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Problems associated with female genital mutilation and educational performance. A case study of Ethiope east local government area, delta state, Nigeria

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ABSTRACT
Majority of the females in Ethiope East has undergone Female circumcision either while as teenage or at the point of getting married orduring conception. Female circumcision is a practice that needs to be discouraged. This would only be possible through public enlightenment campaigns and sensetisation programs to mother and school students alike. The study focused mainly on the causes of Female Circumcision in the area and the consequences of the practice to the victim and the society at large. The rate of this practice was equally looked at and recommendations were also advanced towards discouraging of this practice. In order to achieve this task, a field survey was carried out with various methods. The use of questionnaires, oral interview, direct observation, and archival methods were used in gathering the data. For convenient purpose, six communities were selected in Ethiope East. The communities are Orhoakpor, Kokori Inland, Okpara Inland, Ovu, Eku and Abraka Inland. The data gathered from the field were presented in tables. The Pearson's Product Moment Correlation Co-efficient was used for the testing and validity of the data to determine the degree of relationship between the data.

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Introduction

The objectives and hypotheses were tested and confirmed with tables and a figure that Female Circumcision significantly increased numbers of female school drop-out, teenage pregnancy, vulva disfigurement and life-long painful scare. It was revealed that Female circumcision is on the low side with the educated people but is a general issue in the study area as the practice is tied to tradition. It was also seen from the findings that there the practice has made so many females to be mothers as they sees the practice as passage to motherhood and sign of maturity irrespective of the age at the time of being circumcised. Also there is no programe in place to discourage the practice and level of awareness of its dangers has not be cascaded to the people.

Summarily, the research advanced some recommendations for Female Circumcision reduction in the area studied.

Background to the Study

The practice of female circumcision is widely known as Female Genital Mutilation (FGM). Nigeria in the past had the highest absolute number of cases of Female Genital Mutilation in the world amounting for about one quarter of the estimated 115-130 million circumcised women in the world. The practice is founded in traditional beliefs and societal pressure to conform. The Government of Nigeria in the last decade recognized the practice as harmful to children and women and have embarked on corrective measures, aimed at addressing the end of the practice openly and energetically, through the formulation of policies programmes, legislation and behavioral change that has currently impact reduction in prevalence.

We are all living and studying in increasingly multi-racial, multicultural communities, which afford us many opportunities to learn about, and appreciate various customs and traditions. In every culture there exist important practices which celebrate life cycle transitions, perpetuate community cohesion, or transmit traditional values to subsequent generations. However, female circumcision also known and referred to as female genital mutilation (FGM) is one tradition that cannot be unquestionably regarded as acceptable.

These transitions reflect norms of care and behaviour based on age, life stage, gender, and social class. While many traditions promote social cohesiveness and unity, others erode the physical and psychological health and integrity of community members, particularly girls and women. Harmful traditions exist in many different forms such as early marriage and childbearing, birth practices and female circumcision.

Female Genital Mutilation is often called *female circumcision* implying that it is similar to male circumcision. However, the degree of cutting is far more extensive, often impairing a woman's sexual and reproductive functions and even the ability of girls and women to pass urine normally. This is why World Health Organization refers to the practice as *female genital mutilation*. *Female genital cutting* is also used, particularly where the apparently judgmental phrase *female genital mutilation* might offend and lead to resistance to change. This practice is now considered as a harmful traditional practice, as well as a violation of the human rights of girls and women. Female circumcision is a culturally sanctioned tradition practiced in many Africa countries and has deleterious consequences on women's health, sexuality and fertility.

There are many reasons for performing Female Genital Mutilation and they vary between setting, communities and countries. They can be summarized as relating to control of women and their sexuality, religious motivations, rites of passage, ideas of hygiene, femininity and aesthetics, and social pressures and expectations. Female Genital Mutilation is often

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erroneously linked to Islam and is practiced in some communities where Islam predominates. Some Muslims consider that Islam demands the practice to ensure spiritual purity, although many Islamic scholars disagree with this stating that Female Genital Mutilation is not mentioned in the Qur'an. However, it is clearly a ritual practice that predates the Prophet Mohammed and the Islamic religion. Female Genital Mutilation transcends religious, racial and social boundaries (Webb, 1995). A minority of followers of other faiths, Christians, animists and Jews practice it (Maurad and Hassenein, 1994).

Educationists are interested in this practice in order to bring sucour to those affected. The role of education to those who may come into contact with girls and women who have undergone female circumcision, have a responsibility to provide them with the very best education and awareness on the danger of this practice. They will not be able to do this unless they know about and understand Female circumcision as a practice. That is why I am so pleased to see that a good research in that line would be carried out to create the awareness on why it needs to be discouraged.

This research work will provides the basic background information and the health consequences of Female Genital Mutilation (FGM), and importantly the legislative, child protection and human rights dimensions of this practice with regards to education of the female child.

It is therefore critical that all parents are clear in their minds that Female Genital Mutilation is abuse, and that they have a responsibility to act to protect girls from this type of abuse. To fail to act because of labels of culture, tradition, religion or because of the fear of being labelled 'racist' is unacceptable!

It is hope that reading this research work will challenge you, encourage you to read further, empower you to act when you need to, and motivate you to start raising Female Genital Mutilation with practicing communities – changing long-held beliefs, and resulting in positive, permanent, behaviour change.

Statement of the Problem

Circumcision is the surgical removal of some or all the foreskin from the penis. "Circumcision" comes from Latin circum (meaning "around") and cædere (meaning "to cut"). Religious male circumcision is considered a commandment from God in Judaism. In Islam, though not discussed in the Qur'an, male circumcision is widely practised and most often considered being a sunnah. It is also customary in some Christian churches in Africa.

The Christian faith also has records of circumcision, Luke 1:59-60"So it was, on the eighth day, that they came to circumcise the child; and they would have called him by the name of his father, Zacharias. His mother answered and said, "No; he shall be called John."

The prevalence of circumcision varies mostly with religious affiliation, and sometimes culture. Most circumcisions are performed during adolescence for cultural or religious reasons, in some countries they are more commonly performed during infancy.

Female circumcision (called female genital cutting by its critics) has been practiced by many cultures at one time or the other in several parts of the world (UN, 2005). The widespread nature of this practice makes a single origin unlikely (Hodges, 1997). Its initial practice might have been in relation to mystic rituals and initiation ceremonies for females (ibid).

It was also used by modern physicians in England and the United States, as recently as the 1940s and 1950s, to "treat" hysteria, lesbianism, masturbation, and other so called female deviances (Hodges 2005).The practice has however become firmly established in the traditions of many peoples. Proponents have listed several virtues resulting from female circumcision to include the promotion of chastity, genital hygiene, greater level of sexual stimulation of the husband by the narrow introitus and, it is claimed to make the vulva aesthetically more appealing (Brady 1999) .Others advance religious reasons (Xasan 1989).

In Nigeria where the simple operation (Clitoridectomy) is more common, many of these problems are still encountered (Okonofua et al 2002; Larsen and Okonofua 2002). Iloabachie (1990) has reported the case of an 11 year old female whose urethra was totally excised.

Comfort Momoh discovered how complex the issues around Female Genital Mutilation are and why it remains a problem when she visited Somalia from where many of the women who attend her London clinic originate (2004). Although the Somali government supported the banning of Female Genital Mutilation, such a change could no longer be sustained once civil conflict started in the early 1990s, and the number of women having undergone Female Genital Mutilation is 98%. Mobile populations and strong ideas have made education slow to reach people and affect what they do. Female Genital Mutilation is mainly performed by lay practitioners or family members. However, some qualified midwives and doctors still carry it out although awareness of the harm caused is increasing. Momoh describes the use of 'herbs, salt water, sugar, and camel dung' to stop bleeding, and also leg binding for several days (2004:631).

FGM is practised in about 28 African countries, the Middle East and South East Asia.Women and girls who have undergone Female Genital Mutilation are also found in Europe, Canada, USA and Australia because of the increasing movement of communities and individuals between countries (WHO, 2000). Movements of people seeking refuge and asylum from the Horn of Africa has led to the situation now being taken more seriously in the UK than once was the case.

The situation worldwide:

1. 100 million to 140 million girls and women have undergone some form of Female Genital Mutilation, the majority from Africa (WHO, 2000)
2. An estimated 2 million or more undergo some form of Female Genital Mutilation every year worldwide, and 6,000 are at risk every day (WHO, 1997)
3. Many girls and women die from the short-term effects of Female Genital Mutilation, such as haemorrhage, shock or infection
4. Many more suffer lifelong disability and may die from the long-term effects such as recurrent urinary or vaginal infections. Pain during intercourse and infertility are common consequences of FGM
5. Female Genital Mutilation increases the risk of women dying during childbirth and makes it more likely that the baby will be born dead. This increased risk can be as a result of severe bleeding and obstructed labour in places where safe and appropriate maternal health services are inadequate or inaccessible. In Somalia, where 90% to 98% of women are infibulated one in every 100 women giving birth dies as a result of this procedure.

In the UK:

6. 86,000 women and female children, mostly first-generation immigrants, refugees and asylum seekers living in Britain, are estimated by FORWARD (Foundation for Women's Health, Research and Development) to have undergone Female Genital Mutilation. Around 3,000 to 4,000 FGM acts may be performed each year (Powell et al., 2002). A further 7,000 children and

adolescents under 16 are at risk annually. They are often taken to their countries of origin so that FGMcan be carried out 7. the majority of those living in UK who have experienced Female Genital Mutilation, or are at risk of being cut, come from specific countries or have continuing links to them.

These reasons are debatable for one, sexual urge is not impaired by the removal of the clitoris and circumcised females are no less promiscuous than others (Hodges, 1997). The numerous complications associated with infibulations, a drastic type of female circumcision where the labia majora and minora and the clitoris are totally removed with subsequent encouragement of fusion of the raw edges leaving a narrow introitus have been reported (WHO 2004; Brady 1999).

It is important to remember that the livelihood of those who carry out Female Genital Mutilation for their communities depends on its continuance, so resistance to change may be strong. Such practitioners may also be highly respected members of society. Parents who choose to refuse Female Genital Mutilation for their daughters may come under considerable pressure from family members to conform. There is a very real fear that despite their objections, elders in the extended family will override their wishes and subject their daughters to Female Genital Mutilation.

The above is the gap this study tends to fill in order to bridge the gap between education and female circumcision, this research work was concieved. This is to create the awareness on the dangers of Female Genital Mutilation and the education of the female child.

Purpose of the Study

The aim of the research is to find out the level of education of the people involved in the circumcision and that of their parents. The objectives of this research work are;

i. To examine the degree or extent of female circumcision in the area

ii. To explore the level of education of the female child in the area

iii. To examine the main causes of female circumcision in the area

iv. To examine the consequences of female circumcision in the study area

v. To make relevant recommendations to address female circumcision and education of the Female child in the study area.

Hypothesis

The following hypotheses were postulated which the research hopes to verify in the course of this study. These are;

i. There is significant relationship between educational status and female circumcision in the area

ii. Vulva disfigurement is a function of Female Circumcision in the area

iii. Life-long painful scare is a function of Female Circumcision in the Area

iv. Inability to enjoy sex is a function of Female Circumcision in the study Area

v. Teenage Pregnancy is a function of Female Circumcision in the Area

Population

Three hundred and sixty (360) respondents were purposively selected from six systematically selected communities in Ethiope East Council of Delta State. These are the most developed communities in the Local Government Area.

Sample And Sampling Technique

Six communities were selected which were divided into clusters and 10 females from each cluster were examined. These were females with ages ranging from 14 years and above. These include female heads of families, the spokeswomen, women leaders and other opinion female leaders. In each cluster, the starting point was a purposive sampling technique, involving the targeting of individuals who suited the subject and nature of study using predetermined selection criterion randomly selected and beginning from there, the nearest door rule (i.e. the first house, whose door is nearest to the door of the current house) was used for locating the subjects.

Method Of Data Analysis

The data obtained from the field were presented in tables and statistical diagrams such as tables. These were used to express the relationship between set of data.

Presentation And Analysis Of Data

This section presented and analysed the various data gathered from the field as it concerns this study. Pearson's Product Moment Correlation Coefficient was used in testing the statistics collected. These data were sequentially presented in line with the purposes and hypotheses of the study. Y stands for Yes while X stands for No responses in the tables below :

From the table above, 57 (95%) of the 60 respondents interviewed have been circumcised while 3 (5%) are uncircumcised in Orhoakpor. In Kokori inland, 56 (93.3%) of the respondents were circumcised with 4 (6.7%) were uncircumcised. The figures for Okpara inland and Ovu shows that 58 (96.7%) and 60 (100%) were cicumcised while 2 (3.3%) and 0 (0%) were uncircumcised respectively. Going further, 52 (86.7%) of the respondents were circumcised against 8 (13.3%) were uncircumcised in Eku. However, Abraka inland has 50 (83.3%) of respondents that were circumcised against 10 (16.7%) that were uncircumcised.

Looking at the total for the table above, 333 (92.5%) of the 360 persons interviewed in Ethiope East were circumcised against 27 (7.5%) that were uncircumcised. Therefore, it shows that majority of the respondents have undergone Female Genital Mutilation. This could be attributed to tradition.

From table 3 above, it was clearly seen that the bulk of the females are secondary school certificates holders. 68 (18.9 %) of the females interviewed attended Tertiary institutions. While 233 (64.7%) of the 360 females sampled attended secondary school in the study area. The figure for those that attended primary school is 39 (10.8%) females while 20 (5.6%) of the respondents never went to school. The high figure for the secondary holders could be attributed to the fact that most of the females who undergone FGM dropped out of school due to pregnancy. They see it as being matured and ready for marriage once one is circumcised. This also account for teenage pregnancy amongst the local habitats in the study area. They see FGM as passage to adulthood and getting pregnant as a sign of being productive. From the above table, it could be seen that the major causes or reasons why FGM is being practiced in the area is due to tradition. Tradition has been seen as the main responsible factor for FGM in Ethiope East. 3 (0.8%) of the 360 females sampled agreed that religion is a contibuting factor while females are indulge in FGM. While 351 (97.5%) strongly agreed that tradition is the major causes of FGM in the study area. However, 6 (1.7%) of the respondents agreed that other reasons are responsib ;le for FGM in the study area. Having seen the above table, it could be deduced that tradition is the main causes of FGM in the study. This is due to the fact that the local inhabitats sees it as a rite of passage to adulthood of the female child. The consequences of FGM can not be overemphasised. From the table above, life-long psychological trauma in terms of the pains the female went through has 48 (13.3%) responses

from the 360 females sampled. Infectious diseases has 42 (11.7%) responses as against 16 (4.4%) responses for infertility. The consequences of FGM in the study is mainly on early marriage. Thus, 254 (70.6%) of the females sampled agreed that early marriage is the main consequence of FGM in the area. They agreed that since a circumcised female sees her self as being matured to bear children, the need for procreation to affirm that beleive is strongly encouraged and practiced. This also account for school drop outs and teenage pregnancies. This they do with joy and the education of the female is not seen as a priority in the study area.

Early marriage means marriage or cohabitation with a child or any arrangement made for such marriage or cohabitation (NCCS, 2007:15). This practice affect girl child in numerous ways. UNICEF & GOK, 1998:53) points out that child bride are common in Kenya. The child bride is denied the love and care of her family. The girl child in this situation is exposed to trauma causing sexual experiences and also after the break up with the child brides ends up destitute in the streets or as barmaids and possibly sex workers GOK & UNICEF (1998:53) Mwiti (2006:88) laments that statistics indicate that girls in rural areas are more likely to be married by the time they turn 18 years, than their peers who live in urban areas. She correctly maintains that this practice is fully supported by some communities because of their tradition and cultural orientation. Mwiti (2006:88) reveals that this cultural practice of early marriage is common in Kilifi, Busia, Kisumu and most part of North Eastern Kenya. The National Council for children's services (NCCS 2007) reveals some of the following as reasons for early marriage.

- To preserve and ensure virginity before marriage
- To control promiscuity
- For economic reasons such as acquiring dowry or bride price
- Development of social status –especially for the father and the „old man" marrying young girls.

Discussion Of Findings

The findings of the study show that Female Circumcision is still being practiced in the area and that the level of education of the female child determines the level of involvement.

With reference to figure 1 and table 2, objective i of this research work was achieved. It shows the level of female circumcision in the area.

The study also revealed that the more educated the female child is the less female circumcision of the female child. With increase in education level of the female child, the lesser the number of female circumcision. Thus objective ii was achieved with reference to table 3.

Tradition was seen as the major factor for female child circumcision. The study also revealed that due to female circumcision in the area, large number of girl child are involved in early marriage and school drop-outs. This then encourages teenage pregnancy as those female circumcised sees their status as matured for marriages. The above objective iii of this research work was achieved with reference to table 4.

It was also revealed that life-long psychological trauma, infectious diseases, infertility and early marriage coupled with female school drop-outs are the major consequences of female circumcision in the area. Thus, objective iv of this research work was achieved with reference to table 5.

However, in confirmation of the hypotheses stated for this study, the Pearson's product moment correlation co-efficient was used in testing the hypotheses. The degree of freedom was 4 with critical value of 2.78. Therefore, any calculated value above this critical value of 2.78 means that the null hypotheses would be rejected. While if the calculated value is less than this critical value of 2. 78, the null hypotheses would be accepted and the alternate rejected.

The first null hypothesis which stated that there is significant relationship between education level and female circumcision in the study area was accepted and the alternate rejected. Therefore, there is significant relationship between education level and female circumcision in the area. The Pearson's product moment correlation co-efficient was applied to the data and the result was -1.00 (see Appendix 1 and table 3)

The second null hypothesis which stated that Vulva disfigurement is a function of Female Circumcision in the area was also accepted and the alternate rejected. The Pearson's product moment correlation co-efficient was applied to the data and the result was -1.00 (see Appendix 2 and figure 1)

The third hypothesis was equally accepted and the alternate rejected. Therefore, Life-long painful scare is a function of Female Circumcision in the Area. This was confirmed with reference to table 5. The Pearson's product moment correlation co-efficient was applied to the data and the result was -1.00 (see Appendix 3)

To confirm the testing of the fourth hypothesis, The Pearson's product moment correlation co-efficient was applied to the data and the result was -1.00 (see Appendix 4). The null hypothesis was equally accepted while the alternate which states that Inability to enjoy sex is a function of Female Circumcision in the study Area was rejected.

Finally the fifth null hypothesis which stated that teenage Pregnancy is a function of Female Circumcision in the Area was accepted and the alternate hypothesis which states that teenage pregnancy is not a function of female circumcision in the area was rejected. This was confirmed when Pearson's product moment correlation co-efficient was applied to the data and the result was -30.50 (see Appendix 5 and table 5)

Summary

In summary, the researcher discovered that female circumcision is still being practiced in the region and that the trend seems to be increasing day by day.

It was seen that the level of education and awareness on the consequences of female circumcision is not being well cascaded to the people. But the few that are educated are not being involved in female circumcision. The more the people are educated the lesser the practice of female circumcision.

From the study, it was seen that once a girl is circumcised, she sees herself as being matured to have children. This has led to increase in the number of female drop-outs from schools. This was also the main reason for teenage pregnancies in the region.

The tradition of female circumcision is still being practiced and there is no clear standing on the parts of the people to discourage the practice. Presently, there is little or no efforts to discourage female circumcisioin as it is being practiced in the local government.

Finally, there is no available policy option to discourage this ugly and ancient practice as it affects the girl child in the study area. The onus now lies in us to preach the discouragement of this practice.

Conclusion

There is no corner in Nigeria where Female Circumcision is not being practiced. Females are denied the opportunity to enjoy and posses their rights. Female genital mutilation/cutting has been perpetuated over generations by social dynamics that make it very difficult for individual families as well as individual girls and women to abandon the practice. Even when families are aware of the harm it can bring, they continue to have their

daughters cut because it is deemed necessary by their community for bringing up a girl correctly, protecting her honor and maintaining the status of the entire family. Not conforming to the tradition brings shame and stigmatization upon the entire family and prevents girls from becoming full and recognized members of their community.

The practice of female circumcision should be discouraged and the education of the female child should be given top priority. There should be awareness campagne amongst the rural dwellers on the dangers of female circumcision. This could be done through awareness sessions and introduction of bills and posters in the various schools and health centres in the study area.

Government and non-governmental bodies should be involved in this fight against female circumcision in the region and Nigeria as a whole.

Recommandations

A number of issues were raised in the course of this study and attempt is made here to advance solutions on how to discourage female circumcision in the area.

1. The education of the female child up to the university level
2. Awareness sessions should be organized in the schools
3. Parents should be enlightened on the danger of female circumcision
4. Government to endorse and enforce policies that discourages female circumcision
5. Incentives in form of scholarship should be given to females who will not be circumcised.
6. Strong advocacy campaigns against the practice nationwide by working with the media on information, education and communication campaigns that have an impact on the public's understanding of FGM

Table 2. Number of Female Circumcised Amongst Respondents

Community	Circumcised		Uncircumcised	
	N	%	N	%
Orhoakpor	57	95	3	5
Kokori- inland	56	93.3	4	6.7
Okpara-inland	58	96.7	2	3.3
Ovu	60	100	0	0
Eku	52	86.7	8	13.3
Abraka -inland	50	83.3	10	16.7
TOTAL	333	92.5	27	7.5

Table 3 Level Education of Female Child in the area

Educational level	Orhoakpor	Kokori-inland	Okpara-inland	Ovu	Eku	Abraka -inland	TOTAL	%
Tertiary	3	4	5	2	20	34	68	18.9
Secondary	40	44	45	50	32	22	233	64.7
Primary	10	6	6	7	7	3	39	10.8
None	7	6	4	1	1	1	20	5.6

Table 4: Perception of Respondents on the Causes of FGM in the study area

Causes	Orhoakpor	Kokori- inland	Okpara-inland	Ovu	Eku	Abraka -inland	TOTAL	%
Religion	0	0	1	1	0	1	3	0.8
Tradition	58	59	59	58	60	57	351	97.5
Others	2	1	0	1	0	2	6	1.7

Table 5: Perception of Respondents on the Consequences of FGM in the study area

Consequences	Orhoakpor	Kokori-inland	Okpara-inland	Ovu	Eku	Abraka-inland	TOTAL	%
Life-long psychological trauma	5	10	2	5	12	14	48	13.3
Infections	2	8	6	10	4	12	42	11.7
Infertility	4	2	1	6	1	2	16	4.4
Early marriage	49	40	51	39	43	32	254	70.6

Appendices

Appendix 1

Data for educational status and female circumcision in the area

Community	X	Y	X2	Y2	XY
Orhoakpor	40	20	1600	400	800
Kokori- inland	44	16	1936	256	704
Okpara-inland	48	12	2304	144	576
Ovu	46	14	2116	196	644
Eku	51	9	2601	81	459
Abraka -inland	57	3	3249	9	171
TOTAL	286	74	13806	1086	3354

Appendix 2
Hypothesis two
Data for vulva disfigurement and female circumcision in the area

Community	X	Y	X2	Y2	XY
Orhoakpor	52	8	2704	64	416
Kokori- inland	53	7	2809	49	371
Okpara-inland	48	12	2304	144	576
Ovo	55	5	3025	25	275
Eku	58	2	3364	4	116
Abraka -inland	58	2	3364	4	116
TOTAL	324	36	17570	290	1870

Appendix 3
Hypothesis three
Life-long painful scare and female circumcision in the study area

Community	X	Y	X2	Y2	XY
Orhoakpor	55	5	3025	25	275
Kokori- inland	47	13	2209	169	611
Okpara-inland	39	21	1521	441	819
Ovo	41	19	1681	361	779
Eku	53	7	2809	49	371
Abraka -inland	56	4	3136	16	224
TOTAL	291	69	14381	1061	3079

Appendix 4
Hypothesis four
Inability to enjoy sex and female circumcision in the area

Community	X	Y	X2	Y2	XY
Orhoakpor	59	1	3481	1	59
Kokori- inland	58	2	3364	4	116
Okpara-inland	58	2	3364	4	116
Ovu	60	0	3600	0	0
Eku	57	3	3249	9	171
Abraka -inland	60	0	3600	0	0
TOTAL	352	8	20658	18	462

N=6

$$r = \frac{n\Sigma(xy)-(\Sigma x)\times(\Sigma y)}{\sqrt{n\Sigma x^2-(\Sigma x)^2}\times\sqrt{n\Sigma y^2-(\Sigma y)^2}}$$

$$= \frac{6(3354)-286\times74}{\sqrt{6\times13806-(286)^2}\times\sqrt{6\times1086-(74)^2}}$$

$$= \frac{20124-21164}{\sqrt{82836-81796}\times\sqrt{6516-5476}}$$

$$= \frac{-1040}{\sqrt{1040}\times\sqrt{1040}}$$

$$= \frac{-1040}{32\times32}$$

$$= \frac{-1040}{1024}$$

R= -1.00

N=6

$$r = \frac{n\Sigma(xy)-(\Sigma x)\times(\Sigma y)}{\sqrt{n\Sigma x^2-(\Sigma x)^2}\times\sqrt{n\Sigma y^2-(\Sigma y)^2}}$$

$$= \frac{6(1870)-36\times324}{\sqrt{6\times17570-(324)^2}\times\sqrt{6\times290-(36)^2}}$$

$$= \frac{11220-11664}{\sqrt{105420-104976}\times\sqrt{1740-1296}}$$

$$= \frac{-444}{\sqrt{444}\times\sqrt{444}}$$

$$= \frac{-444}{21.1\times21.1}$$

$$= \frac{-444}{445.2}$$

R= -1.00

N=6

$$r = \frac{n\Sigma(xy)-(\Sigma x)\times(\Sigma y)}{\sqrt{n\Sigma x^2-(\Sigma x)^2}\times\sqrt{n\Sigma y^2-(\Sigma y)^2}}$$

$$= \frac{6(3079)-69\times291}{\sqrt{6\times14381-(291)^2}\times\sqrt{6\times1061-(69)^2}}$$

$$= \frac{18474-20079}{\sqrt{86286-84681}\times\sqrt{6366-4761}}$$

$$= \frac{-1605}{\sqrt{1605}\times\sqrt{1605}}$$

$$= \frac{-1605}{40.1\times40.1}$$

$$= \frac{-1605}{1608}$$

R= -1.00

N=6

$$r = \frac{n\Sigma(xy)-(\Sigma x)\times(\Sigma y)}{\sqrt{n\Sigma x^2-(\Sigma x)^2}\times\sqrt{n\Sigma y^2-(\Sigma y)^2}}$$

$$= \frac{6(462)-8\times352}{\sqrt{6\times20658-(352)^2}\times\sqrt{6\times18-(8)^2}}$$

$$= \frac{2772-2816}{\sqrt{123948-123964}\times\sqrt{108-64}}$$

$$= -44$$

$$\sqrt{44} \times \sqrt{44} = -44$$

$$6.6 \times 6.6 = \frac{-44}{43.56}$$

R= -1.00

N=6

$$r = \frac{n\Sigma(xy)-(\Sigma x) \times (\Sigma y)}{\sqrt{n\Sigma x^2 - (\Sigma x)^2} \times \sqrt{n\Sigma y^2 - (\Sigma y)^2}}$$

$$= \frac{6(480) - 10 \times 350}{\sqrt{6x20420 - (350)^2} \times \sqrt{6x20 - (10)^2}}$$

$$= \frac{2880 - 3500}{\sqrt{122520 - 122500} \times \sqrt{120 - 100}}$$

$$= \frac{-620}{\sqrt{20} \times \sqrt{20}}$$

$$= \frac{-620}{4.5 \times 4.5}$$

$$= \frac{-620}{20.3}$$

R= -30.50

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