INTERNATIONAL JOURNAL OF ACADEMIC RESEARCH IN PROGRESSIVE EDUCATION & DEVELOPMENT

OPEN ACCESS JOURNAL

Vol 1, Issue 2, (2012) E-ISSN: 2226-6348

The Consequences of Genital Mutilation on Women in Cross River State

Otu, Judith.E. (Ph.D), Ukwayi, Joseph .K (Ph.D), Ushie, M.A. (Ph.D)

Department of Sociology, University of Calabar-Nigeria

Email: juthesame@yahoo.com.uk, jukwayi@yahoo.com, ushie@yahoo.com

To Link this Article: http://dx.doi.org/10.6007/IJARPED/v1-i2/11128 DOI:10.6007/IJARPED/v1-i2/11128

Published Online: 26 June 2012

Abstract

The practice of genital mutilation on women does not completely capture the real image of the extent of its harmfulness to women. This paper therefore seeks to examine the consequences of genital mutilation on women in Ikom Local Government Area. Questionnaire were used to obtained information such as demographic characteristic of the people and the causative factors of female genital mutilation in the area. Findings show that female genital multination is a significant determinant factor of reproductive health problems in women in the area. The data collected also revealed that there was a negative pattern of women's attitude to younger generation towards female genital mutilation in the area. However, societal beliefs system, random cultural practices was a major factors militating against the aversion to genital mutilation practices in the area. Therefore, the government most enacts and uses anti-female genital mutilation laws if this practice must be abolished in the area.

Keywords: Genital Mutilation, Cultural Practices, Real Image, Belief System, Sterility.

Introduction

Female circumcision is one traditional practice that has attracted several attention especially to scholar within this field of study Today, female mutilation is one of the several harmful traditional practices in societies where the needs of the woman are still subordinated for their male counterpart (Owumi) The practices is describe as a form of violence against women which has caught across many nations of the world especially in developed countries and Africa in particular (Adebimpe, 1986). Today, an estimated 140 million girls and women, primary in African countries and less commonly in Asia and the middle east, have undergone female gene tail mutilation (Daw, 1970). Beside, over 2 million girls and women undergo the procedure each year due to increased migration from Africa, Asia and the middle east (Johnson, 1994). In Nigeria, southern part the practice is prevalent in state such as Cross River, Imo, Edo, Akwa Ibom, Delta, Ebonyi and Anambra State. While in Northern Nigeria the practice is within the confine of Katsina, Sokoto and Kaduna (Okolo, 2005). This practice is predominant in societies with high rates of illiteracy, ignorance, poverty and low status of women in some countries. It is true that about 2 million women and girls are at risk yearly with over 90% from African countries (Karim 2002) The World Health Organization (WHO)

frowns at the involvement of medical personnel in the practice of female genital mutilation because the involvement of this group of fraud medical personnel in such practices has encouraged their literate and informed commonly members to continue with the practice, by pitching their tent where they assume that complications will be less and if they occur, would be taken care of. Thus serving as an endorsement or an inherently harmful and repressive partite (Nigeria Journal of Medical, 2004). Inspite of the effort made government, international organization such as UN1CEF and WHO, stakeholders and other non-governmental organizations the practice of mutilation on women still poses serious problems in the society. In Cross river State and in Ikom local government in particular over (85%) of the victims is forced into having the operation without prior knowledge of what it involves. This situation has caused health implications, socio and psychological damaged to women in the area. Besides, it has affected the mental and emotional well-being of women due to the fact that in most cases, it result to long-term consequences such as pelvic infection leading to sterility difficulty in urinating and there is a risk of obstructed labor. To this end this paper seeks to evaluate the consequences of genital mutilation on women in Ikom local government area with specific reference to the demographic characteristic of people who are aware of the Genital Mutilation on women and the causative factors of female mutilation in the area.

Study Area

The study was conducted within the confine of Ikom Local Government area of Cross River State. The area is bounded to the Ogoja Local Government Area, to the south by Etung local government area, to the east by Boki and to the west by Obubra local government area. Presently it has a total of 158 villages and 11 wards which are further grouped into four (4) main language groups. However, due to the agrarian nature of the Ikom people polygamy which is one of the characteristics of agrarian societies is part of the Ikom people, who see marriage to two or more wives and big family size resulting from plenty of children, as great resources and very important. Nevertheless, a typical Ikom indigene cannot do without their culture, that is their customs and traditions, that is why most 01 the people are tied to their traditional beliefs.

Methodology

The study was restricted to Ikom Local Government in Cross River State. It focus on the effect of female genital mutilation on women. The study population covered literate men and women aged 18 years and above. Eleven (11) words were selected in the area of which were further divided into four (4) main groups. A sample population of two hundred (200) people was randomly selected from the four (4) main groups. In each of the four wards, thirty five (35) female to fifteen (15) was used while two hundred (200) copies of questionnaire were randomly to the sample population. The questionnaire was to capture the demographic characteristic of the people administered. One hypothesis was tested which was to assess the determinant factor of reproductive health problem in women and also the relationship that exist between female genital mutilation and the tendency *of* complications during childbirth. The stated hypothesis was tested using chi-square (x^2) to assess the relationship that exist between dependent and independent variable at 0.05 confidence level. However, group discussion and interview were conducted with community leaders such as the Clan head, Council of Elders, Women Leaders and youths. This was to examine their various opinions on the genital mutilation on women in the area.

Procedures and Types of Female Genital Mutilation

Toubia (1995) shows that FGM is generally performed on girls between the ages 4 and 12, although it is practiced in some cultures as early as few days after birth or as late as prior to marriage or after first birth. Kosp-thomas (1987) contends that girls may be circumcised alone or with a group of peers from their community or village. Traditional elders (male barbers and female circumstances, carry out the procedure sometimes for pay). In Entrea, Davis and colleagues maintain that the practitioner may or may not have health training, use anesthesia or sterilize the circumcision instruments. Instrument used include; razor blades, glass, kitchen knives, sharp rocks and scalpels which are highly susceptible to infection. Verzin (1999) in Ihejiamaizu (2002) has observed that in Egypt, Kenya, Mali and Sudan, medical professionals such as physicians, nurses, medical professionals such as physicians, nurses, medical professionals such as physicians, nurses and midwives are used to perform the procedure. This is due to the growing recognition of the Health risks associated with female gene tail mutilation and the serious concerned regarding the possible role of female genital mutilation in HIV transmission. Nzeagwu, (2005:161) the procedure may be carried out in the girl's home of a relative or at some designated areas such as tree, river or forest particularly when it has to do with initiation. In some culture the girl may sit in cold water so that the area will be numb to reduce the likelihood of bleeding. However, no step is Taken to reduce the pain. Antiseptic power may be applied or pastes containing local herbs, milk, eggs, ashes or dung. These are believed to help in stopping bleeding and facilitate healing. If the mutilation is infibulations, thorn or stitches may be used to hold the two sides of the labia major together for up to 40 days after which girl is taken to a special place where she is given special treatment in terms of food, gift and traditional teaching for womanhood if the mutilation is initiation purpose. Female genital cutting refers to variety of operation involving partial or total removal of female external genitalia Hosken (1998:4). However, posited that traditional practices have relatively gone stale and that the disappointing effect of female genital cutting in our society have since led to reopening of debate on the best strategy and solution of eradicating this practice. This review of literature will include discussion on the concept of female genital mutilation types and reasons for female genital mutilation, effect of female genital mutilation, reasons the practice continues, prevalence and attitude regarding approaches toward abandonment of the practice and recommendations to end the practice. According to Toubia (2000:4) quoted in Ihejiamaizu (2002) stated that female genital mutilation otherwise known as female circumcision involves the cutting or alteration of the female genitalia for social rather than medical reason. The term female circumcision which was used for several decades to describe the practice has been largely dropped as it implies an analogy with male circumcision. Female circumcision is however a far more damaging and invasive procedure than male circumcision is seen as affirming manhood, female circumcision is perceived as a way of curtailing premarital sexual recklessness and preservation of virginity. Nzeagwu (2005: 157) stated that the origin of female genital mutilation to some school of thought is believed to be a direct follow-up of events recorded in the scripture (Genesis 17:24 - 27) starting from Abraham to his descendants. However, Abraham covenant with God was restricted to male not female. For Nzeagwui (2005) female genital mutilation is a highly exalted culture that should be preserved and protected at all cost and abolition will destroy the tribal system. The practice is one of the traditional practices that adversely affect the physical, mental, emotional and psychological well-being of women and affect all categories of women in both rural and urban societies.

Demographic Characteristics of the Population

The demographic characteristics of the people presented in table 1 show that over 30% of the sampled population falls between ages 18-29, and 26.5% of the sampled population between 30-40years. Those between the ages 41-50 years accounts for 24.5% while those between the ages of 25 years and above accounts for 19.0% of the total population sampled. This result shows that the percentage of those who claimed to have knowledge of female genital mutilation in the area were between the ages of 18 to 40 years. However, this is an indication that the younger generation was more vulnerable to female genital mutilation.

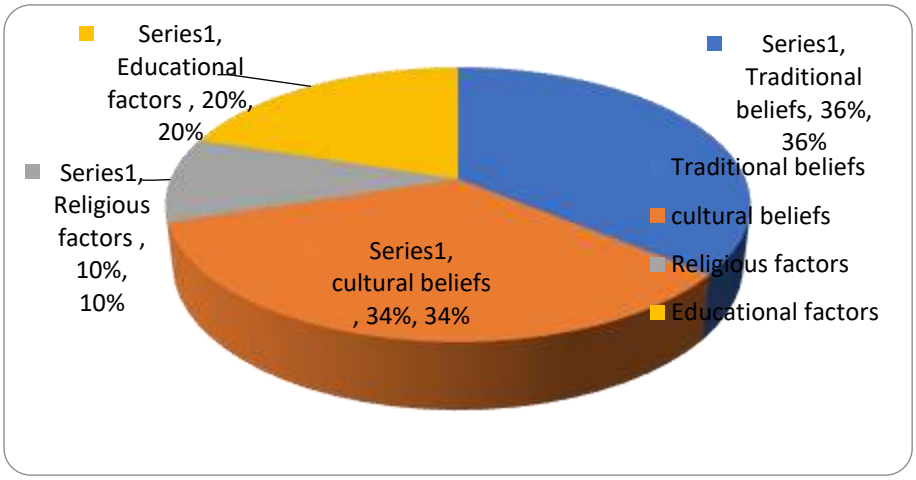
It was observed in table 1 that 33.5% sampled population were married, 30% single, 22% divorced, 11% separated and 22% were widows. This result shows that married women were more conscious of the implication of female genital mutilation in the area. The level of education attainment in the area revealed that only a few of the locals have a diploma or M.Sc. with values of 14.5% and 10% compared to 30% and 20% of those with WASC/NCE and HND/B.Sc. This result shows that the level of education attainment influence the rate of genital mutilation which was evidenced in the occupational profile with 36% of the population engaging in farming activities while 20% were civil servant. The pattern of response as shown in figure 1 indicate that 36% and 34% of the sampled population believed that traditional and cultural beliefs were the major factors militating against the aversion of genital mutilation practice while 10% and 20% of the sampled population were with the opinion that religion and educational factors were also militating against the aversion of the genital mutilation in area.

Table 1:
Demographic characteristics of the sampled population

Age group	**Population sampled**	**Percentage**
1 18-29	60	30
30-40	53	26.5
41-50	49	34.5
51 and *above*	38	19
Total	200	100
Marital status	**Population sampled**	**Percentage**
Married	67	33.5
Single	60	30
Divorce	45	22
Separated	23	11.5
Widow (s)	5	2.5
Total	200	100
Level of Education	**Population sampled**	**Percentage**
No form of education	0	0
FSLC	29	14.5
WASC/NCE	60	30
DIPLOMA	20	10
HND/B.Sc.	40	20
M.Sc./Ph.D	3	1.5
Total	200	100
Occupational Profile	**Population sampled**	**Percentage**
Student	50	25
Civil/public servant	32	16
Teaching	40	20
Farming	36	18
Trading	30	15
Housewife	12	6
Total	200	100

Source: Field work, 2010

Figure 1: Factors militating against the practice of female genital mutilation in Ikom Local Government Area



Source: Field work, 2010

Result Analysis

The result in the analysis of whether female genital mutilation is a determinant factor of reproductive health problem on women during childbirth shows a high calculated value of

9.89 and a low critical value of 7.81% which indicate that female genital mutilation is a significant determinant factor of reproductive health problems on women. In other to assessed the relationship that exist between female genital mutilation and the tendency of complications during childbirth presented in table 2 revealed a high calculated value of 9.84 greater than the critical value of 7.81 indicating that female genital mutilation generates reproductive health problems on women in the area.

Table 2:
Determinant factors of reproductive health problems in women and implication during childbirth

Determinant factor	Population sampled		Total	Percentage	Hypothesis 1
	Female	Male			
A	44	55	99	49.5	0.05
SA	36	22	58	29	Sign. Level
D	18	7	25	125	Cal. Value
SD	10	8	18	9	9.84
Total	108	92	200	100	Tab. Value 7.81
Complications	Population sampled		Total	Percentage	Hypothesis 11
	Female	Male			
A	44	55	99	49.5	0.05
SA	36	22	58	29	Sum Level
D	18	7	25	12.5	Cal. Value
SD	10	8	18	9	9.84
Total	108	92	200	100	Tab. Value 7.81

Source: Data analysis, 2010

Conclusion

This study has shown most of the causative factors and effects associated with the problem of female genital mutilation in the area. However, findings revealed that the people's traditional beliefs system and ignorant of their right as human beings due to low level of education constitute a major problem to the aversion of genital mutilation in the area. Beside the infringements of women reproductive right have so far not been taken into proper consideration. Therefore, much is needed to be done by the various agencies saddled with the responsibility of controlling this menace in Cross River State and in Ikom Local Government in particular.

Recommendations

Based on the sundry of the study on the consequences of genital mutilation of women in Ikom Local Government Area, the following recommendations are put forward to combat the situation.

1). It is pertinent for the government to reenact laws and put them into check so that those involved in this practice should be punished

2). Government should ensure that proper ant-sexist sex education be included in the school curriculum. This would help educate youth on the danger associated with genital mutilation on women

3). NGOs should help in creating the necessary awareness in the society and organized counseling services for behavioral and attitudinal change

4). Religious bodies should make a religious pronouncement clearly stating and strongly considering the practice of female genital mutilation

5). Medical practitioners should oppose all forms of female genital mutilation and make user that offenders are prosecuted

References

Adebimpe, O. (1986). Health implication of Female Genital Mutilation . Ibadan; Longman Nigeria Plc.

Asika, N. (1991). Research methodology in the behavioral sciences. Ibadan. Longman Nigeria Plc.

Charles, J. O., Moses, U. I., Inyang, E. I., & Charles, A. O. (2005). Human Development Child welfare and addiction social work perceptive Lagos: Serenity printing and publishing Co

Dokenoo, E. E. (1992). Female genital mutilation proposal for change. London: England : Minority rights group.

Ihejiamaizu, E. C. (2002). Issues in population policy and health care administration. Calabar. African Scholars.

Karim, S. (2002). Circumcision and mutilations: Male and female. National population council, Cairo, Egypt.

Kouba, L. J. (1985). Female circumcision in Africa: An overview . African studies review.

Nwagbara, E. N. (20010. Doing sociology: The element of social research . Calabar: Baye communication.

Nzeagwu, R. C. (2005). AIDS Education. Kaduna: Datura Prints & publisher Nigeria Journal of Medicine, Vol. 13, No.3, July - September, 2004.

Okolo, G. U. (2005). Violence Against Women. Calabar: Baye communication

Owumi, B. E. (1991). Forms of circumcision and its implication for the female folk. Ibadan Longman Nigeria Plc.

Population Reference Bereau. (2001) Abandoning Female Genital cutting prevalence, attitudes and efforts to and the practice, Washington. D.C.: PRB

Sport, W. J. (1962). Human groups. Harnmondsworth: Penguin Books

Toubia, N. (1995). Female Genital Mutilation: A call for global action. New York: Rainbow publishers.

Koso-Thomas, O. (1987). The circumcision of women : a strategy for eradication. London: Red press.

Verzin, J. A. (1999). Sequela of female circumcision. Tropical doctor. Pp163-169

Hosken, F. C. (1978). The epidemiology of female genital mutilation. Tropical doctor. Pp. 150-156.

Daw, E. (1970). Female circumcision and infibulations: complication delivery. Ppp559-563.

Johnson, K. E. (1994). When cultural practices are health risks: The dilemma of female circumcision. Holistic nursing practice. Pp70-78.