have significant influence on knowledge and attitude (Aikens and Barbarin, 2009; Mandara, 2003; Nnorom, 2007).

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Work status, FGC status, marital status and location of residence are socio demographic factors that can influence knowledge and attitude in relation to FGC. Work status can be inferred from the income or occupation components of an individual's socio-economic status (SES). Hence, an individual's SES can be described as high, medium or low depending on his/her work status and educational qualification or status. According to the National Centre for Educational Statistics (NCES, 2008), income, education and occupation are related to an individual's economic and social position. Due to other contributory factors such as location and religion, there have been several different reports from studies on the effect of SES or its various components on knowledge and attitude in relation to FGC (Karmaker, Kandala, Chung and Clarke, 2011). According to Nnorom (2007), reports from a study on patterns, prevalence and remedies on FGC practice revealed that location of residence as well as educational attainment had great influence on attitudes towards FGC.

FGC status which refers to the 'cut' or 'un-cut' condition of a female and marital status have been reported to significantly affect attitude towards FGC. According to some reports, FGC status has been reported to elicit positive or negative feelings on psychological experience. Such experiences range from attaining social status and having a sense of belonging among peers to stigmatisation for not being cut and low sexual quality of life among married women (Anderson, Rymer, Momoh and Gayle, 2012). Correlation studies of FGC status, psychological experience and age have also shown a negative attitude to the practice, thus implying that age at which FGC is experienced has significant influence on attitude towards the practice. In summary therefore, factors which can influence knowledge acquisition as well as facilitate attitude formation or change in relation to FGC have been identified by several studies, surveys and intervention programmes such as Ahanonu and Victor (2013); Owolabi et. al. (2012), and Denison, Berg, Lewin and Fretheim (2009).

Apart from the issue of limited evaluation studies on FGC activities and programmes that have been implemented, most of the study reports from within and outside Nigeria have focused on demographic and socio-demographic factors in relation to reproductive health consequences caused by the practice. These studies have focused mainly on females within the reproductive age of 15 to 45, with not many of the available studies reporting on issues of psychological experience, especially among females with FGC. Finally, though several FGC activities may have been initiated and/or mainstreamed into existing health programmes in Oyo State, there

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seems to be no reports of such activities. It is therefore imperative that, in order to determine the effectiveness and outcomes of such programmes or activities, there is a need for comprehensive evaluation. This study will therefore set out to determine if objectives for which the intervention programme was implemented have been achieved in relation to expected outcomes for programme beneficiaries and to what extent the objectives have been achieved.

1.2 Statement of the problem

The African Women's Development Fund-Justice, Development and Peace Commission (AWDF-JDPC) Female Genital Cutting Intervention Programme was implemented in 2012 in some selected Local Government Areas (LGAs) in Oyo State, South West Nigeria. Based on reports of high maternal mortality and psychological experiences due to FGC, the aim of the intervention programme was to provide enlightenment on the dangers of FGC and facilitate opportunities and access to expert counselling for females with FGC. The programme employed a multisectoral approach involving update training for healthcare providers, enlightenment activities such as talks, media campaigns distribution of information, education and communication (IEC) materials for community members as well as provision of expert counselling at the established maternal health counselling centres (MHCCs) for females with FGC.

Although the programme ended officially in 2013, some activities of the intervention programmed have been continued; as a result, the implementing organisation (JDPC) has been carrying out intermittent monitoring and evaluation (M and E) activities. These have focused on the rate of females with FGC accessing expert counselling services (output) at the various established MHCCs. Hence, there has been no known independent-external and comprehensive evaluation of the programme to determine the impact (outcome) of the programme. Based on this premise, this corroborates the fact that there is a dearth in appraisal of effectiveness of such programmes.

This study therefore evaluated the AWDF-JDPC programme in LGAs of intervention in Oyo State, to determine its effectiveness (outcomes) on both direct (healthcare providers/programme trainees) and indirect (community members and females with FGC) programme beneficiaries. The study examined the outcome of the key variables namely: FGC intervention programme and psychological experience as well as age, educational level,

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schooling status, parents' educational status, work status, FGC status, marital status and location of residence on knowledge of dangers of FGC and attitude towards the practice among adolescents who are 10 to 24 years of age.

1.3 Evaluation Objectives

Based on the five AWDF-JDPC intervention programme's objectives, this study evaluated the implementation of the intervention programme by examining the effects of its activities, alongside some personal factors such as psychological experience and some socio demographic factors on outcomes of female adolescents' and young adults' knowledge of dangers of FGC and attitude towards the practice. The evaluation objectives are as follow:

1. To describe the characteristics of programme trainees in relation to:
   - knowledge of prior FGC intervention programmes in intervention LGAs
   - effectiveness of intervention strategies used in dissemination of information on dangers of FGC
   - rate of reports on psychological experience due to FGC, and provision of follow-up services for females with FGC.
   - rate of monitoring and evaluation activities by the implementing organisation (JDPC), on access of opportunities and expert counselling in established MHCCs
2. To describe the characteristics of females with FGC in the intervention LGAs and enquire about their views on the most harmful traditional practice that affects the psychological well-being of females as well as identify psychological experiences associated with the practice.
3. To describe the characteristics of female adolescents and young adults in intervention and non-intervention LGAs and assess the outcomes of programme trainees' up-date training on access to opportunities and expert counselling for females with FGC; and enlightenment activities on knowledge of dangers of female genital cutting and attitude towards the practice among intervention beneficiaries, and between intervention and non-beneficiaries.
4. To determine the composite and relative effects of the key variables - FGC intervention and psychological experience; age, adolescents' educational level, schooling status, adolescents' parents' educational status, work status, FGC status, marital status and

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location of residence, on the dependent variables (knowledge and attitude) in LGAs of intervention.

5. To determine if there will be significant differences in outcomes on knowledge of dangers of FGC and attitude towards the practice between:
   i. Female early, middle and late (young adults) adolescent beneficiaries in LGAs of intervention
   ii. Female in-school beneficiaries and out-of-school beneficiaries in LGAs of intervention.
   iii. Female beneficiaries in intervention LGAs and non-beneficiaries in LGAs with no intervention.
   iv. Female in-school beneficiaries in intervention LGAs and female in-school non-beneficiaries in LGAs with no intervention.
   v. Female out-of-school beneficiaries in LGAs of intervention and female out-of-school non-beneficiaries in LGAs with no intervention.

1.4 Research Questions

Based on the stated problem, the study provided answers to the following research questions and hypotheses.

1. What are the characteristics (age, gender, designation and years of working experience) of AWDF-JDPC intervention programme beneficiaries in relation to:

- knowledge on prior intervention programmes on dangers of FGC in LGAs of intervention?
- Extent to which different information strategies were effective in imparting knowledge on the dangers of FGC and facilitating attitude change towards the practice?
- Rate of reporting of psychological experience due to FGC were reported and follow up activities carried out on females with FGC?
- Rate of monitoring and evaluation activities by the implementing organisation (JDPC), on access of opportunities and expert counselling in established MHCCs

2. What are the characteristics (age, educational level, schooling status, parents educational status, FGC status, marital status, work status, location of residence, religion, age and type of cut, number of female children cut, age and type of cut for female children) of the FGC Focus Group Discussants comprising females with FGC in relation to:

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- Views on the most harmful traditional practice affecting the psychological and physical well-being of females' in intervention communities
- Psychological experiences associated with the practice?

3. What are the characteristics of female adolescents and young adults in LGAs of intervention and LGAs with non-intervention in terms of: age, educational level, schooling status, parents educational status, FGC status, marital status, work status, and location of residence?

4i. What is the profile of respondents in intervention and non-intervention LGAs in relation to knowledge on dangers of FGC and attitude towards the practice?

4ii. Is there any significant difference in respondents' knowledge of dangers of FGC and attitude towards the practice in intervention and non-intervention LGAs?

5i. What is the profile of adolescent and young adult respondents in intervention LGAs in relation to knowledge of dangers of FGC and attitude towards the practice?

5ii. Is there any significant difference in adolescent and young adult respondents' knowledge of dangers of FGC and attitude towards the practice in intervention LGAs?

6. What is the composite effect of intervention programme, psychological experience, age, educational level, schooling status, parents educational status, FGC status, marital status, work status, location of residence on knowledge and attitude?
7. What is the relative effect of intervention programme, psychological experience, age, educational level, schooling status, parents educational status, FGC status, marital status, work status, location of residence on knowledge and attitude?
8. What is the effect of psychosocial support (opportunities and access to expert counselling) provided by programme trainees (HCPs), on females with FGC?

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1.5 Hypotheses

1. There is no significant difference between females in early, middle and late (young adults) adolescent stages in LGAs of intervention in relation to:
   (i) Knowledge on dangers of FGC
   (ii) Attitude towards FGC practice
2. There is no significant difference between female in-school respondents and out-of-school respondents in LGAs of intervention in relation to:
   (i) Knowledge on dangers of FGC
   (ii) Attitude towards FGC practice
3. There is no significant difference between female respondents in intervention LGAs and female respondents in non-intervention LGAs in relation to:
   (i) Knowledge on dangers of FGC
   (ii) Attitude towards FGC practice
4. There is no significant difference between female in-school respondents in intervention LGAs and female in-school respondents in non-intervention LGAs in relation to:
   (i) Knowledge on dangers of FGC
   (ii) Attitude towards FGC practice
5. There is no significant difference between female out-of-school respondents in LGAs of intervention and female out-of-school respondents in non-intervention LGAs in relation to:
   (i) Knowledge on dangers of FGC
   (ii) Attitude towards FGC practice

1.6 Scope of the Study

The study covered the five specific objectives of the AWDF - JDPC intervention programme on elimination of FGC in Oyo State. It was limited to females between the ages of 10 and 24 years from four (4) communities each within Ibadan North East and Lagelu LGAs (intervention LGAs) and Ibadan South West and Atiba LGAs (LGAs with non-intervention). The variables of interest were intervention programme, psychological experience, age, educational level, schooling status, parents educational status, FGC status, marital status, work status and location of residence; knowledge on dangers of FGC and attitude towards FGC.

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1.7 Significance of the Study

The findings of this study will first and foremost provide both the programme funder and implementer with empirical information on the extent to which programme objectives were achieved in the intervention LGAs. For community and traditional heads of the various communities where the intervention was implemented, the study will provide information on the views and opinions of female community members in relation to FGC and the need for community and traditional heads' participation in community based activities towards abolishing the practice especially because of the adverse effects of the practice. Findings of this study will also help to identify the most effective means of educating illiterate persons within the communities of intervention so that the can be adequately educated on the dangers of FGC which in turn should influence their attitudes towards the discontinuation of the practice. Also, results from this study can serve as an impetus for replication of the programme in other LGAs of Oyo State considering that though the intervention programme was implemented based on pre-existing conditions reported by the intervention LGAs, other LGAs within the state are prone to have similar conditions considering the high prevalence rate of the practice in Oyo State (62.6%.), among other South Western States.

Secondly, considering that this study is mainly interested in outcomes of the intervention programme among females within the age cohort of 10 to 24 years, this study will provide information on how knowledgeable this group of respondents have become on dangers of the practice even after the completion of the programme. Trained healthcare providers can capitalise on the knowledge acquired by this group by engaging them as animators (agents of change) in FGC based community activities in the various communities where they reside. Still on this age cohort especially those of the early adolescence period (10 – 14), who have been reported to be highly vulnerable to consequences of FGC, information from this study will help to be knowledgeable about some of the consequences of the practice which they may experience as they grow up, and the need to access expert counselling which will help them to accept and cope with their cut status.

Lastly, using all necessary indicators information from this study can be used to make propositions at the various levels of government for the domestication of existing legislations and enforcement of laws prohibiting the practice of FGC, because of its harmful effects. Information from this study could also be a facilitating factor for the inclusion of comprehensive

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FGC and its other related issues, in health related programmes, health education curriculum and health education clubs' in secondary schools. Inclusion of information on dangers of FGC via these means will facilitate enlightenment and serve as a platform for value re-orientation and evaluation of changing trends in relation to knowledge on dangers of FGC, reports of psychological experience and attitude change towards the practice.

1.8 Operational Definitions

- **Access to opportunities:** The extent to which health related services such as maternal and reproductive health counselling, referral and follow-up services are provided for FGC victims within established maternal health counselling centres.
- **Adolescents:** These are females whose ages range from 10 to 14 (early adolescence), 15 to 19 (middle adolescence) and 20 to 24 (late adolescents)**.**
- **Adolescents' and young adults' educational level:** This is the level of education attained by female adolescents and young adults in terms of educational qualifications such as degree, higher institution certificate, senior secondary certificate, junior secondary certificate etc.
- **Age cohort:** These are age ranges of 10 – 14; 15 – 19; and 20 – 24 that will be utilised in the evaluation of knowledge and attitudes in relation to FGC**.**
- **Attitude:** This is the extent to which study participants are favourably or unfavourably dispose to the practice of FGC.
- **FGC intervention programme:** It comprises of all the activities (awareness creation/enlightenment talks, trainings, advocacy, provision of information, education and communication (IEC) materials and media activities and establishment of maternal health counselling centres – MHCCs) used to facilitate knowledge on dangers of FGC.
- **FGC Status:** This refers to the 'cut' or 'uncut' state of a female adolescent i.e. females with FGC and those who have not experienced the practice.
- **Location of residence:** This refers to the placement of an individual's living abode.
- **Maternal Health Counselling Centre (MHCC):** These are psychosocial service centres which have been mainstreamed into regular healthcare centres to provide psychosocial support through programme trainees.
- **Parents' educational status:** This is the level of education attained by parents that identifies them as having 'formal' or non-formal education.

- **Psychological experience:** These are positive or negative feelings as expressed by a female due to the female genitalia being cut or altered, or otherwise.
- **Psychosocial support:** This involves expert counselling services provided to females to help them cope with different complications and consequences that may occur due their FGC status.
- **Schooling status**: This refers to the present active or inactive school attending position of adolescents and young adults in terms of being in school presently or being out of school for at least two (2) years.
- **Step-down training:** These are smaller and less intensive teaching sessions conducted for significant persons in relation to FGC practice, using the course content of the larger and more extensive instruction.
- **Up-date training:** This involves extensive instructional sessions for health care providers/programme trainees, based on well-designed course content in areas of concern relating to FGC outcomes.
- **Young adults:** These are females whose ages range from 20 to 24 (late adolescence).

Conceptual Definitions

- **FGC practice:** The act of partially or totally removing the external female genitalia, with any other alteration or injury to the female genital organ for non-medical reasons.
- **Knowledge:** This refers to acquired information, facts, ideas and supposed truths.
- **Marital status:** This is an individual's position of being married, unmarried; separated or divorced from his or her spouse.
- **Work status:** It is the position of an individual in terms of his or her active work situation or inactive work situation.

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Acronyms

- **AWDF:** African Women's Development Fund
- **CHEWs:** Community health workers
- **DHS:** Demographic Health Survey
- **FGC:** Female genital cutting
- **HCPs:** Health care providers
- **HCDT:** Hofstede' cultural dimension theory
- **IEC:** Information, education and communication materials
- **JDPC:** Justice, Development and Peace Commission
- **LGAs:** Local government areas
- **MHCCS:** Maternal health counselling centres
- **NDHS:** National Demographic Health Survey
- **PHEWs:** Public health workers
- **C/TBAs**: Traditional/community birth attendants
- **IPO:** Input, Process, Output/Outcome
- **HCDT:** Hofstede's Cultural Dimension Theory
- **IDV:** Individualism versus Collectivism
- **UAI:** Uncertainty Avoidance Index
- **PDI:** Power Distance Index
- **MAS:** Masculinity versus Femininity
- **LTO vs STO:** Long Term Orientation versus Short Term Orientation
- **SCT:** Sociocultural Theory

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CHAPTER TWO

REVIEW OF LITERATURE

This chapter presents a review of related literature. Relevant literature will be reviewed under the following sub-headings:

2.1. Concept of Female Genital Cutting

2.1.1. Justifications for Female Genital Cutting Practice

2.1.2. Consequences and Complications of Female Genital Cutting

2.2. Female Genital Cutting Prevalence Rates

2.3. Overview of Female Genital Cutting Intervention Programmes

2.3.1. In-School Female Genital Cutting Programmes

2.3.2. Out-of-School Female Genital Cutting Programmes

2.4. Female Genital Cutting Interventions in Nigeria

2.5. AWDF-JDPC Intervention in Oyo State, South-West Nigeria

2.6. Theoretical Background

2.6.1. Hofstede's Cultural Dimension Theory,

2.6.2. Practice Theory

2.6.3. Sociocultural Theory

2.7. Conceptual Framework

2.7.1. Knowledge and Female Genital Cutting Interventions

2.7.2. Attitude and Outcomes of Female Genital Cutting Practice

2.7.3. Adolescence and Female Genital Cutting Practice

2.8. Empirical Review of Literature

- FGC Intervention programmes in relation to Knowledge on FGC and Attitude towards the Practice
- Psychological experience in relation to Knowledge on FGC and Attitude towards the Practice
- Socio-demographic factors (age, schooling status, parents' educational status, work status, FGC status, marital status and location of residence) in relation to Knowledge on FGC and Attitude towards the Practice

2.9. Evaluation Approaches and Evaluation Models

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2.1. Practice of Female Genital Cutting

Female genital cutting (FGC) is defined as a traditional practice which involves the partial or total removal of the female external genitaila or other injury to the female genital organs for cultural or other non-therapeutic reasons (WHO, 2008). The practice is sometimes referred to as Female Genital Mutilation (FGM), Female Circumcision (FC), Female Genital Surgeries, Female Genital Alteration, Female Genital Excision, and Female Genital Modification (Leye, 2008; Gallo, Tita & Viviani, 2006). It has been acknowledged as one of the most widely practiced harmful traditional practice. The term FGM has been used by stakeholders and anti-FGM groups to emphasise the gravity of the practice; while the use of FC is better received in communities that practice the act, but do not see themselves as engaging in mutilation (Boyle, 2002). It also reduces the onset of unpleasant memories of the practice among victims.

Though FC is believed to be less offensive and judgmental for practicing communities, and less traumatizing for the affected, the term has been rejected on the grounds of the practice being implied as the female equivalent of male circumcision. Also the term is not seen as depicting the true nature of FGM and implies that the practice and the consequences of FGM are far less severe than is the case. In recent times though, the term FGM/C as used by other groups, such as UNFPA and USAID or FGC has emerged, due to increased interest on the issue as a public, research or human rights/legal discourse. Other FGM related terms such as angurya cuts, clitoridectomy, de-infibulation, excision, infibulation or pharaonic circumcision, re-infibulation, sunna amongst others are also used to described the practice (Forward, 2006; Gallo, Tita & Viviani, 2006).

Based on descriptions and continuous review of definitions, the World Health Organisation (WHO) therefore defines FGC as ‘all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons’ (WHO, 2010). The WHO classifies FGC into four types as presented in Figure 2.1.

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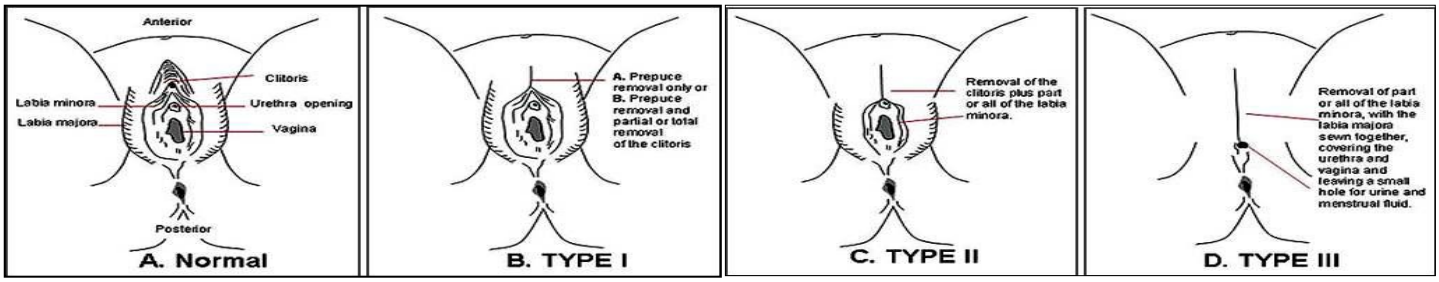

Figure 2.1: Graphical illustrations of FGC Types I, II, III and IV (WHO, 2008)

Type I involves the removal of the clitoral hood or the partial or total removal of the clitoris (clitoridectomy); Type II, often called excision, is the partial or total removal of the clitoris and the inner labia or outer labia. Type III is commonly called infibulation or pharaonic circumcision. It is the removal of all external genitalia; the inner and outer labia are cut away, with or without excision of the clitoris. Type IV according to WHO (2010), are all other harmful procedures to the female genitalia for non-medical purposes; such as pricking, piercing, incising, scraping and cauterization.

2.1.1. Justifications for Female Genital Cutting Practice

According to Zerai (2003), the Centre for Reproductive Rights (2006) and many other reports, various reasons have been given for carrying out the practice as well as for its continuation. The practice is driven by a complex combination of psychosexual and social reasons (Muteshi & Sass, 2005), which are classified into four main reasons with justifications. Firstly, it is the belief of communities that the practice of FGC maintains their customs and preserves their cultural identity by continuing the tradition; secondly, enforcement of FGC in the society is an attempt to control women's sexuality by reducing their sexual fulfillment; thirdly, it is believed to be a religious obligation for Jews, Christians, Muslims, and members of other indigenous religions, though it is also a cultural practice with no links with non-traditional religions; and lastly, due to the need for social acceptance, there is the social pressure from the community especially in a community where most women are circumcised; consequently, family and friends create an environment in which the practice of circumcision becomes a requirement for social acceptance.

Other reasons according to Odeku (2012) also include hygiene purposes considering that the female genitalia are looked upon as being unclean and unsightly in some societies; they are thus removed to promote hygiene. The process of FGC is also considered to be a fertility

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enhancer, facilitates the delivery process which ensures child survival, and increases marriage prospects. Also, in communities where females are considered for inheritance processes, an uncut female does not have any chance of being included during the sharing of assets in whatever form. In addition to all these reasons, though there have been reports of health care providers/programme trainees such as doctors, nurses, and midwives increasingly performing FGM in order to reduce the pain and/or the risk of infection, which is referred to as 'medicalisation process' (WHO, 2010; Reymond, Mohamud, & Ali, 1997), personal reports as well as reports from surveys have indicated that, the act of performing FGC is considered as an alternate and or an additional means of income. Hence, circumcisers and often times, traditional/community birth attendants (C/TBAs) perform the operation for income generating reasons.

Leye (2008) thus summarises reasons for the practice of FGC as: religious, health based, socio-economic, traditional and ethnic, and gender-related reasons. These reasons have been known to facilitate the continuation of the practice, even though there has been no proofs that FGC has health benefits. Rather, the practice has been reported as having damaging effects on healthy and normal female genital tissue, and interfering with the natural functions of girls' and women's bodies which result in consequences and complications. With these facts and study reports consistently reporting on the consequences of the practice and complications that arise at different stages of victims' lives, the need for embarking on more intervention programmes cannot be over emphasised. Also, awareness creation and sensitization on the harmfulness of the practice must be a continuous process, with active involvement of members of FGC practicing communities in order to sustain the goal of eradicating FGC.

2.1.2. Consequences and Complications of Female Genital Cutting

Although reasons and justification for the practice of FGC have continually been extolled by traditional circumcisers, there have also been several reports of the negative outcomes bothering on medical, emotional and mental health risks associated with the practice. These health risks are thus classified as immediate or late complications; short term or long term health risks or consequences (women's health factsheet) or post FGC complications (Tag-Eldin, Gadallah, Al-Tayeb, Abdel-Aty, Mansour & Sallem, 2008), based on the time at which the outcomes of the practice appear. According to Nour (2008), women with types I and II FGC who

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survive the procedure rarely have long-term complications but experience the same immediate complications associated with other FGC types. The most common and immediate complications identified include fever, infections, urinary retention, severe pain, shock, hemorrhage and death (WHO, 1998 as cited by Leye, 2008; Nour, 2008). Their severity may vary due to traditional or medicalised as well as management procedures.

According to Abdulcadir, Margairaz, Boulvain and Irion (2011), infections such as urinary infection, wound infection, septicemia, tetanus; and in the case of unsterile and reused instruments, this may result in hepatitis and HIV infections. Contrary to immediate complications, which are associated with all FGC types, victims of extensive FGC procedures involving infibulations and de-infibulations have been reported to suffer from long term complications (Shell-Duncan, 2001). These extensive procedures interfere with processes of urine and menstrual flow thus causing complications. The most common long-term complications are dysmenorrhea (severe pain associated with menstration), dyspareunia (painful intercourse), recurrent vaginal and urinary tract infections, infertility, cysts, abscesses, keloid formation, difficult labor and delivery, and sexual dysfunction (Nour, 2008).

Sequel to documented health risks associated with FGC, consequences of the practice have been summarised as physical, psychological, social and sexual (Berg, Denison & Fretheim, 2010; WHO, 2008). Physical consequences emanate from some of the late complications that arise from FGC. Hence, infection, obstruction, obstetrical and gynecological problems resulting in infertility, urinary and genital tract dysfunctions, and re-occurrence of difficult labour/birthing processes are some of the late complications (consequences) of FGC (Banks, Meirik, Farley, Akande, Bathija & Ali, 2006).

Due to traumatic experiences attributed to FGC, many girls and women are at risk of psychological and mental breakdown; these are Psychological consequences attributed to the practice. According to Reymond et al. (1997), many studies have not been carried out in the area of psychological consequences, but some reports have associated stress disorder, anxiety, depression, and psychosomatic illnesses such as posttraumatic memory loss with FGC (Toubia, 1993). Also, the Human Reproduction Progress – HRP Newsletter (2006), has identified psychological and psychosomatic disorders such as disordered eating (loss of appetite, weight loss or excessive weight gain) and disordered sleeping habits (sleeplessness and recurring nightmares) as psychological consequences due to FGC.

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Social principle of a group determines the nature of Social consequences of the practice of FGC. Therefore, conforming or refusing to undergo FGC depending on the social convention of a community carries consequences both when it is and when it is not practiced. In complying with the practice of FGC, the female attains a sense of pride and of coming of age, and significant persons attain social status as well as respect and acceptance within that community. Also, in societies where value is attached to undergoing FGC, the female is celebrated, given gifts and attracts a higher bride price (United Nations Children's Fund Report, 2005; Wheeler, 2003). Contrary is however the case when there is failure to conform to the practice.

In the case of Sexual consequences Obermayer (2005) and Reymond et al. (1997) in support of some empirical researches suggest that, FGC does not necessarily prevent sexual activity; rather, according to Elnashar and Abdelhady (2007), loss of libido and dyspareunia (tight vaginal opening causing pelvic infection or vaginismus) are more likely to be some of the physical complications that cause adverse sexual consequences. Nour (2008) treats sexual consequences as psychosocial consequences (which is a combination of the social and sexual aspects of the female). From the psychological point of view, he asserts that infertility caused by anatomic and psychological barriers due to FGC is a psychological complication. This is because the intention of curbing promiscuity through FGC results in the inability to get pregnant within marriage; hence, the issue of infertility for both wives and husbands is questioned.

Although several studies have reported men's preference in marrying uncircumcised women, several other studies such as Gruenbaum (2006) and Herieka and Dhar (2003), have reported contrary preference of men marrying circumcised women. Based on reports of various studies in relation to sexual and psychosocial consequences therefore, the provision of appropriate and adequate information as well as psychosocial support through counselling in these aspects, via FGC intervention programmes cannot be over-emphasised. This is because, most often, female young adults who have been victims of the practice, need such situation or condition appropriate information, counselling and care, in order to cope with complications and consequences being experienced.

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2.2. Female Genital Cutting Practice Prevalence Rates

Female genital cutting as a traditional practice is performed on females within and outside the shores of Nigeria (Nour, 2008; Boyle, 2002 & Frances, 1997). According to a WHO fact sheet (2014), most times it is executed a few days after birth, between ages 5 and 10 years (Ismail, 2009), during adolescence as a rite of passage into adult or woman hood, or just before the birth of a first child of a married woman; and has all FGC types (Types I, II, III and IV) which range from slight to extensive cuttings, being performed at these various times. Newborns, children, adolescents, and young adults are also victims in the various communities that indulge in the practice. The practice of FGC due to its firm roots in culture and tradition as well as the practice of all FGC types has been implicated in the increasingly high prevalence rates being recorded globally (Grabman & Eckman, 2010; Gbadamosi, 2008 & Lescure, 2006).

According to the WHO, 100–140 million women and girls are living with FGM, including 92 million girls over the age of 10 in Africa (WHO, 2010). FGC reports have also showed that the practice exists in 30 (thirty) countries, spanning the Western, Eastern and North-Eastern parts of Africa as well as parts of the middle East, Asia and some immigrant communities in Europe, North America and Australia (Barbarani, 2013; Clarence-Smith, 2012; Abdulcadira et al., 2011 and Berggren, 2005). A recent UNICEF survey report (2013) also supports the WHO assertion in respect to African countries. According to the report, FGC is prevalent in 27 African countries, with all FGC types being practiced. African countries and their prevalence rates according to FGC types from the surveys are presented in Table 2.1.

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Table 2.1: African Countries and Prevalence Rates According To FGC Types

Type II	Types I & II	Types II & III	Types I, II & III	Types I – IV
Benin (13%)	Cameroon (1.4%)	Chad (45%)	Djibouti (90 -98%)	Ethiopia (69.7 – 94.5%)
Burkina Faso (77%)	Central African Republic (25.7%)	Senegal (28%)	Egypt (78 -97%)	Gambia (76%)
Cote d'Ivoire (42%)	Mauritania (71%)	Tanzania (14.6%)	Eritrea (89%)	Nigeria (30%)
Democratic Republic of Congo (5%)	Sierra Leone (91%)		Ghana (3.8 - 40%)	
Liberia (58%)	Uganda (5%)		Guinea (96%)	
Niger (2 – 20%)			Kenya (27%)	
Republic of Congo (5%)			Mali (92%)	
Togo (50%)			Somalia (98%)	
			Sudan (91%)	

Source: Female Genital Mutilation/Cutting Prevalence Rates and FGC Types (UNICEF, 2013)

For Nigeria which has been identified as practicing all FGC types, a 2008 demographic survey (Federal Ministry of Economic Cooperation and Development, Germany, 2011) found that 30% of all Nigerian women had been subjected to FGM. This report therefore corroborates some National survey reports on FGC in Nigeria such as the Demographic Health Surveys –DHS (2003 and 2008), Multiple Indicator Cluster Survey – MICS (2007 and 2011) and the Nigeria Demographic and Health Survey – NDHS (2013). According to the DHS reports, the prevalence rate of the practice was 22% and 30% respectively, with an increase of 8% between 2003 and 2008; while the MICS reports of 2007 and 2011 respectively, reported a prevalence of 27% and 22.10% among other African countries, thus recording a decrease of 4.9% of the practice within this period. However, Nigeria has been reported to have the highest absolute number of cases of FGC in the world.

With the country's over 250 ethnic groups scattered among the six geo-political zones of the country, a combination of the FGC types is found to be in practice. There have thus been reports of prevalence rates undulating between 2.7% and 49.2% (MICS, 2011); the North - East, Central, and West zones are rated as having 2.7%, 13.1%, and 12.3% prevalence respectively, while the South - West, East and South zones have prevalence rates of 46.4%, 49.2% and 35.2% respectively.

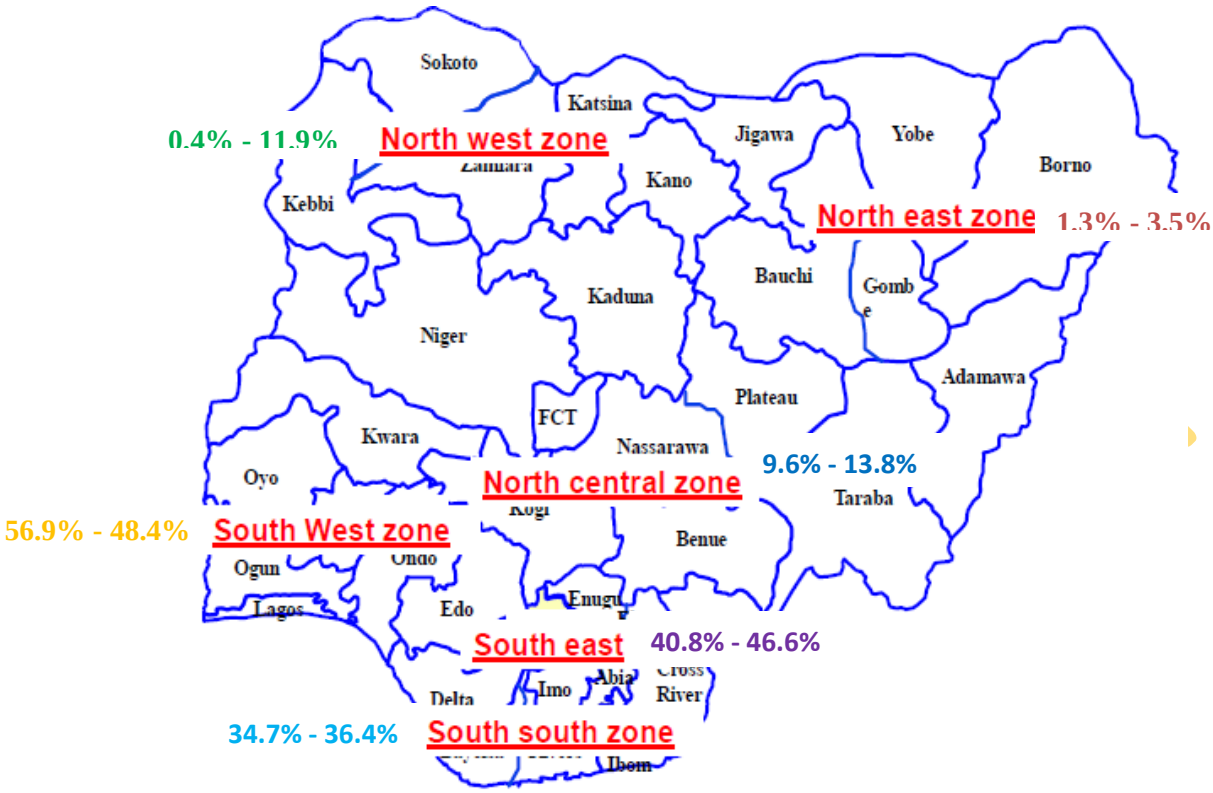

Figure 2.2: Map of Nigeria showing range of FGC prevalence rates according to the geo-political zones (NPC 2003, 2008; MICS 2007, 2011)

Several study reports in addition to cited National Health Surveys have attested to the high prevalence of the practice in Nigeria especially in the South West (46.4%) and South East (49.2%) zones. Such studies include Oyetade (2012), Ibekwe, Onoh, Onyebuchi, Ezeonu & Ibekwe (2012), Iliyasu, Abubakar, Galandanci, Haruna and Aliyu (2012), Adeniran (2011), Abiodun, Oyejola & Job, (2011) and Akinsanya (2011) amongst others. The high prevalence rate has been attributed to cultural dictates (Grabman & Eckman, 2010; Gbadamosi, 2008; and Lescure, 2006), as well as the practice of all FGC types in Nigeria (Inter-African Committee of Nigeria on Harmful Traditional Practices Affecting the Health of Women and Children–IAC (1997) as cited by Ogie (2012). This is also reflected in the South Western region of Nigeria (NDHS, 2013) as presented in Table 2.2. Hence, the practice ranges from extensive to slight cuttings.

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Table 2.2: Percentage of FGC Types among Women Age 15 – 49 in South West States of Nigeria

State	Type of Cut			
	Cut no flesh removed (Type I)%	Cut flesh removed (Type II)%	Sewn closed (Type III)%	Don't know
Ekiti	4.9%	44.1%	2.0%	49.0%
Lagos	2.3%	70.8%	4.4%	22.4%
Ogun	19.6%	68.8%	1.2%	10.3%
Ondo	4.1%	50.2%	1.1%	44.6%
Osun	3.4%	85.2%	2.9%	8.5%
Oyo	1.2%	73.7%	2.8%	22.3%

Source: Nigeria Demographic and Health Survey (2013)

2.3. Overview of Female Genital Cutting Intervention Programmes

In view of many studies and several interventions on FGC, a RHL commentary by Nour (2010), on effectiveness of interventions designed to reduce the prevalence of female genital mutilation/cutting was carried out on sixteen (16) selected studies. These include articles in peer-reviewed journals (2), single studies (3), individual based studies (2), community based studies (4) and five (5) others as published reports to respective funding agencies. The different studies according to Nour yielded different results ranging from training of health care personnel not being effective due to personnel not wanting to play a major role in the eradication of the practice (individual based study in Mali); while in a similar individual based study in Egypt, there was increased knowledge about FGM/C among female university students. In the case of community based studies (Ethopia/Kenya and Nigeria) results showed increased knowledge and awareness among women and men; and regret accompanied by a declaration of abandoning the practice in Senegal and Burkina Faso that had community based empowerment programmes as their approach to reducing FGC.

Also, according to a survey report by Feldman-Jacobs and Rynaik (2007), 92 FGC intervention projects were identified as taking place in African countries; and most of these intervention programmes were executed based on facts that the practice is harmful to the general well-being of females as well as violates their human rights. Hence, several FGC intervention programmes have been embarked upon with the sole aim of eradicating the practice. These have been implemented based on joint international declarations such as that made by the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) in 1997 (WHO, 2008) and UN specialised bodies (UN

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General Assembly, 2012); human rights laws (Table 2.3) at the international and national levels (Leye, Deblonde, Garcia-Anon, Johnsdotter, Kwateng-Kluvitse, & Weil-Curiel, 2007; European Parliament, 2004); and statements from human rights conventions.

Table 2.3: African Countries with Year of Laws and Decrees Related to FGC

1966 – 1999	2000 – 2005	2006 – 2012	1999 – 2006	2008 – 2009	Countries without laws
Central African Republic (1966)	Mali (2001)	DR Congo (2006)	Nigeria (some states, 1999-2006)	Sudan (some states, 2008-2009)	Cameroon
Ghana (1994)	Guinea (2002)	Egypt (Ministerial Decree, 2007)			Gambia
Djibouti (1995)	Benin (2003)	Eritrea (2007)			Liberia
Burkina Faso (1996)	Chad (2003)	Uganda (2010)			Sierra Leone
Côte d'Ivoire (1998)	Niger (2003)	Guinea-Bissau (2011)			
Tanzania (1998)	Ethiopia (2004)	Kenya (revised 2011*)			
Togo (1998)	Mauritania (2005)	Somalia (2012)			
Senegal (1999)	South Africa (2005)				

Source: UNICEF, Female Genital Mutilation/ Cutting: A Statistical Overview and Exploration of the Dynamics of Change (New York: UNICEF, 2013).

Aside of joint international declarations, human rights laws and statements from human right conventions, legal frameworks prohibiting FGC have been adopted in at least 28 FGC practicing African countries. Hence, existing laws against FGC are based on earlier and modified documents hinged on the international human rights law on female genital cutting; as well as on articles or sections in countries' constitutions. Some of such articles and documents include the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979, and the Convention on the Rights of the Child (CRC), 1989; as well as Chapter 4 of the 1999 Nigerian Constitution which states that all citizens are entitled to equal rights, including women. The chapter enshrines fundamental human rights such as right to life, right to dignity of the human person, right to freedom from discrimination and a host of other rights. As a result, these focus on the rights of women and girls and also provide a basis for the elimination of FGM as a human rights violation.

2.3.1. Overview of Laws against Female Genital Cutting

Laws against FGM vary considerably across the 28 countries where the practice is concentrated. The Centre for Reproductive Rights facts sheet (2009) has reports that 18 African countries have enacted laws criminalizing FGM with penalties (penal code) ranging from three months to life in imprisonment or monetary fines are imposed in some cases; while industrialised nations such as the U.S., Canada and its likes (other countries can be found in Appendix 11) as well as some African countries like Ethiopia, Kenya, Somalia and Sudan (Karhu-Rose, 2010) have passed laws criminalizing the practice. Some of the countries that have enacted laws against the practice also consider the different FGC types in line with the WHO definition in order to attach appropriate penalties. Though the Nigerian senate passed a bill criminalising FGC on 5th May, 2015 (Premium Times, 2015), it is yet to be passed into law, with an accompanying penal code. Hence, Nigeria is not yet actually recognised as having a law against the practice, even though a few of its states have out-lawed the practice (Edo, Cross-Rivers, Delta and Ogun) and some others (Akwa Ibom and Bayelsa States) are in the process of passing similar laws (The Lawyers Chronicles, 2013). Despite the fact that some states have out-lawed the practice, reports of data show that prevalence rates are yet to reduce drastically in such states and in Nigeria as a whole.

Based on the need to eradicate the harmful practice of FGC, various approaches have been employed by some intervention programmes in an attempt to persuade communities to abandon FGC. According to Muteshi and Sass (2005), some of such approaches include those based on human rights frameworks, legal mechanisms, health risks, alternative rites, positive deviance, training health workers as change agents, training and converting circumcisers, and the use of comprehensive social development processes (Berg & Denison, 2013). These approaches are targeted at stakeholders at individual, interpersonal, community and national levels and are often funded by international funding bodies through non-governmental - NGO/civil societies. In contrast to international efforts, Kandala, Nwakeze and Kandala (2009) report inadequate efforts on the part of various countries' governments towards eradicating the practice. It is thus assumed that, the issue is often viewed as a private act by individuals and family members.

With reports of execution of FGC intervention programmes, incorporation of issues relating to the practice on other health related programmes as well as reports from FGC studies within and outside Nigeria, schooling status of participants or beneficiaries in relation to the

execution of such intervention programmes or studies is a factor that is not given much attention. As a result, most intervention programmes are majorly designed in a way that prospective beneficiaries of such programmes irrespective of their schooling status are expected to access information and acquire necessary knowledge; but this assumption may not necessarily be correct as there is the need for adequate, appropriate and accurate information/education for specific groups of beneficiaries.

2.3.2. In-School Female Genital Cutting Programmes

Many intervention programmes on FGC are community based. As a result very often such programmes do not have school based activities designed to cater for in-school adolescent participants. With no specific activities targeted at this population, in-school adolescents acquire information via IEC materials, attendance of step down activities and sometimes community activities within intervention communities. Teachers incorporating information on FGC and its resultant consequences and complications into the teaching of human physiology and culture related school subjects, is another avenue by which in-school persons are opportune to be better educated on the nature of FGC and problems associated with the practice. Such subjects include social studies, civics education, physical and health education, biology and home economics; these subjects are offered both at the various levels of post primary education.

Despite the fact that school-based FGC intervention programmes are not common, there are reports of other health related intervention programmes which are implemented in in-school settings. Such interventions include sexual health, substance abuse prevention and nutritional interventions (Lassi, Salam, Das, Wazny & Bhutta, 2015); violence prevention intervention against women and girls (Ellsberg, Arango, Morton, Gennari, Kiplesund, Contreras &Watts, 2015) as well as Family life and HIV/AIDS education - FLHE programme (Ibadan Social and Evaluation Team – ISERT) amongst others. Some of the health related programmes like the FLHE programme which are implemented via regular school curriculum of selected schools as well as through extracurricular activities, incorporate FGC related information into the life skills and gender equality focused curricula of the programme (Marcus and Page, 2014). Again, school selection on the part of the FLHE programme implementers as well as willingness of school officials to accommodate such programmes into the schools' activities, are imitating factors to the existence of such programmes in school settings.

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Though most of such interventions do not have specific topics addressing the issue of FGC, issues relating to the practice are discussed in relation to sexuality and sexual health, HIV AIDS, gender equality, violence against women and girls amongst others. A report by Berg and Denison (2013) on determining the effectiveness of interventions in preventing genital cutting of girls, revealed that information dissemination on health education interventions (such as health intervention programmes earlier mentioned) alongside provision of formal education is one of the most utilized and effective strategies that increases in-school adolescents' knowledge of likely complications of FGC and other problems associated with the practice.

2.3.3. Out-of-School Female Genital Cutting Programmes

Contrary to the in-school adolescent population who acquire information and education on FGC issues via formal educational and informal educational approaches, for out-of-school adolescent populations, it is majorly by informal educational approaches. Hence, intervention programmes that are solely FGC focused or health related programmes that incorporate FGC issues have activities designed to capture the interest and attention of beneficiaries/participants in out-of-school settings; these include community based activities, social mobilization activities, access to IEC materials and health talks in health centers in relation to FGC issues.

Some examples of FGC focused intervention programmes and health related intervention programmes that incorporate FGC issues and have targeted out-of-school populations within and outside Nigeria include the FLHE and Women's Health and Action Research Center - WHARC programmes (Marcus and Page, 2014), focusing on sexuality and life skills and reproductive health issues; the Violence Against Women and Girls – VAWG programme (Jewkes, Floods & Lang, 2014), which was developed to transform the relations, norms and systems that sustain gender inequality and violence; CARE's Reproductive Health Programme in Ethiopia and Kenya (Chege, Askew, Igras & Mutesh, 2004); and the Second-Chance programme for out of school rural adolescent girls in Egypt among other similar programmes.

Irrespective of out-of-school adolescents being exposed to acquiring information and education on FGC issues via various informal educational activities as earlier mentioned, some of this information are not detailed enough and adequately or appropriately linked with problems associated with the practice. As a result this group of persons lack in-depth and appropriate out of school information/education in relation to FGC (or on other reproductive health related programmes that incorporate FGC issues) because they have limited or no educational

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background to facilitate their comprehension of the information being given to them. This is evident in a report by Neema, Musisi and Kibombo (2004) that highlighted limited behaviour change on sexual and reproductive health issues among females with limited education (i.e. primary or post primary) or no education. This result was adduced to inadequate information, misinformation and limited skills of personnel in attending to this group's needs.

Chege, Askew, Igras and Mutesh (2004) reported using only non-formal education approach in a survey on alternative rite of passage against FGC for women and girls in Ethiopia and Kenya. Their results revealed that majority of the female participants (59%) expressed their views of the practice as contravening the rights of women and children. Also, the same group with an additional 34% of female as well as their male counterparts (81%) who participated on the programme via their household participatory status, have no intention of cutting their daughters. Despite reports of FGC focus interventions or otherwise, results of effectiveness or ineffectiveness of the programmes or aspects of programmes that incorporate FGC have not necessarily presented results in relation to schooling status of programme participants.

2.4. Female Genital Cutting Interventions in Nigeria

In Nigeria, prevalence rates of FGC among girls and women ages 15 – 49 years vary based on religion, education, socio-economic status and geo-political zones among other factors (DHS 2013; UNICEF, 2013 & MICS, 2011). Several intervention programmes have been embarked upon in a bid to end the practice which has been recognised as a problem to the psychological and physical well-being of females, a violation of girls' and women's human rights, as well as an obstacle to gender equality. Hence, there have been conscious efforts at the grass-roots and national levels involving various international and national policy statements being made; programme planners implementing several interventions with the aim of educating and empowering communities to abandon the practice; and researchers conducting studies and evaluations for better understanding of prevalence of the practice, types of procedures, as well as reasons for the continued practice of FGC.

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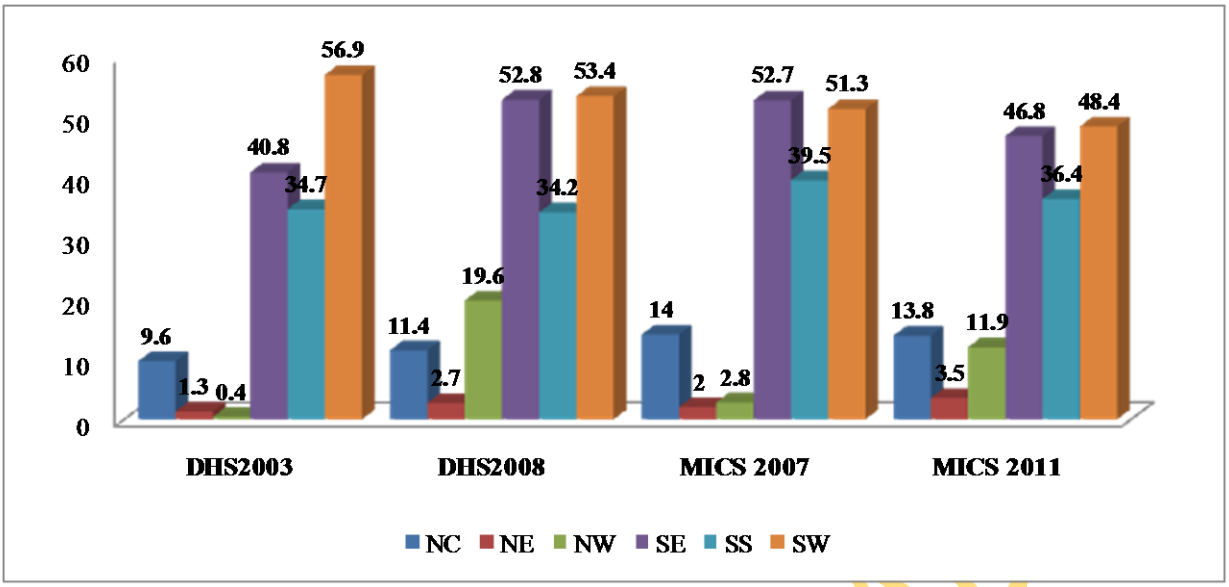

Figure 2.3: FGC Geo-Political Zones Prevalence Rates. Source: NPC 2003 and 2008; MICS 2007 and 2011

With the fluctuations in DHS and MICS prevalence rates as presented in Figure 2.3, it is assumed that the desired outcomes of FGC interventions via their various activities, towards reducing the continuation and eventual eradication of the practice have not been fully achieved. Hence, a major reason for this has been adduced to the fact that though statements and regulations of stopping FGC have been made based on Section 34(1)(a) of the 1999 Constitution of the Federal Republic of Nigeria (U. S. State Department, 2001) which states that "no person shall be subjected to torture or inhuman or degrading treatment"; and bills have been drafted and ratification of declarations have been recorded between 1999 and 2006 (UNICEF, 2013), there is still no federal law banning the practice of FGC in Nigeria. For example, only few states such as Abia, Bayelsa, Cross River, Delta, Ogun, Osun and Rivers States have passed laws to address FGC. Also, lack of adequate, appropriate and accurate group specific information/education (e.g. adolescents, young adults, in/out-of school participants etc) may be connected to limited achievements of such programmes and the observed fluctuations of prevalence rates.

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2.5. AWDF-JDPC Intervention in Oyo South-West, Nigeria

Based on reports of high prevalence of FGC in Oyo and Osun States as presented in Figure 2.4, reported in the 2008 CEDAW report, and with state specific pre-existing conditions of reports on psychological problems and increased maternal mortality due to the practice of FGC in Oyo State, the African Women's Development Fund – AWDF (programme funder) and the Justice, Development and Peace Commission – JDPC, Ibadan (programme planner) intervention programme was implemented. AWDF is a women focused international organisation that targets social justice and women's rights issues. It has since 2001 been working to promote, support and amplify African women and their activities in six (6) thematic areas. These areas include: economic empowerment and livelihoods; HIV AIDS; women's human rights; governance, peace and security; health and reproductive rights and arts, culture and sports (The African Women's Development Fund-AWDF, 2015). Hence, the organisation provides grants to organisations that are working in diverse ways to improve the lives of women and African society at large.

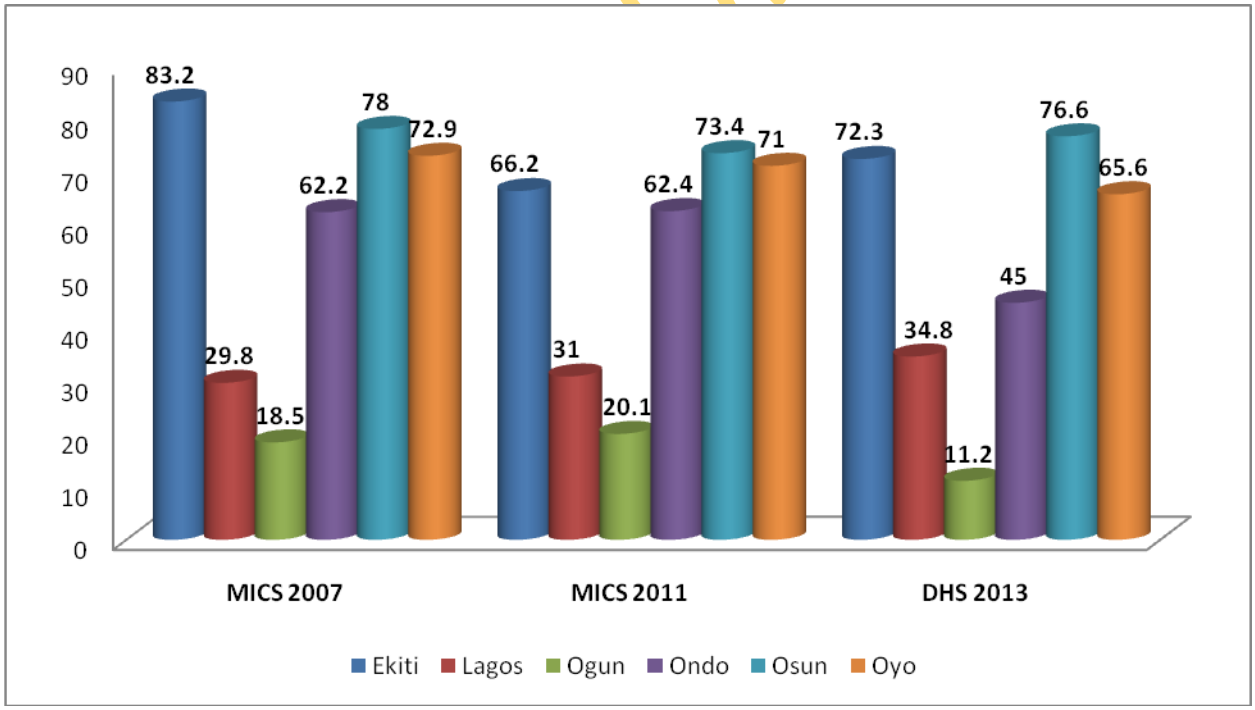

Figure 2.4: FGC South West States' Prevalence Rates. Source: NPC 2013, MICS 2011 and 2007

On the other hand, JDPC is a non-governmental and faith based organisation of the Catholic Archdiocese of Ibadan, and is part of a network of other justice and peace groups that have been in operation since 1995 (Justice, Development and Peace Commission-JDPC, Ibadan, 2010). The commission which is committed to promoting holistic human development through conscientisation of people who are central to sustainable and meaningful development, has six (6) focus areas; these are inmates and ex-inmates of prisons and their families; the underserved, located mostly in the rural areas; People Living with HIV & AIDS; women associations; farmers' groups; and youths. Therefore, in line with the mandate given to the commission to promote justice especially in the defence of fundamental human rights, the commission implemented the intervention programme. This was done in order to reduce to the barest minimum incidences of reported pre-existing conditions within communities of affected LGAs.

The aim of the programme which was to educate members of FGC practicing communities on the dangers of the practice as well as reduce incidences of pre-existing conditions, involved a combination of strategies. Therefore, using a combination of strategies which have been used singularly or otherwise on other FGC related interventions, the AWDF-JDPC programme included update training for healthcare providers (HCPs) as reported to be effective by Sangare, Tandia and Toure (1998) and Diop, Traoré, and Diallo (1998); community based activities which have been proven to be effective in the abandonment of the practice by Diop and Askew (2009), and Chege, Askew, Igras and Mutesh, (2004) were used via advocacy visits, as well as social mobilisations within communities of intervention LGAs. According to results of effectiveness of communication strategies by Babalola, Brasington, Agbasimalo, Helland, Nwanguma and Onah, (2006) in their comparative study of two South Eastern states (Enugu and Ebonyi States), the media communication strategy comprising publications in newspapers and the organisation's quarterly newsletter as well as distribution of IEC materials were also part of the activities used on the intervention. Lastly, psychosocial support involving the mainstreaming of opportunities and expert counselling for FGC victims was integrated into the programme. According to Dawson, Turkmani, Fray, Nanayakkara, Varol and Homer (2014), and Brady, Assaad, Ibrahim, Salem, Salem, and Zibani (2007), based on update training(s) accessed by HCPs, they are better equipped to provide appropriate care and support for FGC victims.

The combination of strategies involving update training for healthcare providers (HCPs), community based activities, media communication and provision of IEC materials as well as psychosocial support for FGC victims thus cumulated into a holistic, integrated and multisectoral approach. According to the Population Reference Bureau – PRB (2013), evidence and experience from various interventions show that utilisation of a holistic, integrated and multisectoral approach helps to initiate formative research, determine effectiveness of intervention through rigorous evaluation and follow up as well as facilitate a sense of community ownership on FGC interventions. Health care providers/programme trainees (intervention's direct/primary beneficiaries) as well as stakeholders (intervention's indirect/secondary beneficiaries) were thus engaged with a potential role in reducing the prevalence of FGC in Oyo State.

Therefore, using a combination of multifaceted activities under the strategies utilised, there was update training for HCPs who were the direct beneficiaries of the programme. The aim of the update training was to help programme trainees update their skills especially in the care and support of FGC victims. Also, considering that the practice carried out by HCPs, especially community/traditional birth attendants (C/TBAs) and training curriculum of formally trained HCPs do not cover the health problems associated with FGC deeply (Diop et. al., 1998; Umar and Oche, 2014), the update training was necessary. Community based activities involved advocacy visits and awareness creation/education on dangers of FGC for community/traditional leaders based on their roles as custodians of tradition, and on the significant influence they have in the abandonment of FGC which is a cultural practice.

Religious leaders were also included in advocacy visits in order to solicit their support in disabusing the minds of community members about FGC being a religious obligation. Aside of the African traditional religion which supports the practice because of its connectedness with culture and tradition, neither of the two Holy books (Bible and Ouran) that guide the Christian and Islamic faith stipulates FGC as a religious obligation. Social mobilisation campaigns, and step-down trainings which were also part of the community based activities were facilitated by HCPs based on the update training accessed by them, their familiarity with community members as well as their constant involvement with victims of FGC due to their profession. For media communication activities, publications on FGC issues and a communiqué from a Gender workshop were published in popular newspapers and in the JDPC, Ibadan quarterly newsletter,

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and IEC materials were developed and distributed strategically. For all other activities aside from that directed at HCPs, community involvement was seen as paramount in the need for stopping FGC, hence the use of activities involving community members especially the leaders.

According to Julia Lalla-Maharajh of the Orchid Project in the PRB (2013), in advocating for legal change and abandonment of FGC, the willingness and readiness of practicing communities must be taken into consideration. Awareness creation and enlightenment talks via social mobilisation campaigns were thus conducted for community members, market leaders, women and men as well as youth groups amongst others, in a bid to educating them on the harms of the practice. She therefore suggests that engaging these stakeholders is necessary in order for community led and community processes to be put in place for abandonment decisions on FGC to last. A report by Babalola et. al. (2006) revealed that communication is a very vital tool in the abandonment of FGC. Media campaigns have therefore been used as a means of communicating information and facilitating public discussions on harmful traditional practices and cultural beliefs. Hence, the AWDF-JDPC programme provided information, education and communication (IEC) materials and used the print media to inform and educate community members on the consequences and complications caused by FGC; as well as facilitate attitude change towards the continuation of the practice within the intervention communities. Also, reports of the aftermath of FGC especially psychological problems, and other health problems such as physical and physiological problems experienced by victims, Maternal Health Counselling Centres (MHCCs) were established.

Based on the update training for HCPs, and the establishment of the MHCCs which were solely targeted at FGC victims, activities were mainstreamed into the regular maternal health centre (MHCs) clinic activities. This activity was modelled after the "Safe house" and "Community based rescue centres" used in Kenya's Maasai region (PRB, 2013). The establishment of the MHCCs was aimed at providing psycho-social counselling services through the intervention of trained CBAs, CHEWs, PHEWs and midwives, to victims of FGC. Hence, the MHCCs provided similar services (though without accommodation) as that offered for girls and women in the safe house and community based rescue centres, who want to escape being cut and/or forced into early marriage.

In line therefore with justifications for the implementation of the AWDF-JDPC intervention programme, the multisectoral approach was used in the execution of the

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programme's activities. Based on investigations of the approach's effectiveness especially for intervention programmes (PRB, 2013), and with the involvement of stakeholders, the programme involved various activities for the different categories of stakeholders within the intervention communities. Hence, intervention activities included update trainings for health care providers; advocacy visits to various categories of leaders within intervention communities (traditional/community, religious, opinion/group, market and youth leaders); use of communication and print media as well as Information, Communication and Education (IEC) materials and the establishment of Maternal Health Counselling Centres (MHCCs) for FGC victims. The holistic nature of the intervention programme is thus an indication of the need for an interactive relationship among these stakeholders to be established, in order for the desired/expected outcomes for the intervention programme to be achieved.

2.6. Theoretical Background

Several theories have been propounded in relation to constructs such as knowledge and attitude, which underline human existence and processes. Some of such theories that have been reviewed as they apply to knowledge and attitude include: Hofstede's Cultural Dimension Theory (HCDT), Practice Theory and Socio-Cultural Theory.

2.6.1. Hofstede's Cultural Dimension Theory (HCDT)

Geert Hofstede's theory of cultural dimensions (2004), postulates that culture of a society has influence on the values, knowledge and attitude of its people. This, in turn, has effect on exhibited behaviours of such a people. The theory focused on aspects of societal beliefs, norms and values (Nardon & Steers, 2009) is one of the most cited models of national culture. In applying this theory in human and social life based studies, five dimensions are analysed namely: Individualism vs. Collectivism; Uncertainty Avoidance; Power Distance; Masculinity vs. Femininity; and Long Term Orientation vs. Short Term Orientation.

- **Individualism (IDV) versus Collectivism** – This dimension focuses on the degree to which a society supports individual or collective actions. It also determines how well interpersonal relationships are encouraged within a society. IDV is determined using the individualism score which is described as high or low. The IDV score is thus used to determine an individual's ability to operate on an individual level or inability to take part in collective activities. In other words, a low individualism score is interpreted as an individual having a

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high ability to operate in collective processes like decision making, thus ensuring positive results through collective actions. On the other hand, a high IDV score is indicative that individuality or individual orientations are more dominant which can result in low or no collective achievements.

- **Uncertainty Avoidance Index (UAI)** – The UAI dimension takes into cognisance the adaptive level of members of a society, due to unplanned or unprecedented situations that may occur. UAI is determined as high or low through the assessment of the cultural orientation of a society. Hence, a society that is culture driven is described as having high UAI. Members of such a society are considered to be more emotionally stable due to routines, rules and ways that govern their lives and societal processes. On the contrary, unstructured situations and changeable environments which facilitate feelings of comfort and acceptance depict a culture with low UAI. Cultures that exhibit the latter level of UAI are considered as more practical in their dealings due to facilitating factors such as knowledge. This makes them more receptive of changes in attitudes, opinions, and processes amongst other aspects of their lives as maybe necessitated.
- **Power Distance Index (PDI)** – This dimension of HCDT focuses on the effect of social hierarchy which can be accessed via observing or measuring the degree of equality or inequality between people within a given society. A society can therefore be described as having low PDI where members relate as equals, irrespective of formal hierarchical positions. In such society, members are more consultative and democratic in nature, considering that views and opinions of less powerful members are respected and put into consideration during decision making processes. This is contrary in a high PDI society where powerful members of the society are seen to operate as autocrats and dictators thereby dominating all aspects of societal processes, hence less powerful members accept that power is not equally distributed and see themselves as subordinates due to their hierarchical position. PDI can therefore be characterised by gender, social status, peer status and accomplishment of peer rites, and formal hierarchical positions amongst others.

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- **Masculinity (MAS) versus Femininity** – Task orientation which is based on emotional roles is the focus of this dimension. According to Hofstede, competitiveness, assertiveness, materialism, ambition and power are some of the task orientations or characteristics in culture which are masculine inclined while person oriented values of culture which deal with relationships and quality of life are feminine directed in nature. According to Hofstede, masculine inclined cultures tend to be enforcement based and are regarded as having a high masculine score, with a high level of gender inequality. On the contrary, a low score on masculinity invariably infers a high feminity score, thus indicating a lower level of gender inequality since both genders are seen as being equal and are assumed to have equal inputs in all aspects of the society. Hence values of modesty and care are considered as core values of such as society.
- **Long Term Orientation (LTO) versus Short Term Orientation (STO)** – This dimension evaluates the degree to which a society upholds traditional values over a space of time. Its interest is therefore in a society's ability to determine when existing processes need to be evaluated, in order to determine their continuation or eradication. According to Hofstede, the space of time for evaluation to take place in a culture or society is referred to as 'Time Horizon.' LTO oriented societies attach more importance to the future, are interested in practical results which may include rewards and are persistent in the continuation of activities or processes which they believe are beneficial; hence such societies are not likely to utilise time horizon which are based on constructs of knowledge and attitude. For STO societies, they promote values that are related to both past and present. Even though they believe in being steady, respecting tradition, preserving integrity and fulfilling social obligations, time horizon is applied in such societies. Hence, constructs of knowledge and attitude are more likely to be utilised.

Summarising the five dimensions of HCDT, it is evident that human processes such as attitude, adaptation, interaction, and eventual behaviour exhibited by an individual, are influenced by knowledge. Knowledge (formal or non-formal) involves cognitive processes of perception, communication, association and reasoning (Cavell, 2002). Based on the cognitive processes of knowledge therefore, communities that practice FGC acquire FGC knowledge from custodians of culture, elders in practicing communities and circumcisers (explicit knowledge).

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Hence, the impartation of knowledge according to some studies (Kaplan**,** Hechavarría**,** Bernal & Bonhoure, 2013) is focused on justification of the practice. Also observing the practice of FGC through individual experiences and the decision to perform same on daughters (implicit knowledge) is another avenue for acquiring knowledge on FGC. These two types of knowledge (explicit and implicit) which are transposed as norms and values that sustain culture therefore facilitate attitude (intention) towards the practice of FGC.

2.6.2. Practice Theory

Practice is the act of repeating a particular process with the aim of improving existing skills, sustaining a particular routine/habit or behaving in accordance to beliefs and customs of a particular culture. According to Dougherty (2004), practice theory deals with the diverse motives and intentions of human beings, bearing in mind the dynamic relationship that exists between the human structure and its workings. It is therefore the assumption of this theory that human beings use facts, information, descriptions as well as skills to adapt or adjust to the environment or situation they find themselves. Scahtzki (2001) as cited by Bronner (2012) thus defines practice theory as 'the skills, or tactic knowledge and presuppositions that underpin activities in daily and ceremonial life.' Ortner (2006) corroborates this definition by explaining that, practice theory seeks to establish the relationship(s) that exists between human actions and some global entity which is called the system.

Similar to Hofstede's theory which focuses on aspects of societal beliefs, norms and values in relation to human beings and social life, practice theory focuses on establishing a balance between structured processes (such as customs and traditions; culture) and the uniqueness of each individual in relation to human processes (methodological individualism), based on acquired knowledge. Practice theory uses embodied or habitual behaviours as well as knowledge based on inquiry and reflection to mould, modify or change attitude. This theory therefore involves concepts of methodological individualism, structuralism, habitus and doxa which are used to explain human processes based on individual actions and attitudes, due to acquired knowledge.

Methodological Individualism according to Heath (2001) is a social phenomenon which can only be understood by examining how activities, practices and habits result from the motivations and actions of individual agents or persons. This concept based on factors of

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knowledge and attitude focuses on the uniqueness of each individual in relation to actions and outcomes. Uniqueness of each individual due to knowledge and attitude are therefore considered as being influential in trends which occur in the environment as well as modifications to culture, due to individual differences that may exist. Contrary to methodological individualism, structuralism presents culture as a structured process which is characterized by common beliefs and values and are exhibited as practices, customs, traditions, phenomenon and activities. According to Levi-Strauss (1972), this structured form makes use of binary opposite terms or society structure and determines where an individual falls. Such levels include: high – low; inside – outside; person – animal; and life – death.

The concept of Habitus is described as life style, values, dispositions and expectations of a particular social group, that are acquired through activities and experiences of everyday life (Scott and Marshall, 1998). The concept which was developed by Bourdieu (1977) emphasizes the process-like habits that govern or guide an individual or groups of individuals' day to day lives. Habitus therefore involves an individual's ability to use an organized pattern of thought or behaviour, perception (knowledge) and disposition (attitude) to adjust into his or her environment. Doxa which means 'common belief or popular opinion' on the other hand is a concept that utilizes internalized societal or field specific presuppositions that cannot be argued against. The concept is belief and opinion oriented and is used for persuasion purposes. Thus persuasion which is reflected in behaviour and practice according to the principles of doxa does not allow for negotiations and personal opinions.

Based on the expatiations of the four concepts which constitute practice theory, it is obvious that the constructs of knowledge and attitude are factors upon which practice as an act or as a theory is predicated. Practice theory therefore emphasizes the use of knowledge acquired from within a setting in which an individual resides (implicit knowledge) and knowledge which is acquired through experiences and outcomes resulting from processes in which an individual is involved (explicit knowledge). The combination of these two types of knowledge as identified by philosophers, scholars and knowledge based managers amongst others, facilitates attitude formation, modification or change. The outcome of attitude formation, modification or change is thus due to inquiry and reflection carried out on both implicit and explicit knowledge acquired by an individual.

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2.6.3. Sociocultural Theory (SCT)

The sociocultural theory (SCT) considers society as being important in the development of an individual. It focuses on aspects of cultural beliefs and attitudes which impact on an individual's perception of the environment in which he/she lives. The theory which was propounded by Lev Vygotsky in 1997 focuses on the interaction between development of a person and the culture within which that individual lives. In support of Vygotsky's assertion, Ellis (2000) as cited by Turuk (2008) further asserts that development, which also involves learning, is achieved through man's ability to consistently interact with his environment. SCT therefore focuses on the role that social interactions and culturally based activities have on the development of an individual. Hence, it operates at two (2) levels with corresponding components guiding the levels of development.

The first level of SCT is referred to as the Social Level. It involves norms, values and beliefs which are acquired or imbibed through contacts and interactions within the environment in which an individual lives. Interrelationships which are outcomes of the interpsychological processes at this level thus facilitate knowledge acquisition. According to Vygotsky (1997) as cited by Valenzuela (2002), acquisition of knowledge at the social level is determined by an individual's ability to solve problems independently, but with adult guidance or in collaboration with more capable and competent persons. The ability to solve problems at this level is dependent on the Zone of Proximal Development (ZPD) component of SCT.

The second level of SCT involves Intrapsychological Processes of internalizing and concept forming based on acquired knowledge. This level can be referred to as the Individuality Level because it focuses on the individual as an entity, and the ability to acquire knowledge from persons (parents, caregivers, relatives, custodians of culture and tradition) who have in-depth cultural knowledge within the environment. Knowledge acquired at this level is guided by the cultural concept component of SCT with an individual being culturally ingrained through guided participation from elders with cultural knowledge. Cultural knowledge acquired is thus internalized for logical thinking and formation of concepts, and based on these intrapsychological processes attitudes can be formed, modified or changed.

In summary, examining the two levels of SCT as guided by the Zone of Proximal Development (ZPD) and cultural components, it is clear that the theory is mindful of the roles which knowledge and attitude factors play in the inter and intrapsychological processes

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experienced by an individual. Therefore, it can be assumed that this theory observes that there is a strong link between knowledge and attitude, which is deduced from the way and manner knowledge is acquired to how acquired knowledge is reflected upon and utilised.

2.7. Conceptual Framework

2.7.1. Knowledge and Female Genital Cutting Interventions

Knowledge is a philosophical construct which deals with facts, information, descriptions and acquisition of skills through formal and informal methods. Knowledge involves complex cognitive processes of perception, communication, association and reasoning (Cavell, 2002), and these influence human processes such as adaptation, interaction, learning, formation of attitude, and exhibition or modification of behaviour among others. The construct of knowledge can therefore be described as a theoretical or practical understanding of a subject.

According to the Oxford Dictionary (2013) knowledge is facts, information and skills acquired through experience and education. According to Cochran-Smith and Lytle (1999) as cited by the In-service Teacher Educators hand book (ISTEs, 2008), knowledge can be explained as a three – concept construct; that is **Knowledge-for- practice (Explicit Knowledge)** which involves formal knowledge generated by research and passed on by expert educators to other educators in order to improve practice; **Knowledge-in- practice (Implicit Knowledge)** that is "practical" or "craft" knowledge embedded in educators' practice and identified through inquiry and reflection in and on practice; and **Knowledge-of- practice (Explicit Knowledge)** which is generated when teachers treat their own classrooms and schools as sites for intentional investigation at the same time as they treat the knowledge and theory produced by others as generative material for interrogation and interpretation. Knowledge can therefore be a result of practical encounters or expertise (Implicit knowledge) or understanding of theories in relation to a subject matter (Explicit knowledge).

Philosophers on the other hand define knowledge as justified true belief. Pardi (2011) supports this definition by further explaining the three (3) conditions under which knowledge is considered as such:

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1. **Belief:** This involves feelings and thoughts of how an individual generally views the world, a situation or an object. Therefore, an individual may think in a certain way which may not necessarily be correct or true.
2. **Truth:** Something is true if the world, situation or object really is that way. Statements of truth are made affirmatively with facts that can be used to defend such statements.
3. **Justification:** This involves using truth with facts to either support or confirm a belief, or to negate a thought or feeling. Justification therefore serves as the determinant for knowledge.

Hence, Pardi (2011) asserts that 'justified interaction of belief and truth is knowledge.'

The quest for understanding the construct of knowledge in relation to human processes cannot be over emphasised. Therefore, different types of knowledge have emerged based on the many perspectives from which knowledge can be assessed. Table 2.4 presents four (4) schemas of knowledge types used by educationists, philosophers, scientists and knowledge based management scholars.

Table 2.4: Knowledge Types and Dimensions

Perspectives of Knowledge Types	**Dimensions of Knowledge**	
	Implicit/Tacit Knowledge	**Explicit Knowledge**
Bloom's Taxonomy	Mega-Cognitive Knowledge	Factual Knowledge Conceptual Knowledge Procedural Knowledge
Philosophy	Personal Knowledge	Procedural Knowledge Propositional Knowledge
Science and Social Sciences	Empirical Knowledge	Logical Knowledge Semantic Knowledge Systemic Knowledge
Knowledge-Based Management	Techne (Skills and craft) Knowledge Phronesis (Practical wisdom) Knowledge	Episteme (Scientific) Knowledge

Sources: Pardi, 2011; Nonaka & Tahoma, 2006; Anderson & Krathwol, 2001 and Pecorino, 2000.

In relation to Female Genital Cutting (FGC) intervention programmes, impartation of knowledge on the harmfulness of the practice is the focus. Based on the focus of FGC intervention programmes therefore, the two knowledge dimensions as identified by educationists, philosophers, scientists and knowledge based management scholars i.e. implicit and explicit, knowledge come into play. According to Goffin and Koners (2011), implicit/tacit knowledge

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which is also known as personal knowledge involves embodied knowledge that is acquired through constant practice of some acts, cultural beliefs, values, attitudes and mental models amongst others. The practice of female genital cutting can therefore be considered as implicit knowledge because the practice has evolved into tradition-like law over a long period of time thus becoming embodied knowledge for individuals who reside in communities where the practice exists. Implicit or tacit knowledge can therefore be described as 'Know-how' involving strategic knowledge, skill and craft or knowledge about cognitive tasks, personal and practical wisdom or self-knowledge, that has been acquired either formally or informally via words, actions or symbols (Botha, Kourie & Snyman 2008).

Explicit knowledge on the other hand deals with facts that show relationship of ideas (logic), meaning of terms (semantic) and operation, manipulation and use of ideas, terms and symbols (Pecorino, 2001); hence, it can be expressed in thoughts, ideas, actions and feelings; codified and stored (Wellman, 2009; ITSE Handbook, 2008). Therefore, considering that the essence of intervention programmes is to impart knowledge about the harms caused by the practice, findings of investigations or studies (thought, ideas, actions and feelings) which have been codified and stored, can be easily and consistently retrieved for teaching and learning as well as dissemination purposes. Based on the foregoing therefore, FGC interventions can be said to serve as facilitators of explicit knowledge.

In order therefore to determine the extent of knowledge on the harmfulness of FGC as a practice, FGC interventions are dependent on implicit knowledge which has to be reflected upon using explicit knowledge. Reports of several studies and position papers have emphasised the positive influence of FGC interventions on knowledge of individuals in communities where FGC is practiced; this has resulted in behaviour change (Brown, Beecham & Barrett, 2013). Ako and Akweonqo (2009) also assert that successful eradication of FGC is dependent on knowledge (education) through dialogue between different anti-FGC groups integrated into FGC interventions and FGC practicing communities (community participation).

2.7.2. Attitude and Outcomes of Female Genital Cutting Practice

Attitude can be viewed from both sociological and psychological perspectives. This is due to the nature of the construct which deals with the social aspects of an individual as a social being and is interested in the interactions and relationships which exist among the three components of attitude (affective, behavioural and cognitive)that result in a specific behaviour.

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As cited by McLeod (2009), attitude is 'a relatively enduring organization of beliefs, feelings and behavioural tendencies towards socially significant objects, groups, events or symbols' (Hogg & Vaughan, 2005). Eagly & Chaiken (1998) also define it as a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour.

Jung's view of the construct of attitude is based on the premise that the psyche acts or reacts in certain ways due to existing opposing tensions or paired conditions. The manifestations of the paired conditions are thus referred to as attitude, and it is reflected in behaviour (Jung, 1966, 1971 & 1989). For proponents of the Implicit – Explicit dichotomy structure (Gawronski, Hofmann & Wilbur, 2006; Fazio & Olson, 2003; and Brehm, Kassin & Fein, 2002), attitude is a hypothetical construct for measurement which focuses on unconscious and conscious cognitive processes. The cognitive processes determine an individual's preference of favour or disfavour towards an object, subject, person, situation or place. Proponents of attitude dimensions such as Delamater, 2006; Millon & Melvin, 2003; Brehm & Kassin's 2002 and Esses & Maio, 2002, view attitude components as being independent of each other. Based on this thrust of thought, focus is on how processes of each attitude component is linked to another, thus facilitating interrelated workings that result in related changes and outcome.

Also, the dimensional view of attitude assesses the causal effects of each attitude component on the other or a combination of its components on one component i.e. how the cognitive component (knowledge or beliefs) affects feelings (affective component) and behavioural tendencies (behavioural component), vice versa or random pairing of component(s) as against other components (unidimensional and bidimensional). It is assumed that assessing causal effects which result in attitude facilitates an individual's ability to summarise evaluations into negative or positive, in an individual's memory (Delamater, 2006).

With attitude being viewed as a social construct, functionalist theorists such as Katz (1960) and Smith, Brunner & White (1956) as cited by Maio, Esses, Arnold & Olson (2004), and Maio & Haddock (2009) suggested that, attitudes serve major functions. Hence, these functions influence reasons for holding or changing attitudes (Public Opinion Quarterly, 2013). Figure 2.6 enumerates the attitude functions purported by earlier functionalist theorists (Katz, 1960; Smith et al. 1956), and their similarities.

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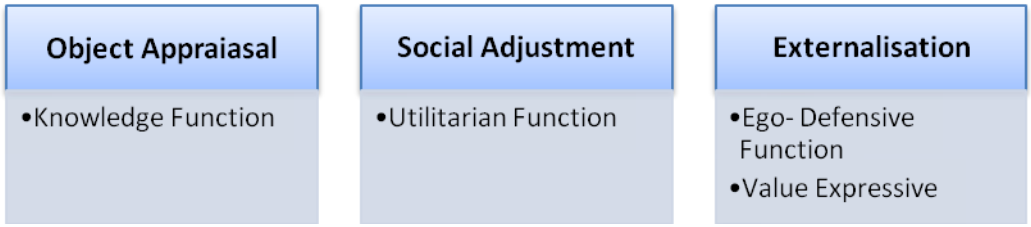

Figure 2.5: Conceptual illustration of similarities between Smith et al. and Katz' attitude functions

According to Smith et al. (1956) and Katz (1960), object appraisal and knowledge function are cognitive processes which involve the ability to organize and summarise perceived information into positive and negative perspectives. An individual is therefore able to determine cause and effects as well as identify beneficial and non-beneficial attributes of an attitude object. Social adjustment and utilitarian function on the other hand focus on the association and adjustment tendencies dispositions of an individual which are based on the perceived pleasant and reward oriented situations and experiences or otherwise caused by an attitude object; hence, positive dispositions are associated with beneficial and desirable attitude objects while negative dispositions are indicative of disassociation from unpleasant and non-beneficial situations. The ego-defensive and value expressive functions of Katz are encompassed by the externalization function of Smith et al, with the 'Self' being the focus. It is assumed that the self which is regulated by self concept and central values based on knowledge, influence an individual's evaluative tendencies and dispositions.

In summary, various researches (Herek, 2000, 1987 & 1986) cited by Maio and Haddock (2010), have postulated attitude functions as having two categories. These categories according to Herek are labeled as **Evaluative Functions** which involve the ability to use attitude to summarise information about the attitude object; and **Expressive Functions** which are exercised when attitude towards the attitude object is expressed via actions. Therefore, ability of individuals of FGC practicing communities to exercise these two categories of attitude is dependent on acquisition of knowledge via mechanisms such as interventions. A combination of the observance of FGC practice as a norm as well as personal experiences which are considered as implicit knowledge and the utilization of acquired information (explicit knowledge) obtained from interventions thus facilitates evaluative functions.

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Reports from several studies have suggested that based on evaluative functions there has been a mix of preference in favour or disfavour to FGC as a practice due to some socio-demographic factors. Some reports have indicated positive attitudes based on justifications for the practice (Schultz & Lien, 2013), while most studies recorded negative attitudes towards the practice due to acquired knowledge on the consequences and complications of FGC on the physical, psychological, physiological as well as psycho-sexual wellbeing of victims and personal experiences (Kaplan, Forbes, Bonhoure, Utzet, Martin, Manneh & Ceesay, 2013; Berg & Denison, 2012 and Nour & Diouf, 2012). Hence the resulting effects of positive or negative evaluations illustrating expressive functions have either been persistence/continuation of the practice (Kaplan, Hechavarría, Martín & Bonhoure, 2011) or negligible reduction in rate of the practice (Alo & Gbadebo, 2011).

2.7.3. Adolescence, Female Genital Cutting Knowledge and Attitude

The different developmental stages in human development are characterised by different levels of cognitive growth and change. According to Piaget (1955) as cited by Nicholas (2009), adolescence involves cognitive growth and change which is characterised by ability to think abstractly and multi-dimensionally as well as control and coordinate thoughts and behaviour (Choudhury, Blakemore & Charman, 2006). Adolescence therefore is a time for rapid cognitive development with cognitive skills being used to develop ideas and concepts based on acquired knowledge for future use in character and personality formation (Smith & Handler, 2007; Choudhury et al., 2006). Cognitive growth and change thus facilitates significant changes in behaviour, expectations and relationships with significant persons or groups.

Based on interdisciplinary perspectives of psychology, biology, history, sociology, education and anthropology, adolescence is viewed as a transitional period between childhood and adulthood, whose cultural purpose is the preparation of children for adult roles (Larson & Wilson, 2004; Kaplan, 2004). According to Coleman & Hendry (1990) as cited by Gross, 2010, this stage of human development thus involves multiple transitions of education, training, employment and unemployment, as well as transitions from one set of living circumstances to another. Adolescence has also been described as the period of physical and psychological development from the onset of puberty to complete growth and maturity (Falaye, 2013; American Heritage Dictionary, 2007).

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According to many researches and reports (WHO, 2013; Omigbodun, 2013; & UNICEF, 2011), adolescence which spans ages 10 to 24 years is one of the most dynamic stages of human growth and development, consisting of physical, intellectual, emotional and social dimensions. For better understanding and due to factors such as early adult assuming positions, economic and cultural shifts (Nicholas, 2009; Smetana, Campione-Barr, & Metzger, 2006; and Kaplan, 2004), as well as the current trend of young people staying longer in school in order to attain more education (Nichols & Good 2004), further sub division of the age span have evolved over time. The three sub divisions according to reports (U.S. Department of Health & Human Services, 2013; Arnett, 2000) are early (10–13), middle (14–17) and late (18–mid-twenties) adolescence. The last level of adolescence is also referred to as early adulthood or young adults as stated in Table 2.5.; it also enumerates the stages of adolescence as well as corresponding changes in cognitive development.

Table 2.5: Stages of Adolescence and Corresponding Cognitive Developmental Changes

Stages of Adolescence	Age Range	Cognitive Development
Early adolescence	11 – 13	• Growing capacity for abstract thought • Mostly interested in present with limited thought for the future • Intellectual interests expand and become more important • Deeper moral thinking
Middle adolescence	14 – 18	• Continued growth of capacity for abstract thought • Greater capacity for setting goals • Interest in moral reasoning • Thinking of the meaning of life
Late adolescence (Emerging adulthood/young adult)	19 – 24	• Ability to think ideas through from beginning to the end • Ability to delay gratification • Examination of inner experiences • Increased concern for future • Continued interest in moral reasoning

Source: U.S. Department of Health & Human Services, 2013

The various descriptions of late adolescence is an indication that higher cognitive processes are utilised based on implicit and explicit knowledge. The use of higher cognitive skills therefore prepares individuals at this level for more adult roles ranging from making and taking decisions independently to assuming parental roles. Although it is assumed that prior levels of adolescence exercise reflective, analytic and evaluative skills, these skills are believed

to be used more extensively during late adolescence due to life changing decisions that have to be made during this period of life. Adolescence can therefore be summarised as a period involving cognitive processing (deductive reasoning, logical understanding and application of thoughts, ideas and concepts) of implicit and explicit knowledge, which facilitates organisation and summarisation of perceived information into positive and negative perspectives, based on an individual's disposition.

Due to cognitive processes of deductive reasoning, logical understanding and application of thoughts, ideas and concepts, acquired through implicit and explicit knowledge, many study reports have indicated more of negative than positive behavioural tendencies towards the practice of FGC. According to several studies (Kaplan, Cham, Njie, Seixas, Blanco and Utzet, 2013; Iliyasu, Abubakar, Galadanci, Haruna and Aliyu, 2012; Mudege, Egondi, Beguy & Zulu, 2012), negative behavioural tendencies have been found to be facilitated by personal experiences of some consequences and complications especially among female young adults. Also, socio demographic factors such as gender, parents' educational status, location of residence, schooling status of adolescents amongst other factors, have facilitated similar reports of negative attitude and behavioural tendencies towards the practice.

Hence, it should be noted that adolescents' behavioural outcome (expressive function of attitude) which is evident through intergenerational attitude change as reported by some studies (Akinsanya, 2011), is due to evaluative functions of attitude which have been utilised by adolescents to evaluate the practice of FGC.

2.8. Empirical Review

Studies on FGC have revealed that different background characteristics combine to influence knowledge and attitude to FGC as a cultural practice. Background characteristics researched of age, gender, FGC status, marital status, educational attainment/level, parents'/mother's educational status, socio-economic status, and location of residence among others are some factors that have been found to affect constructs of knowledge and attitude in relation to FGC. Reports from several studies have also revealed that age, educational level, marital status, FGC status and location factors among others have significant influence on the prevalence rate of FGC as well as psychological experiences which ensue as a result of the practice. For this study therefore, reviewed literature was presented in line with three categories of studies, namely: Global studies, Sub-Sahara African, and Nigerian studies.

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2.8.1 Global Studies

The effectiveness of two educational sessions on in-school female university participants' knowledge and beliefs on reproductive health aspects and FGC was investigated in Egypt by Mounir, Mahdy and Fatohy (2003). Analysing data of study participants (n = 682) with intervention group comprising 354 participants and the comparison group consisting of 328 participants, it was observed that mean age of respondents was 19, and about half of the students were from low social class families. Results for knowledge about dangers of FGC showed a mean score increase of 0.47 and 0.03 points in the intervention and comparison groups respectively. Hence, the mean gain difference at end line was significantly different (MD = 0.44 points on a 0 – 3 scale, 95% CI = 0.14, 0.74). This result thus reveals that basic education with additional information and education on FGC incorporated into other health related discipline curricular, or FGC specifically designed curriculum to be taught as a subject or course (Marcus and Page, 2014) would actually increase knowledge of dangers of the practice.

Similar to Nnorom's (2007) study, Tag-Eldin, Gadllh, Al-Tayeb, Abdel-Aty, Mansour and Sallem (2008) carried out a study to ascertain prevalence rate of FGC, identify persons who perform FGC and rate reported complications, among 38,816 school girls ages 10 to 19 in Egypt. The prevalence of the practice among school girls was rated as 50.3% with girls ages 10 – 18; 46.2% were attendees of government urban schools; 9.2% attended private urban schools and 61.7% were reported to be in the category of those attending private rural schools. These differences in the prevalence rates were found to be due mainly to education status in both rural and urban areas. Parents' educational statuses (both parents) were negatively associated with FGC; i.e. Parents educational status had no relationship with FGC prevalence.

This result like many other studies can be attributed to the practice being basically a cultural or traditional norm, as well as being viewed as a religious obligation considering the country in which the study was carried out. Hence, the study report revealed that 59.5% and 65.1% of parents had no or low education in comparison with parents who had average and higher education ranging between 19.5% and 22.2%. This thus indicates that the higher the education levels the less likely the daughters being circumcised and vice versa for parents with lower or no education. It can also be inferred from this result that parents with low or no education have positive attitude towards the practice because of their educational levels which could imply limited knowledge or no knowledge of problems associated with FGC; while

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parents with higher education have negative attitudes because of their knowledge and awareness levels on FGC issues and complications.

Kizilhan (2011) reveals from an investigation of medical and psychological impacts of FGC among 79 Northern Iraq girls that, 78% of the girls ages 8 – 14 years described feelings of intense fear, helplessness, horror and severe pain; and 74% of them suffered from intrusive re-experiences. Assessment of potential trauma and psychiatric illness revealed that 45.6% experienced some levels of anxiety disorder; 13.9% were suspected of suffering from personality disorders while 36.7% complained about a range of somatic problems especially depression. Kizilhan's hypothetical testing confirmed that girls who had been cut at an earlier age, experience lower self-esteem than uncut girls of their age. Results of this study is thus indicative that psychological impacts of FGC are not limited only to females of older age but also affects and adversely too, younger females who are cut.

Another FGC health related study by Andersson, Rymer, Joyce, Momoh and Gayle (2012) in relation to sexual quality of life (SQOL-F) for women who had undergone FGC was carried out in the UK. The study involved women from Somalia, Sierra Leone, Nigeria or Eritrea (FGC group) and Nigeria and Ghana (control group). One hundred and twenty eight (128) women were recruited of which seventy three (73) made up the FGC group while thirty seven (37) constituted the control group. Results recorded from the study showed that there is a significant main effect of FGC on the sexual quality of life in women. It was reported that women in the control group (no FGC) had higher ratings for SQOL-F (mean = 88.84, SD = 13.74) over the main group – women with FGC (mean = 62.44, SD = 27.93). This accounts for the recorded statistical difference in sexual quality of life score between women who had undergone FGC and those who have not. It was also revealed that women with Type III FGC (35, 62%) have the lowest SQOL-F scores in comparison to the control group. The report of significant difference in SQOL-F by Anderson et al (2012), with cut women having results of low rates is therefore an indication that the sexual function of such women is likely to be affected thus affecting their psychosexual processes which are expected to facilitate either sexual gratification or procreation.

According to Berg and Denison (2013), attempt at discouraging the practice of FGC is done via preventive interventions which can be implemented under five categories, namely: training, formal classroom education, media communication, outreach and advocacy, and

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informal adult education. Based on this categorisation therefore, Chege, Askew, Igras and Mutesh (2004) in their report of using only non-formal education approach in a survey on alternative rite of passage as against FGC for women and girls revealed that 59% girls of female participants on the programme felt that the practice contravenes the rights of women and children, as against 20% of other respondents who were non-participants. Also, the report states that a high percentage of females (93%) and males (81%) in households participating on the programme, compared to their non-participating counterparts (females, 36%; males, 13%) do not intend cutting their daughters. Though the study focused on girls, the study did not analyse or assess the degree to which their schooling status might have influenced their responses.

In line with Berg and Denison (2013) identifying training as one of the categories under which preventive interventions such as those in relation to FGC are carried out, Degni, Suominen, Essen, Ansari and Vehvilainen-Julkunen (2012), conducted a study aimed at exploring physicians-nurses/midwives communication in providing reproductive and maternity healthcare to Somali women in Finland. Their study which involved 4 individual and three focus group discussions consisting of 10 gynaecologists/obstetricians and 15 nurses/midwives from 5 selected clinics revealed that communication (language), cultural issues and religious beliefs were barriers to providing effective reproductive healthcare for immigrant Somali women. Based on their findings, it was observed that physicians of both gender had similar communication style, interpersonal contact and cultural awareness, while nurses/midwives were more inclined towards partnership building with the Somali women in the clinics.

Despite the earlier mentioned medical/healthcare groups having a specific approach relationship with the immigrant Somali women, it was observed that there existed a better mutual understanding between the Finnish reproductive healthcare professionals (RHCPs) and the Somali women in the clinics, than with the physicians and nurses/midwives. This difference in patient-provider relationship may be due to trainings for RHCPs incorporating reproductive health issues in relation to FGC. Hence components on culture and language may have been extensively covered and may have aided their provision of services on reproductive health issues and other related issues and facilitated the observed mutual relationship. The study therefore revealed that communication problems due to culture and language differences can sometimes cause challenging situations in the provision of services in relation to FGC issues, with lack of interpreters who would know medical terminologies also aggravating the situation.

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Based on the influx of immigrant women with FGC, especially Type III, a comprehensive FGC education programme was developed by Jacoby and Smith (2013) for 11 certified nurse-midwives (CNMs) in the U.S. the aim of the programme was to equip the CNMs with skills to provide culturally competent care for this group of women. Also pre surveillance observation which necessitated the study revealed that severally, healthcare professionals (gynaecologists, obstetricians, residents and midwives) were not readily able to identify and classify FGC; hence from the review of medical files, FGC type classifications was correct for only 26.4% of the files reviewed; while FGC was not mentioned in the medical history of 37.2% victims, most of who had FGC Type III. The programme therefore involved instructive information, cases studies, a cultural round table and hands on skills laboratory for de-infibulation and repair practice. Analysing data from pre and post measure of confidence survey instruments, it was observed that CNMs had increased confidence in their abilities to provide culturally competent care for immigrant FGC victims with Type III cuts. Result from the study is therefore an indication that, exposure of health care providers to FGC related education interventions or consistent update trainings in the care and support of FGC in relation to different aspects of consequences that are caused by FGC is necessary. This is because it will better equip healthcare provider with needed skills to give appropriate treatment, management and support to FGC victims.

Also in assertion to there being a beneficial outcome of training programme for healthcare providers in relation to FGC issues, a pilot study by Lazar, Agbakwu, Davis and Ship (2013), was carried out in Columbus, Ohio with the aim of exploring healthcare providers' perceptions of barriers to providing healthcare services to Somali refugee women. The study involved obtaining information from healthcare providers about providers' experiences, training, practices and attitudes surrounding prenatal care, delivery and management of women with FGC. Results from individual semi structured interviews conducted with 14 obstetricians/gynaecologists and nurse midwives, and revealed that though FGC is one of the militating factors in the provision of obstetrical care for Somali women, it is not perceived as a significant barrier. Rather patient-provider communication in terms of language, interpretation and patient autonomy; and lack of training or protocols guiding the management of circumcised women is the challenge. This therefore made discussions in relation to FGC issues with patient discomforting.

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This study supporting the findings and recommendations by Jacoby and Smith (2013) thus concluded that improving the clinical encounter for both patients and providers entails establishing effective dialogue, enhancing clinical and cultural training of providers, improving health literacy and developing trust through community engagement. This result is therefore indicative of the fact that for adequate and appropriate healthcare provision especially for conditions that are FGC related (e.g. caesarean birth), there is a need for comprehensive training with cultural dimensions (i.e. language, cultural practices/activities etc) being incorporated for healthcare providers. This will help to facilitate effective information dissemination and education, as well as encourage community participation on activities.

Corroborating other reports such as that of Kizilhan (2011) that psychological problems is a salient outcome of FGC, and the need for healthcare providers to possess the necessary skills for the provision psychosocial support and management of physical consequences, Mulongo, Martins and McAndrew (2014) in their study focused on identifying problems that ensue after the process of FGC, success of management of women's FGC conditions as well as the role of maternity care professionals. The study using a structured narrative review of 10 studies revealed that 8 of the studies reported Psychological consequences such as post traumatic stress disorder (PTSD) and affective disorders (such as sexual quality of life – SQOL-F as reported Andersson et. al., 2012) as the most reported psychological impacts of FGC on women's lives.

According to Mulongo et. al., their findings indicate that with FGC having adverse psychological effects on its victims, there is a need for increase in FGC studies which focus on the extent to which the different FGC types have adverse effect, circumstances surrounding the cutting of women and girls and level of knowledge of eventual complications and consequences as victims advance in age and develop as was reported by Bjalkander et al. (2012) of mothers to cut daughters. As a result of these suggested areas for studies, raising awareness of the risk of negative psychological consequences is important; hence the need for training of maternal health care professionals in treating and caring for women/girls who are suffering from problems due to the FGC.

A review study by Dawson, Turkmani, Fray, Nanayakkara, Varol and Homer (2015), aimed at identifying how midwives in low and middle income countries (LMIC) and high income countries (HIC) provide care for women with FGC, perceived challenges and required professional development and workplace strategies that might better enhance midwives quality

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service delivery. A total of 18 papers comprising 10 papers from LMIC and 8 papers from HIC from between 2004 to 2014 were reviewed. Though one of the reviewed papers reported the outcomes of an education initiative for healthcare providers as being beneficial, it was observed that training in the area of FGC was limited. The results of the review is an indication that improved opportunities for midwives to learn about FGM and receive advice and support, alongside opportunities for collaborative practice in contexts that enable the effective reporting of FGC to authorities, may be beneficial and require further investigation. This will therefore entail professional education and training, a working environment supported by guidelines and responsive policy and community education, to enable midwives to improve the care of women with FGM and advocate against the practice.

2.8.2 Studies from Sub-Sahara Africa

Similar to reports by Kandala et al. (2009), on older women favouring the practice of FGC, with no education or low educational status being an additional facilitating factor for approval of the practice, a qualitative study was carried out by Karhu-Rose (2010) in Diak, South Sudan. The study which involved four respondents investigated the effects of FGC on women and young girls. Results reveal that, the support of FGC in African communities was found mostly among older persons (male and female), who have no education and support traditional values. Because of such communities' tradition bound nature, it can be assumed that their long term orientation of cultural beliefs inhibited their ability to evaluate and determine the continuation or eradication of FGC based on consequences caused by the practice. On the other hand, girls who relocated and were opportune to access education, (which facilitated their knowledge on a vast number of issues) were able to form their personal opinions on the effects of the practice and consequently oppose the practice.

Owolabi, Laurel, Bailah, Vanja, Staffan, and Lars (2012) in studying 258 girls' and women's FGC related health complications in Sierra Leone found that females between the ages of 10 – 14 years of age reported similar complications as older age women, thus corroborating other reports' findings. Fever was also commonly reported and its incidence rate was higher in girls who had undergone FGC before 10 years of age. As indicated in several studies, age at which FGC is performed on females is based on culture and personal decision. Hence, this study revealed that majority of the respondents were cut between ages 0 to 9 (23.7%), 10 to 14 (43.4%) and; 15 ≥ (26.7%) years; with 84.5% among those ages 10 to 15 years reporting complications

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after the procedure. The most reported complications for respondents less than 10 years of age as well as older respondents were wound (32%) and swelling complications (52%).

Though all respondents had been cut at various ages, there was no significant report on psychological consequences. This may be attributed to lack of knowledge and ability to perceive and associate some psychological manifestations with FGC. Also, non-reportage of psychological experience, according to Bjalkander et al. (2012) may be due to mothers educating girls who were young as at the time they were cut, of the procedure and likely complications they may experience during their life time. Consequently, recall of the experience may not be as traumatising or have extensive adverse effect on the psychological well-being of the girl. Based on the reports by younger girls of complications especially fever, it is an indication that pre-pubertal girls are more vulnerable to serious complications compared to females who undergo FGC later in life. This is similar to the report of Kizilhan (2011) which asserts that psychological impact and other consequences of FGC are more adverse in younger females who have FGC performed on them.

Karmer, Kandala, Chung and Clarke (2011) in their study of factors associated with FGC in Burkina Faso, interviewed 12,049 women pooled from the 14 provinces of the country. Results showed that age, place of residence, socioeconomic (health/wealth index) factor, maternal education, and province of residence were all significantly related to the two outcomes of mothers and daughters experiencing FGC. Similar to many studies within and outside Nigeria, FGC experience was prevalent among older respondents (83.1%) as well as among their daughters (45.9%); women from rural areas (77.6%) and their daughters (30.8%) were significantly more likely to have undergone FGC, compared to their counterparts in urban areas (74.7% - women; 27.6% - daughters). The total absence of education (79%; 31.1%) was shown as having significant influence on the high prevalence of the practice in comparison with those who had some level of education (69.2%; 18.5%).

With claims of several studies for material benefit, being a major reason for the continuation of the practice, an inverse u-shape association between FGC and the wealth index revealed lower rates of FGC in middle income earning women and their daughters, compared to those in the higher and lower income earning groups. This nonlinear relationship between FGC and socioeconomic status (asset index) can be attributed to factors of moderate educational level; healthcare decisions by women; and religious denomination among other factors.

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Digressing from the norm of only females or both genders being respondents on FGC studies, Kaplan, Cham, Njie, Seixas, Blanco and Utzet (2013) conducted a survey study of men's knowledge and attitude towards FGC in Gambia. The results from respondents' age 16 to 60 years and above revealed mean age to be 36.5 years. It was observed that, the practice is wide spread among Gambia's 6 ethnic groups (70%) with statistically significant differences from the prevalence rate found mainly among the Mandikas, Djolas, Fulus and Serahules. The prevalence rate was attributed to males embracing the practice through their approval of its continuation (61.8%) as well as the intention to have the practice performed on daughters (60.7%).

Reporting awareness of problems associated with FGC, Kaplan et al. (2013) results showed that, according to the ethnic groups, Wolof men (47.9%) and in respect of occupation, health and educational professionals (48% and 46.3%) ages 31 to 45 years as rating highest. Hence, the overall sample showed that 72.9% of the respondents have no intention of having the practice performed on their daughters. This is indicative of a negative attitude towards the practice based on knowledge of the negative impact of FGC on the health and well-being of females. Contrary to several studies report of prevalence of the practice being found among older ages (i.e. 35 years and above), respondents ages 31 to 45 revealed that 39.8% of girls are subjected to FGC before the age of 4years; whilst respondents 60 years and above (67.4%) claim that girls are only cut as from age 4. Summarising the results from this report, it is obvious that the prevalence of FGC is high due to the overall approval of men for the practice (but which is least prevalent among the Wolof ethnic group, 12.4%) which is evident from their decisions of having daughters cut. None awareness of problems associated with the practice as well as their belief of not having any role to play in the discontinuation of the practice is thus indicative that lack of knowledge (among agriculturalists; 24.7%, service sector; 24.2% and students; 26%) has facilitated the present attitude of men towards the practice which have helped to increase prevalence rates.

In a cross-sectional study, Tamire and Molla (2013) assessed the prevalence and belief in the continuation of FGC among High School Girls in Hadiya Zone, Southern part of Ethiopia. It was found from the self-administered questionnaires on 780 high school girls that, 82.2% were circumcised at a mean age of 11(±2.3) years. A few of the circumcised girls (9.4%) supported their status as circumcised girls as against 90.6% who did not support their statues of being cut, but only 5% believe in the continuation of FGC. The probability of being cut was higher among

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girls whose fathers and mothers had educational status lower than high school level (AOR = 2.04; 95% CI: 1.25, 3.09) and (AOR = 1.84; 95% CI: 1.01, 3.38) respectively when compared to those whose parents had attended high school and above. The probability of believing in the continuation of FGC was 2.33(95% CI: 1.01, 5.33) times higher among those who responded that FGC was practiced in their areas which were rurally located.

Also, cultural beliefs related to the hygiene of female genitalia and other social factors contribute to sustaining the practice.Therefore, parents with higher levels of education were not likely to have their daughters cut, and girls not residing in rural areas were not likely to support the continuation of the practice. This is an indication that negative attitude towards the practice can be assumed from these outcomes. The negative attitude of school girls (87.2%) is also attributable to claims of hearing messages against FGC thus facilitating their belief of discontinuing the practice. These messages without doubt have impacted positively on knowledge thus facilitating negative attitude towards continuation of the practice.

2.8.3 Studies from Nigeria

Mandara (2003) carried out an FGC study in Nigeria among 500 females. Results from the study revealed that age at which FGC is performed has an influence on the increase in prevalence rate of the practice. From data collected, only 77 (45%) out of 170 respondents were aware that their external genitalia had been cut; while 93 (55%) respondents had no knowledge of being cut. Physical examinations were thus conducted on all respondents to confirm the presence of FGC and type performed, and 197 (34%) of the respondents were found to have had some form of genital cutting. With high prevalence rates being attributed to justification for the practice, the study revealed that 62% of those who had experienced FGC had no knowledge of why they were cut; this it was assumed may have been due to the age at which FGC was performed them.

A comparison of educational status and experiences in relation to decision of cutting daughters in the study revealed that 21% (104) intend having their daughters cut, with those having no education rating highest (25.8%) and those with tertiary education rating lowest (13.0%); respondents who experienced less extensive forms of FGC (Type I), agreed to cutting (40), while only 4 respondents who experienced Type IV procedure (scarification) conceded to having their daughters cut. It can therefore be assumed that the less severe the FGC procedure, the more acceptable the practice (positive attitude) and the more severe/extensive the cut which

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cause more severe and lasting problems, the less acceptable the practice (negative attitude). This result thus indicates that psychological experience which varies based on extent of cut as well as any other FGC procedure performed are important factors for determining attitude towards the practice.

Assessing the impact of a communication based FGC elimination programme on knowledge, attitudes and behavioural intents; Babalola, Brasington, Agbasimalo, Helland, Nwanguma and Onah (2006) carried out a comparative study between two states in South East Nigeria: Enugu (intervention) and Ebonyi (no intervention) States. Gender, marital status and religious denomination were found to have significant influence on programme outcomes in the intervention state. In reporting exposure to the programme through the mass media comprising FGC radio and television discussion programme and newspaper article on FGC, 63.2% of women were found to have reported having less exposure than men (78.2%) who reported having exposure. Also, results revealed that married women in contrast to single women were more likely to have participated in community based activities involving participation in community meetings with FGC as a focus; training workshop/seminar on FGC; and mobilization for own community as well as other FGC practicing communities abandonment of FGC; while they were less likely (21.8%) than men to report exposure to the programme through mass media (23%). It was also observed that respondents were predominantly Christians comprising protestants and pentecostals, and overall exposure to mass media based activities was significantly higher among non-Catholics (72.3%) than among Catholics (51.2%).

Using the Health Communication Partnership (HCP), FGC data of 2003 and 2004, the intervention programme was found to be effective in the intervention state (Enugu) in relation to indicators of knowledge about FGC. This is evident in the percentage increase recorded in the intervention state for both men and women (37.9%) in contrast to that recorded in Ebonyi State (23.8%). This indicates that while there was an increase in knowledge due to the intervention programme in Enugu State, there was decrease, stagnation or negligible increase in knowledge about FGC in Ebonyi State. Also, Enugu State, analysis of the report on attitude towards the discontinuation of the practice at community level, showed a 45.1% percentage change for both men and women favouring the discontinuation of the practice. Similar results for personal approval of the practice was recorded with a significant decline of 21.9% from 35.2% in Enugu State and only a decline of 1.5% from 28.3% in Ebonyi State. Therefore outcomes on community

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support for discontinuation and personal attitude towards the practice in Enugu State, as well as magnitude of impact on women (35.9%) over men (24.5%) can be attributed to the intervention programme.

Nnorom (2007) using data collected during the NDHS 1999 survey on FGM studied types and extent of prevalence in Nigeria. 8,206 females, ages 10 to 49 years were interviewed from different zones of the country, with ages 10 to 14 specifically being analysed descriptively based on incidences of teenage pregnancy, motherhood and early age at commencement of sexual activities. Similar to many studies' reports, it was revealed that most women within 30 to 49 age categories had experienced one form of FGC or the other with contrary results among younger women. This outcome was attributed to awareness campaigns on the practice's harmful effects which may not been available as at the time they were cut. Hence, knowledge or awareness of problems associated with the practice was negligible. According to Nnorom, results of respondents with no education having lowest records of being circumcised followed by those with other levels of education (secondary, primary and higher education respectively) were surprising.

Assumptions are that this result may be due to educated respondents being circumcised at a very tender age when they had no say as to being cut or otherwise; as well as parents' low educational status which has significant influence in decision of being cut. On location basis, results showed that females in urban areas were circumcised more than their rural counterparts. This result thus supports many other studies which have shown that the practice of FGC is more of a cultural than religious practice.

Kandala, Nwakeze and Kandala (2009) using the 2003 NDHS report for a study on the spatial distribution of female genital mutilation (FGM) in Nigeria found that the mean age from 7620 women (ages 15 to 49) who had experienced FGC and had at least a daughter undergoing the practice was 37.8. This mean age in comparison to mean age of 27.8 indicates that female adults, above 37 years support the practice while contrary are the case with those below or 27 years. Their findings also revealed 55.6% of older respondents not having education thus suggesting that this may affect knowledge on consequences and complications of the practice. Lack of knowledge is thus an indicator for positive or undecided attitude among respondents thus resulting in high prevalence in some states of the country. On the whole, though the level of education was found to be relatively high in the southern zones of Nigeria, the prevalence rate of

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FGC was found to be higher in same zones. It was also observed that urban compared to rural women were significantly more likely to have FGM and have also circumcised their daughters. This therefore suggests as many reports have stated that the practice of FGM is deeply rooted in culture not withstanding level of education.

Akinsanya (2011) and Abiodun, Oyejola and Job (2011) in their studies of intergenerational attitude change and FGC prevalence and attitude in Nigeria, affirmed that mothers of older age (35 to 49 years) were found more likely to have experienced FGC. Similar to study reports of effectiveness of intervention programme in Enugu State by Babalola et al. (2006), Abiodun et al. attributed decline of prevalence of FGC in recent times to awareness intervention programmes. But Akinsanya from his study asserted that mothers of older age were more likely to, and had some or all of their daughters cut despite the high level of awareness (52%) especially within the South Western zone of Nigeria. Results from his study further showed that post-secondary education level in comparison with lesser levels of education (secondary, primary and no education) for mothers had significant influence on decision of daughters not being cut.

Using the binary logit model and the inclusion of Quranic education as a level of education, Abiodun et al. (2011) recorded similar results as reported by Akinsanya (2011). According to them, respondents with primary, secondary and higher education were less likely to support continuation of the practice than those with Quranic education. Hence, it can be deduced from both studies that the practice of FGC declines with the increase in the level of education attained. According to Abiodun et al. (2011), education which can involve exposure to awareness programmes (interventions), is recognised as a significant factor in the disapproval and discontinuation of FGC. Approval and decision on continuation or discontinuation of FGC can therefore be summed up as attitude towards the practice.

From Akinsanya's study therefore, though prevalence rate of FGC was 75% for mothers as against daughters (71%), the level of awareness and respondents' disapproval of the practice (85.7%) indicates a negative attitude towards FGC; while from the study by Abiodun et al., respondents' accessing awareness programmes through various approaches such as mass media (radio and television programmes), involved in discussing FGC and HIV AIDS issues, were less likely to support continuation of FGC practice, due to their acquired knowledge of the problems associated with the practice.

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In Akinsanya's study report on location, a negative attitude was inferred from the intergenerational difference of 8% and 3% recorded between mothers and daughters for Lagos and Oyo States respectively. The intergenerational difference between the states (5%) can be attributed to access to awareness programmes/activities which may be readily available in Lagos State than Oyo and other South Western States in Nigeria. Similar results pertaining to urban and rural locations were recorded by Abiodun et al., using data from the 2005 National HIV/AIDS and Reproductive Health Survey (NARHS). It was also observed that urban dwellers were less likely to support the continuation of FGC.

The study on perception, experience and attitudes towards FGC, conducted among 700 respondents in Apomu Local Government Area (LGA) of Osun State (Adeniran, 2011), revealed that 99.3% of respondents aged 15 – 90 were aware of FGC due to their FGC status. Though 90.1% of these were knowledgeable about the practice in terms of procedures relating to the different FGC cuttings, there was low knowledge (18.9%) as regards knowledge of consequences and complications caused by the practice. Results also showed that 82.3% of respondents who had experienced FGC (mostly at infancy) have the intention of having their daughters cut too (66.1%). This intention is thus indicative that there is a favourable disposition towards the practice and its continuation. Hence, this positive attitude can be adduced firstly to lack of knowledge of consequences and complications due to FGC; even though bleeding, HIV AIDS transmission and difficulty during child delivery were mentioned by some respondents as some outcomes of the practice. But due to ignorance respondents have not been able to associate these outcomes with the practice of FGC. Secondly, because the practice is executed at infancy (eight days after naming the child) with Type I (cutting of only the tip of the clitoris) commonly done, there is not likely to be adverse experience since extensive cutting or stitching is not done; hence the favourable disposition towards the practice and its continuation.

In line with Adeniran's (2011) report on attitude towards continuation of FGC, Oyetade (2012) in her study of 756 respondents in assessing sensitization and enlightenment activities of governmental and non-governmental organisations in Ogun and Osun States, discovered that the difference between respondents not in support (382, 50.5%) and those in support (374, 49.5%) of the practice and its continuation, was negligible. This is thus indicative that there is a positive disposition towards the practice. Furthermore, the study compared the attitudes of female adults and adolescents to the practice. It was revealed that both categories of respondents were

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favourably disposed to FGC, with adolescents' response being slightly higher than that of adults. For both groups, the trend of positive attitude was adduced to the belief that FGC reduces sexual immorality which has become rampant in the society. The positive attitudes reported by Adeniran (2011) and Oyetade (2012) and acknowledgement of the practice being based on tradition are reasons why the practice has continued, thus resulting in high prevalence rates. Also, lack of knowledge as well as inability of respondents to associate with some reported outcomes of the practice after being cut, have enhanced intentions to continue the practice of cutting daughters and significant others.

A study report on current knowledge and practice of FGC in South East Nigeria by Ibekwe, Onoh, Onyebuchi, Ezeonu and Ibekwe (2012) presented a 50% FGC prevalence rate among females (260) of reproductive age (15 – 40 years) in Abakaliki, the Ebonyi State capital. This prevalence rate according to the authors is approximately equal to the national average prevalence rate and is higher than that of other regions in Nigeria. It was observed that, irrespective of respondents' FGC status, 91% of the respondents were aware of FGC; 71% were knowledgeable about problems associated with the practice while 36% were not aware of any problems associated with the practice. With reports of most respondents having formal education especially at tertiary level (62%), high level of knowledge and awareness of problems associated with the practice, and none support of the practice (82%), it would be expected that prevalence rate of the practice should reduce. But in a situation where this is not the case, parents' educational status which was not a factor for investigation could be assumed to be influential in the recorded outcome of high prevalence rate (50%).

Disapproval of the practice (61.5%) which is an indication of negative attitude to the practice was found more among respondents 20 to 29 years of age who are married (90%). Hence, marital status, awareness of problems associated with the practice and psychological experience may have been influential in respondents' disapproval of the practice. A juxtaposition of gender also revealed significant influence of males' contribution to high prevalence of the practice as results showed that 88.8% of the respondents conceded to support the practice while 11.2% would not support FGC.

Similar to the report by Ibekwe et. al. (2012) on high prevalence rate of FGC among females of reproductive age i.e. 15 to 40 years, Iliyasu, Abubakar, Galadanci, Haruna and Aliyu (2012) also reported similar trends among 359 university students in Northern Nigeria. Their

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study revealed that 6.1% to 13.3% in age cohorts of 20 – 24 and 25 – 29 respectively had experienced FGC. This increasing trend therefore is an indication that age was a predictor in the increase of prevalence rates among female respondents aged 17 – 40 years. Though awareness of problems associated with FGC was not investigated in the study, most of the respondents expressed displeasure towards the practice because of the complications which they assumed is due to the practice. The combination of displeasure and assumptions of complications caused by the practice can thus be inferred as a negative attitude towards the practice.

In relation to procreation, a study by Slanger, Rachel, Snow, and Okonofua (2002), on impact of female genital cutting on first delivery among one thousand one hundred and seven (1,107) women in South West Nigeria revealed that, though FGC affects women who have experienced the practice negatively, complications and procedures at first delivery is not peculiar to them. For first delivery female respondents who were the target population for the study, results show that haemorrhage (2%), obstructed labour (3%), perineal tear (4%), caesarean section (7%), and episiotomy (31%) were reported as some of the complications and procedures associated with FGC women at first delivery. The study summarised its results as, complications and procedures that were associated with FGC women at first delivery are not peculiar to women who have experienced the procedure only. Hence, social correlates such as, delivery conditions, delivery place (i.e. institutionalised health delivery centre or otherwise) and assistance were considered as strong factors that impinge on first delivery of women who have experienced FGC or otherwise.

A study on mothers' perceptions of female genital mutilation by Ahanonu and Victor (2013) reveals like other studies that the practice of female genital cutting is widespread in Nigeria. A sample of 95 mothers which was pooled from a primary healthcare centre in Lagos revealed that over half of the respondents (56.8%) perceived the practice of FGM as not being beneficial. Though 44.2% thought that uncircumcised girls will become promiscuous, 30.5% believed that FGM promotes a woman's faithfulness to her husband. These beliefs were attributed to justifications for the practice which have been passed down through generations. Hence, the mothers held indecisive beliefs about the practice. About a quarter (26.3%) reported that women who have undergone FGM are not at any risk of gynaecological complications. There was a significant relationship between the educational background of the mothers and the perception that uncircumcised girls will be promiscuous. The three major results from the study

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of indecisive beliefs about the practice, reports of gynaecological complications not being associated with FGC and relationship between educational status promiscuity of uncut females are indications that there is a lack of knowledge on problems associated with the practice. It is thus assumed that with these outcomes from the study, positive or undecided attitudes are more likely to ensue rather than negative attitudes towards the practice of FGC.

2.9. Evaluation Approaches and Evaluation Models

In every sphere of life, human beings tend to take an inventory of what is needed to achieve a plan and how far the execution of such plans have been achieved based on availability of relevant resources needed to achieve such plans. This process of taking inventory is generally referred to as evaluation. Evaluation has therefore been defined as: a systematic, rigorous, and meticulous application of scientific methods to assess the design, implementation, improvement, or outcomes of a programme (Ross, Ellipse & Freeman, 2004); "the critical assessment, in as objective a manner as possible, of the degree to which a service or its component parts fulfills stated goals" (St Leger and Wordsworth-Bell); and "a study designed to assist some audience to assess an object's merit and worth" (Shuffleboard), as cited by Reeve and Paperboy (2007). A critical perusal of these definitions therefore indicates focus on an empirical based knowledge which determines the value and worth of a programme.

Based on the above definitions as well as other similar definitions, various evaluation approaches have emerged. Using distinct ways of thinking, designing and conducting evaluations, proponents of different evaluation approaches include: House (1978), Stufflebeam and Webster (1980) and Payne (1994) amongst others. For the purpose of this study therefore, Payne's evaluation models approach as cited by Youker (2007), will be used to discuss different evaluation models; these models are: Management approach, Judicial approach, Anthropological approach and Consumer model approach. According to Payne (1994), the management approach involves an evaluator providing information to management to help them make decisions about programmes and products amongst other management issues. An example of this evaluation approach is the Context evaluation, Input evaluation, Process evaluation and Product evaluation (CIPP) model of Stufflbeam (1971) which is currently referred to as 'Decision/Accountability-Oriented Evaluation' (Stufflebeam, 2001).

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According to Deniz (2002), CIPP is a system based approach evaluation model with its main focus being to improve programmes or make decisions about the worth or effectiveness of a programme. Hence, **Context** focuses on obtaining information about a situation to decide on the need for a programme and establishing programme objectives thus facilitating programme planning decisions; **Input** involves identifying relevant strategies that will facilitate achieving desired results, It helps in making programme structuring decisions; **Process** deals with assessing the implementation of the programme, as a result processes are evaluated and the results are utilised for implementing decisions; and **Product** focuses on gathering of information regarding the results of a programme. This is used to determine a programme's value and merit. Based on the four components of this model and their functions, the CIPP Model can be used for formative or summative evaluative decisions.

The Judicial or adversary-oriented evaluation approach according to Payne (1994) is implemented in a judicial-like setting. This approach is based on the assumption that there is a potential for evaluation bias, hence a panel of evaluators are set up to examine and present evidence for terminating or continuing a programme. This approach therefore facilitates objectivity via checks and balances and ensures that all examiners as well as alternative explanations are assessed. According to Worthen and Sanders (1999), this is referred to as meta-evaluation which is simply an evaluation of an evaluation process. Based on considerations of arguments and evidences, a decision is taken. An example of this evaluation approach is the blue-ribbon panel, where multiple experts of different backgrounds argue the merits of some policy or programme. Also, from observations in relation to human processes, the judicial approach is used extensively. This is exemplified even in the International Centre for Education Evaluation (ICEE), Institute of Education procedure for determining the worth of a proposed study, in relation to the work contributing to existing knowledge.

For the anthropological approach, investigations are qualitative in nature with exploration through observation, and collection of descriptive data being used to determine the worth of a programme. According to Payne (1994) examples of evaluation models that are anthropological in nature include responsive evaluation by Robert Stake (2004); goal-free evaluation developed by Scriven; and naturalistic evaluation which is attributed to Guba and Lincoln. These models areas of focus and operations are enumerated in Table 2.6.

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Table 2.6: Anthropological Approach Models and Modes of Operation

Evaluation Model	Modes of Operation
Responsive Evaluation	This involves evaluators being flexible and responsive to the concerns and issues of programme stakeholders. It relies mainly on formal plans and measurement of pre-specified programme objectives.
Goal-free Evaluation	It involves an evaluator assessing activities on the field with the aim of learning about a programme and drawing conclusions about its worth or effectiveness without being aware of the specific objectives of the programme.
Naturalistic Evaluation	An evaluator is expected to collect data in an as much as possible unobtrusive manner (observation) in order not to disrupt natural processes in which a programme is being implemented. Other additional data can be collected via focus groups discussions, interviews and questionnaires to supplement data from observations for the purpose of triangulation.

Source: Evaluation Models (Payne, 1994)

The consumer evaluation approach by Michael Scriven was developed on the premise that the value of a programme or product can be ascertained from programme beneficiaries (programme impact) or consumers of a product. These according to Payne (1974) are exemplified in programme reports (quarterly, bi-annual or annual) and consumer reports. The consumer evaluation approach can therefore be considered as a summative type of evaluation which uses checklist-like instruments (evaluation checklist) to evaluate an evaluand.

2.9.1. The IPO Evaluation Model for FGC Intervention Programmes

Interventions are systematically planned programmes involving various activities which are executed via the provision of goods, services, infrastructure, as well as establishment of facilities amongst others. Their aim often, is to provide training or alleviate uncomfortable conditions of an individual or group of individuals. Therefore in order for programme planners and implementers to improve interventions or make judgement about the worth or effectiveness of programmes, various evaluation frameworks/models are used to describe logical linkages among programme resources, activities, outputs and outcomes related to a specific problem or situation. Programme evaluation can therefore be defined as the examining or judgement of the worth, quality, importance, significance or the degree of relevance of specific programmes/projects in an area of interest (Emeke, 2013).

In order to determine the relevance, efficiency, effectiveness, impact and sustainability of completed programmes or interventions, a system based evaluation approach (System-based models) is required. According to Deniz (2002), the most influential models under the systems approach include: Context, Input, Process, Product (CIPP) Model (Worthen & Sanders, 1987); Training Validation System (TVS) Approach (Fitz-Enz, 1994); and Input, Process, Output, Outcome (IPO) Model (Bushnell, 1990). According to proponents of the Input-Process-Output (IPO) model, it is a functional model that identifies programmes' inputs, the processing steps required to transform inputs into outputs, and the outputs.

The model is based on the premise that evaluations should assess and report an entity's merit, worth and significance, in terms of inputs and outputs. Hence, considering the model's many interdisciplinary applications, it has at least three distinct components and these are: Input, Process and Output. Input deals with the various resources that are inputted into a programme, thus resulting in output(s)/outcome(s); Process refers to procedures involved in the utilization of resources; and Output/Outcome consists of quantifiable (i.e. number reached) or qualitative results (i.e. impact/effectiveness) obtained due to the processing of inputs made into a programme (outcome/impact). The IPO structure which is similar to the logic model (also a system approach model) uses narrative or graphical methods to describe processes. In similar ways, they both establish a sequence of cause and effect by linking inputs (resources), activities, and outputs which can consist of initial (short term) and long term (impact) outcomes, in a deducible manner when evaluating a system or programme. In using the IPO model, systematic data based enquiries involving quality data collection and verifiable indicators are utilised. These two factors in relation to the aims of the evaluation are used to obtain credible findings (United Nations Evaluation Group - UNEG, 2012).

According to Todd (2007), the determining of worth and effectiveness/impact of a programme is dependent on information obtained by evaluation; hence it provides information on the benefits of the programme which facilitates its sustainability by stakeholders. In summary therefore, the IPO model of evaluation can be viewed as both a formative and summative type of evaluation. According to Royse, Thyer and Padgett (2009), formative evaluations serve more to guide and direct programmes; hence, it helps to determine whether a programme has been implemented as planned. Formative evaluation can therefore be used

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during an on-going programme with its activities being carried out within a stated duration of execution; and after the expiration of a planned programme, but which has on-going activities being carried out in line with the programmes' stated objectives. Summative evaluation on the other hand is basically used to determine the worth of a programme and uses information from formative evaluation to take a decision. Stufflebeam and Shinkfield (2007) describe this evaluation as occurring after the development of a product, completion of a programme and end of a service cycle.

The IPO model can therefore be said to consist of both types of evaluations and uses qualitative and quantitative data to provide information on programme effectiveness during and after the completion of a designed programme. It thus consists of other sub evaluations as presented in Table 2.7.

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Table 2.7: Sub Evaluations Constituting IPO Model of Evaluation

Evaluation Type	Purpose	Uses
Summative	Provides information on effectiveness of a completed programme.	To help determine whether a programme should be continued/discontinued or expanded to other locations.
Process	Determines if specific programme strategies were implemented as planned, thus focusing on programme implementation.	To determine why an established programme has changed over time due to unforeseen situations during programme implementation. This helps to give accurate information for replication of programme.
Outcomes	Determines effectiveness of programme via the changes in comprehension, attitudes, behaviors, and practices that result from programmes activities. These results can be short and long term.	To decide whether programme/activity affect participants outcomes, thus helping to determine benefits of the programme.
Impact	Focuses on long term, sustained changes as a result of the programme activities.	To ascertain the impact of the programme using comparison groups. This helps to influence policy in relation to areas of interest.

Adapted: Different Types of Evaluation. CYFERnetsearch, University of Minnesota (2014)

2.10. Gaps in the Literature

From the review of cited literature, it is observed that within and outside Nigeria, many researchers have researched majorly on issues of socio-demographic variables consisting of background characteristics and how they affect knowledge on FGC issues and attitude to the practice. Most studies have thus focused on identifying factors which have spurred prevalence rates rather than designing interventions that are multi-sectoral in nature, to tackle identified factors which escalate the continuation of FGC. With several of these study reports revealing that these variables have facilitating effects on large increase and or negligible decrease in prevalence rates, it is imperative that studies especially in Nigeria need to be designed based on pre-existing conditions, in order to evaluate the impact of comprehensive FGC intervention programmes and activities, as well as socio demographic variables on the knowledge of dangers of FGC and attitude towards the practice.

According to scholars, and health and economic based organizations, many interventions to encourage individuals, families and communities to abandon FGC have been undertaken over the past 70 years by church groups, colonial administrators, international organizations,

government and non-government bodies, and civil societies (World Health Organization 1999; Population Reference Bureau 2001; Toubia and Sharief 2003). In confirmation of this, 92 FGC interventions have been identified as having been executed in Africa (Feldman-Jacobs and Rynaik, 2007) and 4 (four) in Nigeria. Based on this information, reviews of several of these interventions carried out so far, reveal that only 35 studies (8 effectiveness; 27 context studies), with none from Nigeria, have been identified as meeting the criteria for systematically planning, documenting and evaluating the interventions programmes executed.

In relation to schooling status which is an important factor in achieving the desired outcomes in relation to knowledge acquisition of dangers of FGC and attitudinal change towards the continuation of the practice, it is unfortunate that there are not many studies that have included this factor in their analysis of data. The absence of reports on this crucial factor is not likely to present a true picture of results or effectiveness of FGC intervention programmes considering that in and out-of-school adolescent participants acquire information and education on FGC issues in basically two ways (formal and non-formal). Hence, participants in both groups are not likely to acquire information and education of FGC issues at the same rate and level.

Of major importance, it was observed during the review of literature that studies or interventions on FGC involving males are very negligible in spite of the fact that they are influential towards the continuation of the practice. Last but not the least, a number of reviewed studies focused mainly on females whose ages range from 15 to 49 years and above; and the gynaecological and obstetrical problems experienced. Hence, very few studies have investigated females less than 15 years who according to several literature have been found to be more vulnerable to the consequences of the practice, especially with regards to psychological based problems. This study, using the IPO evaluation model and a non-experimental research design, therefore investigated the influence (outcome) of the AWDF-JDPC intervention programme, psychological experience as well as age, educational level, schooling status, parents educational status, work status, FGC status, marital status and location of residence on knowledge of dangers of FGC as well as attitude towards the practice, of female adolescents and young adults in Oyo State, Nigeria.

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CHAPTER THREE

METHODOLOGY

This chapter outlined the methodology used in the study. It therefore discussed the research design, evaluation model, variables in the study, population, sampling technique, instrumentation, procedure for data collection and method of data analysis.

3.1. Research Design

The study is a survey research type. This research type was most appropriate considering that variables in the study were not controlled or manipulated. Rather, the impact of the key variables (FGC intervention programme and psychological experience) and other independent variables (age cohorts, adolescents' educational level, parents educational status, socio-economic status, FGC status, marital status and location of residence) on the dependent variables (knowledge and attitude), were investigated. The study also investigated the composite and relative effects of the key variables (intervention programme and psychological experience) and other independent variables on the dependent variables.

3.2. Evaluation Model

The Input, Process and Outcome (IPO) evaluation model was used for the study. The model which is a functional model describes logical linkages of the programme resources (what resources have been put into a programme), activities (processes involving utilization of resources) and outcomes (changes or benefits resulting from inputs). According to McCawley (1997) as cited by Hanley (2008), it is a logical model that uses narratives and graphical depictions to explain the causal relationships of resources, activities, outputs and outcomes of a programme. This evaluation model was considered appropriate for use because of the relationship among its three components which facilitates detailed answers to both qualitative and quantitative questions derived from the objectives of the study.

The **Input** is the first component of the model. It involves resources such as materials, finance, infrastructure, facilities, staff, and equipment that are invested in a programme in order to achieve programme objectives. For this study therefore, inputs were identified as provision of training for healthcare providers, training manuals for programme trainees

(i.e. Community/Traditional Birth Attendants [C/TBAs], Public Health Workers [PHEWs], Community Health Workers [CHEWs] and midwives), establishment of Maternal health Counselling Centres [MHCCs] facilities and media publications. The second part is the **Process** component. This component identifies utilisation processes of resources that are invested into a programme. Execution of step-down trainings, dissemination of information, education and communication (IEC) materials, psycho social/counselling activities in MHCCs, enlightenment talks, advocacy and media campaigns activities constituted the second evaluation component. The third part is the **Outputs and or Outcomes** component. It determines the effect of utilised resources (inputs) to achieve programme objectives (outcomes). Outputs and outcomes are thus observable quantitative and qualitative measures which determine the impact of an intervention.

The IPO model of evaluation as applied in this study, with variables of interest, data source, relevant instruments for data collection and analysis is presented in Table 3.1.

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Table 3.1: IPO Evaluation Model

Evaluation Components	Variables of Interest	Research Questions and Method of Analysis	Data Source	Instruments(s)
a. <u>Input Objective:</u> To report on resources used in the implementation of the programme, in relation to: (i) Programme trainees (ii) Facilities and services **Evaluation objective 1 (a and b)**	• Characteristics of HCPs • Characteristics of MHCCs attendees • Attendance of MHCCs • Information dissemination and education strategies	RQs. 1a and 1b Descriptive analysis of frequency counts	Programme trainees	FGC In-depth Interview (FGC-IDI) Guide
b. <u>Process Objectives:</u> To report on processes (actions/activities) in relation to: Utilisation of programme resources **Evaluation objectives 1 (c and d), 2 and 3a**	• Intervention activities (advocacy visits, step down trainings, use of training manuals, distribution of IEC materials, media campaigns) • Opportunities and expert counselling • M and E of counseling activities	**(Eva.obj.1)** RQs. 1c and 1d; 2a and 2b Descriptive analysis of frequency counts **(Eva.obj. 3a)** RQ 8 Simple Linear Regression	Programme trainees; FGC victims programme trainees	FGC In-depth Interview (FGC-IDI) Guide; FGC Focus Group Discussion (FGC-FGD) Guide; FGC Update Training Rating Scale (FGC-UDTRS); FGC Victims Counselling Rating Scale (FGC-VCRS)
c. <u>Outcome Objectives:</u> To report on results of processes (actions/activities) in relation to: (i) Knowledge and (ii) Attitude **Evaluation objectives 3b, 4 and 5;**	• Knowledge on dangers of FGC • Attitude towards FGC	**(Eva.obj. 3b)** RQs. 3 Descriptive analysis of frequency counts RQs. 4 i and ii - Descriptive analysis of frequency counts - Chi-square RQs. 5 i and ii - Descriptive analysis of frequency counts - Independent t-test **(Eva.obj. 4)** RQs. 7 and 8 - Multiple Regression **(Eva.obj. 5)** Hypothesis 1 - ANOVA Hypotheses 2 – 5 - Independent t-test	Female adolescents and young adult beneficiaries in intervention LGAs and non-beneficiaries in LGAs with no intervention	FGC Knowledge Test (FGCKT) FGC Attitude Rating Scale (FGCARS), FGC Psychological Experience Perception Rating Scale (FGC-PEPRS), FGC-Intervention Programme Rating Scale (FGC-IPRS)

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3.3. Variables in the Study

3.3.1 Independent Variables

- Intervention programme
- Psychological experience
- Age
- Educational level
- Schooling status
- Parents' educational status
- Work status
- FGC status
- Marital status
- Location of residence

3.3.3 Dependent variables

- Knowledge of dangers of FGC
- Attitude towards FGC practice

3.4. Population

The study had 2 (two) categories of population; these were the quantitative participants and the qualitative participants. The target population for the quantitative part of the study comprised female adolescents and young adults with FGC or otherwise, whose ages range from 10 and 24 years. This group of respondents were pooled from two (2) intervention LGAs and two (2) LGAs of no intervention in Oyo State, using the 2006 population census figures of females for Ibadan North East and Lagelu LGAs (intervention LGAs) and Ibadan South West and Atiba LGAs (LGAs of no intervention) respectively. Female population figures for Ibadan North East and Lagelu LGAs are 167,600 and 73,913 respectively; while that of Ibadan South West and Atiba LGAs are 143,476 and 83,980 respectively (Federal Republic of Nigeria Official Gazette, 2009).

The target population for the qualitative aspect of the study consisted of all healthcare providers (T/CBAs, PHEWs, CHEWs and midwives) who participated in the update training facilitated by the intervention programme; and FGC victims who accessed psychosocial services from the five (5) established maternal health counselling centres (MHCCs) in the LGAs of intervention, as at the duration of the study.

3.5. Sampling Technique and Sample

A multistage sampling technique was used in the selection of the target samples this is because issues of age cohort, intervention status of Local Government Areas (LGAs) and nature of location of the LGAs were put into consideration. Hence, the first stage of sampling involved the purposive cluster sampling technique. This was used to select the two (2) senatorial districts; this was done because the interventions Local Government Areas (LGAs) were selected from these senatorial districts i.e. Oyo Central and Oyo South Senatorial districts. Subsequently, selection of four (4) LGAs was carried out based on their intervention and non-intervention statuses from within the selected senatorial districts, using the purposive sampling technique. Hence, Lagelu and Atiba LGAs in Oyo Central Senatorial district served as intervention and non-intervention LGAs respectively, while Ibadan North East and Ibadan South West LGAs in Oyo South Senatorial district also served in the capacity of intervention and non-intervention LGAs. The choice of Atiba and Ibadan South West LGAs as non-intervention groups (i.e. comparison groups) was based on their membership of same senatorial districts as the intervention LGAs, as well as their similarities of location characteristics and female population figures. Purposive sampling technique was also used to select both qualitative and quantitative participants for the study. Qualitative participants therefore comprised healthcare providers who accessed update training, and FGC victims who accessed opportunities and expert counselling via the established MHCCs within the intervention; while quantitative participants were constituted by participants from ages 10 to 24 years within both intervention and non-intervention LGAs.

The purposive sampling technique was used to select 400 quantitative participants from each of the four (4) LGAs for the study. Hence, a total of one thousand, six hundred (1,600) participants were pooled from four communities each from the intervention and non-intervention LGAs. Therefore, communities for Lagelu and Ibadan North East intervention LGAs comprised: Olorunda-Aba, Lalupon, Oyedeji and Igbo-Elerin; and Oranyan, Oje, Labiran and Atipe communities respectively; while Atiba and Ibadan South West non-intervention LGAs were constituted by Agunpopo, Koso, Oyo town, and Laguna; and Oke Ado, Molete, Oluyole and Challenge communities respectively. Based on the purposively selected number of participants per LGA, a non-proportional quota sampling of 2:1 was used to select samples according to age cohorts of 10 -19 and 20 -24. A total of 267 (two hundred and sixty seven) and 133 (one

hundred and thirty three) samples for age cohorts of 10 -19 and 20 -24 as presented in Table 3.2 were thus selected for each LGA.

Table 3.2: Sampling Frame according to LGAs and Age Cohorts

Senatorial Districts in Oyo State	LGAS of Intervention/LGA with no Intervention	Respondents 10 – 19	Respondents 20 – 24	Sample size per LGA
Oyo Central	Lagelu LGA	267	133	400
	Atiba LGA	267	133	400
Oyo South	Ibadan North East LGA	267	133	400
	Ibadan South West LGA	267	133	400
2	**4**	**1068**	**532**	**1,600**

In order to cater for appropriate representation of in school and out of school samples in Lagelu and Atiba LGAs, the non-proportional quota sampling of 2:1 was used to select participants. This is due to their semi-urban locations and based on the assumption that there will be more in-school adolescents and young adults, than their out of school counterparts. Also, in Ibadan North East and Ibadan South West LGAs, the non-proportional quota sampling technique of 2:2 was used to select in school and out of school participants considering that both LGAs are located in urban settlements and are more likely to have equal population of both in and out of school respondents. The sampling distributions are presented in Table 3.3.

Table 3.3: Sampling Frame for In and Out of School Respondents According To LGAs and Age Cohorts

Senatorial Districts in Oyo State	LGAS	In School Respondents 10 – 19	Out of School Respondents 10 – 19	In School Respondents 20 – 24	Out of School Respondents 20 – 24	Sample size per LGA
Oyo Central	Lagelu LGA	178	89	89	44	400
	Atiba LGA	178	89	89	44	400
Oyo South	Ibadan North East LGA	134	133	66	67	400
	Ibadan South West LGA	133	134	67	66	400
2	**4**	**623**	**445**	**311**	**221**	**1,600**

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Considering that one of the gaps in literature is limited reports on knowledge of dangers of FGC and attitude towards the practice among females from ages 10 to 14, a ratio of 2:1 was used to purposively select respondents of this age cohort from among in-school and out-of-school adolescents. Table 3.4 therefore shows the sampling frame for in and out of school early adolescents.

Table 3.4: Sampling Frame for In and Out of School Early and Middle Adolescents Respondents According To LGAs

Senatorial Districts in Oyo State	LGAS	In School Respondents 10 – 14	In School Respondents 15 – 19	Out of School Respondents 10 – 14	Out of School Respondents 15 – 19	Sample size per LGA
Oyo Central	Lagelu LGA	119	59	59	30	267
	Atiba LGA	119	59	59	30	267
Oyo South	Ibadan North East LGA	89	45	89	44	267
	Ibadan South West LGA	89	44	89	45	267
2	**4**	**416**	**207**	**296**	**149**	**1068**

The random sampling technique was used to select in-school adolescents from randomly selected schools located within the selected communities. The same sampling technique was used to select in-school young adults who were targeted during group gatherings such as religious based youth activities or forum, and other similar activities that were identified and utilised by health care providers/programme trainees during enlightenment talks and step down trainings. Random sampling technique was also used to select out of school adolescents and young adults. Out-of-school adolescents were targeted at their various places of learning a trade and during low sales periods at the various market locations. Out of school young adults on the other hand were targeted at their places of apprenticeship, during religious based youth activities or forum and during the various clinics at the established Maternal Health Counselling Centres (MHCCs) and during low sales periods at the various market locations. Twenty nine (29) health care providers/programme trainees were purposively selected based on their participation in the update training. These programme trainees served as FGC In-depth interviewees for the study and respondents for the FGC Update Training Rating Scale (FGC-UDTRS). With the help of the health care providers/programme trainees, discussants that had been confirmed as having

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experienced FGC were purposively selected. These also served as respondents to the FGC-VCRS instrument based on their cut statuses.

Table 3.5: Summary of FGC-FGD and FGC-VCRS Samples

Focus Maternal Health Counselling Centres (MHCCs)	No of FGC Discussants/ FGC-VCRS Respondents
Lalupon PHC, Lagelu LGA	9
Lalupon-Oyedeji, Lagelu LGA	10
Alegongo PHC, Lagelu LGA	11
Alafara PHC, Ibadan North East LGA	12
Oja-Gbo PHC, Ibadan North LGA	10

Table 3.5 presents the total number of females who have experienced FGC that were purposively selected for the 4 (four) Focus Group Discussions sessions, and respondents to the FGC Victims Counselling Services Rating Scale (FGC-VCSRS) instrument. These were pooled from 4 (four) out of the 5 (five) focus MHCCs within the LGAs of intervention.

3.6. Instrumentation

Both qualitative and quantitative research instruments were used to collect data for the study. The complementary use of qualitative data collection guides involving in-depth descriptions and explanations were used to support results obtained from the quantitative data through the administration of quantitative instruments. Hence, two (2) interview guides and six (6) quantitative instruments respectively were used to collect qualitative data from the qualitative respondents (i.e. Healthcare providers/programme trainees and females who have experienced FGC) and quantitative data from quantitative respondents comprising in and out of school adolescents of ages 10 to 24 years, who have experienced or not experienced FGC. Both interview guides as well as four (4) of the quantitative instruments were developed by the researcher; while the other two (2) quantitative instruments were adapted.

In observance of the ethics of research, informed consent forms were designed and presented to prior identified signatories for the various categories of respondents and participants; also the issue of confidentiality was observed as required. For quality information In to be obtained from the IDI interviewees and focus group discussants, consent forms as well as quantitative instruments were translated into the Yoruba language before administration to

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respondents of the quantitative instruments. This was done in order to cater to non-English speaking respondents/participants. Hence, the Yoruba language was used as necessitated. The instruments used for the study are as follows:

1. FGC In-depth Interview Guide – FGC-IDI Guide (Appendix 1)
2. FGC Focus Group Discussion Guide – FGC-FGD Guide (Appendix 2)
3. Female Genital Cutting Knowledge Test – FGCKT (Appendix 3, Section B)
4. Female Genital Cutting Attitude Rating Scale – FGCARS (Appendix 3, Section C)
5. Female Genital Cutting Psychological Experience Perception Rating Scale – FGC-PEPRS (Appendix 3, Section D)
6. Female Genital Cutting Intervention Programme Rating Scale – FGC-IPRS (Appendix 3, Section E)
7. Female Genital Cutting Victims Counselling Services Rating Scale – FGC-VCSRS (Appendix 4)
8. Female Genital Cutting Update Training Rating Scale – FGC-UDTRS (Appendix 5)

3.6.1 FGC In-depth Interview Guide (FGC – IDI Guide)

The in-depth interview guide was administered on Community/Traditional Birth Attendants (C/TBAs), Public Health Workers (PHEWs), Community Health Workers (CHEWs) and Midwives, who were responsible for enlightenment talks, step down trainings, provision of expert counselling as well as opportunities for other health related services at the established MHCCs. The IDI made use of a structured interview guide with open ended survey questions. Probe questions were also used to obtain as much information for a cross-comparison of responses. Questions were ordered in a sequential manner to ensure adequate coverage of all aspects of the intervention programme. In order to avoid loss of information and for verification purposes, notes were taken during the interview session with the knowledge and consent of the interviewees.

3.6.2 FGC Focus Group Discussion Guide (FGC-FGD Guide)

This instrument was developed to guide the discussion process during the Focus Group Discussions (FGD) Sessions. It was used to obtain qualitative information on psychological experience of victims of FGC. The guide comprised of semi structured questions considering that the aim of the group discussion was to obtain more detailed and comparable responses in relation

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to psychological experience due to FGC. Some of such questions were: what traditional practice is considered most harmful to females; are there any advantages or disadvantages attached to the practice; what psychological problems ensue for the practice, amongst others. Questions were ordered in a sequential manner in order to sustain coherence in responses and assess group members' ability to list their experiences in order of importance.

3.6.3 Female Genital Cutting Knowledge Test (FGCKT)

This instrument measured the cognitive component of female adolescents and young adults who have or have not experienced FGC. The instrument was made up of two (2) sections. Section A captured data on the profile of respondents (Age, educational level, parents' educational status, FGC status, Marital Status, Work status and Location of residence) while section B comprised seventeen (18) after the construct validity and reliability values as well as the content validity value of the instrument had been determined, based on developed items using a test blue print for FGC knowledge (Table 3.6).

Table 3.6: Table of Specification for FGC Knowledge Test Instrument (FGCKT)

Content/Topic	Knowledge (i.e. specific information)	Comprehension (understanding of specific information)	Thinking (ability to reason or reflect on information obtained)	Total
Overview of FGC	2	2	1	5
Complications and consequences of FGC	5	5	2	12
Psycho-social support of FGC victims	1	1	1	3
Total	**8**	**8**	**4**	**20**

In line with Bloom's Taxonomy of learning outcomes (Huitt, 2011), the instrument assessed respondents' cognition levels of knowledge, comprehension, application, analysis, synthesis and evaluation, with the last four (4) levels of the taxonomy being collapsed into a single level referred to as 'Critical Thinking' level. These four levels that constitute critical thinking involves making clear reasoned judgements (Beyer, 1995) through active and skilful conceptualising, applying, analysing, synthesising and evaluating of information gathered or generated; hence, they were treated as a single unit. The test therefore covered the knowledge,

comprehension and thinking levels of respondents in relation to FGC practice and its dangers. It used categorical responses of **YES, NO** and **I DO NOT KNOW**.

3.6.4 Female Genital Cutting Attitude Rating Scale (FGCARS)

This instrument was administered to both female adolescents and young adults who have or have not experienced FGC. The scale consisted of two parts; the first part (Section A) covered age, educational level, parents' educational status, FGC status, Marital Status, Work status and Location of residence. Based on the construct validity and reliability values as well as the content validity value of the instrument, fifteen (15) attitude statements representing respondents' views constituted section B. Responses were rated on a 4-point Likert type scale as: 4 - Very True (VT), 3 – True (T), 2 – Untrue (UT) and 1 – Most Untrue (MUT)**.**

3.6.5 Female Genital Cutting Psychological Experience Perception Rating Scale (FGC-PERS)

This instrument was administered to female adolescents and young adults who have or have not experienced FGC. The instrument was designed to obtain information on respondents' perception of psychological experience. Respondents socio-demographic profile was captured in section A; while section B of the instrument comprised 10 (ten) psychological experience perception statements after its psychometric properties of construct validity and reliability values as well as the content validity value had been determined. Responses for the instrument were rated on a 4-point Likert type scale as follows: 4 - Very applicable (VA), 3 - Applicable (A), 2 - Not applicable (NA) and 1 - Very inapplicable (VIA).

3.6.6 FGC Intervention programme Rating Scale (FGC-IPRS)

This instrument elicited responses from female adolescents and young adults on execution, access and effectiveness of intervention programme activities in imparting knowledge on the dangers of FGC and changing attitude towards continuation of the practice. Section A covered respondents' profile data of age, educational level, parents' educational status, FGC status, Marital Status, Work status and Location of residence. After duly determining the psychometric properties of construct validity and reliability values as well as the content validity value, 23 (twenty three) items were retained for section B. Ratings of items were: 4 – Very large extent (VLE), 3 – Large extent (LE), 2 – Small extent (SE) and 1 – Not executed (NE).

3.6.7 FGC Victims Counselling Services Rating Scale (FGC-VCSRS)

This instrument was administered to only young adults from ages 20 to 24 that have experienced FGC and reported issues of psychological experience. The instrument assessed the impact of expert counselling by health care providers/programme trainees/programme trainees on FGC victims. Section A covered profile data of age, educational level, parents' educational status, FGC status, Marital Status, Work status and Location of residence, while section B involved respondents rating 24 (twenty four) retained items after the construct validity and reliability values as well as the content validity value of the instrument had been determined. The rating for assessing the impact of counselling services was: 4 - Very Effective (VE), 3 – Effective (E), 2 – In Effective (IE), and 1 – Very Ineffective (VIE).

3.6.8 FGC Update Training Rating Scale (FGC-UDTRS)

The instrument was administered to health care providers/programme trainees who attended the update training on dangers of FGC. The scale was adapted from the provider knowledge, attitude and practices survey questionnaire on gender-based violence – GBV (Bott, Guedes, Claramunt and Guezmes, 2004). It was adapted with the aim of obtaining information on the impact of the update training in relation to expert counselling, acquired on the programme. General information consisting of state, LGA and name of clinic/health centre (which doubles as a maternal health counselling centre), as well as socio demographic data of sex, designation, number of years as a health provider, and age range constituted section A of the instrument; while section B consisted of 21 (twenty one) update training impact statements after the psychometric properties of construct validity and reliability values as well as the content validity value of the instrument had been determined. Responses were rated on a 4-point Likert type scale as follows: 4 - Very well trained (VWT), 3 – Well trained (WT), 2 – Averagely trained (AT) and 1 – Not adequately trained (NAT).

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3.7. Validation and Reliability of the Instruments

The 2 (two) qualitative instruments, FGC In-depth Interview (FGC – IDI) guide and FGC Focus Group Discussion (FGC – FGD) guide were subjected to face validity and content validity by the researcher's supervisor, judgement of experienced persons in the field of qualitative research in disciplines of evaluation, sociology, psychology, humanities and health. The 6 (six) quantitative instruments were validated through pilot testing of the instruments on similar population for the study. Construct validity and reliability of the instruments were established using Cronbach alpha. Their content validity were established using the Lawshe Content Validity Ratio (CVR) with 15 (fifteen) subject matter experts (SMEs) serving as panellists to determine how 'essential', 'useful' or 'not necessary' the items of each instruments were; and SMEs comprised of 4 (four) evaluators, 3 (three) health educationists, 4 (four) persons in the area of psychology and 4 (four) persons in the area of nursing and obstetrics and gynaecology. Subsequently, Content Validity Index (CVI) of the instruments was determined using the following formula, proposed by Lawshe (1975).

$$\text{Content Validity Index (CVI)} = \frac{\sum \text{CVR}}{\sum \text{Retained Items}}$$

Where: (a) ∑CVR is total value of items rated as essential or content valid by SMEs; (b) ∑ Retained Items is the total number of retained items

The CVI is rated on a continuum of between -1.0 and 1.0. The closer an instrument's CVI is to 1.0, the more essential or content valid the instrument is; and the closer to -1.0 an instrument's CVI value is, the more non-essential or non-content valid it is. Table 3.7 presents the construct and reliability values as well as CVI values for the 6 (six) quantitative instruments used for data collection.

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Table 3.7: Cronbach Alpha, CVI and CVR Values

S/N	Instrument	Cronbach's Alpha Total Item Correlated Range (≥ 0.30)	Cronbach's Alpha Value	Lawshe CVI Value Range (≥ 0.49)	Lawshe CVI Value
1.	FGC Knowledge Test (FGCKT)	0.31 – 0.68	0.71	0.6 – 0.99	0.84
2.	FGC Attitude Rating Scale (FGCARS)	0.33 – 0.58	0.68	0.6 – 0.99	0.95
3.	FGC Psychological Experience Perception Rating Scale (FGC-PEPRS)	0.30 – 0.69	0.78	0.6 – 0.99	0.81
4.	FGC Intervention Programme Rating Scale (FGC-IPRS)	0.26 – 0.75	0.87	0.6 – 0.99	0.94
5.	FGC Victims Counselling Rating Scale (FGC-VCRS)	0.30 – 0.79	0.80	0.6 – 0.99	0.86
6.	FGC Up Date Training Rating Scale (FGC-UDTRS)	0.25 – 0.85	0.87	0.6 – 0.99	0.94

3.8. Data Collection Procedure

The researcher with 5 (five) trained interviewers conducted the FGC In-depth Interviews (FGC-IDIs) for 29 (twenty nine) programme trainees (healthcare providers) and administered the FGC Up-Date Training Rating Scale (FGC-UDTRS) to the same group; and 5 (five) FGC Focus Group Discussion (FGC-FGD) sessions in the 5 (five) established MHCCs were conducted by the same team, using the developed guides for the interview and discussion sessions. The in-depth interview and FGC-FGD sessions were recorded with the consent of interviewees and discussants respectively. Both the FGC-IDI sessions and administration of the FGC-UDTRS, as well as the FGC-FGD sessions and administration of the FGC-VCRS instrument were conducted concurrently in order to execute the activities within the planned time frame of 3 (three) weeks. Hence, 5 (five) independent groups different from the FGC-FGD groups consisting 10 (ten) female young adults per established MHCC were gathered with the help of interviewed programme trainees, for the administration of the FGC-VCRS instrument.

The same team with 18 (eighteen) additionally trained teachers administered 4 (four) quantitative instruments – FGC Knowledge Test (FGCKT), FGC Attitude Rating Scale (FGCARS), FGC Perception Rating Scale (FGC-PEPRS), and FGC Intervention Programme Rating Scale (FGC-IPRS) among female in school adolescents, in LGAs of intervention, leaving out only the FGC-IPRS instrument for LGAs with no intervention. In the LGAs of intervention, the same instruments as those administered to in school adolescents was administered on in

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school young adults, out of school adolescents and out of school young adults. These consisted mainly of respondents who are self-employed or are apprenticing in crafts and trades such as fashion designers (trainers and trainees), hair dressers (trainers and trainees), boutique/shop attendants. These groups of respondents were identified and located with the help of religious leaders and programme trainees who due to their various activities such as religious youth programmes, one-on-one interaction, enlightenment talks, and step down training activities, had established cordial relationships with such persons. Out of school adolescents and young adults in LGAs with no intervention were located with the help of the various artisan associations such as association of fashion designers, association of hair dressers, market women associations; and in school young adults on the other hand were accessed via religious based youth forum programmes. The FGCKQ, FGCARS, and FGC-PEPRS instruments were administered on the respondents and Yoruba translated instruments were administered to respondents who were not fluent with the English Language.

3.9. Scoring of the Instruments

The socio demographic variables consisting of respondents characteristics were scored as follows:

1. Age range: 10 – 14 (1) - (early adolescence) 15 – 19 (2) - (middle adolescence)
   20 – 24 (3) - (late adolescence)
2. Present educational level: JSS (1) SSS (2) Higher education (3)
   No formal education (4)
3. **(For out of school adolescents)** How long have you been out of school?
   Less than or 3 years (1) 4 – 6 years (2) 7 years and above (3)
4. Last level of education: Primary (1) JSS (2) SSS (3) Higher education (4) None (5)
5. Parent(s) educational status:

Primary education	(1)
Secondary education	(2)
Grade II Certificate/NCE	(3)
Higher education	(4)
No formal education	(5)

6. FGC status: Have you experienced female genital cutting? NO(1) YES (2)
7. Marital status: Single (1) Married (2) Divorced (3) Separated (4)
8. Work status: Are you working presently? NO (1) YES (2)

9. What type of work do you do presently? Formal job (1) Trading (2) Artisan (3) Farming (4) Apprentice (5) Others (6)
10. Location of residence: Rural (1) Urban (2)

Female Genital Cutting Knowledge Test (FGCKT): This instrument assessed respondents' knowledge on dangers of FGC practice. The response format was: **YES, NO and I DO NOT KNOW** and these were scored as:

Answer not correct or known/No response	= 0
Correct answer	= 2

Female Genital Cutting Attitude Rating Scale (FGCARS): This instrument elicited responses in relation to respondents' attitude to the practice of FGC. The responses were scored as:

Very true	= 4
True	= 3
Untrue	= 2
Most untrue	= 1

Female Genital Cutting Psychological Experience Perception Rating Scale (FGC-PEPRS): This instrument elicited responses in relation to respondents' perception of psychological experience which is caused by the practice of female genital cutting. The responses were scored as:

Very applicable (VA)	= 4
Applicable (A)	= 3
Not applicable (NA)	= 2
Very inapplicable (VIA)	= 1

Female Genital Cutting Intervention Programme Rating Scale (FGC-IPRS): This instrument aimed at finding out to what extent FGC intervention programmes activities were carried out, and how effective they were in enlightening respondents on dangers of FGC. The scoring format was:

Very Large Extent (VLE)	= 4
Large Extent (LE)	= 3
Small Extent (SE)	= 2
Not Executed (NE)	= 1

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Female Genital Cutting Victims Counselling Services Rating Scale (FGCV-CSRS): This instrument aimed at finding out to what extent opportunities and expert counselling by programme trainees were carried out and how effective they were. The following scoring format was used:

Very Effective (VE)	= 4
Effective (E)	= 3
Ineffective (IE)	= 2
Very ineffective (IE)	= 1

Female Genital Cutting Update Training Rating Scale (FGC-UDTRS): This instrument aimed at finding out to what extent up date training was effective in providing enlightenment on dangers of FGC, as well as providing opportunities and expert counselling for FGC victims. The following scoring format was used:

Very Effective (VE)	= 4
Effective (E)	= 3
Ineffective (IE)	= 2
Very ineffective (IE)	= 1

3.10. Method of Data Analysis

3.10.1. Qualitative Instruments

The responses from the FGC In-depth interview (FGC-IDI) for health care providers/programme trainees/programme trainees involved generating a record of each interview session. The instrument focused on eliciting responses in relation to awareness of other FGC intervention programmes within LGAs of intervention; aim of the African Women's Development Fund and Justice, Development and Peace Commission (AWDF-JDPC) intervention programme, as well as aims of the trainings and established facilities; contents of update trainings, step-down trainings and enlightenment talks; operations of the Maternal Health Counselling Centre (MHCCs); and most accessed and effective intervention strategies. The responses from the instrument were organised into a list-like format in order to facilitate the collation of the responses. These were finally analysed using descriptive statistics. The responses from the FGC Focus Group Discussion (FGC-FGD) sessions were analysed using the same procedure as that used in analysing the FGC In-depth Interview (FGC-IDI) responses, but based on group basis. View of FGC as a harmful traditional practice; at what age is its harmfulness

more prominent (i.e. if the practice is considered harmful); if and what psychological detriments occur; attitude toward 'cutting' the girl-child; as well as opinion on effectiveness of opportunities and expert counselling provided by health care providers/programme trainees were the focal points of the FGC-FGD instrument.

3.10.2. Quantitative Instruments

Quantitative data were collected based on 8 (eight) research questions and 5 (five) hypotheses. These were analysed using descriptive statistics of frequency counts and percentages, Chi-square, analysis of variance (ANOVA), multiple regression (MR), independent t-test and simple linear regression respectively. Considering the scoring format and analyses methods used for the FGCKT and FGCARS instruments, the total obtainable marks for the FGCKT was eighteen (18). This is because it is an 18-item instrument with every correct response attracting two (2) marks, while every wrong or no response attracted no (0) mark. For the FGCARS which is a 15-item Likert-type instrument based on the structuring of the items, the total obtainable marks were 15 to 60. Hence, assigning of marks for items is summarised as follows:

1. Positively structured items + negative response = negative attitude (1 mark)
2. Negatively structured items + positive response = negative attitude (4 marks)
3. Positively structured items + positive response = positive attitude (4 marks)
4. Negatively structured items + negative response = positive attitude (1 mark)

As a result, the total obtainable marks for respondents in categories 1 and 4 respectively was fifteen (15) marks; while that for those in categories 2 and 3 was sixty (60) marks. Table 3.8 presents a summary of research questions and method of data analysis.

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Table 3.8: Summary of Research Questions and Methods of Data Analysis According to Programme and Evaluation Objectives

Programme Objectives	Evaluation Objectives	Research Questions	Hypotheses	Respondents/ Source of Data	Instruments	Analysis
1	3a	3	-	FGC victims	FGC-FGD	Descriptive analysis of frequency
	4	6 & 7	-	Female adolescents and young adults in intervention	FGCKT, FGCARS, FGC-PERS and FGC-IPRS	Multiple regression
	5		1, 2, 3, 4 & 5	Female adolescents and young adults in intervention and non- intervention LGAs	"	• ANOVA • Independent t-test
2	1i	1a	-	Programme trainees	FGC-IDI	Descriptive analysis of frequency
	1ii	1b				
3	3b	4, 5 & 8	-	• Female adolescents and young adults in intervention and no intervention LGAs • Female adolescents and young adults in intervention LGAs • Programme trainees and FGC victims	• FGCKT, FGCARS, FGC-PERS and FGC-IPRS • FGC-UDTRS and FGC-VCRS	• Descriptive analysis of frequency • Chi-square • Independent t-test • Simple Linear Regression
	2	2a and 2b	-	FGC victims	FGC-FGD	Descriptive analysis of frequency
4	1iii	1c	-	Programme trainees	FGC-IDI	Descriptive analysis of frequency
5	1iv	1d				

3.11. Ethical Considerations

The study focused mainly on female adolescents and young adults who are members of communities where the intervention programme was carried out. As such, principals of schools or heads of academic management teams were presented with a letter introducing the researcher, the purpose of the study, copies of the informed consent and a complete compilation of the six (6) quantitative instruments. At the point of data collection, principals (or significant persons acting in the capacity of such) of schools were presented with the informed consent forms for their signatures as they served as representatives of parents of the in school adolescents, while the assistant vice principals signed on behalf of the respondents. This approach of obtaining consent on behalf of respondents' parents and the respondents themselves was adopted,

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considering that obtaining consent from each respondent's parents and from them also may elongate the period allotted for data collection. The instrument administrator also signed acknowledging prior persons signatures and their willingness for their pupils to be part of the study. Adolescents of older ages i.e. 20 to 24 years on the other hand were allowed to read and sign the informed consent form after necessary clarifications.

Similar procedures of obtaining informed consent for in-school adolescents were also adopted for out of school adolescents; this involved chairpersons of artisan and market women associations, as well as religious group leaders. A letter introducing the researcher and the aim of the study were presented to significant persons and informed consent form as well as a compilation of the instruments was presented for necessary persons' perusal and eventual signature. With the permission of significant persons, out of school young adults were allowed to read the informed consent or had it read out to them. Clarifications were made where necessary and signatures and or thumbprints were appended as required. For FGC-IDI and FGC-FGD respondents, a letter of introduction was presented to the Primary Health Centre (PHC) Coordinators for each MHC that had a programme trainee. The letter also covered focus group discussion sessions that were carried out at the PHC/MHCCs; and the FGC-VCRS which were administered to females with FGC. Informed consents were verbally obtained from the FGC-IDI respondents, while a representative of each FGC focus group signed or thumb printed on behalf of other group members and the PHC coordinator signed as witnesses.

Issues of confidentiality and privacy were observed as necessitated for all categories of respondents or participants. For the FGC-IDIs, interviews were conducted at the convenience of the HCPs/programme trainees and at venues of their choice. This was done so that interviewees would not have extensive prior knowledge of questions that have been asked from earlier interviewees. Also for venue of their choice, this was agreed to in order to safe guard any information relating to the running and management of the PHCs which may be considered as important information which is not meant for public consumption. The quantitative respondents especially in-school respondents of secondary school age after selection were re-located to quite areas on the school premises. This was to ensure that they are not distracted by their peers, and that their responses to the various items are not influenced. For in-school young adults and out-of-school respondents, they made the choice of time and venue for the administration of the instruments.

3.12. Methodological Challenges

As various issues relating to human health are discussed leisurely and without restrictions, the practice of FGC is not considered as one of such issues especially as it relates to females. Thus, in order to get the target population to take part actively in the discussion sessions as well as respond truthfully to items of the various instruments, the researcher and members of her team embarked on pre-visits to schools, maternal health centres, various artisan associations and markets that were selected for the study. A brief explanation of the study was given with the aims and objectives serving as reference points.

Convincing out of school female adolescents and young adults to respond to the FGC questionnaire was a little difficult. This was due to respondents' sense of insecurity considering the country's state of security, and that most times interventions of any sort have never needed filling questionnaires as was required on this study. Faced with several of these situations, the researcher and members of the team solicited help of significant persons within artisan groups or similar groups to access out of school adolescents. Similar approach was used at the PHCs where focus group discussions and responding to the FGC-VCRS were carried out. Also, in order to gain access to respondents who are traders, market leaders were co-opted into the mobilisation exercise and this facilitated selection of respondents.

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CHAPTER FOUR

RESULTS AND DISCUSSIONS

The results obtained from qualitative and quantitative data are presented in this chapter. Based on the five (5) evaluation objectives for the study, this chapter discussed the results obtained from the statistical analysis of data according to the eight (8) research questions and five (5) hypotheses formulated for the study.

4.1. Research Question 1: What are the characteristics of the programme trainees/Health Care Providers (HCPs) in terms of age, gender, designation and work experience?

Table 4.1: Characteristics of Programme Trainees/HCPs (N=29)

Variables		Frequency	Percentages
Age	25 – 34 years	1	3.4
	35 – 44 years	3	10.3
	45 years and above	25	86.2
Gender	Male	4	13.8
	Female	25	86.2
Designation	DDMS	1	3.4
	CNO	7	24.1
	PNO	3	10.3
	SNO	1	3.4
	CHO	3	10.3
	CHEW	7	24.1
	C/TBA	7	24.1
Work Experience	7 – 9 years	1	3.4
	10 years and above	28	96.6

Key: Deputy Director Midwives Services [DDMS]; Chief Nursing Officer [CNO]; Principal Nursing Officer [PNO]; Senior Nursing Officer [SNO]; Chief Health Officer [CHO]; Community Health Extension Worker [CHEW]; Community/Traditional Birth Attendants [C/TBAs].

Results from the qualitative data using the FGC-IDI reveals that twenty nine (29) AWDF-JDPC programme trainees consisting of twenty two (22) government employed Health Care Providers (HPCs) and seven (7) self-established and mission based Community/Traditional Birth Attendants (C/TBAs) were interviewed. Table 4.1 shows interviewees' ages ranging from 25 to 45 years of age and above, with 25 (86%) of the interviewees having attained 45 years and above. 3 (10%) of the respondents were between the ages of 35 to 44 years, while only one respondent (4%) was found to be within the age range of 25 to 34 years. For gender, 4 (14%) were males, while the remaining 25 (86%) were females.

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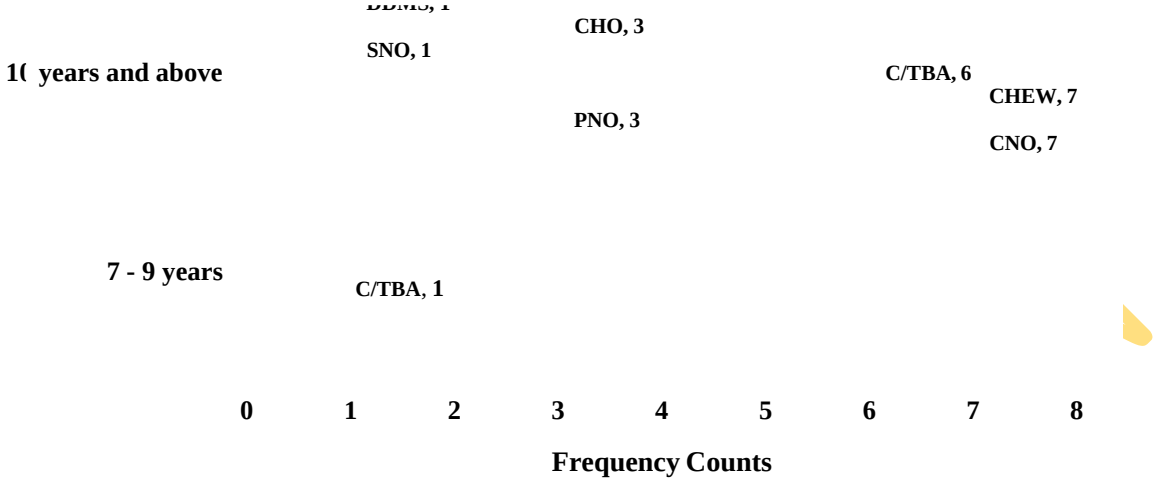

Figure 4.1: Frequency count of interviewees according to designations and years of working experience.

Figure 4.1 shows the seven (7) designations of the AWDF-JDPC programme trainees. It was observed that there was only one respondent each for the positions of Deputy Director Midwives Service Scheme [DDMS] and Senior Nursing Officer [SNO]. These made up 2 (7%) of the interviewees and they had over ten (10) years experience working as Health Care Providers (HCPs). The designations of Community Health Officer [CHO] and Principal Nursing Officer [PNO] had three (3) interviewees each, and a total of six (6) respondents for both groups accounted for 21% of interviewees assessed during the FGC-IDI sessions. Respondents within these groups like their DDMS and SNO counterparts also had over ten (10) years experience working as HCPs. Further analysis showed that seven (7) respondents were trained and certified Community/Traditional Birth Attendants [C/TBAs], seven (7) respondents had designation of Community Health Extension Worker [CHEW] and seven (7) respondents held the position of Chief Nursing Officer [CNO]. Hence, the last three (3) designations accounted for 72% of the interviewees. Of the 21 (72%) holding these positions, only one interviewee from among the (C/TBA) had less than 10 years of working experience as a HCP.

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Discussion

A close observation of the results presented in Table 4.1 reveals that although majority of the interviewees (28) were within the age range of 35 to 45 years and above, there was a gross gender imbalance among the interviewees (males, 4; females, 25). This is a reflection of what exists in the HCP's profession. Figure 4.1 on the other hand shows that the different designations of HCPs are well represented with extensive years of work experience. Based on these premise, it is assumed that a combination of personal and professional experiences of the trainees which come with age and work experience as well as additional skills acquired from the update training are the factors needed to facilitate experience sharing, provision of appropriate and adequate information as well as timely attention in relation to FGC issues.

A combination of results presented in Table 4.1 and Figure 4.1 in relation years of working experience as well as the different HCPs designations can be seen as a follow up to the need for improved opportunities for midwives to enhance quality service delivery for women with FGC as identified by Dawson, Fray, Nanayakkara, Varol and Homer (2015). The identified HCPs background is a facilitator for improved opportunities to learn about FGC, support and collaborative practice that enables service delivery to women with FGC.

4.1a. Research Question 1a: What other intervention programmes have been carried out prior to the AWDF-JDPC intervention programme, in relation to knowledge on dangers of FGC?

Results on programme trainees' awareness of prior FGC intervention programmes in LGAs of intervention revealed that there had been no prior FGC intervention programme executed before the AWDF-JDPC intervention in LGAs of intervention. Hence, all interviewees (29) attested to the fact.

Discussion

The attestations by the programme trainees are tenable considering that majority of the interviewees have over 10 (ten) years of working experience as healthcare providers (HCPs) around and within the AWDF-JDPC LGAs of intervention. Also, with the various work designations attained over the years, which are accompanied with intra and inter LGA primary healthcare centre (PHC) transfers, HCPs are formally informed about intended health based programmes especially those that are expected to be main streamed into routine health care

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services. According to most of the programme interviewees, for programmes that are not formally communicated to HCPs, they get to know of such programmes through community members who have participated in such programmes and have access to PHC facilities. Hence, such programmes more often are social mobilisation activities, and as such, execution of any health based intervention programme is not likely to take place without the direct or indirect knowledge of HCPs.

4.1b. Research Question 1b: To what extent were different information strategies or medium used by programme trainees, effective in imparting knowledge on the dangers of FGC and facilitating attitudinal change towards the practice?

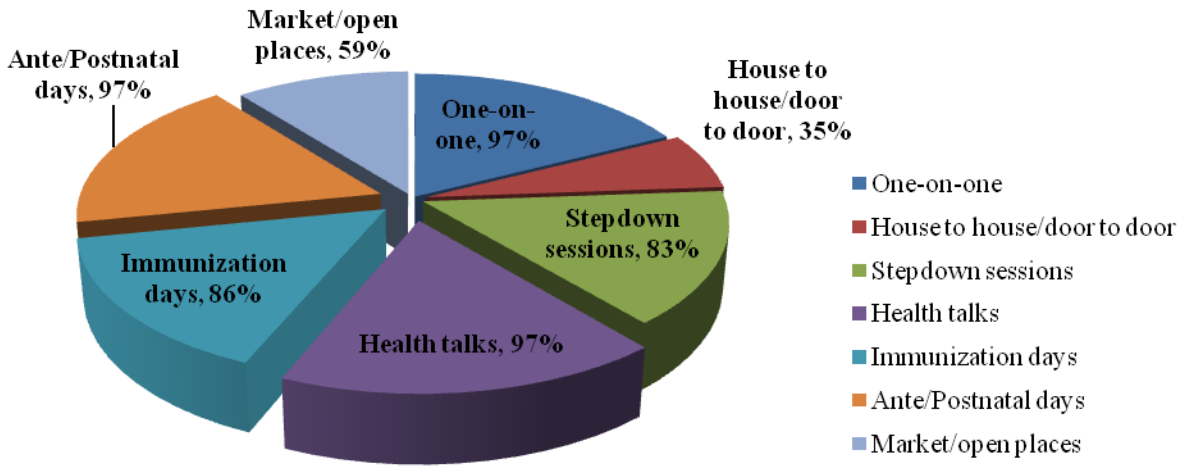

Figure 4.2: Information disseminating medium used by interviewees

The pie chart in Figure 4.2 reveals that both individual and group approaches were used by programme trainees to disseminate information as well as educate community members on the dangers of FGC. Hence, seven (7) media ranging from one on one talks to enlightenment talks in market/open spaces were means of community members accessing information, clarifying, erasing misconceptions and verifying views and opinions on the issue of FGC. Antenatal and postnatal clinic sessions, health talks and one-on-one approaches were the major means by which 28 (97%) of the programme trainees disseminated information and educated community members on dangers of FGC and opportunities available for management of FGC induced conditions; 5 (86%) and 3 (83%) of the interviewees reported using immunization clinic

sessions and step down sessions within and outside the facility, at various community, faith based and age grade/society gatherings as well as among other HCP colleagues who were not opportune to be part of the training; while 7 (59%) interviewees also used market/open space as a means of disseminating information and 10 (35%) used house-to-house/door-to-door approach. It was observed that the door to door (house to house) approach was the least used approach and this may not be unconnected with the situation of insecurity which has become more of a problem in recent times.

Table 4.2: Effectiveness of Information Disseminating Media

Information Dissemination Medium	Frequencies			
	High Effect	Moderate Effect	Low Effect	No Response
One on One	27	1	-	1
House to house/door to door	10	-	-	19
Step down activities	21	3	-	5
Health talks	26	1	-	2
Immunization days	24	1	-	4
Antenatal/Postnatal sessions	27	-	-	2
Market/open spaces	16	1	-	12

Table 4.2 presents frequencies of interviewees on effectiveness of the various media used to disseminate information on dangers of FGC, as well as opportunities available for managing FGC induced conditions. Based on the frequency figures in the table, it is assumed that frequency figures under no response are interviewees who did not use corresponding information disseminating media; while for high and moderate effect, frequency figures are evidence of corresponding information disseminating media that were used. Hence, one-on-one has the highest number of interviewees using the medium and recording a high effect; while house to house/door to door, in spite of having a small number of interviews using the medium, still recorded high effect. The analyses of results further shows that, five (5) of the media used (one-on-one, step down sessions, health talks, immunization clinic sessions and market/open spaces) were found to have dual ratings of high and moderate effectiveness; while house to house/door to door and antenatal/postnatal sessions, had singular ratings of high effect.

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Discussion

In summary, it was observed that all approaches were rated as moderately or highly effective in imparting knowledge on the dangers of FGC as well as providing information on opportunities available for managing FGC induced conditions. The observed reduction of request for FGC in PHCs and the engagement of the services of C/TBAs for 'female circumcision' can therefore be adduced to the effectiveness of the various media used for disseminating information. Also, in relation to maternal mortality which was one of the pre-existing conditions for which the intervention programme was implemented, prolonged labour is identified as a major cause. But it has been observed that reports do not state the specific facilitating causes leading to prolonged labour. Hence, in the opinion of interviewees blockage of the vagina for females with FGC was a major cause of prolonged labour which more often results in the death of either or both mother and child or retardation of the child.

Based on their observations and opinions therefore, comprehensive discussions with possible management solutions for child delivery were incorporated into information disseminated. Although most times capturing of maternal mortality do not disaggregate the different causes of prolonged labour, for females with FGC with FGC Types II and III cuts who more often than not experience this condition, it was observed that there is a reduction of maternal mortality. This was because many such affected persons were willingness to go along with prescribed delivery processes appropriate to their FGC conditions. The interviewees thus associated maternal mortality reduction and adherence to advised delivery processes with effectiveness of the media for disseminating information. In addition, reports of interviewees confirming that members of the community have also embarked on self-initiated drives of educating traditional circumcisers 'Ololas' on the dangers of the practice for victims as well as for them the circumcisers, is an indication of the effectiveness of the various media used by the interviewees.

From reports on effectiveness of media utilised in the dissemination of information, it was deduced that contents of enlightenment talks was an important factor. Hence, it was observed that majority of the interviewees provided information in the following areas, in relation to FGC: An over view of FGC (which included definition for FGC, different terms of FGC, FGC Types with descriptions, and reasons for FGC); Consequences and complications of FGC (Physical, psychological, social and psychosexual); Reproductive health and FGC; and

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Psychosocial support for females with FGC. With the aspects covered in relation to information dissemination, it is assumed that community members had good understanding of the topics discussed, and were able to internalise information at their disposal. Hence, the more related topics or issues for discussion in relation to FGC are, the better the level of understanding and association of information with victims' FGC status. Several of the interviewees also attested to the fact that, in the course of disseminating information during step down trainings and sensitisation talks, other issues such as primary and secondary infertility due to FGC; personal hygiene; FGC myths etc. were raised and discussed.

Therefore, reports by the interviewees on reduction of request for FGC in PHCs and the engagement of the services of C/TBAs for 'female circumcision' as well as community members serving as informants to the traditional circumcisers on the dual harm of the practice for both they and females with FGC alike, can be assumed to be a modification or change in attitude, towards the continuation of the practice. This shift in attitude can therefore be linked to the effectiveness of the various media used in the dissemination of information as well as aspects of focus for information provided. This outcome is therefore in line with Abiodun, Oyejola and Job's (2011) findings in their study of FGC prevalence and attitude in Nigeria study. In the study, respondents' disapproval of FGC and its continuation which was interpreted as negative attitude was adduced to respondents' exposure to awareness programmes involving discussions on FGC and HIV AIDS issues, via the mass media such as radio and television.

4.1c. Research Question 1c: To what extent was psychological experience reported by females with FGC, and follow-up activities carried out for females with FGC?

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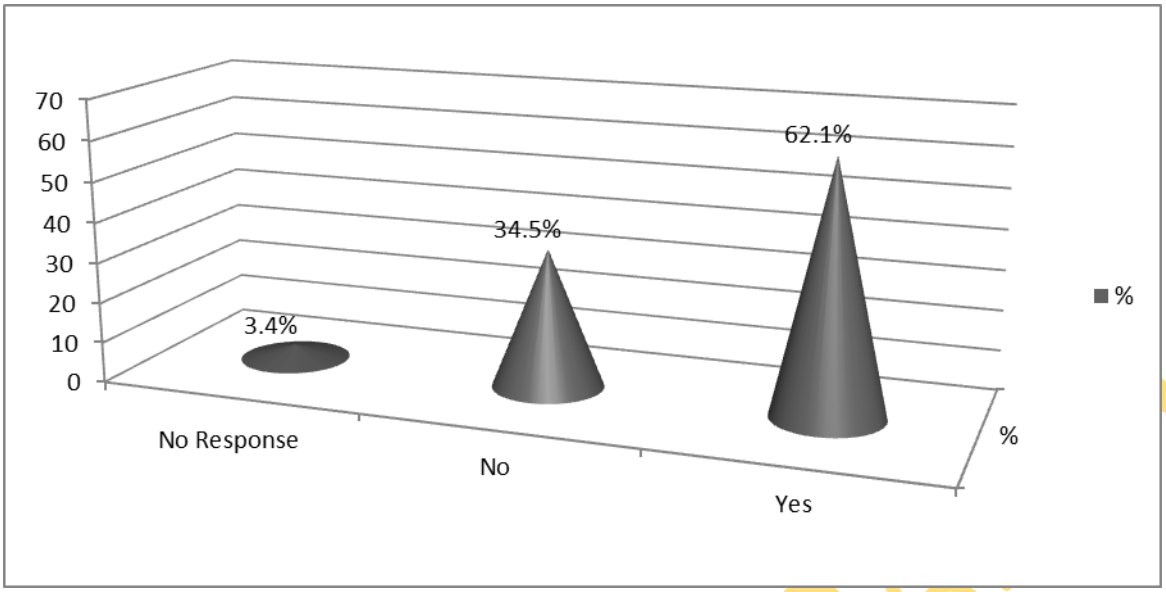

Figure 4.3: Programme Trainees Reponses on Extent of Psychological Experience Reports

Figure 4.3 shows that 18 (62%) of the interviewees reported that there were reports of psychological experiences by victims of FGC, while 10 (35%) reported otherwise and one interviewee (3%) did not respond. This result also revealed that as at the time the study was carried out, there was a high rate of reports in relation to psychological experiences due to FGC. Also, interviewees mentioned that, the opinion of females who had experienced FGC is that there are no benefits derived from the practice; as a result psychological experiences were negative in nature.

Discussion

With this high rate of psychological reports, and the outcome of these being negative, it thus confirms the fact that FGC is a harmful traditional practice. This therefore corroborates reports and views of international organisations, health surveys, studies and human rights activists that FGC has no beneficial effect on females who have experienced the practice.

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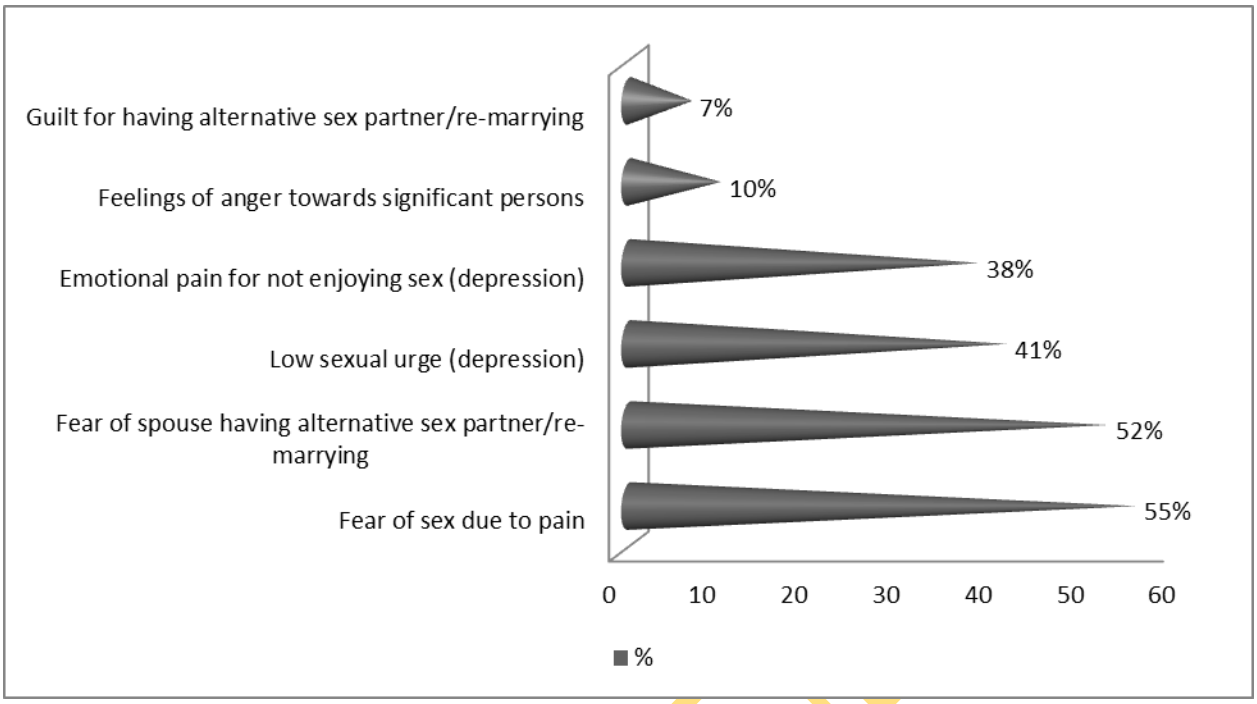

Figure 4.4: Frequently reported psychological experience

Interviews with the AWDF-JDPC programme trainees further revealed that as at the time of this study, an array of psychological experiences had been reported by women with FGC. These ranged from fear of sex due to pain during the process of intercourse to guilt for having alternative sex partner/re-marrying (Figure 4.4). Hence, of the 29 (twenty nine) interviewees, 16 (sixteen) claimed to have had reports of fear of sex due to pain during the process of intercourse; 15 (fifteen), fear of spouse having alternative sex partner or re-marrying; 11 (eleven), low sexual urge and emotional pain for not enjoying sex. Other psychological experiences reported and mentioned by interviewees include: feelings of anger towards significant person/s (3) and guilt for having alternative sex partner or re-marrying (2). These psychological issues are also considered as psychosexual issues which can lead to depression, due to the fact that psychosexual functioning involves a combination of psychological and sexual processes which are manifested as behaviour through the affective domain. Hence, results from Figures 4.3 and 4.4 give a strong indication of depression considering that the practice of FGC has no benefits for victims, but rather compounds natural processes such as sexuality.

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Figure 4.5 shows the percentage frequency ratings of attendees at MHCCs and specifically for FGC related issues.

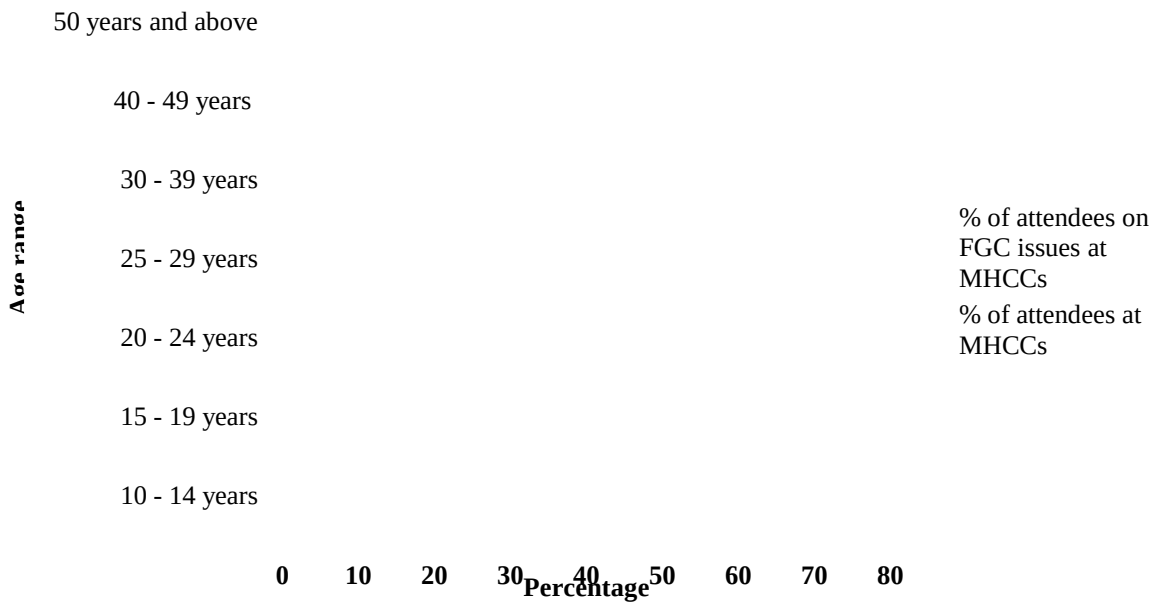

Figure 4.5: Attendance rating of females attending MHCCs for FGC related reasons and percentage frequency of general attendance.

A critical examination of Figure 4.5, with reports from the FGC-IDI sessions revealed that fear of sexual intercourse was predominantly high among attendees of MHCCs who are in their reproductive years i.e. 20 to 39 years. Hence, 12 (43%), 18 (62%) and 20 (69%) interviewees respectively reported age ranges of 20 – 24 years, 25 – 29 years, and 30 – 39 years as having high rate of attendance on FGC related issues. This report is in line with studies such as Ibekwe, Onoh, Onyebuchi, Ezeonu and Ibekwe (2012) and Iliyasu, Abubakar, Galadanci, Haruna and Aliyu (2012) in Ebonyi State and Northern Nigeria respectively that have reported FGC being found predominantly among females of reproductive age (15 to 40 years) in Ebonyi State and 20 – 29 years in Northern Nigeria. Further analysis also revealed that 48%, 48% and 41% interviewees respectively reported high frequency of attendance for other health related issues by the same age groups. In contrast to these age groups' high rate of attendance at MHCCs, and on FGC related issues, their counterpart age groups i.e. 10 – 14 years, 15 – 19 years, 40 – 49 years and 50 years and above were observed as having low attendance at MHCCs

on FGC related issues, but had a mix of moderate and low attendance ratings for other health related issues. Such other health related issues included Family Planning (FPL) and Antenatal/Postnatal sessions (15 – 50 years); general health complaints (10 – 50 years and above); counselling on FGC (10 – 49 years); unwanted pregnancy and FPL (10 – 49 years); teenage pregnancy and FPL (10 – 19 years) and request for FGC.

Although females of ages 10 to 19 were not identified as accessing the MHCCs on FGC related issues, it was observed from reports of 12 (twelve) interviewees that this age cohort access the MHCCs for other health related issues especially in relation to teenage pregnancy, FPL and request for abortion. In comparison to other health related issues, attendance at the health facility on these aspects were high. In addition, 3 (three) of the interviewees also reported that though the number of females between ages 15 to 19 requesting for more information on FGC related issues was negligible, it was an indication that they may have been cut; hence their need for additional information on complications and consequences to confirm their present experiences or have better knowledge of complications and consequences which may occur as they grow older. These results are indicative of the fact that females between the ages of 10 to 50 years and above who attended the MHCCs were opportune to acquire knowledge on dangers of FGC, especially in relation to maternal health. This was achieved through facilitations of the various clinic sessions by the programme trainees. Some of such clinic sessions included antenatal and postnatal clinics, immunization clinics and FPL clinics.

The result of females' ages 30 to 39 years having a high prevalence rate of being cut, thus experiencing various consequences and complications associated with the different FGC types is similar to studies of Nnorom (2007) and Kandala, Mwakeze and Kandala (2009). Findings from Nnorom's study on extent of prevalence of FGC types in Nigeria revealed that most women within age 30 to 49 years had experienced one form of FGC or the other; while Kandala et al from their study on spatial distribution of FGM in Nigeria found the mean age of females who had experienced FGC and had at least a daughter undergoing the practice as 37.8. It would be observed that the reported age range of this present study (30 to 39 years) falls within the age range and mean age of females with FGC in both studies. From the reports, it can be inferred that females within this age ranges must have been cut due to approval of the practice by older persons (male and female) in practicing communities as at that time. This thus corroborates Kandala et al (2009), Karhu-Rose (2010), Akinsanya (2011) and other similar studies'

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summations that older persons in practicing communities with other factors such as educational status, location of residence amongst others, can result in high prevalence rates.

Also, results from Nnorom's study found contrary results of high prevalence of FGC in younger women; instead high prevalence on issues of commencement of sexual activities at an early age, thus leading to teenage pregnancy, and safe motherhood was reported of them. Incidentally interviewees from this present study reported that younger females (10 to 19 years) were found to have issues of teenage pregnancy and need for family planning (FPL) while older females (40 to 49; 50 years and above) had issues of unwanted pregnancy, need for FPL, request for FGC, and general health complaints. It can therefore be concluded from the cited studies and with reports of the FGC-IDIs that FGC is prevalent among females within the age range of 30 to 40 years. High prevalence of the practice for females in this age range may be associated with little or no awareness creation on dangers of the practice, during the period when victims were cut, as reported by several studies (Abiodun, Oyejola and Job, 2011; Babalola, Brasington, Agbasimalo, Helland, Nwanguma and Onah, 2006). As a result, decision makers/mothers were not enlightened about the dangers of the practice; and they were not equipped to know their rights on taking a decision as to their daughters being cut or otherwise, since there has been no formal binding law in Nigeria against FGC.

Analysis of responses of interviewees revealed that 17 (59%) interviewees reported conducting follow-up services, using 3 (three) major means; while (12) 41% reported not conducting follow-up services due to several reasons. Medium of carrying out follow-up services and reasons for not conducting follow-up are presented in Figure 4.6

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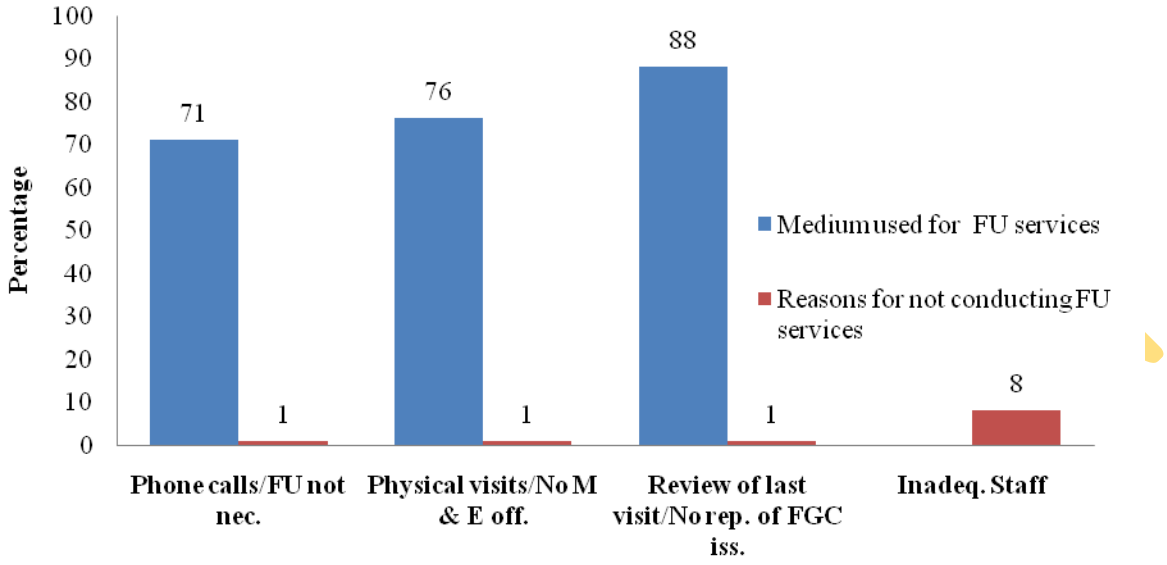

Figure 4.6: Medium of follow-up services and reasons for not conducting follow-up services for Females with FGC

According to results of analyses presented in figure 4.6, out of 17 interviewees who reported conducting follow-up services (blue coloured bars), 12 (71%) used phone calls; 13 (76%) used physical visits, and 15 (88%) used reviews of victims last visits. However, 12 (41%) of the interviewees who did not conduct follow-up services (red coloured bars) gave various reasons which include: follow-up for females with FGC not being considered as necessary, no monitoring and evaluation (M and E) officer, and no reports of FGC. These (1, 8%) were the least reported reasons for not conducting follow-up services for females with FGC; while inadequate staff was a major reason (8, 67%) for interviewees' not conducting follow-up services for females with FGC.

Discussion

From the analyses of conduct of follow-up services, it was observed that there is an overlap of media used by the HCPs to carry out follow up activities. Also from the analyses for none execution of follow-up services, with the major reason of inadequate staff, it can also be deduced that based on routine medical practice, only review of patients' last visit was the major avenue for follow-up activity being carried out for both out patients and females with FGC, irrespective of psychologically induced conditions that may arise for females with FGC. The issue of inadequate staff is thus a pointer that, if staff strength is increased, there is the likelihood

that provision of follow-up services for females with FGC, as well as for females without FGC who may be experiencing other medical psychologically induced conditions will appreciate.

4.1d: Research Question 1d: To what extent were monitoring and evaluation activities in relation to opportunities and access to expert counselling in established MHCCs?

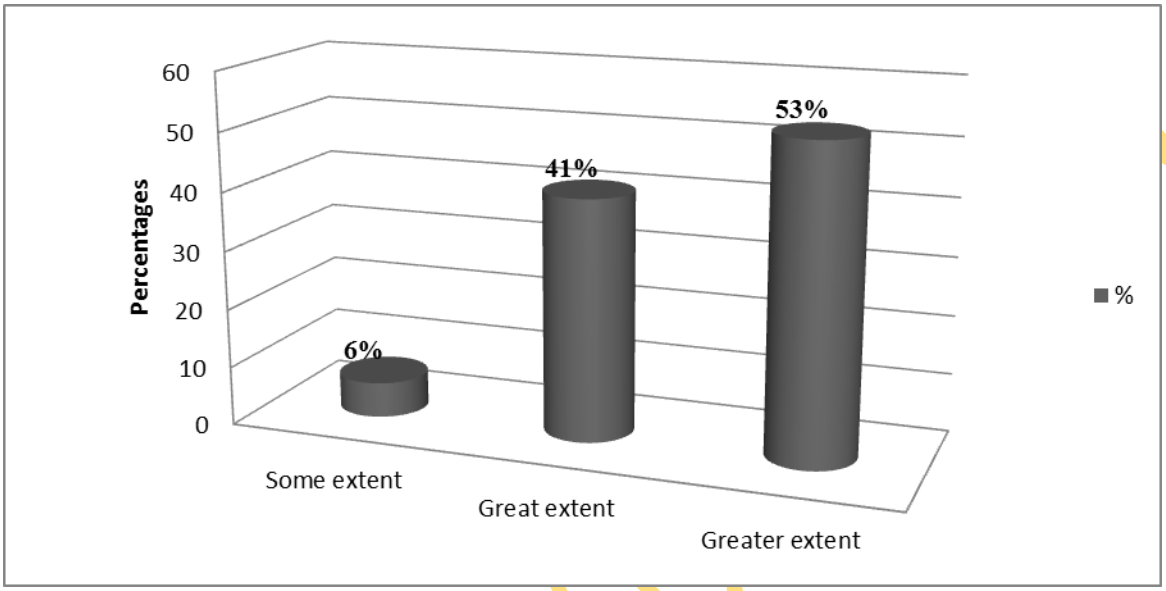

Figure 4.7: Extent of monitoring activities in established MHCCs

With regards to monitoring and evaluation (M and E) activities in relation to opportunities as well as access to expert counselling in established MHCCs, Figure 4.7 shows that seventeen (17) interviewees rated M and E activities. These activities were executed by implementers of the AWDF-JDPC intervention programme, via the Women Development and Promotion Department which has its focus on women, children and youth health issues, as well as other issues affecting them. Nine (9,) of the interviewees were of the view that M and E activities were carried out to a greater extent, seven (7) rated the activity as having being executed to a great extent, while one (1) rated same activity as having being executed to some extent.

Discussion

A few of the interviewees reported carrying out internal M and E activities also. The aim of this was to find out the rate of increase in attendance at the various routine clinic sessions held within the health facilities; and level of attention and willingness of community members during immunization outreaches to stop the practice. There were reports that, after the update training

for HCPs several of the programme trainees incorporated in depth and regular FGC talks at antenatal/postnatal sessions as well as immunization clinics. As a result, there has been a great increase in attendance at these sessions, likewise with outreach immunization programmes, community members have become more attentive and appreciative of information on the dangers of FGC and management alternatives available for FGC induced conditions.

4.2. **Research Question 2:** What are the characteristics of the females with FGC for the FGC Focus Group Discussion (FGC-FGD) participants and Victims Counselling Rating Scale (FGC-VCRS) respondents in terms of: age, current and last educational level, parents educational status, marital status, work status, religion, age and type of cut, number of female children cut, age and type of cut for female children?

Table 4.3: Focus Group Discussants According to PHCs in Intervention LGAs

Intervention LGAs	Primary Health Centre (PHC)/Focus MHCCs	Number of Discussants
Lagelu	Lalupon PHC	9
	Lalupon-Oyedeji PHC	10
Ibadan North East	Alegongo PHC	11
	Alafara PHC	12
	Oja-Gbo PHC	10
	Total	**52**

Table 4.3 presents the number of focus groups (5) according to the Primary Health Centres [PHCs] in the LGAs of intervention that had maternal health counselling activities (i.e. opportunities and expert counselling) mainstreamed into their routine activities. The observed variance in number of discussants in each group was due to the willingness of available persons to participate in the various FGD sessions per MHCC. Hence, the advisable discussant limits of 8 (eight) to 12 (twelve) discussants for an FGD session was not violated. As a result, all discussants in the 5 (five) groups participated actively during the sessions.

Characteristics of the fifty two (52) discussants (women with FGC) covered age, current and last educational level, parents educational status, marital status, work status, religion, age and type of cut, number of female children cut, age and type of cut for female children. Data collected revealed that, focus group discussants' ages ranged from middle adolescence to 40 years, with a high concentration of discussants falling within 25 to 29 years (24, 46%) and 30 to 40 years (15, 29%). A lesser concentration of discussants were within the age range of 15 to 19

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years (8, 15%) and 20 to 24 years (5, 10%). For educational attainment, 12 discussants (23%) reported being in school currently in various higher institutions within the South West region, while 42 (81%) reported having attained various educational levels ranging from junior secondary school (JSS) to higher education within and over the last 7 (seven) years. In order of highest educational level attained by discussants' parents, 12 (23%) reported parents as having attained grade II/NCE education; 11 (21%), secondary school education; 19 (37%), primary school education, while 10 (19%) had no formal education. Majority of the discussants (48) are married with a negligible number (4) being single; 50 (96%) are majorly workers engaged in formal jobs such as teaching; and non-formal jobs which include trading, fashion designing, hairdressing, patent chemist services, catering and apprenticeship in various works, while 2 (4%) do not work. For religious affiliation there were more Christian discussants (30, 58%) than Muslims (22, 42%).

Table 4.4: Cross Tabulation of Focus Group Discussants' Developmental Stage at Cut and Type of Cut

		FGC Type				Total
		Type I	Type II	Type III	I don't know	
Developmental stage at cut	**infant**	10	6	4	12	32
	toddler	4	2	0	0	6
	adolescent	8	5	0	1	14
Total		**22**	**13**	**4**	**13**	**52**

Footnote: FGC Type I – Olopon; FGC Type II – Alabede; FGC Type III – Apa ati enu.

Table 4.4 presents results on discussants' age and type of cut experienced. According to the data, 32 (61%) were cut during infancy, 6 (12%) as toddlers or at a young age, and 14 (27%) experienced FGC at adolescence. Considering that there were no physical examinations to ascertain discussants cut status as well as FGC type carried out, the researcher had to rely on information provided by discussants in relation to their status and type of cut experienced. Based on the information on the stage/ages of experiencing FGC as reported by discussants, these reports are similar to a study by Owolabi, Laurel, Bailah, Vanja, Staffan and Lars (2012), on girls' and women's FGC related health complications in Sierra Leone. It was reported that respondents were cut at different ages i.e. 0 to 9 years (23.7%), 10 to 14 years (43.4%) and 15 ≥ (26.7%); but type of cut done was not reported. FGC types carried out on discussants was predominantly Type I (42%) referred to as 'Olopon', followed by Type II (25%) also known as

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'Alabede', and Type III (8%) called 'Apa ati enu'. 13 (25%) had no knowledge of the FGC type carried out on them.

Table 4.5: Focus Group Discussants' Number of Female Children, Age at Cut and Type of Cut

	No of female children by age			Age at cut			Type of cut		
	No female child(ren)	**Only 1 female child**	**> 1 female child(ren)**	**NA**	**0-3 years**	**4-6 years**	**NA**	**FGC Type I**	**I don't know**
	8	16	28	32	18	2	32	10	10
Total	**52**			**52**			**52**		

Table 4.5 presents results on discussants' number of female children, age at cut as well as type of cut carried out on discussants female children that experienced FGC. According to the data, 8 (15%) discussants had no female children as a result only male circumcision was performed on such children. Sixteen (31%) of the discussants had at least one (1) female child of which 10 (19%) were not cut, but the remaining 6 (16%) had FGC carried out on them; and 28 (54%) discussants had more than one (1) female child of which 14 (27%) were not cut, but the other 14 (27%) were cut. Further analysis using data from the table, revealed that 44 (84%) discussants had at least one (1) daughter, and out of these, 20 (45%) had FGC carried out on a daughter or all daughters between ages 0 to 6 years, with or without their consent.

Discussion

This report corroborates the report of Karmer, Kandala, Chung and Clarke (2011) in their study of factors associated with FGC in Burkina Faso, which had results of daughters who had been cut, more likely to have mothers who had been cut too. The difference between the present study and that of Karmer et al. is on location of cut women/mothers. For the present study, cut mothers who reside in urban locations are expected to have had better access to awareness programmes that would inform them of the dangers of the practice; unlike in the study by Karmer et al. where mothers were from rural areas. This contrast in results in relation to location and the practice of FGC thus agrees with studies within and outside Nigeria that have stated that, FGC is a practice that is culture bound.

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For discussants' female children's age and type of cut, this was not applicable to 32 (62%) of the discussants since they either did not have female children or if they did have, did not have FGC carried out on them. Those whose female children were cut, 18 (35%) were cut during infancy, while 2 (4%) were cut as toddlers. For the 20 (38%) respondents whose daughters had undergone FGC, only FGC Type I – Olopon was carried out on 10 (19%), and the remaining 10 (19%) had no knowledge of the FGC type carried out on their daughters since the decision to have their daughters cut was not theirs, rather the process was carried out at the insistence of mother-in-laws, and by the traditional circumcisers referred to as 'Ololas'.

4.2a. Research Question 2a: What traditional practice is harmful to females' psychological and physical well-being in this community?

All of the 52 (100%) focus group discussants identified FGC as the most prominent harmful traditional practice which affects females' psychological and physical well-being as well as cause maternal mortality within their communities.

Discussion

In the words of a discussant (using the Yoruba Language):

> "*There are several cultural practices that exist in our community and in the Yoruba speaking parts of Nigeria, some of which inflict pain and regrets over time. The most common of these are tribal marks or facial/body scarring (Ila oju) and female genital cutting (Ki kola oju ara). The former is commonly carried out on both males and females for various reasons ranging from beautification to identification purposes. But the practice of cutting the genitals of females which is very painful, harmful and affects every aspect of a female's life including child bearing is still very much in existence and more common in our communities considering that people see it as a cultural practice. Meanwhile facial/body scarring is not considered as being fashionable or necessary anymore*." (Focus group discussant, Laloupon PHC.)

It was observed from the different discussions that the practice goes by various local terminologies such as: 'A be di da obirin'; Ila fun obirin'; Di da abe omo 'birin'; A da 'be obirin'; and Ki ko ila fun omo 'birin'; all these referring to FGC. Aside from confirming facts on detrimental effects of the practice as have been documented in several international health based organizations, health survey and study reports, they were also able to mention other consequences of the practice; these were mainly physical consequences which include blockage

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of the birth canal, excessive loss of blood during child birth due to tears of FGC scars; pain during sexual intercourse, passing of urine and menstrual period; and contraction of different types of infections in the genital region. Fourteen (14, 27%) who were cut at adolescence, and had more severe FGC types (Type II – Alabede, 13; Type III – Apa ati enu, 4) carried out on them, were able to recount vividly their experiences and how they have relived the FGC process till date via the their negative physical experiences due to the practice. A lady in her late 30s recounted her experience of being cut at the age of 7. She said:

> "*It was like being taken to a slaughter house. Girls screamed while being cut; others sustained injuries while struggling not to be cut, while others like me just passed out because of the unpreparedness for the pain and the sight of so much blood. I experienced excruciating pains each time I needed to pass urine for at least two weeks. I had a Type 2 cut which has made sexual intercourse and child bearing a night mare for me. I only endured sexual intercourse so that I could have the 3 (three) children I have always wanted; this one I am nursing is my third child, so no more torments for me. I hated my mother for a long time, but over time I came to realize that she had no say in the decision of my being cut or other, because it is a cultural practice*."(Focus group discussant, Alegongo PHC).

Further discussions revealed that to the knowledge of the discussants, there is no other known harmful traditional practice that adversely affects females' psychological and physical well-being which result in psychological problems and maternal mortality respectively. According to them, though the practice is part of the customs and traditions of the people in some parts of the South Western region of Nigeria, it is a tradition that should be abolished in order to reduce the psychological and physical problems as well as maternal mortality incidences associated with or caused by the practice. Also, in spite of reasons that have been adduced for the continuation of the practice, discussants were of the opinion that reasons given as benefits for FGC were not tenable.

For the discussants, two (2) of the major reasons generally given by the supporters of FGC and which they had contrary views on were (i) Reduction of promiscuity in females; and (ii) Prevention against death of a new born baby during the delivery process. In their opinion, FGC does not debar a female from being promiscuous; rather the decision to be or not to be promiscuous is that of a female to make irrespective of her FGC status. Also, many of them were of the opinion that the scars formed due to the FGC operation may adversely affect the elasticity of the genital area thereby hindering contraction which signals the onset of delivery process or

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labour. According to them, based on their personal experiences, hindrances during labour results in obstructed labour, perineal tear (oju ara a ya – meaning the vagina tears open), haemorrhage and eventually episiotomy or caesarean section is done to avoid maternal mortality. This recount of delivery experience corroborates reports from the study of Slanger, Snow and Okonofua (2002) on complications and procedures for FGC women.

During discussions on the advantages and disadvantages of the practice, most of the discussants were able to mention the numerous disadvantages, while categorically rejecting the assumed advantages adduced for the practice by those promoting it. On the grounds of reasons for the practice being mistaken as advantages, it was suggested by discussants that similar focus group discussions with women of older age should be organised in order to disabuse their minds on what they thought were the advantages associated with the practice. This suggestion by the discussants thus revealed that the practice of FGC is enforced not only by men but also women of older age, due to their belief of the practice being a legitimate traditional one. It thus corroborates the findings of some studies that report high prevalence rates being attributed to justifications for the practice (Mandara, 2003) and positive attitude for FGC among older person (men and women) in practicing communities (Karhu-Rose, 2010).

4.2b. Research Question 2b: What are some of the psychological experiences associated with females with FGC?

Closely related to the reaction of discussants on what they considered as harmful consequences to female psychological and physical well-being (Research question 2a) were excessive blood loss during child birth due to tears of FGC scars, painful sexual intercourse, infections and blockage of the birth canal.

Discussion

Psychological experience such as fear, pain, depression, recall of unpleasant memories and shame (embarrassment for cut status) were the frequently mentioned psychological experiences (also referred to as wahala okan; okan ri ru; ipo ri ru okan in the Yoruba language) associated with FGC. Majority of the discussants who had more severe FGC types carried out on them, i.e. Types II or III, were found to be fearful of sexual intercourse because of the pain experienced during penile penetration; as a result some were of the opinion that their spouses may resort to settling for alternative sexual partners or even re-marrying. Many of the

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discussants were also found to be fearful of the delivery process considering that those who had infibulations due to scar formations from the healing of the cut need to have de-infibulations in order to enlarge the opening through which the unborn child is delivered.

The de-infibulation process though very painful, is the only way of moderating the problem of inelasticity of the genital area during labour and delivery. In the course of the discussions, majority of the discussants came to the conclusion that for females with FGC, there is a close relationship between fear and pain considering that it is fear of the pain to be experienced during intercourse or labour that is the actual problem, not the actual act of intercourse or child birth. Also, for them, it is the fear of losing their spouses to alternative sexual partners, and the need to have children, that makes them bear the pain of sexual intercourse and child birth.

The recall of unpleasant memories and depression are outcomes of the affective domain that are manifested via exhibition of behaviours which can be negative or positive in nature depending on how favourable or unfavourable a situation or condition is. For majority of the discussants who were cut at stages beyond infancy, they claimed to have negative reminiscences of the FGC process which have facilitated negative feelings. These include feelings of rejection towards spouses' advances for sexual intercourse and anger towards significant persons for their cut state; sadness and at times waves of confusion and mood swings, due to their unbalanced thoughts and feelings.

Again, like fear and pain, majority of the discussants concluded that there is a close relationship between recall of unpleasant memories of the FGC process and depression. This is because such memories do not elevate a cut females' morale because of the fear, pain and sadness associated with the practice; rather the person is demoralised and this results in depression. Shame which was explained as 'embarrassment for ones cut status' was a psychological experience strongly expressed by victims between ages 19 to 29 years (37, 71%). A few discussants within this age range felt shameful of their cut status because rather than their spouses being considerate of their conditions of sexual inactivity, low libido or low sexual urge, their spouses or partners had mocked them, settled for alternative sex partners or out rightly remarried.

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This report by discussants corroborates results of Andersson, Rymer, Joyce, Momoh and Gayle (2012) on sexual quality of life (SQOL-F) of women who have experienced FGC. Their comparative study of cut and women revealed that there was a statistical difference in sexual quality of life score between this group of women; and that women with Type III FGC (35, 62%) have the lowest SQOL-F scores in comparison to the control group. Hence, sexual activity for women with FGC is considered only for sexual gratification purposes for spouses and procreation for them the victims. Further discussions revealed that, several cut females in their desperation have also sort succor with alternative sex partners (as reported by 7% of programmes trainees) who are emphatic to their plight and have even ended up getting married to such partners even after having children in their previous marriage.

Discovering how distorting psychological experience can be, it is expected that follow-up services would be an integral part in the provision of opportunities and access to expert counselling. But this is not the case as was observed from reports of some HCPs (12, 41%) as well as from the focus group discussants (52, 100%). Reports by discussants revealed that follow-up services by HCPs was low, and if conducted at all, was carried out as a group counselling session during some of the routine clinic sessions. Discussants revealed that unlike the HCPs, C/TBAs that were mission based or individually established, conduct follow-up services more than HCPs and they used the one-on-one approach; this they carried out through physical visits and phone calls. This disclosure by discussants substantiates the fact that one of the major reasons for lack of follow-up services by HCPs was that of inadequate staffing. Unlike the HCPs in government run health facilities who are plagued with attending to different health issues, C/TBAs are more into birth delivery processes which may not come as often as birth deliveries that occur in health facilities. With these facts, it is assumed that, C/TBAs are likely to have enough time to conduct follow-up services more readily than their HCP counterparts in government run health facilities.

Although average age of discussants was 20 to 24 years, intense fear, severe pain and intrusive re-experience which was found in Kizilhan's (2011) study of 79 Northern Iraq girls (8 to 14 years) was also reported by the discussants in this study. This thus confirms that FGC has psychological impacts as well as adverse effect on cut victims irrespective of the age of the victim, especially when the FGC type is of a more severe type, involving deep and extensive cutting, as well as stitching. In Adeniran's (2011) study report, respondents' experience was in

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relation to their cut status, which was found to be more of FGC Type I. Based on the context in which 'experience' (i.e. FGC status) is encapsulated, respondents were reported as having positive attitudes towards the practice due to their experience of the less severe FGC type (Type I). This report is in contrast to findings by Kizilhan (2011) and the present study in relation to psychological experiences and negative attitudes portrayed by most of the respondents in these studies It can therefore be observed that 'experience' can be interpreted in various ways in relation to FGC, depending on the thrust of a study.

4.3. **Research Question 3:** What are the characteristics of female adolescents and young adults in LGAs of intervention and LGAs with no intervention in terms of: age, educational level, schooling status, parents educational status, FGC status, marital status, work status, and location of residence; and what is their profile in relation to knowledge on dangers of FGC and attitude towards the practice?

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Table 4.6: Characteristics of Female Adolescents and Young Adults in LGAs of Intervention and LGAs with No Intervention (N=1,600)

Variables		Intervention LGAs - Lagelu and Ibadan North East (N = 800)			No Intervention LGAs - Atiba and Ibadan South West (N = 800)		
		Age range	**Freq.**	**%**	**Age range**	**Freq.**	**%**
Age		10 – 14 years	356	44.5	10 – 14 years	344	43
		15 – 19 years	178	22.3	15 – 19 years	189	23.6
		20 – 24 years	266	33.3	20 – 24 years	267	33.4
Present educational level	**Current**	JSS	208	26	JSS	208	26
		SSS	103	12.9	SSS	103	12.9
		Post-secondary/Higher institution	156	19.5	Post-secondary/Higher institution	156	19.5
		None	333	41.6	None	333	41.6
	Last	Primary	71	8.9	Primary	122	15.2
		JSS	199	24.9	JSS	106	13.3
		SSS	57	7.1	SSS	42	5.3
		None	6	0.75	None	63	7.9
Schooling status		In-school	467	58.4	In-school	467	58.4
		Out-of-school	333	41.6	Out-of-school	333	41.6
Parents' educational status		Primary	111	13.9	Primary	74	9.3
		Secondary	273	34.1	Secondary	287	35.9
		Post-secondary/Grade II,NCE	93	11.6	Post-secondary/Grade II,NCE	96	12
		Higher education	188	23.5	Higher education	202	25.3
		None	135	16.9	None	141	17.6
FGC status		No	379	47.4	No	419	52.4
		Yes	332	41.5	Yes	332	41.5
		I do not know	89	11.1	I do not know	49	6.1
Marital status		Single	708	88.5	Single	737	92.1
		Married	80	10	Married	51	6.4
		Divorced	3	0.38	Divorced	6	0.75
		Separated	9	1.1	Separated	6	0.75
Work status		No	150	18.8	No	195	24.4
		Yes	126	15.8	Yes	195	24.4
		Schooling and working	524	65.5	Schooling and working	410	51.3
Location of residence		Rural	509	63.6	Rural	247	30.9
		Urban	291	36.4	Urban	553	69.1

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Eight hundred (800) female respondents each from within two LGAs of intervention (Lagelu and Ibadan North East) and two LGAs with no intervention (Atiba and Ibadan South West) responded to the Female Genital Cutting Questionnaire (FGCQ). For the intervention LGAs, 66.8% of the respondents were at the adolescent stage with 44.5% and 22.3% being within the age ranges of 10 to 14 years and 15to 19 years respectively and 33.3% were late adolescents/young adults with an age range of 20 to 24 years; while 66.6% of adolescent respondents from the LGAs with no intervention were constituted by 43% and 23.6% of respondents ages 10 to 14 and 15 to 19 years respectively, and young adults ages of 20 to 24 years were 33.4%. Educational level revealed that for both groups of intervention and no intervention LGAs, 58% of the respondents are in-school adolescents and young adults. Out of these, 26% were in Junior Secondary School (JSS), 12.9% were in Senior Secondary School (SSS), while 19.5% were in higher institution. For out of school respondents from the intervention LGAs group, 41.7% had primary schooling (8.9%), JSS (24.9%), SSS (7.1%) and no education (0.8%) as their last level of education; while 15.2%, 13.3%, 5.3% and 7.9% in the no intervention LGAs groups had primary, JSS, SSS and no education respectively as their last level of education.

It is therefore inferred from the statistics on educational level of both intervention LGAs group and no intervention LGAs group that 58.4 % of the respondents were in-school adolescents and young adults, while 41.6% are out-of-school respondents. The descriptive statistics presented parents of respondents in the intervention LGAs group as 13.9% having primary school education, 34.1% with secondary education, 11.6% as having obtained Grade II/National Certificate of Education (NCE), 23.5% having higher education and 16.9% with no educational qualification; while for parents of respondents in no intervention LGAs group 9.3% have primary, 35.9% have secondary, 12% have post-secondary qualifications of Grade II or NCE certificates and 17.6 have no qualification or education respectively.

For status variables, statistics revealed that for FGC status in intervention group, three hundred and seventy nine (379) of the respondents constituting 47.4% claimed not being cut, three hundred and thirty two (332) constituting 41.5% were cut, while eighty nine (89) constituting 11.1% had no knowledge of their being cut or otherwise; and for no intervention group, four hundred and nineteen (419, 52.4%) were cut, three hundred and thirty two (332, 41.5%) were not cut and forty nine (49, 6.1%) did not know their FGC status. Marital status

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revealed that a total of seven hundred and eight (708, 88.5%) respondents were single, eighty (80, 10%) were married, three (3, 0.38%) separated and nine (9, 1.1%) were divorced in the intervention group; while for the no intervention group, seven hundred and thirty seven (737; 92.1%) respondents were single, fifty one (51, 6.4%) were married, six each (6, 0.75%) were divorced or separated. For working status in the intervention group, 150 (18.8%), 126 (15.8%) and 524 (65.5%) respondents respectively accounted for respondents not working, those working and those both schooling and working; while in the no intervention group, 195 (24.4%), 195 (24.4%) and 410 (51.3%) respectively represent respondents not working, those working and those both schooling and working. Location of residence revealed that for intervention group, 63.6% and 36.4% of respondents reside in rural and urban areas respectively; while 30.9% and 69.1% of respondents in the no intervention group reside in rural and urban areas respectively.

4.4a. Research Question 4ai. What is the profile of respondents in intervention and non-intervention LGAs in relation to knowledge on dangers of FGC?

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Table 4.7: Profile of Respondents in Intervention LGAs and Non-Intervention LGAs in Relation to Knowledge on dangers of FGC (N=1,600)

S/N	Intervention LGAs (N = 800)		Non-Intervention LGAs (N = 800)		χ^2 Value	Sig.
	Correct	%	Correct	%		
1.	800	100	591	74	240.40	.000*
2.	800	100	538	67	313.30	.000*
3.	790	99	460	58	399.51	.000*
4.	793	99	316	40	668.71	.000*
5.	792	99	366	46	567.72	.000*
6.	790	99	491	61	350.98	.000*
7.	793	99	465	58	400.95	.000*
8.	800	100	485	61	392.78	.000*
9.	800	100	552	69	293.49	.000*
10.	766	96	397	50	437.42	.000*
11.	800	100	404	51	526.24	.000*
12.	800	100	432	54	477.92	.000*
13.	800	100	416	52	505.26	.000*
14.	749	94	365	46	453.18	.000*
15.	779	97	426	53	423.64	.000*
16.	800	100	467	58	420.52	.000*
17.	800	100	471	59	414.16	.000*
18.	800	100	459	57	433.36	.000*

N.B. * p < .05

Table 4.7 shows the response of 800 respondents each in intervention and non-intervention LGAs to an 18-item instrument designed to measure respondents' knowledge on dangers of FGC. The intervention group had a higher number of total obtainable marks (36) in comparison to the non-intervention group, considering that each correct answer/response was awarded one (2) marks.

4.4a. Research Question 4aii. Is there any significant difference in respondents' knowledge of dangers of FGC between the intervention group and no intervention group?

Using the Chi-square analysis (Table 4.7) results revealed that the intervention group performed much better on all 18 items of the FGC knowledge test in comparison to the non-intervention group.

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Discussion

Results from both research questions 4ai and 4aii are indications that the intervention programme had impact on the knowledge of respondents in the intervention group via their expose to both formal and informal information dissemination and education strategies (Berg and Denison, 2013); while their non-intervention counterparts may have accessed 'no curriculum or content guided' information on FGC issues unconsciously. As a result, the non-intervention group were unable to internalise or apply such information.

In addition, with the effective execution of the various multifaceted community based activities comprising awareness creation in FGC practicing communities for community leaders, enlightenment talks, health talks at various clinic sessions in the PHCs by HCPs, step-down trainings amongst other activities, as well as media communication activities involving publications in well read newspapers and distribution of IEC materials, it is expected that the intervention LGAs should have better knowledge of dangers of FGC in comparison to their counterparts in the no intervention LGAs as shown by the results. This is because the content of information for dissemination by programme trainees (HCPs) in relation to FGC was well planned, in-depth and appropriate.

This result is therefore in line with studies that have shown that formal and informal information disseminating and education strategies (Mounir et. al., 2003; Abiodun et al. 2011), community based and communication activities (Babalola et. al., 2006) are instrumental in facilitating knowledge on dangers of FGC and preventing the continuation of the practice. The study has also corroborated findings of studies (Degni et. al., 2012; Jacoby and Smith, 2013) which have identified the need for training of HCPs in order to facilitate acquisition of new skills and update existing ones, so as to enhance their service provisions to females with FGC. Data in Table 4.7 therefore shows that the responses can be relied upon, and that when situated into the population from which the sample was taken, it is very likely that respondents will be able to answer correctly.

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4.4b. Research Question 4bi. What is the profile of respondents in intervention and non-intervention LGAs in relation to attitude towards the practice?

Table 4.8: Profile of Respondents in Intervention LGAs and Non-Intervention LGAs in Relation to Attitude towards FGC (N=1,600)

S/N	HCDT Dimen.	Intervention LGAs (n = 800)		No Intervention LGAs (n = 800)		χ^2 Value	Sig.
		VT/T	UT/MUT	VT/T	UT/MUT		
1.	UAI	544	256	791	9	286.54	.000*
2.	*UAI	166	634	0	800	189.14	.000*
3.	UAI	413	386	799	0	508.94	.000*
4.	UAI	519	279	701	99	231.11	.000*
5.	UAI	451	347	308	492	388.46	.000*
6.	UAI	239	561	522	278	460.51	.000*
7.	MAS	263	530	263	537	7.6	.132
8.	*MAS	234	566	234	566	.000	1.00
9.	IDV	480	316	691	109	288.64	.000*
10.	IDV	550	250	679	121	152.87	.000*
11.	IDV	474	324	631	169	190.84	.000*
12.	*PDI	156	641	95	705	67.62	.000*
13.	PDI	364	432	366	434	4.02	.403
14.	PDI	534	266	292	508	355.19	.000*
15.	LTO vs STO	283	511	199	655	38.00	.000*

N.B. * p < .05; *negatively structured questions in line with the 6 HCDT dimensions
Keys: IDV: Individualism versus Collectivism; **UAI:** Uncertainty Avoidance Index**; PDI:** Power Distance Index; **MAS:** Masculinity versus Femininity; **LTO vs STO:** Long Term Orientation versus Short Term Orientation
VT/T: Very True/True; **UT/MUT:** Untrue/Most Untrue

Table 4.8 shows the response of 800 respondents in intervention (400) and non-intervention (400) LGAs to a 15-item questionnaire designed to measure respondents' attitudes towards FGC. Results show that the intervention group and non-intervention group had different attitude ratings on twelve (12) of the items, and similar attitude ratings for three (3) items. The difference in attitude ratings for the 12 items revealed that, the intervention group had higher negative/disagreement (untrue/most untrue) responses to positively structured items and positive/agreement (very true/true) to negatively structured items respectively, in comparison to the no intervention group; and there was no significant difference between the two groups for three (3) of the items.

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4.4b. Research Question 4**bii**. Is there any significant difference in respondents' attitudes towards FGC between the intervention group and non-intervention group?

Chi-square analysis from Table 4.8 shows that 80% (12) of the items recorded significant differences (*p<0.05) in response to attitudes towards FGC by respondents in the intervention and non-intervention groups.

Discussion

This result is an indication that, the intervention group had a higher negative attitude towards FGC in comparison to the non-intervention group. Similar to the result trend observed in the profile of respondents of both groups, in relation to knowledge on dangers of FGC, this result can be adduced mainly to the effectiveness of the multisectoral approach used in the implementation of the intervention programme as well as the effectiveness of the various media for information dissemination and education employed by the programme trainees. Hence, the view of Berg and Denison (2013) on all categories under which intervention programmes can be executed (training, formal classroom education, media communication, outreach and advocacy, and informal adult education) being utilised, putting into consideration specific characteristics of the group for whom intervention is being facilitated is germane.

Based therefore on intervention group's attitude towards FGC and the various activities under training of HCPs, media communication, and outreach and advocacy, which facilitated negative attitude towards the practice, the result supports the views of Degni et. al. (2012), Lazar et. al. (2013), Mulong et. al. (2014) and Dawson et. al. (2015), on the need for HCPs to be trained and be exposed to routine update trainings in relation to reproductive, psychological and other health related conditions for FGC women. In relation to effectiveness of the various media for information dissemination and education employed by the programme trainees, it was reported by programme trainees who served as study interviewees and by focus group discussants that cultural dimensions (e.g. HCPS executing step down trainings and enlightenment talks and explaining FGC terminologies in the local language of the communities, and discussing other cultural practices in relation to FGC, having one-on-one encounters with members of practicing communities) were incorporated. It is therefore assumed that incorporation of cultural dimensions which has been recommended as part of FGC preventive interventions strategies by Jacoby and Smith (2013) may have been instrumental in the observed

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attitude towards FGC by intervention group respondents. This is because, with information and education being communicated in the local language and being related to other existing cultural practices, community members are able to understand better the dangers of the practice thereby invariably affecting their attitude.

Therefore, the data presented in Table 4.4.2 shows that the responses obtained can be generalised to the population from which the study sample was pooled. Hence, these responses can be relied on and it is an indication of intervention LGAs respondents' negative attitude towards FGC.

4.5 Research Question 5ai: What is the profile of adolescent and young adult respondents in intervention LGAs in relation to knowledge of dangers of FGC?

Table 4.9: Profile of Respondents in Intervention LGAs in relation to Knowledge on Dangers of FGC

S/N	Adolescents (Early & Middle) (N = 534)		Young Adults (Late adolescents) (N = 266)		χ^2 Value	Sig.
	Correct	%	Correct	%		
1.	534	100	266	100	-	-
2.	534	100	266	100	-	-
3.	529	99	261	98	1.28	.258
4.	534	100	259	97	14.17	.000*
5.	529	99	263	99	.066	.798
6.	532	99	258	97	9.97	.002*
7.	533	99	260	98	8.75	.003*
8.	534	100	265	99	2.01	.156
9.	534	100	266	100	-	-
10.	526	98	240	90	29.88	.000*
11.	534	100	266	100	-	-
12.	534	100	266	100	-	-
13.	534	100	266	100	-	-
14.	496	93	253	95	1.47	.224
15.	525	98	254	95	5,54	.019*
16.	534	100	266	100	-	-
17.	534	100	266	100	-	-
18.	534	100	266	100	-	-

N.B. * p < .05

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Table 4.9 presents the combined response of early and middle adolescent (534) and young adult/late adolescent (266) respondents in intervention LGAs (800) to an 18-item instrument designed to measure respondents' knowledge on dangers of FGC. Overall, the early and middle adolescent respondents group recorded a higher number of obtainable total marks on eleven (11) items in comparison to the young adult/late adolescent respondents' group which had obtainable total marks on nine (9) items.

Based on results of the Chi-square analysis, only nine (9) items of the FGCKT were analysed for significant differences thus providing χ^2 values and corresponding significant levels. The other 9 items (1, 2, 9, 11, 12, 13, 16, 17 and 18) that did not have results for χ^2 values and corresponding significant levels was due to respondents in both groups obtaining total obtainable scores. As a result, χ^2 values and corresponding significant levels for these items were not generated because results for the items are constant. Fifty six percent (5) of the items out of the analysed items were observed as having significant differences (*$p<0.05$) in responses by respondents (adolescents and young adults); while there were no significant differences in response to the remaining items constituting forty four percent. The significant differences in the groups' with the adolescent group having higher correct responses in comparison to the young adults (late adolescents) group can be adduced to the population sizes of the groups. Adolescents constituted 67% of the population, while the remaining population (33%) comprised young adults.

Data in table 4.9 shows that the responses can be relied upon, and that when situated into the population from which the sample was taken, it is very likely that respondents will be able to answer correctly.

Research Question 5aii: Is there any significant difference in adolescent and young adult respondents' knowledge of dangers of FGC in intervention LGAs?

Table 4.10: Independent t-test for Differences in Adolescents' and Young Adults' Knowledge on Dangers of FGC

Group	Number	Mean	SD	Df	t-value	Sig.	d
Adolescents	534	35.74	.771				
				798	4.897	.000	0.34
Young adults	266	35.40	1.194				

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The independent t-test analysis in Table 4.10 reveals that adolescents in intervention LGAs had a higher mean score (mean = 35.74; SD = .771) than young adults in intervention LGAs (mean = 35.40; SD = 1.194) in relation to knowledge on dangers of FGC. The mean difference between the two groups was 0.34 and the 95% confidence interval for the mean difference between the two groups is between 0.48 and 0.20. The analysis further revealed that the difference between the two groups was significant ($t = 4.897$, $df = 798$, $p < .001$, two-tailed). The null hypothesis is therefore rejected. The effect size of 0.34 (Cohen's d) was small. Based on this result, it can be concluded that the grouping of early and middle adolescents against young adults (late adolescents) had a small effect on respondents' knowledge on dangers of FGC.

Discussion

The presented result of significant difference between the two groups i.e. adolescents (early and middle) and young adults (late adolescents) respectively, (35.74 and 35.40) on knowledge on dangers of FGC as well as the effect size (small) of the grouping is an indication that the early and middle adolescents group had better knowledge of dangers of FGC. This result is adduced to the fact that, side of information acquired through the intervention, adolescents especially those in school presently (i.e. basic and secondary levels), may have had other means of acquiring additional information. One of such other means may be through the Family Life and HIV/AIDS Education (FLHE) Programme (ISERT, 2014), which is operated as a formal instructional package or as an extra curricula activity programme within some schools. Although this programme was developed and introduced with the aim of facilitating adequate preparedness of sexual life, formation of positive attitudes as well as beliefs, values and life skills issues of FGC are also discussed in relation to topics on sex education, acceptable values and prevention of sexually transmitted infections (STI).

In spite of the fact that not many schools in Oyo State implement the programme as a formal instructional package or as an extra curricula activity, the curriculum for some subjects (Berg and Denison, 2013) such as Social Studies, Civics Education and Health Education have been found to incorporate some topics on traditional practices. Hence, FGC which is one of the focal harmful traditional practices is discussed extensively in these subjects, with some focus on the disadvantages of the practice. Also for out of school adolescents, it is assumed that they might have been exposed to some sexuality education programmes, including having access to

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health talks, awareness creation programmes within and outside some Primary Health Care (PHC) facilities and Maternal Healthcare Centres (MHCCs).

Research Question 5bi: What is the profile of adolescent and young adult respondents in intervention LGAs in relation to attitude towards the practice?

Table 4.11: Profile of Adolescent and Young Adult Respondents in Intervention LGAs in Relation to Attitude towards FGC

S/N	Adolescents				Young Adults					
	MUT	UT	T	VT	MUT	UT	T	VT	χ^2 Val.	Sig.
1. UAI	127	212	98	97	73	132	30	31	15.27	.002*
2. *UAI	47	85	161	241	15	19	77	155	19.08	.000*
3. UAI	108	167	134	125	61	78	92	35	15.82	.001*
4. UAI	149	181	70	134	96	95	29	46	9.55	.023*
5. UAI	109	221	77	126	35	86	56	88	19.91	.001*
6. UAI	53	92	196	193	30	64	82	89	8.69	.069
7. MAS	80	90	174	190	31	69	89	77	11.17	.011*
8. *MAS	42	125	148	219	13	54	99	100	8.77	.033*
9. IDV	99	190	73	169	80	111	36	38	33.15	.000*
10. IDV	158	178	91	107	108	106	30	22	27.74	.000*
11. IDV	168	147	108	111	80	79	59	46	5.85	.211
12. *PDI	49	76	66	342	12	19	42	191	17.24	.002*
13. PDI	117	145	95	175	47	55	63	99	9.19	.057
14. PDI	170	205	72	87	73	86	54	53	9.49	.023*
15. LTO vs STO	68	104	127	231	57	54	76	76	21.21	.000*

N.B. * p < .05; *negatively structured questions in line with the 6 HCDT dimensions
Keys: IDV: Individualism versus Collectivism; **UAI:** Uncertainty Avoidance Index**; PDI:** Power Distance Index; **MAS:** Masculinity versus Femininity; **LTO vs STO:** Long Term Orientation versus Short Term Orientation
VT/T: Very True/True; **UT/MUT:** Untrue/Most Untrue

Table 4.11 presents the response of early and middle adolescents (534) and young adult/late adolescent (266) respondents in intervention LGAs (800) to a 15-item rating scale designed to measure respondents' attitudes towards FGC. In contrast to the FGCKT that dealt with ability to answer items correctly, the attitude rating scale dealt with opinions of respondents towards the practice of FGC. Hence, based on the negative or positive structure of the items, 12 (80%) of the items were observed as having significant differences in responses by respondents (adolescents and young adults); while there was no significant differences in response for 3 (20%) items. Similar to the result trend observed in profile of respondents in relation to

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knowledge on dangers of FGC, significant differences between the adolescent group and young adults group was observed in the attitude profile.

This result trend can also be adduced to the population sizes of the groups with adolescents constituting 67% of the population, and the remaining population comprising young adults (33%). The data presented in Table 4.11 further shows that the responses obtained can be generalised to the population from which the sample for the study was pooled. Hence, these responses which can be relied upon and is an indication of respondents' negative attitude towards FGC.

Research Question 5bii: Is there any significant difference in adolescent and young adult respondents' attitude towards the practice of FGC in intervention LGAs?

Table 4.12: Independent t-test for Differences in Adolescents' and Young Adults' Attitudes towards FGC

Group	Number	Mean	SD	Df	t-value	Sig.	D
Adolescents	534	39.77	5.85				
				798	1.81	.070	0.13
Young adults	266	38.99	5.55				

Analysis of data presented in Table 4.12 revealed that adolescents (early and middle) adolescents had a higher mean score (mean = 39.77; SD = 5.85) than young adults (late adolescents) in intervention LGAs (mean = 38.99; SD = 5.55). The mean difference between the two groups was 0.78 and the 95% confidence interval for the mean difference between the two groups is between 1.63 and 0.065. An independent t-test showed that the difference between the two groups was not significant ($t = 1.81$, $df = 798$, $p < .001$, two-tailed). The null hypothesis is therefore not rejected. The effect size of 0.13 (Cohen's d) shows no effect. On the basis of this result, it can be concluded that the grouping of early and middle adolescents against young adults (late adolescents) had no effect on respondents' attitudes towards FGC.

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Discussion

The result of no significant difference in attitude towards FGC between early and middle adolescents as against and young adults (late adolescents) (36.80 and 36.35) as well as the independent t-test analysis showing that these grouping had no effect (Cohen'd = 0.13) on obtained result, can be associated with factors of experience of complications and consequences due to FGC, multifaceted means of acquiring formal and informal education on dangers of the practice and exposure to other health related programmes that have incorporated FGC issues. The reliving of personal experiences by young adults due to their developmental stage and internalization of acquired formal and informal information on dangers of the practice for them and adolescents could be facilitators for the result obtained. Also, exposure of both groups to other health related programmes that have incorporated FGC issues could be associated with the intervention programme not having any effect.

This result of low (negative) attitude towards FGC and no significant differences between adolescents and young adults is contrary to the reports of Adeniran (2011) and Oyetade (2012). According to Adeniran, positive attitude of respondents (15 to 90 years) was adduced to age at which FGC was carried out (infancy, 82.3%), and low knowledge on consequences and complications of the practice (18.9%), hence the inability to associate some of the complications experienced during child delivery and other FGC induced problems to the practice. Based on this result, respondents have the intention to continue cutting their daughters. Oyetade's report revealed that adolescents' positive attitude was slightly higher than those of adults, and their support for the practice is so that sexual immorality that has become rampant in the society may be reduced. Likewise, Oyetade's study found out that lack of knowledge on consequences and complications, inability to associate experiences and problems induced by FGC as well as justifications for the practice, are some of the reasons for high prevalence rates and positive attitudes towards the continuation of the practice.

Further analysis of respondents' attitudes towards the practice of FGC using Hofstede's Cultural Dimension Theory (HCDT) is presented in Table 4.13.

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Table 4.13: Attitude Profile of Adolescent and Young Adult Respondents According To HCDT Dimensions in Intervention LGAs

S/N HCDT Dimensions	ATTITUDES							
	Adolescents		Young Adults		Total		Total	
	MUT/UT	T/VT	MUT/UT	T/VT	MUT/UT	%	T/VT	%
1. UAI	339	195	205	61	544	**68**	256	**32**
2. *UAI	132	402	34	232	166	**20.75**	634	**79.25**
3. UAI	275	259	139	127	413	**51.6**	386	**48.25**
4. UAI	330	204	191	75	519	**64.87**	279	**34.87**
5. UAI	330	203	121	144	510	**63.75**	324	**40.5**
6. UAI	145	389	94	171	239	**29.87**	560	**70**
7. MAS	170	364	100	166	263	**32.87**	530	**66.25**
8. *MAS	167	367	67	199	234	**29.25**	566	**70.75**
9. IDV	289	242	191	74	480	**60**	316	**39.5**
10. IDV	336	198	214	52	550	**68.75**	250	**31.25**
11. IDV	315	219	159	105	474	**58.25**	324	**40.5**
12. *PDI	125	408	31	233	156	**19.5**	641	**80.12**
13. PDI	262	270	102	162	364	**45.5**	432	**54**
14. PDI	375	159	159	107	534	**66.75**	266	**33.25**
15. LTO vs STO	172	359	111	152	283	**35.37**	511	**63.87**

***Negatively structured questions resulting in positive responses are interpreted as <u>NEGATIVE ATTITUDE</u> towards the practice of FGC.**

Keys: IDV: Individualism versus Collectivism; **UAI:** Uncertainty Avoidance Index**; PDI:** Power Distance Index; **MAS:** Masculinity versus Femininity; **LTO vs STO:** Long Term Orientation versus Short Term Orientation

VT/T: Very True/True; **UT/MUT:** Untrue/Most Untrue

Table 4.13 presents analysis of responses according to the Hofstede's theory of five dimensions which are: Uncertainty Avoidance (UAI); Power Distance (PDI); Masculinity vs. Femininity (MAS); Individualism vs. Collectivism (IDV); and Long Term Orientation vs. Short Term Orientation (LTO vs STO). It would be observed that positively structured statements resulted in high scores of negative attitudes, while negatively structured statements resulted in high scores of positive attitudes. The expressed attitudes based on the structuring of items were therefore considered a decisive factor in determining the attitudes of respondents in relation to the dimensions measured.

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Discussion

The Uncertainty Avoidance Index (UAI) dimension focuses on the adaptive level of members of a society, due to unplanned or unprecedented situations that may occur. All the UAI items (items 1 to 6) showed high scores of negative attitudes. Although FGC is a traditionally based practice, it can be deduced that the responses depict a culture with low UAI because, based on respondents acquired knowledge of dangers associated with the practice, as well as psychological and physical experience they might have had, the respondents were willing to change their behaviour towards continuation of FGC which would facilitate all-round well-being for females.

For Power Distance Index (PDI) which measures the degree of equality or inequality between people within a given society based on social hierarchy, the results from items 12, 13 and 14 showed that responses depicted a high PDI. This means that in relation to FGC, powerful members of the society which may include custodians of tradition, fathers/parents, decision makers in the extended family etc. operate as dictators and dominate all aspects of societal processes. Hence, according to custodians of culture, females' consent is not sort before they are cut because FGC is considered a traditional practice that must be observed; and because of material and or status benefits which may be attached to the practice, a father or either parents, or prospective husbands, consent to their daughter or wife to be being cut. Based on this analogy therefore, PDI can be characterised by gender, social status, and peer status amongst others.

Analysing responses on attitudes using the MAS i.e. Masculinity vs Femininity, it was observed from responses that in relation to FGC, both masculine and feminine cultural tendencies exist within the community. As a result, respondents who were of the opinion that FGC is encouraged by the men folk, were seen to have a high masculinity score therefore depicting that FGC is a masculine inclined culture which encourages a high level of gender inequality. On the contrary, a higher score rating was obtained for the practice being discouraged by men because of the psychological effect it has on females thus indicating a low masculine score but a higher feminity score and a lower level of gender inequality. This result is indicative of the fact that, though FGC is a traditional practice, with the assumed material benefits attached to it, and reasons been given for the continuation of the practice, males may have gradually started having a modification of behaviour on continuation of the practice. This may be due to information on the dangers associated with it, especially on aspects that deal with the

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psychological well-being of the female, which affects them too, as well as the issue of gender inequality that is linked with the practice.

Results of score ratings for the IDV and LTO vs STO dimensions revealed that, there was a high score of negative attitude towards taking decision for a female to be cut; and a high score of positive attitude for alternative activities for rites of passage for females into woman/adulthood. With a high number of individuals having high negative ratings for the IDV items, it is apparent that respondents have a high ability to operate in collective processes like decision making through collective actions. This therefore means that, with the exhibited tendency of collectivism, facilitating processes for action towards reduction and eventual eradication of FGC from practicing communities will not be too difficult for members of such communities. The positive high score rating for STO in relation to alternative processes or activities for rites of passage into woman/adulthood is also an indication that communities within the intervention LGAs uphold traditional values. At the same time through their rejection of the practice based on their evaluation of the existing process of FGC as a traditional practice, it is evident that time horizon and acquired knowledge on dangers of FGC have been utilised, considering their high positive response to alternative activities for rites of passage for females.

In relation to the fifty two (52) focus group discussants and their attitudes towards the practice of FGC; they had similar negative attitudes towards the practice as was observed of the quantitative respondents. This is evident in their responses of their unwillingness to have their female children being cut; or being party to significant females experiencing FGC. A total of 32 (thirty two) discussants who either had no female children (8) or had but did not have them cut (22), vowed not to engage in the practice or allow in-laws, especially mother-in-laws to influence their decisions. For the 20 (twenty) discussants who had their female children cut at infancy (18), and at toddler stage (2) with or against their wishes, it was a decision making time to discontinue the practice of cutting their female children and stand their grounds for their wishes and decisions to be respected.

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4.6. **Research Question 6a:** What is the composite effect of intervention activities (training, step down training, provision of IEC materials and training manuals, enlightenment talks, advocacy visits, media publications and establishment of MHCCs), psychological experience, age, educational level, schooling status, parents educational status, FGC status, marital status, work status, location of residence on knowledge of dangers of FGC?

Table 4.14: Correlation Matrix, Mean and Standard Deviation for Knowledge and Predictor Variables

Variables	Knowl.	IA/P	PSE	AR	PEL/S	PES	FGCST	MS	WS	LOR
Knowl.	1.000									
IP	-.038	1.000								
PSE	.015	-.120	1.000							
AR	-.145	.346	.022	1.000						
PEL/S	-.282	.087	-.084	.305	1.000					
PES	.011	.013	.048	.026	-.099	1.000				
FGCST	-.072	.011	.063	.134	.090	-.083	1.000			
MS	-.096	.176	-.017	.386	.209	-.046	.038	1.000		
WS	.264	.028	-.055	-.322	-.524	.122	-.208	-.207	1.000	
LOR	.108	.230	-.164	-.033	-.448	.138	-.141	-.130	.335	1.000
Mean	35.63	50.98	28.3	1.89	3.18	2.95	1.64	1.14	2.47	1.36
SD	.94	16.03	5.68	.875	1.67	1.34	.674	.443	.790	.481

Predictors: Intervention programme (IP); Psychological experience (PSE); Age range (AR); Present educational level/status (PEL/S); Parents' educational status (PES); FGC status (FGCST); Marital status (MS); Work status (WS); and Location of residence (LOR)

Table 4.14 presents the inter-correlation matrix for knowledge and the predictor variables (Intervention activities/programmes, Psychological experience, Age range, Present educational level/status, Parents' educational status, FGC status, Marital status, Work status and Location of residence). The review of the correlation coefficients shows that no two predictors have Pearson correlation values that exceed 0.85. This shows that there is no multicolinearity in the inter-correlation matrix. Also, the table shows that there is a good correlation among the variables with a moderate correlation between work status and present educational level/status (.524); and low correlations between parents' educational status and knowledge (.011), and FGC status and intervention programme/activities (.011).

Table 4.14.1: Model Summary for Knowledge and Predictor Variables

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.320[a]	.102	.092	.90219

From Table 4.14.1, the multiple correlation R = .320 shows that the relationship between the nine predictors (Intervention activities/programmes, Psychological experience, Age range, Present educational level/status, Parents' educational status, FGC status, Marital status, Work status and Location of residence) and the criterion (Knowledge) is moderate and positive. The adjusted R Square R^2 adj = 0.092 shows that this model accounts for 9.2% of variance in respondents' knowledge on dangers of FGC.

Table 4.14.2: ANOVA for Knowledge and Predictor Variables

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	73.199	9	8.133	9.992	.000[a]
Residual	643.020	790	.814		
Total	716.219	799			

Table 4.14.2 shows that the overall model of nine IVs significantly predicts respondents knowledge on dangers of FGC $F(9,790) = 10.00$, $p < .05$.

Discussion

The moderate correlation between work status and present educational level/status as revealed from the correlation matrix is an indication that the joint contribution of these socioeconomic variables can predict knowledge in relation to FGC. Hence, the two variables can influence knowledge on dangers of FGC either positively or negatively. For educational variables such as educational level/status, findings from studies such as Mounir (2003), Tag-El-Din et. al. (2008), Karhu-Rose (2010) and Akinsanya (2011) amongst others have confirmed that the higher the educational status or attainment, the higher the knowledge on dangers of FGC. Educational level/status can therefore be assumed to be a facilitating factor in the acquisition of knowledge on dangers of FGC.

To further reiterate the influence of educational level/status on knowledge of dangers of FGC, Tamire and Molla (2013), reported significant relationships between parents' educational status and intention to have their daughters cut; and location of residence of girls and support for

the continuation of FGC. Results revealed a negative outcome for both relationships, thus indicating a negative attitude. The expressed attitude according to Tamire and Molla is not unconnected with higher levels of educational attainment of parents which has made them more knowledgeable about dangers of the practice; as well as urban migration of girls from rural locations. The migration of girls from rural locations exposes them to better opportunities to learn or acquire information on the dangers of FGC.

Though this study revealed low correlations between parents' educational status and knowledge (.011), there is still a significant relationship. This is in line with results obtained from a study by Tamire and Molla (2013). In their study, there was a significant relationship between parents' educational status and intervention programme. In the case of this study, intervention programme can be interchanged with knowledge considering that the main aim of FGC intervention programmes is to create awareness and impart knowledge.

Research Question 6b: What is the relative effect of intervention activities (training, step down training, provision of IEC materials and training manuals, enlightenment talks, advocacy visits, media publications and establishment of MHCCs), psychological experience, age, educational level, schooling status, parents educational status, FGC status, marital status, work status, location of residence on knowledge?

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Table 4.15: Regression Coefficients for Knowledge and Predictor Variables

DV	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	35.850	.333		107.600	.000
Activities (IP)	.000	.002	-.005	-.121	.904
Experiences (PSE)	.000	.006	.002	.055	.956
Age Range (AR)	-.022	.044	-.021	-.505	.614
Present educational level (PEL)	-.118	.025	-.208	-4.674	.000
Parents educational status (PES)	-.018	.024	-.025	-.739	.460
FGC status (FGCST)	-.036	.049	-.026	-.732	.464
Marital status (MS)	-.036	.079	-.017	-.458	.647
Work status (WS)	.187	.050	.156	3.714	.000
Location of residence (LOR)	-.077	.081	-.039	-.950	.342

Table 4.15 presents the Regression coefficients for knowledge on dangers of FGC. Review of the beta weights in table specify that only two variables namely: present educational level $\beta = -.208$, $t\ (790) = -4.674$, $p < .001$ and work status $\beta = .156$, $t\ (790) = -3.714$, $p < .001$ significantly and singularly contributed to the model. The other seven variables: intervention programme/activities $\beta = -.005$, $t\ (790) = -.121$, $p < .001$; psychological experience $\beta = .002$, $t\ (790) = .055$, $p < .001$; age range $\beta = -.021$, $t\ (790) = -.505$, $p < .001$; parents' educational status $\beta = -.025$, $t\ (790) = -.739$, $p < .001$; FGC status $\beta = -.026$, $t\ (790) = -.732$, $p < .001$; marital status $\beta = -.017$, $t\ (790) = -.458$, $p < .001$, and location of residence $\beta = -.039$, $t\ (790) = -.950$, $p < .001$, did not significantly contribute to the model.

Discussion

The result of present educational level/status and work status having relative contributions to the model is indicative that these variables singularly also influence knowledge in relation to FGC. Hence, these variables can also be juxtaposed with parents' educational level/status and work status. Using the juxtaposition of parents' educational level/status and work status therefore, this result corroborates the findings of Nnorom (2007) and Abiodun et. al. (2011). Their results revealed that parents' educational level/status (low or otherwise) is a significant factor that influences the continuation or discontinuation of the practice of FGC. The

contributory status of this factor is therefore an indication that the ability of parents to comprehend, analyse and internalise disseminated information and education in relation to dangers of the practice is to a large extent dependent on their educational status.

Also, for work status which was found to contribute to the model, this result aligns with the result of Karmer et.al. (2011). The study reports socioeconomic factor (health/wealth index) and five other factors as having significant relationship on outcomes of mothers and daughters experiencing FGC. From the results of the present study and that of Karmer et. al., it can be assumed that, females who go out to work are more likely to be exposed to information and education opportunities on issue related to FGC and consequently acquire relevant knowledge on its dangers, while those who do not work, or work within their immediate environs (farmers, petty traders amongst others) are likely not to have similar or in-depth learning opportunities as the former.

4.7. Research Question 7a: What is the composite effect of intervention activities (training, step down training, provision of IEC materials and training manuals, enlightenment talks, advocacy visits, media publications and establishment of MHCCs), psychological experience, age, educational level, schooling status, parents educational status, FGC status, marital status, work status, location of residence on attitudes towards FGC?

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Table 4.16: Correlation Matrix, Mean and Standard Deviation for Attitude and Predictor Variables

Variables	Attitude	IA/P	PSE	AR	PEL/S	PES	FGCST	MS	WS	LOC
Attitude	1.000									
IA/P	.087	1.000								
PSE	-.151	-.120	1.000							
AR	-.081	.346	*.022	1.000						
PEL/S	.094	.087	-.084	.305	1.000					
PES	*-.029	*.013	*.048	*.026	-.099	1.000				
FGCST	.057	*.011	.063	.134	.090	-.083	1.000			
MS	*.001	.176	*-.017	.386	.209	*-.046	*.038	1.000		
WS	-.131	*.028	*-.055	-.322	-.524	.122	-.208	-.207	1.000	
LOR	.095	.230	-.164	*-.033	-.448	.138	-.141	-.130	.335	1.000
Mean	36.65	50.98	28.30	1.89	3.18	2.95	1.64	1.14	2.47	1.36
SD	5.58	16.03	5.68	.875	1.67	1.34	.674	.443	.790	.481

Predictors: Intervention programme (IP); Psychological experience (PSE); Age range (AR); Present educational level/status (PEL/S); Parents' educational status (PES); FGC status (FGCST); Marital status (MS); Work status (WS); and Location of residence (LOR)

Table 4.16 presents the inter-correlation matrix for attitude and the predictors (Intervention activities/programmes, Psychological experience, Age range, Present educational level/status, Parents' educational status, FGC status, Marital status, Work status and Location of residence). The review of the correlation coefficients shows that no two predictors have Pearson correlation values that exceed 0.85. This shows that there is no multicolinearity in the inter-correlation matrix. Also, the table shows that there is a good correlation among the variables with a moderate correlation between work status and present educational level/status (.524); and low correlation between marital status and attitude (.001)

Table 4.16.1: Model Summary for Attitude and Predictor Variables

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.316	.100	.089	5.33449

From Table 4.16.1, the multiple correlation R = .316 shows that the relationship between the nine predictors (Intervention activities/programmes, Psychological experience, Age range, Present educational level/status, Parents' educational status, FGC status, Marital status, Work status and Location of residence) and the criterion (Attitude) is moderate and positive. The

adjusted R Square R^2 adj = 0.089 shows that this model accounts for 8.9% of variance in respondents' attitudes towards FGC.

Table 4.16.2: ANOVA for Attitude and Predictor Variables

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	2486.207	9	276.245	9.708	.000[a]
Residual	22480.882	790	28.457		
Total	24967.089	799			

Table 4.16.2 shows that the overall model of nine IVs significantly predicts respondents attitudes towards FGC $F(9,790) = 10.00$, $p < .05$.

Discussion

Reporting significant relationships between variables of interest and attitude, Ahanonu and Victor (2013) in their study on mothers' perception of female genital mutilation, found a significant relationship between educational background of mothers and the assumption that uncircumcised girls will be promiscuous; hence their positive or undecided attitude towards the continuation of FGC. Although educational background for mothers was not captured separately, for this study it is assumed to be subsumed into parents' educational status which was found to have significant and positive relationships with five (5) other variables, namely: parents' educational status and attitude (.029); intervention programme (.013); psychological experience (.48); age range (.026); and marital status (.46). It can therefore be assumed that the joint contribution of all five (5) relationships had significant impact on adolescents' and young adults' attitudes towards the practice, based on acquired knowledge on dangers of FGC, thus resulting in negative attitudes.

The low correlation on the other hand between marital status and attitude even though as indicated from the table as having significant effect, may be due to extraneous factors. This result is in consonance with the report of Babalola et. al. (2006) on a comparative study between two states in South East Nigeria: Enugu (intervention) and Ebonyi (no intervention) States where marital status among other variables (gender and religious denomination) were found to have significant influence on programme outcomes such as attitudinal change towards continuation of FGC. Also, the result of this variable (marital status) is in line with the report of Ibekwe et. al. (2012) that suggests that marital status as a joint contributor with awareness of problems associated

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with FGC and psychological experience may have been influential in respondents' disapproval (negative attitude) of FGC as a practice.

Research Question 7b: What is the relative effect of intervention activities (training, step down training, provision of IEC materials and training manuals, enlightenment talks, advocacy visits, media publications and establishment of MHCCs), psychological experience, age, educational level, schooling status, parents educational status, FGC status, marital status, work status, location of residence on attitudes towards FGC?

Table 4.17: Regression Coefficients for Attitude and Predictor Variables

DV	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	T	Sig.
Constant)	38.914	1.970		19.753	.000
Activities (IP)	.036	.013	.102	2.692	.007
Experiences (PSE)	-.109	.035	-.111	-3.159	.002
Age Range (AR)	-1.417	.263	-.222	-5.387	.000
Present educational level (PEL)	.359	.149	.108	2.413	.016
Parents educational status (PES)	-.010	.143	-.002	-.068	.945
FGC status (FGCST)	.549	.290	.066	1.895	.058
Marital status (MS)	.301	.469	.024	.641	.522
Work status (WS)	-1.372	.298	-.194	-4.606	.000
Location of residence (LOR)	1.991	.480	.171	4.148	.000

Table 4.17 presents the Regression coefficients for attitudes towards FGC. Review of the beta weights in the table specify that six variables intervention activities/programme $\beta = .102$, $t(790) = 2.692$, $p < .001$; psychological experience $\beta = -.111$, $t(790) = -3.159$, $p < .001$; age range $\beta = -.222$, $t(790) = -5.387$, $p < .001$; present educational level $\beta = .108$, $t(790) = 2.413$, $p < .001$; work status $\beta = -.194$, $t(790) = --4.606$, $p < .001$; and location of residence $\beta = .171$, $t(790) = 4.148$, $p < .001$, significantly contributed to the model. The other three variables: parents' educational status $\beta = -.002$, $t(790) = -.068$, $p < .001$; FGC status $\beta = .066$, $t(790) = 1.895$, $p < .001$; and marital status $\beta = .024$, $t(790) = .641$, $p < .001$, did not significantly contribute to the model.

Discussion

The result of intervention activities/programme, psychological experience, age range, present educational level, work status and location of residence contributing singularly to the attitude model is an indication that these factors have a direct connection with the affective domain which determines behavioural tendencies and behaviours that are eventually manifested. This result corroborates findings of studies by Abiodun et. al. (2006) on intervention programme as a significant factor in the disapproval and discontinuation of FGC; Kizilhan (2011) on psychological impacts of FGC; Owolabi et. al. (2012) and Kandala et. al. (2009) on age and location that state that these variables have significant influence on the continued practice of FGC as well as increased rate of the practice. For parents' educational status, FGC status and marital status which did not significantly contribute to the model, it can be assumed that due to their position as background characteristics (distal variables), they cannot be manipulated and as a result, may not have any significant influence on the affective domain.

4.8. Research Question 8: What is the effect of psychosocial support services (opportunities and access to expert counselling) provided by programme trainees (HCPs), on Females with FGC?

Data collected were analysed using SPSS 17; Mean score for update training rating was 50.0 (SD = 46.45) while the mean score for Females with FGC' rating for opportunities and access to expert counselling was 68.0 (SD = 5.33).

Table 4.18: Model Summary for Psychosocial Services and Females with FGC

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.561	.315	.301	4.46070

Table 4.18.1: ANOVA for Psychosocial Services and Females with FGC

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	457.108	1	457.108		
Residual	994.892	50	19.898	22.973	.000[a]
Total	1452.000	51			

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Tables 4.18 and 4.18.1 present Model Summary and Regression ANOVA. Analysis of results indicate that the model (update training for programme trainees/HCPs) significantly predicts FGC victim's opportunities and access to expert counselling, R = .561; R^2 adj = .301, F (1, 50) = 22.97, p < .05. The model accounts for 30.1% of variance in females with FGC rating of opportunities and access to expert counselling.

Table 4.18.2: Regression Coefficients for Psychosocial Services and Females with FGC

Model	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	71.285	.923		77.206	.000
training	-.064	.013	-.561	-4.793	.000

Table 4.18.2 presents the Regression coefficients. From the table, β = -.561, t (50) = -4.793, p < 0.05. This result reveals that, update training of programme trainees/HCPs is a strong predictor of females with FGC' opportunities and access to expert counselling. The observed significance level which is less than 0.05 supports the hypothesis that update training of programme trainees/HCPs and females with FGC' opportunities and access to expert counselling are linearly related.

Discussion

This result is an indication that, though most HCPs are nurse/midwives and have acquired fundamental skills of nursing and midwifery via formal curriculum based trainings, other trainings in areas of reproductive health care, as well as update training which focused on psychosocial support (AWDF-JDPC intervention) were instrumental in providing effective services in aspects of counselling in relation to FGC and reproductive health issues, other health related conditions due to FGC as well as referrals. Therefore contrary to the report of Degni et. al. (2012), that identified communication, cultural issues and religious beliefs as barriers in providing effective healthcare for Somali women; and in line with the study report of Jacoby and Smith (2013) on the impact of trainings for HCPs with culture being an underlining factor, these were facilitators to achieving the obtained result because these aspects had been adequately attended to during the course of the update training executed for HCPs, as well as community based activities which involved community/traditional and religious leaders and community members.

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Also with training being included in the range of intervention activities, it can be assumed that due to the multifaceted nature of intervention programmes i.e. a combination of activities making a whole; intervention programmes can have a singular significant effect on attitude. Hence, activities in addition to trainings for HCPs comprising community based activities, media communication and provision of IEC materials are sure to facilitate females with FGC accessing psycho social support from the MHCCs. Outcomes of this activity is similar to that recorded in Kenya's Maasai region (PRB, 2013), with the Safe house and Community based rescue centres.

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4.9 Testing of Hypotheses

4.9.1 Hypothesis 1: There is no significant difference between female early, middle and late (young adults) adolescent beneficiaries in LGAs of intervention in relation to:

(i) Knowledge on dangers of FGC

(ii) Attitude towards FGC practice

Table 4.19: Descriptive

Knowledge	N	Mean	Std. Deviation	Std. Error
early adolescence	367	35.7384	.75184	.03925
middle adlescence	167	35.7605	.81558	.06311
late adolescence/young adults	266	35.4023	1.19426	.07322
Total	800	35.6313	.94678	.03347

Table 4.19 presents the descriptive statistics obtained from the ANOVA analysis for the three (3) adolescent stages. Tables 4.19.1 and 4.19.2 present the ANOVA summary and Scheffe Multiple comparisons in relation to knowledge on dangers of FGC among the adolescent stages.

Table 4.19.1: ANOVA

Knowledge	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	20.953	2	10.476	12.009	.000
Within Groups	695.266	797	.872		
Total	716.219	799			

Table 4.19.2: Multiple Comparisons

Knowledge

(I) Devstage	(J) Devstage	Mean Difference (I-J)	Std. Error	Sig.
early adolescence	middle adlescence	-.02206	.08718	.968
	late adolescence/young adults	.33616*	.07521	.000
middle adlescence	early adolescence	.02206	.08718	.968
	late adolescence/young adults	.35822*	.09221	.001
late adolescence/young adults	early adolescence	-.33616*	.07521	.000
	middle adlescence	-.35822*	.09221	.001

A one-way analysis of variance was conducted to determine the effect of the intervention programme on early, middle and late (young adults) adolescents' knowledge on dangers of FGC. Results of Table 4.19 reveals that the middle adolescents group had a high mean score (Mean = 35.76; SD = .815) while the late adolescents (young adults) group had the least mean score (Mean = 35.40; SD = 1.19). Table 4.19.1 shows that the observed mean differences among the three groups is statistically significant, $F(2,797) = 12.00$, $p < 0.05$. Table 4.19.2 which is the result of the scheffe' post hoc test shows that middle and early adolescent groups were statistically different from the late adolescent (young adults) group. Though the independent t-test conducted between adolescents and young adults showed that the grouping had a small effect on respondents' knowledge of dangers of FGC, the ANOVA result shows that there were significant differences in knowledge among the three groups (i.e. early, middle and late adolescents) in the intervention group.

Discussion

Based on the result from the ANOVA table (4.19.1.), there were significant differences among the three (3) stages of adolescence. This result is in line with the result obtained from the Chi-square analysis in Table 4.10., where adolescents (early and middle combined) obtained a higher number of obtainable marks (18) in comparison to young adults (late adolescents). The result of the ANOVA and multiple comparison tables show that though when combined, early and middle adolescents had a higher means score, singularly (Table 4.19.1) young adults obtained a higher number of obtainable marks in comparison to the other adolescent groups singularly. This is an indication that, young adults may have used implicit (personal) and explicit (acquired) knowledge. Hence, they were able to use reflective, analytic and evaluative skills (U.S. Department of Health and Human Services, 2013) commensurate to their age group in responding to the FGC knowledge test.

Table 4.19.3: Descriptive

Attitude	N	Mean	Std. Deviation	Std. Error
early adolescence	367	40.2262	5.90874	.30843
middle adlescence	167	38.7964	5.61575	.43456
late adolescence/young adults	266	38.9962	5.55895	.34084
Total	800	39.5188	5.76400	.20379

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Table 4.19.3 presents the descriptive statistics obtained from the ANOVA analysis for the three (3) adolescent stages. Tables 4.19.4 and 4.19.5 present the ANOVA summary and Scheffe Multiple comparisons in relation to attitude towards FGC among the adolescent stages.

Table 4.19.4: ANOVA

Attitude	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	343.416	2	171.708	5.223	.006
Within Groups	26202.303	797	32.876		
Total	26545.719	799			

Table 4.19.5: Multiple Comparisons

Attitude

(I) Devstage	(J) Devstage	Mean Difference (I-J)	Std. Error	Sig.
early adolescence	middle adlescence	1.42975*	.53520	.029
	late adolescence/young adults	1.22992*	.46171	.029
middle adlescence	early adolescence	-1.42975*	.53520	.029
	late adolescence/young adults	-.19983	.56609	.940
late adolescence/young adults	early adolescence	-1.22992*	.46171	.029
	middle adlescence	.19983	.56609	.940

Using a one-way analysis of variance, early, middle and late (young adults) adolescents' attitudes towards FGC was determined based on the intervention programme. Results of Table 4.19.3 reveal that the early adolescents group had a high mean score (Mean = 40.22; SD = 5.90) while the middle adolescents group had the least mean score (Mean = 38.79; SD = 5.61). Table 4.19.4 shows that the observed mean differences among the three groups is statistically significant, $F(2,797) = 5.22$, $p < 0.05$. Table 4.19.5 which is the result of the scheffe' post hoc test shows that attitude towards FGC of early adolescents group was significantly different from that of the middle and late adolescents groups.

Discussion

In contrast to results of no significant differences obtained from the independent t-test conducted between adolescents (i.e. early and middle) and young adults (late adolescents) (Table 4.12), results obtained from the ANOVA and multiple comparison (Tables 4.19.4 and 4.19.5) revealed that there were significant difference in attitudes between one of the adolescent groups (early adolescence) as against the other two (2) adolescent groups (middle and late adolescence). This result can be adduced to the differences in the number of obtainable marks based on the negative or positive structure of attitude items in the rating scale. Therefore, with this result as well as the effect size value of 0.13 (Table 4.12) which shows that the three (3) groupings of adolescence did not influence respondents attitudes towards FGC, it is an indication that more of individual opinion as well as knowledge acquired from the intervention programme and other means, were used to arrive at exhibited attitude. The result of early adolescent group having a higher mean among the three (3) adolescent groups can be associated with the evaluative and expressive functions of attitude (Maio and Haddock, 2010). According to Maio and Haddock, these functions of attitude can guide an individual's negative or positive disposition. Based on this assertion, it can be assumed that early adolescents for evaluative function of attitude organised and summarised acquired information on dangers of FGC (formal and informal education) into positive and negative perspectives thereby appraising the object (practice of FGC) using their acquired knowledge and determining the beneficial and non-beneficial attributes of the practice (social adjustment/utilitarian function). Hence, the group's negative disposition in comparison to its other counterparts is a function of individual self-concepts and central values which result as an expressive function of attitude (Maio and Haddock, 2010).

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4.9.2 Hypothesis 2: There is no significant difference between female in school beneficiaries and out of school beneficiaries in LGAs of intervention in relation to:

(i) Knowledge on dangers of FGC

(ii) Attitude towards FGC practice

Table 4.19.6 Independent t-test for Differences in Knowledge of Dangers of FGC for In-School and Out-of-School Respondents in LGAs of Intervention

Group	Number	Mean	SD	Df	t-value	Sig.	d
In-School	467	35.82	.67				
				798	7.121	.000	0.5
Out-Of-School	333	35.35	1.17				

In-school respondents in intervention LGAs had a higher mean score (mean = 35.82; SD = .67) over their out-of-school counterparts (mean = 35.35; SD = 1.17). The mean difference between the two groups was 0.47 and the 95% confidence interval for the mean difference between the two groups is between 0.59 and 0.32. An independent t-test showed that the difference between the two groups was significant ($t = 7.121$, $df = 798$, $p < .001$, two-tailed). The null hypothesis is therefore rejected. The effect size of 0.5(Cohen's d) was moderate. Based on this result, it can be concluded that schooling status had a moderate effect on in-school beneficiaries' knowledge on dangers of FGC.

Discussion

Considering the mean scores of both groups, it is an indication that in comparison with out-of-school respondents, in-school respondents who obtained a higher score out of the total obtainable score (36) on the FGCKT, had better knowledge on dangers of FGC than their out-of-school counterparts. In line with reports by Ibekwe et. al. (2012) on formal education especially tertiary level (62%) facilitating knowledge of dangers of FGC, Tamire and Molla (2013) reporting 90.6% of high school girls having knowledge of FGC based on their cut statuses, and learning about the problems caused by the practice as well as results from this study revealing in-school respondents as having better knowledge of dangers of the practice, it can be assumed that schooling status is an important factor in the prevention and continuation of FGC.

As has been earlier mentioned, school subjects and post-secondary/tertiary institutions courses that have aspects of culture and humanity, and deal with human physiology as well as

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the incorporation of aspects of FGC for discussion, also facilitate knowledge of dangers of the practice. Although FGC specific intervention programmes are limited (Berg and Denison, 2013), and are not school based most times, however several health related interventions and life building programmes which are community based and cover both in-school and out-of-school beneficiaries (FLHE programme (ISERT, 2014); WHARC programme (Marcus and Page, 2014) etc) have been known to incorporate FGC issues and to execute activities that facilitate acquisition of knowledge on general health or other specific health issues, life building skills etc. But often times, these programmes do not provide adequate and in-depth group specific information and education in relation to FGC, necessary for adequate knowledge which will drive the needed zeal to facilitate attitude formation to prevent as well as discontinue the practice.

Based on this premise therefore, it is not surprising that in Adeniran's (2011) study (which did not investigate influence of schooling status), 90.1% of respondents were knowledge about FGC in terms of procedures, while low knowledge (18.9%) was recorded in relation to consequence and complications caused by the practice. Also, in relation to the zeal for attitude formation to prevent and discontinue the practice, it was observed that due to the period of cut, 82.3% of the respondents cut in infancy (66.1%) were favourably disposed to having their daughters cut too. This therefore shows lack of or inadequate information and education in relation to dangers of the practice. Also in relation to the first level (social) of the sociocultural theory (SCT) which deals with interpsychological processes which facilitates interrelationships, it can be assumed that with implicit knowledge of FGC (i.e. norms, values and beliefs in relation to FGC) and acquired knowledge (explicit knowledge) through formal education, in-school respondents are better skilled to apply and analyse what they have learnt as dangers of FGC to what they grew up knowing about the practice. This is made possible via the teaching – learning process of subjects and courses that are cultural, humanity and health based.

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Table 4.19.7: Independent t-test for Differences in Attitudes towards FGC for In-School and Out-of-School Respondents in LGAs of Intervention

Group	Number	Mean	SD	Df	t-value	Sig.	d
In-School	467	36.17	5.47				
				798	2.891	.004	0.2
Out-Of-School	333	37.32	5.68				

Out-of-school respondents' had a higher mean score for attitudes towards FGC in intervention LGAs (mean = 37.32; SD = 5.68) over their in-school counterparts (mean = 36.17; SD = 5.47). The mean difference between the two groups was 1.15 and the 95% confidence interval for the mean difference between the two groups is between 0.37 and 1.94. An independent t-test showed that the difference between the two groups was significant ($t = 2.891$, $df = 798$, $p < .001$, two-tailed). The null hypothesis is therefore rejected. The effect size of 0.2 (Cohen's d) was small. Based on this result, it can be concluded that schooling status had a small effect on out-of-school beneficiaries' attitudes towards FGC.

Discussion

This result is an indication that the out-of-school respondents had higher positive attitude towards negatively structured attitude statements and vice versa for positively structured attitude statements in comparison to in-school. This result can therefore be adduced to the effectiveness of the various information dissemination and educative media used by the programme trainees (HCPS). Based on this assumption, studies by Jacob and Smith (2013), Degni et. al. (2012), Lazar et. al. (2013) on the importance of HCPS being trained in various aspects of issues relating to FGC cannot be compromised. This is because where out of school respondents are unable to acquire knowledge through classroom teaching (formal education) community based activities which incorporate cultural dimensions such as those used on the intervention as well as mainstreaming FGC issues/ talks into routine clinics in PHCs (informal education)with well packaged content for different categories of out-of-school beneficiaries may have facilitated knowledge acquisition as well as achieved intended attitude formation of/and change towards the continuation of the practice.

Also, in relation to the sociocultural theory (SCT), this finding could be as a result of internalizing and concept formation of acquired knowledge which is an intrapsychological

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process. Hence, with group appropriate information and education on dangers of FGC by program trainees, it is assumed that based on the uniqueness of each individual, the cultural knowledge in relation to FGC was internalized for logical thinking and formation of concepts resulting in their negative higher attitude towards FGC. In addition, from the analyses of respondent's characteristics out of the 400 out-of-school respondents, over half of them (266) were late adolescents/young adults. Using this fact and figure, in line with the U.S. Department of Health and Human Services (2013), on stages of adolescence, the result of higher negative attitude of the group could be associated with commensurate cognitive development skills for this group (Table 2.5; page 49). Hence based on cultural knowledge of FGC (implicit knowledge) group appropriate information and education on dangers of FGC (explicit knowledge), this group which comprised more of late adults/young adults (266) may have utilized cognitive developmental skills commensurate to their age, thus resulting in the obtained result.

4.9.3 Hypothesis 3: There is no significant difference between female beneficiaries in intervention LGAs and non-beneficiaries in LGAs with no intervention in relation to:

(i) Knowledge on dangers of FGC

(ii) Attitude towards FGC practice

Table 4.19.8: Independent t-test for Differences in Knowledge of Dangers of FGC for Female Beneficiaries in Intervention LGAs and Non-Beneficiaries in LGAs with No Intervention

Group	Number	Mean	SD	Df	t-value	Sig.	d
Intervention LGAs	800	35.63	.94	1598	43.83	.000	2.2
No Intervention LGAs	800	24.10	7.37				

Beneficiaries in intervention LGAs had a higher mean score for knowledge on dangers of FGC (mean = 35.63; SD = .94) than non-beneficiaries in LGAs with no intervention (mean = 24.10; SD = 7.37). The mean difference between the two groups was 11.53 and the 95% confidence interval for the mean difference between the two groups is between 12.0 and 11.0. An independent t-test showed that the difference between the two groups was significant (t = 43.83,

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df = 1598, p < .001, two-tailed). The null hypothesis is therefore rejected. The effect size of 2.2 (Cohen's d) was large. Based on this result, it can be concluded that the intervention had a large effect on intervention LGAs' female beneficiaries' knowledge on dangers of FGC.

Table 4.19.9: Independent t-test for Differences in Attitudes towards FGC for Female Beneficiaries in Intervention LGAs and Non-Beneficiaries in LGAs with No Intervention

Group	Number	Mean	SD	Df	t-value	Sig.	d
Intervention LGAs	800	39.50	5.77	1598	9.67	.000	0.5
No Intervention LGAs	800	37.29	2.94				

Female beneficiaries had a higher mean score for attitudes towards FGC in intervention LGAs (mean = 39.52; SD = 5.77) over that of non-beneficiaries in LGAs with no intervention (mean = 37.29; SD = 2.94). The mean difference between the two groups was 2.21 and the 95% confidence interval for the mean difference between the two groups is between 2.66 and 1.76. An independent t-test showed that the difference between the two groups was not significant (t = 9.67, df = 1598, p < .001, two-tailed). The null hypothesis is therefore rejected. The effect size of 0.5 (Cohen's d) was moderate. Based on this result, it can be concluded that the intervention had a moderate effect on intervention LGAs female beneficiaries' attitudes towards FGC.

4.9.4 Hypothesis 4: There is no significant difference between female in-school beneficiaries in intervention LGAs and female in-school non-beneficiaries in LGAs with no intervention in relation to:

(i) Knowledge on dangers of FGC

(ii) Attitude towards FGC practice

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Table 4.19.10: Independent t-test for Differences in Knowledge on Dangers of FGC for Female In-School Respondents in LGAs of Intervention and Female In-School Respondents in LGAs with no Intervention

Group	Number	Mean	SD	Df	t-value	Sig.	d
In-School Respondents (Intervention LGAs)	467	35.82	.679				
				865	29.461	.000	1
In-School Respondents (LGAs with no Intervention)	400	26.55	6.765				

In-school female respondents in LGAs of intervention had a higher mean score for knowledge on dangers of FGC (mean = 35.82; SD = .679) than in-school female respondents in LGAs with no intervention (mean = 26.55; SD = 6.765). The mean difference between the two groups was 9.76 and the 95% confidence interval for the mean difference between the two groups is between 9.89 and 8.65. An independent t-test showed that the difference between the two groups was significant (t = 29.461, df = 865, p < .001, two-tailed). The null hypothesis is therefore rejected. The effect size of 1 (Cohen's d) was large. Based on this result therefore, in school status can be said to have a large effect on intervention LGAs female respondents' knowledge of dangers of FGC.

Table 4.19.11: Independent t-test for Differences of Attitudes towards FGC for Female In-School Respondents in LGAs of Intervention and Female In-School Respondents in LGAs with no Intervention

Group	Number	Mean	SD	Df	t-value	Sig.	d
In-School Respondents (Intervention LGAs)	467	39.00	5.657				
				865	5.157	.000	.35
In-School Respondents (LGAs with no Intervention)	400	37.40	2.728				

Attitudes of in school adolescents and young adults in LGAs of intervention towards FGC (mean = 39.00; SD = 5.657) was different from that of in school adolescents and young adults in LGAs with no intervention (mean = 37.40; SD = 2.728). The mean difference between the two groups was 1.597 and the 95% confidence interval for the mean difference between the two groups is between 2.20 and .989. An independent t-test showed that the difference between the two groups was significant (t = 5.157, df = 865, p < .001, two-tailed). The null hypothesis is therefore rejected. The effect size of 0.35 (Cohen's d) was moderate. On the basis of this result, it can be concluded that in school status had small effect on respondents' attitude towards FGC.

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4.9.5. Hypothesis 5: There is no significant difference between female out-of-school beneficiaries in LGAs of intervention and female out-of-school non-beneficiaries in LGAs with no intervention in relation to:

(i) Knowledge on dangers of FGC

(ii) Attitude towards FGC practice

Table 4.19.12 Independent t-test for Differences in Knowledge on Dangers of FGC for Female Out-School Respondents in LGAs of Intervention and LGAs with no Intervention

Group	Number	Mean	SD	Df	t-value	Sig.	d
Out-of-School Respondents (Intervention LGAs)	333	35.35	1.175				
				731	34.527	.000	2
Out-of-School Respondents (LGAs with no Intervention)	400	21.66	7.157				

Out-of-school respondents in LGAs of intervention had a higher mean score for knowledge on dangers of FGC (mean = 35.35; SD = 1.175) than out-of-school respondents in LGAs with no intervention (mean = 21.66; SD = 7.157). The mean difference between the two groups was 13.69 and the 95% confidence interval for the mean difference between the two groups is between 14.47 and 12.91. An independent t-test showed that the difference between the two groups was significant ($t = 34.527$, $df = 731$, $p < .001$, two-tailed). The null hypothesis is therefore rejected. The effect size of 2 (Cohen's d) was large. Based on this result, it can be concluded that out of school status of respondents had a large effect on respondents' knowledge.

Table 4.19.13: Independent t-test for Differences of Attitudes towards FGC for Female Out-of-School Respondents in LGAs of Intervention and LGAs with no Intervention

Group	Number	Mean	SD	Df	t-value	Sig.	d
Out-of-School Respondents (Intervention LGAs)	333	40.21	5.868				
				731	8.934	.000	.64
Out-of-School Respondents (LGAs with no Intervention)	400	37.17	3.140				

Out-of-school respondents attitudes towards FGC in LGAs of intervention (mean = 40.21; SD = 5.868) was different from that of out-of-school respondents in LGAs with no intervention (mean = 37.17; SD = 3.140). The mean difference between the two groups was

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3.038 and the 95% confidence interval for the mean difference between the two groups is between 3.70 and 2.37. An independent t-test showed that the difference between the two groups was significant (t = 8.934, df = 731, p < .001, two-tailed). The null hypothesis is therefore rejected. The effect size of 0.64 (Cohen's d) was moderate. On the basis of this result, it can be concluded that out of school status had a moderate effect on respondents' attitudes towards the practice of FGC.

Discussion

The results of significant differences in relation to knowledge of respondents between intervention LGAs and LGAs with no intervention (Tables 4.19.8, 4.19.10, and 4.19.12) is an indication that irrespective of the schooling status of female adolescent intervention beneficiaries had better knowledge of dangers of FGC. These results are in line with similar intervention studies such as Babalola et al (2006) that had a comparison of intervention effectiveness. The intervention programme which involved exposure to mass media i.e. FGC radio and television discussion programmes and newspaper articles, for the intervention state (Enugu), had knowledge about FGC as the indicator for measuring programme effectiveness. Results revealed that there was increase in knowledge of FGC in the intervention state (23.8%), between 2003 and 2004; while Ebonyi State (comparative group), recorded a decrease, stagnation or negligible increase in knowledge, due to lack of exposure to any sort of intervention programme. Hence, the significant difference in knowledge about FGC was due to the intervention status of both states.

Similar to reports of significant differences in attitudes towards the practice of FGC in the study of Babalola et al (2006), between Enugu (intervention state) and Ebonyi (State with no intervention), significant differences in attitudes were obtained between adolescents, young adults, in school and out of school respondents in intervention LGAs and LGAs with no intervention (Tables 4.19.9, 4.19.11, and 4.19.13). Again, as was reported for knowledge, significant difference in attitude in the study of Babalola et al was associated with exposure to intervention programme via the mass media. For this study, intervention programme involved advocacy visits to traditional/community, and market leaders, women groups and the associations of circumcisers and community/traditional birth attendants (C/TBAs). The programme also included update training for HCPs in PHCs, provision of IEC materials as well as media publications and articles.

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Aside from the main reason for the advocacy visit which was to intimate community/traditional leaders as well as religious leaders on the aim of the intervention programme, based on the reports of psychological experiences and high mortality rates associated with the practice, they were also educated on the dangers of FGC. This was done with the aim of their being part of the programme for eradicating the practice of FGC in their various communities, in spite of they being custodians of culture. Also, it was assumed that, in taking this approach, they as leaders in the community along with community members, will eventually have a sense of ownership towards the programme, thereby facilitating a change of attitude towards the continuation of the practice. Inclusion of HCPs in various PHCs was to provide update training on psychosocial support for females with FGC, considering that reports of pre-existing conditions of psychological problems and maternal mortality were high at this level of health care delivery. Also, the trained HCPs in the various PHCs disseminated information on the dangers of the practice as well as provided opportunities and expert counselling for victims of FGC. IEC materials were also provided with the aim of augmenting whatever information had been provided by HCPs via the various media used. Media publications as well as article on FGC through newspapers and the JDPC Quarterly newsletter were included so that community members could have documented facts and figures to make reference to.

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CHAPTER FIVE

SUMMARY AND CONCLUSION

This chapter highlights the summary of findings discussed in chapter four, the conclusion, implications, suggestions for further studies and recommendations.

5.1. Summary of Findings

The major findings of the study are summarised below:

1. The study revealed that 86% of the programme trainees were age 45 years and above; majority of the trainees are females (86%) while males constituted 14%. The programme trainees designations spanned over seven (7) positions with 76% of them being certified and government employed persons with positions of DDMS (3%), SNO (3%), PNO (10%), CNO (24%), CHO (10%), and CHEW (24%); while 24% are C/TBAs. They attested to the absence of any other intervention programme on FGC in LGAs of intervention where the AWDF-JDPC intervention was executed.
2. According to 62% of the programme trainees interviewed, the mainstreaming of opportunities and expert counselling into routine PHC delivery services for FGC victims brought about the high rate of reports on psychological experience; as well as fear of sexual intercourse being identified as the most reported psychological experience among females with FGC age 20 to 39 years.
3. Most of the programme trainees (59%) reported using single approach or a combination of approaches (phone calls, physical visits and/or review of FGC victims' last visit) to carry out follow up visits; while 41% did not provide such service due mainly to inadequate staff in PHCs/MHCCs; and that 53% admitted that monitoring activities of focus PHCs/MHCCs were carried out to a greater extent by the implementing organisation - Justice, Development and Peace Commission (JDPC), Ibadan.
4. Complications during child delivery especially prolonged labour have been identified as a major factor which facilitates maternal mortality rates. According to all the programme trainees, facilitating causes of this complication such as severity of FGC type in relation to FGC victims is not captured or disaggregated during capturing of data on maternal mortality.

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5. 97% of the programme trainees used ante/postnatal clinic sessions, health talks and one-on-one approach as major means of disseminating information on the dangers of FGC as well as available management opportunities for FGC victims. Five (5) out of the seven (7) approaches (one-on-one, step down, health talks, immunization clinics and market/open spaces) were found to have dual ratings of high and moderate effectiveness; while two (2) of the approaches (house to house/door to door and ante/postnatal clinic sessions) had singular ratings of high effect.
6. Fifty two (52) focus group discussants within the age ranges of 15 to 19 yrs (15%), 20 to 29 years (56%) and 30 to 40 years (28%) were pooled from five (5) focus PHCs/MHCCs in the two (2) LGAs of intervention of these 19% were currently in school at higher education level, 81% had their last levels of education as JSS, SSS, Grade II/NCE. Others had formal trainings and higher education; while their parents' educational status ranged from no education (19%) to Grade II/NCE (81%).
7. For status factors of marriage and work, majority of the discussants (92%) are married while 8% are unmarried; and a negligible number (4%) are not working while those who are working (96%) are engaged in professions such as trading, fashion designing, hairdressing, patent chemist, catering, as well as apprentices on similar professions.
8. In respect of religious affiliation, 58% were Christians and 42% were Muslims, majority were cut as infants (61%), as toddlers (12%) and as adolescents (27%), with FGC Type I (Olopon) being dominant among the discussants (22, 42%), while the other 13 (25%) and 4 (8%) had FGC Types II and III (i.e. Alabede and Apa ati enu) respectively. Thirteen (13, 25%) did not know the FGC type that was carried out on them.
9. In relation to number of female children and their cut status, 44 (85%) discussants have female children, of which 20 (45%) were cut at infancy, 18 (90%) and 2 (10%) as toddlers; while the remaining 24 (55%) did not have FGC carried out on their female children.
10. Female genital cutting (also referred to as A be di da obirin'; Ila fun obirin'; Di da abe omo 'birin'; A da 'be obirin'; and Ki ko ila fun omo 'birin), was identified by the fifty two (52) discussants as the most prominent traditional practice that affects females' psychological and physical well being as well as cause maternal mortality in practicing communities in LGAs of intervention in Oyo State; and they had contrary views on FGC

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(i) Reducing promiscuity in females; and (ii) Preventing death of a new born baby during the delivery process.

11. Psychological experience (also referred to as wahala okan; okan ri ru; ipo ri ru okan) of fear, pain, depression, recall of unpleasant memories and shame (embarrassment for cut status) were the frequently mentioned experiences associated with FGC by discussants. Victims of Types II or III (17, 33%) were found to be fearful of sexual intercourse because of anticipated and experienced pain during penile penetration as well as de-infibulations and episiotomy during the delivery process.
12. Discussions with interviewees revealed that though causes of prolonged labour are not disaggregated, blockage of the vagina which is a major cause of prolonged labour due to the healing of more extensive FGC cut types (FGC Types II and III), is a contributory factor in maternal mortality, especially among FGC victims.
13. As part of the outcomes of discussions with mothers who have experienced FGC, it was concluded that there is a close relationship between fear and pain, and recall of unpleasant memories of the FGC process and depression.
14. The age of respondents from intervention and no intervention LGAs ranged from 10 to 14 years (700; 44%), 15 to 19 years (367, 23%) and 20 to 24 years (533, 33%); with 934 (58%) currently in school and 666 (42%) having their last levels of education as secondary, primary, and no education.
15. For status factors of parents' education, FGC, marriage and work, 83% of respondents parents had either primary, secondary or higher education; 50% of parents are not cut, 41% are cut while 9% do not know their FGC status. Majority of the respondents are single (89%), 9% are married and a negligible number are either separated or divorced. Work status is inferred from respondents educational level: working, 42% and not working 58%; and the majority of the respondents 844 (53%) reside in Urban areas; while the remaining 756 (47%) resided in Rural areas.
16. Profile of respondents from intervention LGAs on knowledge revealed a significant difference on only nine (9) items with adolescents performing better than the young adults, with an independent t-test analyses corroborating the result; while profile of intervention LGAs respondents in relation to attitude showed significant differences for

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80% (12) of the items, but no significant difference between adolescents and young adults was observed using the independent t-test analysis.

17. Also, the result of Hofstede's Cultural Dimension Theory (HCDT) analysis for intervention LGA respondents showed that attitudes towards the practice of FGC are negative, with communities having low UAI; high PDI; high feminity score; high IDV and STO score.
18. The obtained equation resulting from a set of nine predictors (intervention activities/programmes, psychological experience, age range, present educational level/status, parents' educational status, fgc status, marital status, work status and location of residence) allowed reliable prediction of the criterion (knowledge on dangers of FGC); and present educational level and work status significantly contributed to the prediction model on knowledge.
19. The obtained equation resulting from a set of nine predictors (intervention activities/programmes, psychological experience, age range, present educational level/status, parents' educational status, fgc status, marital status, work status and location of residence) allowed reliable prediction of the criterion (attitude towards FGC); and intervention activities/programme, psychological experience, age range, present educational level, work status and location of residence significantly contributed to the prediction model for attitude.
20. Analysis of results indicate that update training for programme trainees/HCPs had a positive-significant relationship with opportunities and expert counselling accessed by FGC victims.
21. The result of the independent t-test analyses for early, middle and late (young adults) adolescents from intervention LGAs in relation to knowledge showed that there was a significant difference in their knowledge of dangers of FGC with middle adolescents performing better than the early and late (young adults); while for attitude towards the practice, early adolescents had a higher mean score than middle and late (young adults) adolescents.
22. Results of significant differences in knowledge of dangers of FGC and attitude toward the practice of FGC for intervention LGAs revealed that in-school respondents performed

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better on the FGCKT, while out-of-school respondents had higher negative attitudes towards FGC.

23. The independent t-test results on knowledge of dangers of FGC and attitudes towards FGC between all the female respondents, female in-school respondents and female out-of-school respondents in intervention LGAs and LGAs with no intervention revealed that, respondents in intervention LGAs had higher mean scores than their counterparts in LGAs with no intervention.

5.2. Conclusion

The aim of female genital cutting (FGC) intervention programmes at the grassroots, national, and international levels, as well as activities of governmental and non governmental agencies/organisations is to reduce the prevalence of or possibly eradicate the practice in practicing communities. This study therefore evaluated the African Women's Development Fund and Justice, Development and Peace Commission, Ibadan (AWDF-JDPC) intervention programme, executed in two (2) Local Government Areas (LGAs) in Oyo State.

Available data suggests that the intervention which utilised a multi-sectoral approach in the implementation of the intervention programme was effective in the imparting of knowledge on dangers of FGC, facilitating attitude change towards continuation of the practice and in provision of opportunities and expert counselling for FGC victims. The multi-sectoral approach involved the incorporation of different categories of community leaders, healthcare providers (HCPs) and community/traditional birth attendants (C/TBAs), as well as community members via programme activities such as advocacy visits with enlightenments talks for community leaders; and step down trainings and health talks within and outside healthcare facilities, availability of information, education and communication (IEC) materials and provision of psychosocial support targeted at community members.

Confirming the effectiveness of the intervention programme which was implemented between 2011 and 2012 is the outcome of significant differences in knowledge of dangers of the practice as well as attitude towards FGC between intervention LGAs and LGAs with no intervention. Intervention LGAs had better knowledge on the complications and consequences of the FGC, hence their negative attitude towards the continuation of the practice. Also, reports of significant decrease in pre-existing conditions of high prevalence rates and maternal mortality, and FGC victims accessing psychosocial support at focus MHCCs and other PHCs

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where trained HCPs operate is an indication of the intervention's impact in LGAs of intervention.

Based on outcomes of the AWDF-JDPC intervention programme, it is apparent that utilisation of the multi-sectoral approach yielded expected results despite the number of years after implementation of the intervention. It can therefore be concluded that, the aim of the intervention programme which is to drastically reduce (if not totally eradicate) the prevalence of FGC and maternal mortality in practicing communities has been achieved. This, achievement has been made possible because of the sense of ownership by key stakeholders such as traditional/community and religious leaders, HCPs and C/TBAs, and community members themselves in the practicing communities in the intervention LGAs.

5.3. Implications of the findings for the study

The findings of this study which sought to evaluate the AWDF-JDPC intervention programme in Oyo State has implications for the funding and implementing organisations, government and non-governmental agencies, stakeholders within the health care provider sector, as well as community leaders and members.

1. The significant difference in knowledge with adolescents having better knowledge on dangers of FGC than young adults in LGAs of intervention implies that apart from the AWDF-JDPC intervention programme, adolescents who are in school may have been exposed to other means of acquiring information such as school subjects which deal with culture, health and society (e.g. Civics Education, Social Studies, Health Education and aspects of Biology that deal with the reproductive organs and physiological make up of females). They as well as their out-of-school counterparts may also have been exposed to aspects of sexuality and life skills education/activities under the Family Life and HIV/AIDS Education (FLHE) programme, where FGC is a focal issue in relation to sexuality.
2. The acceptance of the null hypothesis of no significant difference in adolescents and young adults' attitude towards FGC, implies that although some respondents in both categories of developmental stages may or may not have been cut, the knowledge on dangers, complications, and consequences acquired through the intervention programme

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and other means of information, or through personal psychological experience, are influential factors that have facilitated outcomes of negative attitude by both groups.

3. In view of the outcomes of the intervention programme on reduced reports of pre-existing conditions of high prevalence of FGC, maternal mortality and psychological problems due to FGC, the implication of this is that HCPs will be expected to intensify disseminating information on dangers of FGC via the different means that have been initially used, and other additional means that may serve in achieving the objectives of the programme. This will help sustain and increase more attitude change towards continuation of the practice, and will facilitate further reduction of the mentioned pre-existing conditions.
4. The outcome of the linearity relationship between HCPs update training and FGC victims accessing opportunities and expert counselling as well as the dissemination of information on dangers of FGC in this study, is an indication that HCPs utilised skills acquired from the training exhaustively and at any given opportunity. Hence, trained HCPs should endeavour to have in house step down trainings for colleagues and community members as this will help in covering large areas of the LGAs.
5. Programme trainees/HCPs (100%) attesting to the fact that there has not been any prior intervention programme aimed at educating community members on dangers of FGC in LGAs of intervention implies that, researches or health surveys that have been carried out may have focused on knowledge of FGC in terms of females' cut or uncut status. As a result the need for traditional/community leaders, HCPs and community members to continue disseminating information on the dangers of FGC and the need for attitude change towards the practice cannot be over emphasised.
6. Furthermore, programme trainees identifying the healing of severe FGC types among FGC victims as a facilitating factor for prolonged labour, thus cumulating in maternal mortality, is an indication that for prevalence rates of maternal mortality to be controlled (especially among FGC victims), there is a need for the disaggregation of data encapsulating possible causes resulting in prolonged labour. In the case of victims of FGC which is the focus of this study, this will help facilitate HCPs knowledge on possible presentations of prolonged labour, due to FGC type presented. Hence,

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appropriate preparation and management procedures can be put in place in case of any eventualities.

7. The report by focus group discussants of follow up services by HCPs being low, but moderate for C/TBAs is an indication that the intervention programme in relation to psychosocial support for FGC victims was far from perfect, considering that follow up is an integral aspect of a counselling process.
8. The ascribed percentages of 10.2% (knowledge) and 8.9% (attitude) are indications of the total variance of respondents' knowledge on dangers of FGC and their attitudes towards the practice respectively; this is accounted for by the intervention programme, psychological experience, two (2) demographic factors and five (5) status factors. These results imply that, aside from the intervention programme, the psychological experience, two (2) demographic factors and five (5) status factors, the respondents may have been exposed to multi-sources of information on dangers of FGC, which must have further influenced their negative attitude to the practice.
9. The assessment of the accuracy of the models across different samples shows that the full models are capable of predicting respondents of a different sample of data from the same population. The implication of this is that the results of this study can be generalized to the population. This is an indication that inferences based on these results from the randomly selected samples from the selected communities can be made in relation to other respondents in LGAs of intervention.
10. The significant difference in knowledge on dangers of FGC and attitude towards the practice with intervention LGAs having better knowledge and higher negative attitudes than their no intervention counterparts, implies that the multi-sectoral approach used was very appropriate. Hence, key stakeholders identified (i.e. traditional/community leaders, HCPs and community members) and incorporated into the implementation of the programme, are change oriented factors that can facilitate sustenance of the present attitude for discontinuation of the practice through community based activities.

5.4. Limitations and suggestions for further studies

1. This study was limited to four communities each in LGAs of intervention i.e. Olorunda-Aba, Lalupon, Oyedeji and Igbo-Elerin for Lagelu LGA, and Oranyan, Oje, Labiran and Atipe for Ibadan North East LGA. Considering that several of the programme trainees have been

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transferred from LGAs and PHCs where they were serving during the intervention programme, it is suggested that a similar study as this be carried out using a combination of other communities within the LGAs of intervention to determine if skills acquired by programme trainees via the update training are being utilised in their present PHCs of assignment. Also, for LGAs where programme trainees have been transferred, the study can be replicated with the aim of accessing level of knowledge on dangers of FGC and attitude towards the practice. This will help determine if appropriate and adequate information is being disseminated.

2. For this study, the target population were females between the ages of 10 and 24 years. Though there have been several studies targeted at females from 15 years and above, these studies have focused on single or a combination of two (2) or three (3) factors with less interest on psychological consequences associated with the practice. It is therefore suggested that this study be replicated using the same factors among females of reproductive age i.e. 20 to 40 years, with psychological experience as a key factor to be investigated in relation to FGC.
3. In this study, the focus group discussion sessions comprised mainly females in the reproductive age, with a negligible number being in their late adolescence (15 to 19 years). Based on discussants inability to mention advantages associated with the practice and their assumption that older women (60 years and above) who are in support of the continuation of the practice will know of benefits associated with FGC, it is suggested that other qualitative studies using the exploratory approach be carried out. These studies should involve older women for the purpose of eliciting from them any authentic evidence of their assumed benefits or advantages associated with the practice.
4. Though like other studies this study targeted females, therefore there is a need to digress from the norm of engaging only females in FGC studies. Based on this premise therefore, it is suggested that this present study be replicated in the AWDF-JDPC intervention LGAs and communities, but having males as the target population. Considering that the intervention was community based, it will also be a welcome addition to research to investigate males' knowledge on dangers of FGC and their attitude towards the practice.
5. This study which adopted the survey research type method presented results on the effect of the intervention programme and psychological experience on knowledge of dangers of FGC and attitude towards the practice among females. Using results from this study and results from the suggested replication of the study involving males, a comparative study

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of both studies can be carried out. Such a study involving both female and males from the intervention LGAs will help determine if there will be any significant difference in knowledge on dangers of FGC and attitude towards the practice between males and females, and highlight possible factors which may contribute to the results of the study.

6. In this study, child delivery complication(s) in relation to FGC victims was not a focal issue. But most health based survey reports have it as a crucial part of their maternal mortality data. Based on this premise therefore, possible facilitating causes of such complications, especially prolonged labour should be disaggregated when data is being captured, with specific attention on FGC victims. This will help in establishing trends on causative factors of child delivery complications, which will serve as a basis for comparison.

5.5. Recommendations

The following recommendations are made based on the findings of the study:

1. In order to sustain acquired knowledge and further reduce prevalence rate of the practice in the practicing communities, it is advisable that media used in the dissemination of information on dangers of FGC as well as mainstreaming of opportunities and expert counselling into PHC services should be continued.
2. As follow up to sustaining acquired knowledge on dangers of FGC and ensuring attitudinal change, AWDF-JDPC programme trainees in intervention LGAs, should engage community members in their enlightenment activities within the communities using road shows, dance dramas, and other attention catching approaches. These will further facilitate community members interest in learning about dangers associated with the practice and change their attitudes towards continuation of FGC.
3. Also, with focus on the intervention LGAs, it is recommended that a forum of stakeholders comprising traditional/community and religious leaders, representatives of women groups, in and out of school adolescents and young adults, and representatives of HCPs should be formed with the aim of advocating for the abolishment of FGC. This should be carried out using a ‘bottom-up’ or ‘hierarchical advocacy approach’ starting from within practising communities (grassroots level) through to the state and finally national levels.

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4. Male health care providers (AWDF-JDPC programme trainees) can organise enlightenment activities on problems associated with FGC for males in FGC practicing communities in order to enlighten them on helpful practices towards females with FGC (i.e. their affected wives) especially on physical and psychosexual issues.
5. For PHCs in FGC practicing communities to solely cater to the needs of females with FGC, separate clinic days like the ante/postnatal and immunization clinics should be put in place for one-on-one expert counselling to facilitate adequate time for such person that may need more time to express and talk about problems they may be experiencing as a result of the cut status.
6. Sequel to the preceding recommendation, it is necessary that a PHC staff be assigned to keep records of females with FGC attending such clinics, and may need additional counselling sessions; hence scheduled follow-up sessions can be put place.
7. For attitudinal change towards the continuation of FGC to be achieved, there is a need for FGC as a topic to be included in humanities and health based subjects (e.g. Civics education, Social studies, Biology, Health sciences and Physical and health education) and teachers who are teaching these subjects to be encouraged to elaborate as much as possible on the issue of FGC when teaching so as to gradually start achieving the goal of eradicating the practice.
8. With the negligible margin in incidences of females with FGC between the intervention (Lagelu and Ibadan North East) and non-intervention (Atiba and Ibadan South West) LGAs, it is advisable that similar interventions such as that of the AWDF-JDPC should be implemented, or replicated in other LGAs so as to guard against increased prevalence rates and problems associated with the practice can be stalled in Oyo State.

5.6. Contribution to knowledge

1. The findings of the study has shown that well planned and implemented intervention FGC programmes with relevant stakeholders being co-opted are important factors needed to achieve expected outcomes.
2. This study has been able to show that factors which facilitate knowledge acquisition may not necessarily be the same with those that facilitate attitudinal change. Hence, factors which have been found to have positive and significant effect on outcomes on knowledge

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of dangers of FGC and attitudinal changes towards the practice may be due to other extraneous factors that were not part of this study.

3. The findings of the study which have shown that constructs of knowledge and attitude in relation to FGC may be linked to some factors as those used in this study is an indication that these factors can be capitalised on, to improve intervention activities within practicing communities.
4. With the very few FGC studies and health reports that focus on adolescents and young adults, the findings of this study will form a major addition to the literary works on the concept of FGC intervention programmes and other related variables, as well as provide empirical information to the programme funders and implementers and other stakeholders within and outside the LGAs of intervention on the extent to which programme objectives were achieved.

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APPENDICES

APPENDIX 1

FGC IN-DEPTH INTERVIEW (FGC-IDI) GUIDE

1. To your knowledge has there been any intervention programme on female genital cutting (FGC) among selected communities within this LGA?

Probe: if any intervention programmes have been executed...

   i. Which organisation(s) funded and implemented the intervention?
   ii. What was the aim of the intervention
   iii. Who were the direct and or indirect beneficiaries of the intervention

2. To your understanding, what was the aim of the AWDF-JDPC intervention programme on FGC
3. Can you please tell me of some of the activities executed as part of the intervention programme

Probes: Were there...

   i. Trainings?
   ii. Establishments of facilities?
   iii. Awareness creation activities?
   iv. Production of IEC materials?
   v. Media coverage?

3b. What was the aim of the trainings?
What was the content of the training?
What was spectacular about the training?

3c. What was the aim of the established facilities?
what is the facility called in relation to the intervention programme?
How many established facilities are there in this LGA?

4a. To your knowledge what enlightenment approaches were used by the intervention programme in creating awareness on the dangers of FGC?

   i. Media (IEC materials, newspaper features, radio jingles)?
   ii. Sensitization talks (one-on-one talks, step down trainings, health talks, and different clinics in health facilities)?
   iii. Rallies (market places, open spaces)?

4b. From your observation, which of the intervention strategies was most assessed?

4c. Which of these intervention strategies would you consider as being most effective in achieving the aim of the intervention programme?

4d. For you as a programme trainee, what opportunities did you use to create awareness on the dangers and outcomes of FGC?

5. What was the content of the sensitization talks that facilitated knowledge acquisition among community members?

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Probe: Were they informed on...

i. Different names by which FGC is known?
ii. Types of FGC with descriptions?
iii. Consequences and complications of FGC?
iv. Psychological experiences due to FGC?

6. What categories of females attended the MHCCs

Probes: What type of problems did they present?
What was the rate of these reports?

7. Were there reports of psychological experiences by females who attended the MHCCs?

Probe:

i. Were the psychological experiences positive or negative in nature?
ii. Can you please mention examples of positive or negative psychological experiences mentioned
iii. Which of the experiences were frequently mentioned?

8. Do you conduct follow-up services for FGC victims?

Probes: If Yes, how?

Phone calls; physical visits; review of patient's last visit to the MHCC; other ways (name other ways)

If No, Why?

Not knowledgeable in follow-up services; It is not necessary; inadequate staff at the MHCC; No Monitoring & Evaluation (M & E) officer; other reasons (name other reasons)

9. How will you rate evaluation activities carried out in relation to utilisation of established maternal health counselling centres (MHCCs) and its other activities?

High ( ) Moderate ( ) Low ( )

10. **(For programme trainees that are presently working in health centres different from that which they were working during the up-date training)**

Considering that you are working in a different health centre from that which you were working during the up-date training, have you been presented with situations that needed you to utilise information and skills gained during the training?

Probe: To what extent have you been able to utilise information and skills gained during the training?

Large extent ( ) Moderate Extent ( ) Low Extent ( )

Thank you for your time and co-operation

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APPENDIX 2

FGC FOCUS GROUP DISCUSSION (FGD) GUIDE

1. Can you please mention some of the harmful traditional practices that are carried out on women in this community?

Probe: Is it female genital cutting one of them?

2. Which of the harmful traditional practices is the most common and affects women during child birth?

Probe: Is female genital cutting one of them?

3. What are the reasons for carrying out the practice of FGC; and can you please mention some of the reasons for the practice?

Probe:

i. Does it have any benefits or detriments?

ii. Can you please mention some of the practices' benefits or detriments?

4. To your knowledge, what are the advantages and/or disadvantages associated with FGC; could you please mention some of these advantages and/or disadvantages?

Probe: (if psychological problems/experience is not mentioned)

Will you consider psychological problems/experience also as part of disadvantages associated with the practice of FGC?

5. From experience can you please mention some psychological experiences peculiar to FGC victims?

Probe: Is there a constant feeling of emotional pain, regret, unhappiness, sense of pride, sense of beauty, hatred towards significant persons, fear, sense of belonging etc.

6. From experience, do you feel having FGC a few days after the birth of a female child would reduce negative feelings?

Probe: If **Yes/No**, why?

7. With your personal psychological experience and present knowledge on dangers of the practice, will you carry out FGC on your female child?
8. How will you rate the follow-up activities by the health care providers based on your accessing of the MHCCs?

   High ( ) Moderate ( ) Low ( )
9. How do health care providers in the MHCCs carry out follow-up activities for FGC victims?

Probe: Phone calls ( ) Physical visits ( ) Review of FGC victim's last visit to the MHCC

Thank you for your time and co-operation

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APPENDIX 3

FEMALE GENITAL CUTTING QUESTIONNAIRE (FGCQ)

INTERNATIONAL CENTER FOR EDUCATIONAL EVALUATION
INSTITUTE OF EDUCATION
UNIVERSITY OF IBADAN

Dear respondent,

This questionnaire is a collection of instruments designed to assess your knowledge on dangers of Female Genital Cutting (FGC), your attitude towards the practice, your perception of psychological experiences caused by the practice as well as your perception of the effectiveness of the AWDF-JDPC intervention programme in this LGA/community. All information you give will be used **ONLY** for the purpose of this research and shall be treated with utmost confidentiality. Kindly be as honest as possible with your responses.

Thank you for your co-operation.

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SECTION A – BIO DATA

1. **Local Government Area (LGA):** _____
2. **Name of community:** _____
3. **Age range:** 10 – 14 ( ) 15 – 19 ( ) 20 – 24 ( )
4. **Present educational level:** JSS ( ) SSS ( ) Higher education ( ) No formal education ( )
5. **(For out of school adolescents) How long have you been out of school?**
   Less than or 3 years ( ) 4 – 6 years ( ) 7 years and above ( )
6. **(For out of school adolescents) Last level of education:**
   Primary ( ) JSS ( ) SSS ( ) Higher education ( ) No formal education ( )
7. **Parent(s) educational status:**
   - Primary education ( ) Secondary education ( )
   - Grade II Certificate ( ) Post-secondary education
   - No education ( ) (NCE/Higher education) ( )
8. **FGC status:** FGC – Yes ( ) FGC – No ( )
9. **Marital status:** Single ( ) Married ( ) Divorced ( ) Separated ( )
10. **Work status:** Are you working presently? **YES ( ) NO** ( )
11. **Location of residence:** Urban ( ) Rural ( )

PLEASE, DO NOT WRITE YOUR NAME

ÌBÉÈRÈ NÍPA DÍDÁ ABÉ FÚN OBÌNRIN

ẸKA TÍ WỌ́N TI ǸKỌ́ NÍPA ÌTÚPALẸ̀ ÈTÒ ẸKỌ́ LÁGBÀÁYÉ,

LÁBẸ́ ẸKA TÍ WỌ́N TI ǸKỌ́ NÍPA ÈTÒ ẸKÓ, NÍ ILÉ ẸKỌ́ FÁSÌTÌ ÌBÀDÀN

Onídàhún wa,

Ààtò àwon ìbéèrè wọnyí ló wà láti fi mọ ibi tí òyẹ yín gbé dúró nípa ewu tó wà nínú dí dábé fún ọmọ obìnrin, tó fi mọ́ ìhà tí ẹ kọ sí dídá abẹ́ fún obìnrin àti àwon àkóbá tí dídá abẹ́ lè se fún ìròrí àwọn obìnrin, tí ó fi mọ́ èrò yín nípa owó ìrànwọ́ tó wà fún ìdàgbàsókè àwon obìnrin nílẹ adúláwò (AWDF) àti ètò ìdásí àjọ tóún rísí ìdàgbàsókè ìdájọ́ òdodo àti ìfẹsẹ̀múlè àlááfíà (JDPC). Gbogbo ìròyìn tí ẹ bá fún wa ní a yóò lò fún isẹ́ ìwádìí nìkan. Ẹ jọ̀wọ́ ẹ bá wa fi òtítọ́ inú dáhùn gbogbo ìbéèrè yìí.

Ẹ seun fún àgbóyé yín.

ÌPÍN I (ÌRÒYÌN NÍPA ONÍDÁHÙN)

1. Ìjọba ìbílẹ̀ tí ẹ ti wá: .....
2. Agbègbè yín: .....
3. Ọjọ́ orí yín: 10-14 ( ) 15-19 ( ) 20-24 ( )
4. Ìpele ẹ̀kọ́: JSS ( ) SSS ( ) Ìpele Ẹ̀kọ́ gíga ( ) Ẹ kò ní ẹ̀kọ́ kan kan ( )
5. Fún èyin tí ẹ ti parí ẹ̀kọ́: Ó ti tó ìgbà wo tí ẹ ti kúrò nílé ẹ̀kọ́ ?
   Ọdún méta séyìn ( ) 4-6 ( ) ọdún méje sókè ( )
6. Fún èyin tí ẹ ti parí èkò: Ìpele ẹ̀kọ́ wo lẹ kà gbèyìn
   Ìpele aláìkọ́bẹ̀rẹ̀ ( ) Ìpele ẹ̀kọ́ JSS ( ) Ìpele ẹ̀kọ́ SSS ( ) Ìpele ẹ̀kọ́ gíga ( ) Ẹni tí kò ní ìmọ̀ ẹ̀kọ́ rárá ( )
7. Ẹ̀kọ́ àwon Obí Yín:
   Aláìkóbẹ̀rẹ̀ ( ) Ilé ẹ̀kọ́ Girama ( ) Ìpele ẹ̀kọ́ Ìkọ̀ni Grade II ( ) Ètò ẹ̀kọ́ ilé èkó Gíga ( )
   Aláìní ìmọ̀ èkó rárá ( )
8. Njé èyin dá abẹ́ gẹ́gẹ́ bíi obìnrin ? Bẹ́ẹ̀ni ( ) Bẹ́ẹ̀kọ( )
9. Irúfe èmìyàn tí ẹ jẹ́ : Omidan ( ) Abilékọ ( ) Ẹni tí ó ti kọkọ ( ) Dálémosú ( )
10. Njé ẹ ti ń sisé: Bẹ́ẹ̀ni ( ) Bẹ́ẹ̀kọ́ ( )
11. Ibùgbé yín: Ìlú Ńlá ( ) Igbéríko ( )

Ẹ JỌ̀WỌ́ Ẹ MÁ KỌ ORÚKO YÍN

Section B: Female Genital Cutting Knowledge Test (FGCKT)

This instrument is designed to assess your knowledge on dangers of Female Genital Cutting (FGC) practice. Please, read all statements carefully before responding to the items (questions) and tick (√) the most preferred response in the space provided using the following:

YES ( ) NO ( ) DO NOT KNOW ( )

S/N	QUESTIONS	YES	NO	Don't know
1.	FGC means Female genital cutting.			
2.	Female genital cutting is also referred to as female circumcision.			
3.	FGC is the partial or total removal of the female external genitalia or any other injury to the female genital organs for cultural or non medical reasons.			
4.	FGC I, II, III and IV are the 4 FGC Types that are practiced.			
5.	Cutting, excising, sewing and any other forms of alterations or additions in the female genital area are procedures of FGC Types I, II, III and IV			
6.	Problems caused by FGC are referred to as complications and consequences			
7.	Complications and consequences due to FGC can be immediate or later in nature.			
8.	FGC Types II and III which involve deep cutting and sewing procedures can lead to excessive blood loss, shock and death.			
9.	Pain is an immediate effect of FGC Types I, II, III and IV.			
10.	Less severe cutting of the female genitalia will result in less severe, immediate and long term complications and consequences.			
11.	Difficulty during child delivery due to blockage of the birth canal is an example of a physical problem caused by FGC.			
12.	Remembering of the FGC process causes psychological problems.			
13.	Pain, fear, mockery and ostracizing are examples of psychological experiences caused by FGC.			
14.	Psychosocial and psychosexual issues are aspects of psychological consequences of FGC.			
15.	Inability to sleep well, fear of pain during passing of urine, mockery and ostracizing are some examples of psychological experiences caused by FGC			
16.	Psychosocial support is the same as counselling			
17.	Psychosocial support helps victims and non-victims of FGC to cope with consequences of FGC			
18.	Psychosocial support for FGC victims and non-victims involves listening, understanding, feeling, discussing and empowering affected persons to cope with their FGC status and make positive choices			

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ÌPÍN II

ÌBÉÈRÈ ÌMỌ̀ YÍN NÍPA DÍ DÁ ABẸ́ FÚN ỌMỌBÌNRIN

Èyí wà láti bèèrè ìmọ̀ yín nípa ewu tó rọ̀ mọ́ dídá abẹ́ fún ọmọbìnrin. Ẹ jọ̀wọ́ ẹ ka àwon ìbéèrè yìí dáadáa kí ẹ tó dáhùn wọn, kí ẹ sì fà igi sí **BẸ́Ẹ̀NI, BẸ́Ẹ̀KỌ́** tàbí **MÍ Ò MỌ̀,** láti fí dáhùn ìbéèrè yìí.

S/N	ÌBÉÈRÈ	BẸ́Ẹ̀ NI	BẸ́Ẹ̀ KỌ	MÍ Ò MỌ̀
1.	Ìdábé fún Obìnrin, túmò sí Dídábé fún ọmọbìnrin			
2.	Gígé idọ abẹ́ obìnrin túmọ̀ sí dídá abẹ́ fún obìnrin			
3.	Dídá abẹ́ fún obìnrin níise pẹ̀lú ìbọ̀wọ̀ fún àṣà àwùjọ			
4.	Ìpele kíní, ìkejì, ìketa, àti ìkẹrin, jé irúfé èyà Ìdabé tí o'wà			
5.	Gígé tàbí rírán abala kan ni ojú ara obìnrin jé ara ìgbésè Ìdábé fún obìnrin			
6.	Wàhálà tí ìdábé fún obìnrin máa ń fà, ni wọn le sọ pé ó máa ń le púpò			
7.	Ìnira tí Abé dídá máa ń fà ló máa ń wáyé ní kété tí wọn parí abẹ́ dídá fún obìnrin			
8.	Ìpele kejì àti ìkẹta ìdábé fún obìnrin, tó níise pẹ̀lú gígé tàbí rírán abala kan lábé obìnrin, ní o le wú, àti ìpàdánù èjẹ̀ tí è yí sì le fa iku			
9.	Ìrora wà lára okùnfa àwọn ìpele abẹ́ dídá			
10.	Gígé ìwonba dìe lara ìdọ abẹ́ obìnrin yóò mú ìnira dìe lọ́wọ́			
11.	Ìnira lásìkò ìbímọ wà lára okùnfa abẹ́ dídá lásìkò fún obìnrin			
12.	Ìrántí abẹ́ dídá, ló le dá ìròrí obìnrin bẹ̀ẹ̀ rú			
13.	Ìnira, èrù bíbà, àti ìdójútì wà lára ewu tó rọ̀ mọ́ abẹ́ dídá fún obìnrin			
14.	Ìnira lásìkò ìbálópọ̀ akọ àti abo wà lára okùnfa abé dídá fún obìnrin			
15.	Ìnira lásìkò òórùn, tàbí lásìkò ìtọ̀ títọ̀, nàà wà lára okùnfa abẹ́ dídá fún obìnrin			
16.	Ìfọwọ́sowọ́pọ̀ láàrin àwùjọ nàà ni a lè pè ní Ìgbani lámọ̀ràn			
17.	Ìgbanilámọ̀ràn le se ìrànwọ́ fún ẹni tí wọn ti dá abẹ́ fún			
18.	Ìgbanilámọ̀ràn fún ẹni tí wọn ti dá abẹ́ fún tàbí ẹni tí wọn kò fi dá abẹ́ fún ló níise pẹ̀lú, gbígbó àgbọ̀yé ọ̀rọ̀ nípa ìdábé fún obìnrin. Ní ó le sèrànwọ́ púpò fún àwọn tí ọ̀rọ̀ nàà kàn ·			

Section C: Female Genital Cutting Attitude Rating Scale (FGCARS)

This instrument is designed to obtain information on your attitude towards the practice of female genital cutting. Please, read all statements carefully before responding to the items (questions) and tick (√) the most preferred response in the space provided using the following:

4 – Very true (VT), 3 – True (T), 2 – Untrue (UT) and 1 - Most untrue (MUT)

S/N	QUESTIONS	VT	T	UT	MUT
1.	Female genital cutting (FGC) is a good traditional practice because it improves the reproductive health of cut females. (UAI)				
2.	FGC is a bad cultural practice that should be stopped. (UAI)				
3.	FGC is an accepted practice that reduces promiscuity among females in the community. (UAI)				
4.	FGC is a good traditional rite that elevates the status of a female from that of being a girl to becoming a woman. (UAI)				
5.	FGC is a bad traditional practice that is considered as necessary in upholding our culture. (UAI)				
6.	FGC is a good traditional practice because material benefits are attached to it. (UAI)				
7.	FGC as a traditional practice is encouraged by men because of the material benefits attached to it. (MAS)				
8.	FGC is considered a bad traditional practice by men because it affects the psychological well being of females. (MAS)				
9.	Taking the decision for females to undergo FGC by significant relations is a good practice. (IDV)				
10.	FGC is a good traditional practice which should be compulsory for every eligible female. (IDV)				
11.	FGC is a good traditional practice because the decision to undergo FGC is usually taken by females in practicing communities. (IDV)				
12.	Forcing females to undergo FGC without informed consent is wrong. (PDI)				
13.	The practice of FGC is more common among persons of low social status, because it elevates their social status. (PDI)				
14.	FGC is a traditional practice that is carried out on unenlightened females in rural areas only. (PDI)				
15.	Using FGC as a rite of passage into woman/adulthood is a good practice. (LTO vs. STO)				

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ÌPÍN III

Àwọn ìbéèrè wònyí ló wà láti fi mọ ìhùwàsí yín tàbí ònà tí ẹ ń gbà faramọ́ dídá abẹ́ fún ọmọbìnrin. Ẹ jọ̀wọ́ ẹ ka gbogbo àwọn ìbéèrè wònyíi dáadáa kí ẹ tó fi ìdáhùn sii. Kí ẹ sì rí ìi dájú wípé ẹ fa ìlà sí abẹ́

ÒTÍTỌ́ TÓ FẸ̀SẸ̀ RINLẸ̀ ( ) ÒTÍTỌ́ ( ) IRỌ́ ( ) IRÓ PÁTÁPÁTÁ ( )

S/N	ÌBÉÈRÈ	ÒTÍTỌ̀ TỌ́ FẸSẸ̀ RINLẸ̀	ÒTÍTỌ́	IRỌ́	IRỌ́ PÁTÁPÁTÁ
1.	Ìdábẹ́ fún ọmọbìnrin jẹ́ àṣà tó dára láwùjọ látàrí wípé ó máa ń sèrànwọ́ fún ìsọ̀wọ́ bímo àwọn obìnrin				
2.	Ìdábẹ́ fún obìnrin jẹ́ àṣà tó burú jáì tí ó yẹ kí òpin débá				
3.	Ìdábẹ́ fún obìnrin jẹ́ oun tó dára nítorí pé ó mú àdínkù bá ìṣekúse láàrin àwọn obìnrin				
4.	Ìdábẹ́ fún obìnrin jẹ́ àṣà tí ó dára púpọ̀ nítorí pé ó ń sọ ọmọdébìnrin dí àgbàlagbà				
5.	Ìdábẹ́ fún ọmọbìnrin jẹ́ àṣà tó burú tí wọn sàmúlò láti fi se àgbéga àṣà wa				
6.	Ìdábẹ́ fún ọmọbìnrin jẹ́ àṣà tó dára nítorí pé ó wúlò lọ́pọ̀lọ́pọ̀				
7.	Ìdábẹ́ fún ọmọbìnrinjẹ́ ohun tí àwọn okùnrin maa fọ́wọ́ sí nítorí ìwúlò rẹ̀				
8.	Àwọn ọkùnrin ò faramọ́ Ìdábẹ́ fún ọmọbìnrin nítorí pé ó máa sàkóbá fún ìrorí ọmọbìnrin				
9.	Àwọn ẹ̀bí tóun se ìpinu fún obìnrin láti dá abẹ́ jẹ́ àṣà tó dára				
10.	Ìdábẹ́ fún ọmọbìnrin jẹ́ àṣà tó gbọ̀dọ̀ pọndàndàn fún gbogbo obìnrin				
11.	Ìdábẹ́ fún ọmọbìnrin jẹ́ àṣà tó dára láwùjọ nítorípé àwọn obìnrin ló máa se ìpinu àti dá abẹ́ fún ara wọn lawọn agbègbè kan				
12.	Fífi agídí dá bẹ́ fún ọmọbìnrin jẹ́ àṣà tí kò dára				
13.	Ìdábẹ́ fún ọmọbìnrinjẹ́ àṣà tó wọ́pọ̀ láwùjọ àwọn tí ó wà ní ipò tó kéré láwùjọ, láti mú àgbéga bá wọn				
14.	Ìdábẹ́ fún ọmọbìnrin jẹ́ àṣà tó wópọ̀ fún àwon obìnrin tí kò ní òye tó ní ìlú ńlá				
15.	Lílo Ìdábẹ́ gégé bíi ònà àti fi ọmọdébìnrin sí àwùjọ àwọn abilékọ jẹ́ àṣà tó dára				

Section D: Female Genital Cutting Psychological Experience Perception Rating Scale (FGC-PEPRS)

This instrument is designed to obtain information on your perception of psychological experiences as they may apply to you. Please, read all statements carefully before responding to the items (questions) and tick (√) the most preferred response in the space provided using the following:

4 - Very applicable (VA), 3 - Applicable (A), 2 - Not applicable (NA) and 1- Very inapplicable (VIA)

S/N	ITEMS	4	3	2	1
1.	I constantly fear pain of any sort.				
2.	I am not able to control my emotions when faced with violent situations				
3.	I feel bad when people make fun of me				
4.	I feel a sense of betrayal, bitterness or anger towards my parents				
5.	I do not feel depressed				
6.	I often feel emotionally unstable				
7.	I do not usually sleep well				
8.	I have feelings of pride				
9.	I do not observe any change in my social status				
10.	I do not feel that I am incomplete physically				

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IPIN IV

Àwọn ìbéèrè wọ̀nyí ló wà láti fi mọ̀ òye yín nípa, ìròrí ẹ̀ni tí wọ́n dá abẹ́ fún, gégẹ́ bí ó ṣe kan èyin gann. Ẹ jọ̀wọ́ ẹ ka gbogbo àwọn ìbéèrè wọ̀nyíi dáadáa kí ẹ tó fi ìdáhùn ṣíi. Kí ẹ sì ríi dájú wípé ẹ fa ìlà sí abẹ́

4- Ó KÀN MÍ GIDI 3- O KÀN MÍ 2-KÒ KÀN MÍ 1- KÒ KÀN MÍ RÁRÁ

S/N	Ìbéèrè	4	3	2	1
1.	Mo máa rí ìmira lórísírísi				
2.	Mí o kíí ń lè mú ara ró lásìkò tí mo bá rí ìí wàhálà				
3.	Inú mi kìí dùn bí mo bá rí ìí àwọn tóún fí mí se yèyé				
4.	Mo máa ń ní léró wípé ìkà ni àwon òbí mí se fún mi				
5.	Mí ò kíí rí ìnira				
6.	Mo máa rí àìbalè ọkàn				
7.	Mí ò kíí ń rí oorun sùn dáadáa				
8.	Mo máa ní ìròrí ìgaju ni				
9.	Mò ń rí ìyatọ̀ nínú ipò mi lawùjọ				
10.	Mi ò kíí ni léró wípé mi ò pe lára				

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Section E: Female Genital Cutting Intervention Programme Rating Scale (FGC-IPRS)

This instrument is designed to obtain information on your perception of the effectiveness of FGC Intervention programme activities carried out in your LGA/community. Please, read all activities carefully before responding to the items (questions) and tick the most preferred response in the space provided using the following:

4 – Very large extent (VLE), 3 – Large extent (LE), 2 – Small extent (SE) and 1 – Not executed (NE).

S/N	Intervention activities	4	3	2	1
A	**To what extent were advocacy visit activities carried out to the following:**				
1.	Traditional leaders				
2.	Community leaders				
3.	Market leaders				
4.	Women groups				
5.	Association of circumcisers/Community birth attendants (CBAs)				
B	**To what extent have the following health care providers been empowered through provision of update training with training manuals to impart knowledge on the dangers of FGC, and providing psychosocial support for FGC victims**				
6.	Chief nursing officers (CNOs)				
7.	Community health officers (CHOs)				
8.	Community health workers (CHEWs)				
9.	Public health workers (PHEWs)				
10.	Midwives				
11.	Community birth attendants (CBAs)				
C	**To what extent were the following IEC materials influential in imparting knowledge on dangers of FGC and changing attitude towards the practice**				
12.	T-shirts				
13.	Posters				
14.	Stickers				
D	**To what extent were step down trainings or enlightenment talks carried out at the following community gatherings**				
15.	In market places				
16.	In schools				
17.	At association meetings				
E	**To what extent were enlightenment talks on FGC related complications or consequences carried out**				
18.	At established MHCCs				
19.	During ante-natal and post natal clinics				
20.	During immunization clinics				
F	**To what extent were the following media publications influential in the dissemination of information on dangers of FGC**				
21.	Write-up on gender based workshop by JDPC				
22.	Write-up on Effects of Female Genital Cutting in Nigeria by JDPC				

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IPIN V

Ìbéèrè wọnyíí lo wà láti mọ bóyá ẹ ti ẹ ní òye nípa èto to wà fún ìdábé obìnrin ni ìjọba ìbílè yín. Ẹ jọwó ẹ ka gbogbo àwọn ìbéèrè wọnyíí dáadáa kí e to fi ìdáhùn sii. Kí ẹ sìr íi dájú wípé e fa ìlà si abẹ ìdáhùn wọnyíí,

4-DÁADÁA GAN **3-DÁADÁA** **2-DIẸ** **1-RÁRÀ**

S/N	ORÍSIRÍSI ÈTO	4	3	2	1
A	**Báwo ni ẹ se máa n' kàn si àwon olùrànlọwọ wọnyíí**				
1.	Àwọn olórí ilú				
2.	Àwọn olórí agbègbè				
3.	Àwọn olórí Ọjà				
4.	Olórí egbé Obìnrin				
5.	Ẹgbẹ àwọn tí oun dá abé fún ọmọbìnrin				
B	**Báwo ni wọn se rọ àwon eléto ìlera wònyíí lágbára síí nípasè ìdanilẹkò láti lè da àwọn èniyàn lékò nípa ewu tó rọ mọ dída abẹ fún ọmọbìnrin**				
6.	Olórí àwọn Nọọsì				
7.	ELéto ìlera alámójuto àyíká				
8.	Òsisẹ eléto ìlera àyíká				
9.	Eléto ìlera mùtúmùwà				
10.	Àwọn Agbèbí				
11.	Àwọn agbèbí agbègbè				
C	**Báwo ni àwon nnkan wọnyíí se wúlò síí nínú kíkọ àwon ará ìlu lékò nípa ewu tó rọ mó dídábé fún obìnrin àti ọnà àti jáwọ nínú iwà yíí**				
12.	Aso wíwọ				
13.	Iwé iléwó ògiiri				
14.	Ìwé pélébé				
D	**Báwo ni èto ìdánilékò se n wáyé sí láwon agbègbè wònyí lórí ìdábé fún obìnrin**				
15.	Láárin Ọjà				
16.	Nílé ìwé				
17.	Nibi Ìpàdé egbẹ				
E	**Báwo ni èto ìdánilékò sé n wáyé sí láwon àsìkò yíí lórí ewu tó rọ mó díd á abé fún obìnrin**				
18.	Láwon ibùdó to wà fún ìgbani lámòràn lórí òrọ to jẹ mọ iku lásìkò ìbímo				
19.	Lásìkò Ìpàdé Aboyún nílé iwòsan				
20.	Lásìkò igba abẹrẹ àjesára fún ọmọdé				
F	**Báwo ni àwọn abala ìroyìn yíí se n sisé sí nínú ìdánilékò àwon ará ìlú nípa ewu tó rò mọ ìdábé fún obìnrin**				
21.	Apilẹko nípa Nipa obìnrin				
22.	Apileko Nípa ewu tó rọ mọ dída abẹ fún omobìnrin lórílè-ède nàìjíríà				

APPENDIX 4

FEMALE GENITAL CUTTING VICTIMS COUNSELLING SERVICES RATING SCALE (FGC-VCSRS)

INTERNATIONAL CENTER FOR EDUCATIONAL EVALUATION, INSTITUTE OF EDUCATION UNIVERSITY OF IBADAN

Dear Respondents,

This instrument is designed to obtain information on the impact of expert counselling for FGC victims. All information you give will be used ONLY for the purpose of this research and shall be treated with utmost confidentiality.

Kindly be as honest as possible with your responses. Thank you for your co-operation.

IBADAN

SECTION A – BIO DATA

1. **Local Government Area (LGA):** _____
2. **Name of community:** _____
3. **Age range:** 10 – 14 ( ) 15 – 19 ( ) 20 – 24 ( )
4. **Present educational level:** JSS ( ) SSS ( ) Higher education ( ) No education ( )
5. **(For out of school adolescents) How long have you been out of school?**
   Less than or 3 years ( ) 4 – 6 years ( ) 7 years and above ( )
6. **Last level of education:** Primary ( ) JSS ( ) SSS ( ) Higher education ( ) No education ( )
7. **Parent(s) educational status:**
   - Primary education ( )
   - Secondary education ( )
   - Grade II Certificate/NCE ( )
   - Higher education ( )
   - No education ( )
8. **FGC status:** FGC – Yes ( ) FGC – No ( )
9. **Marital status:** Single ( ) Married ( ) Divorced ( ) Separated ( )
10. **Work status:** Are you working presently? **YES ( ) NO** ( )
11. **Location of residence:** Urban ( ) Rural ( )

PLEASE, DO NOT WRITE YOUR NAME

ÌGBÉLÉWỌ̀N ÌLÀNÀ ÌGBANI LÁMỌ̀RÀN TÓ RỌ̀ MỌ́ DÍDÁ ABẸ́ FÚN ỌMỌ̀BÍRIN ÈKA TÍ WỌ́N TI ŃKỌ́ NÍPA ÌTÚPALẸ̀ ÈTÒ ÈKỌ́ LÁGBÀÁYÉ, LÁBẸ́ ÈKA TÍ WỌ́N TI ŃKỌ́ NÍPA ÈTÒ ÈKỌ́, NÍ ILÉ ÈKỌ́ FÁSITÌ ÌBÀDÀN

Onídàhùn wa,

Àwọn àtòjọ ìbéèrè wọ̀nyí ló wà láti fi mọ̀ ipa àwọn akọ̀semọ̀sẹ́ olùgbanilámọ̀ràn, nínú ìgbé ayé ẹni tí wọ́n ti dá abẹ́ fún lọ́mọdé. Ìwádìí ìjìnlè̀ nìkan ni aó lò ìdáhùn yín fún tí a kò sì ní se àgbéjáde rẹ̀ fún ẹni tí kò tọ́.

Ẹ jọ̀wọ́ ẹ fi òtítọ́ inú dáhùn àwọn ìbéèrè wònyíi. Ẹ seun fún àgbóyé yín,

ÌPÍN I (ÌRÒYÌN NÍPA ONÍDÁHÙN)

1. Ìjọba ìbílẹ̀ tí ẹ ti wá: .....
2. Agbègbe yín: .....
3. Ọjọ́ orí yín: 10-14 ( ) 15-19 ( ) 20-24 ( )
4. Ìpele èkọ́: JSS ( ) SSS ( ) Ìpẹle Ẹkọ́ gíga ( ) Ẹ kò ní ẹkọ́ kan kan ( )
5. Fún èyin tí ẹ ti parí èkọ́: Ó ti tó ìgbà wo tí ẹ ti kúrò nílé èkó ?
   Qdún méta séyìn ( ) 4-6 ( ) qdún méje sókè ( )
6. Fún èyin tí ẹ ti parí ẹ̀kọ́: ìpele ẹ̀kọ́ wo lẹ kà gbẹ̀yìn
   Ìpele alákọ̀bèrè ( ) Ìpele èkọ́ JSS ( ) Ìpele ẹ̀kọ́ SSS ( ) Ìpele ẹ̀kọ́ gíga ( ) Ẹni tí kò ní ìmọ̀ ẹ̀kọ́ rárá ( )
7. Ẹ̀kọ́ àwọn Obí Yín: Alákọ́bèrè ( ) Ilé ẹ̀kọ́ Girama ( ) Ìpele ẹ̀kọ́ Ìkọ́ni Grade11 ( )
   Ètò ẹ̀kọ́ ilé ẹ̀kọ́ Gíga ( ) Alàìní ìmọ̀ ẹ̀kọ́ rárá ( )
8. Ǹjẹ́ ẹyin dá abẹ́ gẹ̀gẹ́ bíi obìnrin ? Bẹ́ẹ̀ni ( ) Bẹ́ẹ̀kọ́( )
9. Irúfé èniyàn tí ẹ jẹ́ : Omidan ( ) Abilékọ ( ) Ẹni tí ó ti kọkọ ( ) Dálé mosú ( )
10. Ǹjẹ́ ẹ ti ń sisẹ́: Bẹ́ẹ̀ni ( ) Bẹ́ẹ̀kọ ( )
11. Ibùgbé yín: Ìlú Ńlá ( ) Igbèríko ( )

E JOWO E MA KO ORUKO YIN

Please, read all directions carefully before responding to the items (questions) and tick the most preferred response in the space provided using the following: **4 - Very effective (VE), 3 – Effective (E), 2 – Ineffective (IE) and 1 - Very ineffective (VIE). Kindly be as honest as possible with your responses.**

SECTION B: Impact of Expert Counselling for FGC victims

S/N	**How effective has expert counselling been for you in ...**	**VE**	**E**	**INE**	**VIE**
1.	learning about FGC and its different types				
2.	associating knowledge of FGC types with your FGC status				
3.	learning about the consequences and complications of FGC practice				
4.	associating your FGC status with consequences or complications due to FGC				
5.	accepting your FGC status				
6.	discussing about FGC practice with peers				
7.	discussing about FGC practice with community members				
	Coping with the following psychological experiences caused by FGC.				
8.	Tendency to anticipate pain				
9.	Recall of unpleasant memories				
10.	Fear				
11.	Low self esteem				
	Coping with the following physical consequences caused by FGC	**VE**	**E**	**INE**	**VIE**
12.	Infections due to FGC (e.g. tetanus, sepsis, Urinary tract infections-UTI, chronic pelvic infections, HIV)				
13.	Abnormal swellings and blockages causing vaginal obstruction and difficult labour				
14.	Menstrual disorders due to tight vagina or severe scars leading to narrowing of the vaginal orifice				
15.	Retention of urine				
	Coping with the following psychosocial consequences caused by FGC	**VE**	**E**	**INE**	**VIE**
16.	Infertility				
17.	Betrayal of trust with family				
18.	Humiliation for being cut				
	Dealing with other health related issues such as reproductive and maternal health				
19.	Adolescent sexual health problems (e.g. teenage pregnancy, abortion etc)				
20.	Sexually Transmitted Diseases (STDs) and HIV AIDS				
21.	Safe motherhood (i.e. Effective, acceptable and affordable contraception methods - Family planning, preconception, prenatal and postnatal care)				
22.	Mother and child hygiene				

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Ẹ jọwọ́ ẹ ka gbogbo àwon ìbéèrè wọnyíi daadaa kí ẹ tó fi ìdáhùn sii. Kí ẹ sir íi dájú wípé ẹ fa ìlà sí abẹ́ ìdáhùn wònyíi: **4-DÁADÁA GAN 3-DÁADÁA 2-DÍẸ 1-RÁRÁ**

IPIN II

IPA ÌGBANILÁMỌRÀN FÚN ẸNI TÍ WỌN TI DÁ ABẸ́ FÚN RÍ

S/N	**Báwo ni olùdámòràn yìí se n sisé fún yín sí**	4	3	2	1
1.	Kíkó nípa orísirísi Abẹ́ dídá tó wà				
2.	Síse àgbéyèwò orisirísi Abẹ́ dídá pẹ̀lú irúfẹ́ èyí tí ó jẹ́ ti yín				
3.	Kíkọ́ nípa orísirísi ewu àti tí ó rọ̀ mọ́ abẹ́ dídá				
4.	Síse ìgbéléwọ̀n orísirísi isé abẹ́ tó wà pẹ̀lú irúfẹ́ ewu tó rọ̀ mọ́ abẹ́ dídá tí èyín				
5.	Gbígba irúfẹ́ Abẹ́ dídá tí yin				
6.	Jí jíròrò irúfé abẹ́ dídá yín pẹ̀lú àwọn òré				
7.	Jí jíròrò irúfé abẹ́ dídá yín pẹ̀lú àwọn olórí ilú				
Gbígbé pẹ̀lú àwọn ìsòro tí abẹ́ dídá ti fà					
8.	Mómáa ní ìretí ìnira				
9.	Ìrànrí igbá tó le				
10.	Ibẹ̀ru				
11.	Ibú ara ẹni kù				
Gbígbé pẹ̀lú àwon ìsòro wònyíi tí abé dídá ti fà ninú èyà ara					
12.	Àìsà tí Abẹ́ dídá fà. (àrùn HIV, KÌKÒRÒ JẸJẸRẸ)				
13.	Ìnira nípasè ìbímo,				
14.	Ìnira nípa síse nnkan osù, látàrí oju ara tó fún pọ̀				
15.	Ìpamọ́ ìtọ́ fún ìgbà pípé				
Gbígbé pẹ̀lú ìnira tí abẹ́ dídá ti fà nípasè ìrọrí					
16.	Àyì rí ọmọ bí				
17.	Àìní ìfọkantán àwọn mọ̀lébí				
18.	Ìtìjú				
Gbígbé pẹ̀lú àwọn wàhálà àilera mìíràn nípasẹ abẹ́ dídá					
19.	Ìnira láìkó ìbálòpò				
20.	Àìsàn látì ara ìbálòpọ̀				
21.	Ìrọrùn lásìkò ibímo "				
22.	Ìtójú ìyá àti ọmọ				

APPENDIX 5

FEMALE GENITAL CUTTING UPDATE TRAINING RATING SCALE (FGC-UDTRS)

INTERNATIONAL CENTER FOR EDUCATIONAL EVALUATION, INSTITUTE OF EDUCATION
UNIVERSITY OF IBADAN

Dear Respondents,

This instrument is designed to obtain information on the extent to which update training on expert counselling has impacted on your counselling services for FGC victims attending your clinic/health centre. All information you give will be used ONLY for the purpose of this research and shall be treated with utmost confidentiality. Kindly be as honest as possible with your responses.

Thank you for your co-operation.

SECTION A

GENERAL INFORMATION

1. **State:**
2. **Local Government Area (LGA):** _____
3. **Name of community:** _____
4. **Name of clinic/Health centre:**_____

BIO DATA

5. **Sex:** Male ( ) Female ( )
6. **Designation:** Midwife – CNO ( ) PNO ( ) PHEW ( ) CHEW ( ) TBA ( )
7. **No. of years as a health provider:** Less than and 3 years ( ) 4 – 6 years ( ) 7 – 9 years ( ) 10 years and above ( )
8. **Age range:** Less than 25 years ( ) 25 – 34 ( ) 35 – 44 ( ) 45 years and above ( )

PLEASE, DO NOT WRITE YOUR NAME

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Please, read all directions carefully before responding to the items (questions) and tick the most preferred response in the space provided using the following: **4 - Very well trained (VWT), 3 – Well trained (WT), 2 – Averagely trained (AT) and 1 – Not adequately trained (NAT).**

SECTION B: Impact of Update Training for Health providers (Programme Trainees)

S/N	**How well trained were you to ...**	**VWT**	**WT**	**AT**	**NAT**
1.	Discuss with women about FGC				
2.	Discuss with women about the consequences and complications of FGC practice				
3.	Detect cases of FGC				
4.	Detect the different types of FGC				
	Provide counselling on the following psychological experiences due to FGC				
5.	Anticipated pain				
6.	Recall of unpleasant memories				
7.	Fear				
8.	Low self esteem				
	Provide counselling on the following physical consequences due to FGC				
9.	Infections (e.g. Urinary tract infections, chronic pelvic infections, HIV)				
10.	Abnormal swellings and blockages causing vaginal obstruction and difficult labour				
11.	Menstrual disorders due to tight infibulations or severe scaring leading to narrowing of the vaginal orifice				
12.	Retention of urine				
	Provide counselling on the following social consequences due to FGC				
13.	Infertility				
14.	Stigmatization for not being cut				
15.	Betrayal of trust towards family				
16.	Humiliation for being cut				
	Provide counselling on the following sexual consequences due to FGC				
17.	Difficulty having sexual intercourse				
18.	Lack of sexual satisfaction				
	Provide counselling services in the following other health related areas and activities				
19.	Reproductive health				
20.	Maternal health				
21.	Referral services				
22.	Follow-up activities				
23.	Documentation of complaints due to FGC				
24.	Documentation of other complaints				
25.	Provision of feedback to patients				

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APPENDIX 6

INFORMED CONSENT
(In and Out of School Adolescents and Young Adults)

INTERNATIONAL CENTER FOR EDUCATIONAL EVALUATION
INSTITUTE OF EDUCATION
UNIVERSITY OF IBADAN

KNOWLEDGE, ATTITUDE AND PSYCHOLOGICAL EXPERIENCES OF FEMALE ADOLESCENTS TOWARDS FEMALE GENITAL CUTTING PRACTICE IN OYO STATE

Participation Information Sheet

Good day Sir/Ma. Under the supervision of the International Centre for Educational Evaluation (ICEE), Institute of Education, University of Ibadan, we are conducting a survey in relation to impact of the African Women Development Fund (AWDF) and Justice Development and Peace Commission (JDPC) Intervention Programme on dangers of Female Genital Cutting (FGC) in selected LGAs in Oyo State. You/your child (ward) are/is being invited to take part in this study which intends to find out how effective the intervention programme is based on female adolescents' and young adults' knowledge of the dangers of FGC and their attitude towards the practice based on their understanding of psychological experiences caused by practice.

The study will involve a total of 1,600 female in school and out of school adolescents and young adults between ages 10 to 24 who have either been cut or otherwise. They will respond to a 4 (four) page questionnaire on their knowledge of dangers of FGC, attitude towards the practice, and psychological experiences caused by the practice as well as their views on the effectiveness of the various enlightenment activities executed by the intervention programme. The questions will take about 30 to 60 minutes. Your choice of participating/allowing your child (ward) to participate in the study is your decision and responses indicated in the questionnaire will be kept confidential and will be shared with only members of the research team.

You/your child (ward) do/does not have to answer any questions that you/she are/is not comfortable with, and you/she can decide to leave the study at any point. If you choose/choose to allow your child (ward) to participate in the study, please indicate by signing/thumb printing (parents/guardian/respondent) the informed consent form below.

Informed Consent

Sign./Thumbprint of Respondent: _____ Date: _____

Sign./Thumbprint of Parent/Guardian: _____ Date: _____

Sign. of Interviewer: _____ Date: _____

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ÌBÉÈRÈ FÚN ÌPINU OLÙKÓPA

ẸKA TÍ WỌN TI ŃKÓ NÍPA ÌTÚPALẸ̀ ÈTÒ ẸKỌ́ LÁGBÀÁYÉ,

LÁBẸ̀ ẸKA TÍ WỌN TI ŃKỌ́ NÍPA ÈTÒ ẸKỌ́, NÍ ILÉ ẸKỌ́ FÁSITÌ ÌBÀDÀN

ÌMỌ̀, ÌHÙWÀSÍ, ÀTI ÌRÒRÍ, NÍPA ẸNI TÍ WỌN DÁ ABẸ́ FÚN GẸ́GẸ́ BÍI OBÌRIN, GẸ́GẸ́ BÍI WỌN SÉ MÁA Ń SE NÍ ÌPÍNLẸ̀ ỌYỌ́

ÌWÉ YÌÍ WÀ FÚN OLÙKÓPA NÍNÚ ẸỌ ÌWÁDÌÍ ỲÍÍ

E kú dẹ́édẹ́e ìwòyí, lábẹ́ àmójútó, ẹka tí wọn tí ńkọ́ nípa ìtúpalẹ̀ ètò ẹkọ́ lágbàáyé,lábẹ́ ẹka tí wọn ti ńkọ́ nípa ètò ẹkọ́, ní ilé ẹkọ́ fásitì Ìbàdàn, a gùnlé ìwádìí yìí, ní ìbámu pẹ̀lú ìpa owó ìrànwọ́ tó wà fún ìdàgbasóke àwọn obìnrin nílẹ̀ adúláwọ̀ (AWDF), àti ètò ìdásí àjọ tóún rísí ìdàgbasóke ìdájó òdodo àti ìfẹ̀sẹ̀múlẹ̀ àlááfíà (JDPC), lórí ewu tó rọ̀ mọ́, dídá abẹ́ fún ọmọbìnrin (FGC) láwọn agbègbè ìjọba ìbílẹ̀ kan ní ìpínlẹ̀ ỌYỌ́. A pè ọmọ yín láti kópa nínú ìwádìí yìí, èyí tí ó wà láti mọ̀ ipa àwọn ètò òlọ́kan-ò-jọ̀-kan tó wà fún àwọn obìnrin láti ní ìmọ̀ nípa ewu tó rọ̀ mó abẹ́ dídá fún obìnrin, àti ìhùwàsí wọn sí dídá abẹ́ fún obìnrin, àti ìròrí wọn nípa abẹ́ dídá.

A ó se àmúlò obìnrin tí ó tó ẹgbẹ̀ta-lé-lẹ́gbẹ̀rún kan, tí ó wà ní ilẹ́ ìwé àti àwọn tí ó ti kúrò ní ilé ìwé, lágbà àti lọ́mọdé, tó wà láàrin ọdún méwà sí ọdún mérìnlélógún, tí ó se wípé, wọn ti dá abẹ́ fún wọn lọ́na kana bí òmìíràn.wọn yóò dáhùn ìbéèrè olójúewé mérìn tí a ti se àtò rẹ́ lórí orísirísi ewu tó rọ̀ mọ́ abẹ́ dídá, àti ìhùwàsí wọn sí, tó fi mọ́ ìròrí wọn, àti ojú tí wọn fi n wo orísirísi ètò ìtanijí tó wà láti fi dènà abẹ́ dídá láwùjọ. Wọn yóò lò to ìséjú àádọ́ta ọgbọ̀n tàbí ìséjú kan gbákò láti dáhùn àwon àtò ìbéèrè wònyí. Ẹyin gẹ́gẹ́ bí òbí lè ní àsẹ láti fàáyè gba ọmọ yín kí o tó le kópa nínú ìwádìí wa yìí, tí awá yóò sì rí dájú wípé a kò se àgbéjáde àwọn ìròyìn nípa ọmọ yín èyí tí ó bá fún wa bí kò se láti fi se ìwádìí nìkan.

E kò níló àti dáhùn ìbéèrè tí ẹ báa rí wípé kò ba yín ni ara mu, tí ẹ sì ní agbára àti má tèsíwájú nínú ìwádìí yìí bí ó bá wù yín.

Bí ẹ bá gbà wípé kí ọmọ yín kópa nínú ìwádìí wáy ìí ẹ jọ̀wọ́ ẹ bá wa tí ọwọ́ bọ ìwé àdéhùn yìí.

Ìbuwólù Akópa_____ **Déètì**_____

Ìbuwọ́lù àwọn òbí akópa_____ **Déètì**_____

Ìbúwọlù olùsèwádìí_____ **Déètì**_____

APPENDIX 7

INFORMED CONSENT
(Focus Group Discussants)

INTERNATIONAL CENTER FOR EDUCATIONAL EVALUATION

INSTITUTE OF EDUCATION

UNIVERSITY OF IBADAN

KNOWLEDGE, ATTITUDE AND PSYCHOLOGICAL EXPERIENCES OF FEMALE ADOLESCENTS TOWARDS FEMALE GENITAL CUTTING PRACTICE IN OYO STATE

Participation Information Sheet

Good day Sir/Ma. Under the supervision of the International Centre for Educational Evaluation (ICEE), Institute of Education, University of Ibadan, we are conducting a survey in relation to impact of the African Women Development Fund (AWDF) and Justice Development and Peace Commission (JDPC) Intervention Programme on dangers of Female Genital Cutting (FGC) in selected LGAs in Oyo State. You are being invited to take part in this study via a focus group discussion and filling of a questionnaire to find out how effective the intervention programme has been based on opportunities and expert counseling provided by health care providers.

The focus group discussions will involve a total of 5 (five) groups per MHCC in LGAs of intervention. These groups will involve 8 to 10 members per group. Respondents for the questionnaire will also involve minimum of 50 (fifty) females from all MHCCs in LGAs of intervention. The FGD sessions will last between 30 to 45 minutes; while responding to the questionnaire will not exceed 20 to 30 minutes.. Your choice of participating in the study is your decision and responses indicated in the questionnaire will be kept confidential and will be shared with only members of the research team.

You do not have to answer any questions that you are not comfortable with, and you can decide to leave the study at any point. If you choose to participate in the study, please indicate your intention by writing your name in the FGD list.

Informed Consent

Sign. of Rep. of Focus Group: _____ Date: _____

Sign. of witness of FGD Session (PHC coord.): _____ Date: _____

Sign. of FGD Facilitator: _____ Date: _____

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ÌBÉÈRÈ FÚN ÌPINU OLÙKÓPA

(ÈYÍ WÀ FÚN ÌKỌ OLÙJÍRÒRÒ)

ÈṢKA TÍ WỌ́N TI ŃKỌ́ NÍPA ÌTÚPALẸ̀ ÈTÒ ÈṢKỌ́ LÁGBÀÁYÉ,

LÁBẸ́ ÈṢKA TÍ WỌ́N TI ŃKỌ́ NÍPA ÈṢTÒ ÈṢKỌ́, NÍ ILÉ ÈṢKỌ́ FÁSITÌ ÌBÀDÀN

ÌMỌ. ÌHÙWÀSÍ, ÀTI ÌRÒRÍ, NÍPA ẸNI TÍ WỌ́N DÁ ABẸ́ FÚN GẸ́GẸ́ BÍI OBÌRIN, GẸ́GẸ́ BÍI WỌ́N SE MÁA Ń SE NÍ ÌPÍŃLÈ ỌỌ́YỌ́

ÌWÉ YÌÍ WÀ FÚN OLÙKÓPA NÍNÚ EO ÌWÁDÌÍ YÌÍ

E kú dẹ́edẹ́e ìwòyí, lábé àmójutó, èṣka tí wọn ti ńkọ́ nípa ìtúpalè èto èṣkọ́ lágbàáyé,lábé èṣka tí wọn ti ńkọ́ nípa èto èṣkọ́, ní ilẹ́ èṣkọ́ fásiti Ìbàdàn, a gùnlé ìwádìí yìí, ní ìbámu pẹ̀lú ipa owó ìránwọ́ tó wà fún ìdágbàsóke àwon obìnrin ńilè adúláwò (AWDF), àti èto ìdásí àjọ tóún rísí ìdágbàsóke ìdájó òdodo àti ìfẹṣẹmule àlááfíà (JDPC), lórí ewu tó rò mọ́, dídá abẹ́ fún ọmọbìnrin (FGC) lawọn agbègbè ìjọba ìbílè kan ní ìpínlẹ̀ ỌỌ́Ọ́.a pè yín láti kópa nínú ìwádìí yìí nípasẹ onikò-jí-kọ̀ àti ìdáhùn àtòjọ ìbéèrè láti mò bí àwon èto ìtanijí àwon elétò ilera se ń sisẹ́ sí, nípasẹ̀ ìgbani lamọ̀ran.

Ikọ̀ márùn ní a ńlò ní ìjọba ìbílẹ̀ kòòkan tí ikọ̀ kòòkan yóò ní èniyàn méjọ̀ sí méwà nínú. Gbogbo àwon tí yóò dáhùn àwọn ìbéèrè wa ní kò ní dín àádóta (50) obìnrin lawọn ibùdó tí wọn ti gba àwọn obìnrin lámọ̀ran lórí òrọ̀ tó jẹ mọ́ ikọ̀ lásìkò ìbímo, ní ìjọba ìbílè kòòkan.

Wọ́fun ni ìkópa yin nínú iṣe ìwádìí yìí, pèlu bí a kò se níg bé ìròyìn nípa yín sítà fún ẹni tí kò tọ́ bí kò se láti fi se iṣẹ́ ìwádìí, láàrin àwọn olùwádìí tí a jọ ń sisẹ́ papò.

Ẹ kò ńlò àti dáhùn ìbéèrè tí ẹ báa rii wípé kò ba yín ní ara mu, tí ẹ sì ní agbára àti má tẹṣíwájú nínú ìwádìí yìí bí ó bá wù yín.

Bí ẹ bá gbà láti kópa nínú ìwádìí wa yìí ẹ jọ̀wọ́ ẹ bá wa tí ọwọ bọ ìwé àdéhùn yìí kí ẹ sì kọ́ orukọ yín síle.

Ibuwólù Asójú ikọ̀ Akopá_____ **Déeti**_____

Ibuwólù àwọn elérìí (Alákoso èto ìwádìí)_____ **Déeti**_____

Ibuwólù Ẹni tó se àgbékalè iṣé ìwádìí yìí_____ **Déeti**_____

APPENDIX 8

INFORMED CONSENT
(AWDF-JDPC Programme Trainees)

INTERNATIONAL CENTER FOR EDUCATIONAL EVALUATION

INSTITUTE OF EDUCATION

UNIVERSITY OF IBADAN

EVALUATION OF AFRICAN WOMEN DEVELOPMENT FUND AND JUSTICE, DEVELOPMENT AND PEACE COMMISSION INTERVENTION PROGRAMME IN OYO STATE, SOUTH WEST NIGERIA.

Participation Information Sheet

Good day Sir/Ma. My name is **CHRISTINE UDOH EMOKHARE/Name of the Interviewer**. Under the supervision of the International Centre for Educational Evaluation (ICEE), Institute of Education, University of Ibadan, we are conducting a survey in relation to the African Women Development Fund (AWDF) and Justice Development and Peace Commission (JDPC) Intervention Programme which involved an up-date training for healthcare providers within Ibadan North East and Lagelu LGAs of Oyo State.

Based on your participation as a trainee of the intervention programme, I would be grateful if you will oblige to be interviewed. The interview should last a duration of between 30 to 45 minutes, using an interview guide. The interview will focus on the up-date training attended in relation to provision of information on the dangers of FGC, available management of problems caused by the practice as well as availability of opportunities and expert counselling for FGC victims. Any other information that you feel will be useful to this research work will be very much welcome. Please be assured that the decision of being interviewed or otherwise is your choice to make, and it will in no way affect your person or your present employment status. All responses from the interview will be kept confidential and will be used only for the purpose of this research.

Thank you in anticipation of your cooperation.

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APPENDIX 9

LETTER REQUESTING INFORMATION ON AWDF-JDPC INTERVENTION PROGRAMME

EMOKHARE, Christine Cynthia Ekojoka

C/o Mr. Paul Anthony Emokhare. Diamond FM 101.1, University of Ibadan, Ibadan Email: chrisemokhare@yahoo.com
Phone: 234-(0)803-481-5553, (0)802-338-7846, (0)807-518-2447

Approved
Owoeye
24/02/14

21st February, 2014

The Director,
Justice, Development and Peace Commission,
Bashorun,
Ibadan.

Dear Rev. Fr. E. A Owoeye,

REQUEST FOR INFORMATION ON FEMALE GENITAL MUTILATION/CUTTING (FGM/C) INTERVENTION PROGRAMME

I am Emokhare Udoh Christine E., a Ph.D student of the International Centre for Educational Evaluation of the University of Ibadan.

I propose evaluating an FGM/C intervention programme in fulfilment of the doctor of philosophy requirement. I therefore humbly write to request for permission to access information on a recent female genital mutilation/cutting (FGM/C) intervention programme facilitated by your organisation.

I will be most grateful if approval is given to access such information. Thank you in advance of your consideration.

Yours sincerely,

Emokhare Udoh Christine E

APPENDIX 10

INTRODUCTION LETTER

UNIVERSITY OF IBADAN, IBADAN NIGERIA
INSTITUTE OF EDUCATION

DIRECTOR:
Professor E. Adenike Emeke, O.P
B.Ed, M.Ed, Ph.D. (Ibadan)

SECRETARY:
Ruth A. Adeyinka (Mrs.)
B.A. Ed.(Ilorin), M.Ed.(Ibadan)

OFFICE OF THE DIRECTOR
Telegrams: UNIVERSITY OF IBADAN
Director: 08054459158, 08023294917
Secretary: 08162488968, 08059978586
E-mail: instituteofeducation2010@gmail.com

27-02-2015

.....

I.O.E

.....

.....

Dear Sir,

LETTER OF INTRODUCTION OF CHRISTINE EKOJOKA UDOH EMOKHARE - A RESEARCH STUDENT

I write to introduce to you the bearer, **Christine Ekojoka Udoh Emokhare** who is a Postgraduate research student of the International Centre for Educational Evaluation (ICEE), Institute of Education, University of Ibadan.

Mrs. Emokhare seeks to conduct her Ph.D research on: **"EVALUATION OF AFRICAN WOMEN DEVELOPMENT FUND- JUSTICE, DEVELOPMENT AND PEACE COMMISSION INTERVENTION PROGRAMME IN OYO STATE, NIGERIA".** Kindly give her the necessary information for the purpose of her research.

Thank you for your usual consideration of this request.

Yours faithfully,

Adewale

Dr. J. G. Adewale
Head of ICEE

APPENDIX 11

LAWS OF THE WORLD ON FEMALE GENITAL MUTILATION

This page provides links to laws and policies of the world dealing with female genital mutilation. (Updated as of 2 February 2010).

Australia Australian Capital Territory: Crimes (Amendment) Act (No. 3) 1995.

Australia New South Wales: Crimes Act 1900 [Section 45] [initially enacted by Act (No. 58 of 1994) to amend the Crimes Act 1900 to prohibit female genital mutilation, 22 September 1994].

Australia Northern Territory: Criminal Code of the Northern Territory of Australia [Section 186A-186D] [initially enacted by the Criminal Code Amendment Act (No. 2) 1995, 28 December 1995].

Australia South Australia: Criminal Law Consolidation Act 1935 [Sections 32-33B] [initially enacted by the Statutes Amendment (Female Genital Mutilation and Child Protection) Act 1995 (Act No. 24 of 1995), 27 April 1995].

Australia Victoria: Crimes (Female Genital Mutilation) Act 1996 (Act No. 46 of 1996), 26 November 1996.

Belgium: Law of 28 November 2000 on the criminal protection of minors [Article 29].

Burkina Faso: Law No. 43/96/ADP of 13 November 1996, the Penal Code [Articles 380-382].

Canada: Act to amend the Criminal Code (child prostitution, child sex tourism, criminal harassment and female genital mutilation), 25 April 1997 [Section 5], as incorporated into the Criminal Code as Section 268.

Chad: Law No. 006/PR/2002 of 15 April 2002, on the promotion of reproductive health.
Democratic Republic of Congo: Law No. 06/018 of 20 July 2006 [amends the Penal Code with respect to female genital mutilation].

Denmark: Law No. 490 of 17 June 2008 [amends the Penal Code to bring within Danish jurisdiction female genital mutilation carried out outside the country by or against a person with a Danish connection].

Djibouti: Penal Code, 1995 [Article 333]. Decree No. 2008-0098/PR/MS of 7 April 2008, the Code of Medical Ethics. National Health Development Plan 2008-2012.

Egypt: Order No. 261 of 8 July 1996 of the Minister of Health and Population. Law No. 126 of 2008 amending the provisions of the Child Law, 15 June 2008.

France: Penal Code; Decree No. 95-1000 of 6 September 1995 setting forth the Code of Medical Ethics [Article 41].
Ghana: An Act (484 of 1994) to amend the Criminal Code, 1960 (Act 29) to include in the Code the offence of female circumcisions and for connected purposes, 4 August 1994. Criminal Code (Amendment) Act, 2007 (Act No. 741), 7 August 2007.

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Guinea: Decree No. D/96/205/PRG/SGG of 5 December 1996 promulgating the Code of Medical Deontology [Article 40].

Ivory Coast: Law No. 98-757 of 23 December 1998 on the repression of certain forms of violence against women.

Madagascar: Decree No. 98-945 of 4 December 1998 setting forth the Code of Medical Ethics [Article 39].

Mali: Ordinance No. 02-053/P-RM of 4 June 2002 creating a National Program to Fight the Practice of Female Genital Mutilation. Circular No. 0019/MSP-AG-SG of 7 January 1999 of the Ministry of Health, the Aged, and Solidarity [prohibits the performance of female genital mutilation in health establishments].

Mauritania: Ordinance No. 2005-015 of 5 December 2005.

New Zealand: Crimes Act (1961-1999) Act No. 20 of 1999 [Sections 204A-205A] [initially enacted by the Crimes Amendment Act 1995 (Act No. 49 of 1995), 2 August 1995].

Niger: Law of 24 May 2006, Law on Reproductive Health.

Norway: Law No. 74 of 15 December 1995 prohibiting female genital mutilation. Law No. 74 of 19 June 2009 [amends the Penal Code with respect to female genital mutilation]. Action Plan for Combating Female Genital Mutilation, 2008.

Senegal: Law No. 99-05 of 25 January 1999 amending various provisions of the Penal Code [Article 2], as incorporated into the Penal Code, Article 299bis.

South Africa: Promotion of Equality and Prevention of Unfair Discrimination Act, 2000 (Act No. 4 of 2000) [Section 8].

Spain: Organic Law No. 11/2003 of 29 September 2003 on measures relating to the safety of citizens, domestic violence, and the social integration of foreigners.

Sweden: Law No. 316 of 27 May 1982 prohibiting female circumcision.

Tanzania: Sexual Offences Special Provisions Act, 1998 (Act No. 4 of 1998), 1 July 1998 [Section 21].

Togo: Law No. 98-016 of 17 November 1998 prohibiting female genital mutilation in Togo. Law No. 2007-017 of 6 July 2007, the Children's Code.
Uganda: The Children Statute 1996 (Statute No. 6 of 1996) [Section 8].

United Kingdom: Female Genital Mutilation Act 2003 (Chapter 31 of 2003), 30 October 2003.

United States: Public Law No. 104-208, 30 September 1996 [Sections 579, 644, and 645].

Zimbabwe: Domestic Violence Act, 26 February 2007.

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APPENDIX 12

LIST OF SECONDARY SCHOOLS USED FOR THE STUDY

SNDT	LGA	INTERV. STATUS	SCH. TYPE	NAME OF SCHOOL
OCSD	LAGELU	Intervention	Public	Anglican Gram. Sch., Oyedeji Community Gram. Sch., Lalupon N.O Idowu Comp. High Sch. Olorunda
			Private	Atorise Comp. College, Olorunda-Aba Hope College, Ejioku
	ATIBA	Non-Intervention	Public	Alaafin High School, Oyo Community Secondary Sch., Oke-Ololа Oranyan/Oranmiyan Gram. Sch., Oyo
			Private	Aatan Comp. High Sch., Koso God's Mercy Comp. College, Alaafin
OSSD	IBNE	Intervention Group	Public	Fasil O'Mar (FOA) Gram. Sch., Aremo Queen of Apostles, Oluyoro
			Private	Aanu Olu Int'l College, Alaadorin Headquarters Int'l College, Adekile
	IBSW	Non-Intervention	Public	People's Girls Gram. Sch. Molete St. Teresa's College, Oke-Ado
			Private	Oluyole Private Int. College, Oluyole ROCHAS Int. College, NTC-Joyce B Rd.

Key: SNDT: Senatorial District; LGA: Local Government Area; OCSD: Oyo Central Senatorial District; OSSD: Oyo South Senatorial District; IBNE: Ibadan North East; IBSW: Ibadan South West

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