PDF - ASSESSMENT OF FEMALE GENITAL MUTILATION IN NIGERIA - researchcub.info**CHAPTER ONE**

INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Female Genital Mutilation (FGM) also known as Female Genital Cutting (FGC), Female circumcision, or Female Genital Mutilation/cutting (FGM/C) is defined by the World Health Organization (2007) as "all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organ for non-medical reasons. The practice of FGM is one of the most significant health and human right issues in the world (UNICEF 2005). Thorpe (2002) on his part describe Female Circumcision as excision, where part of the labia minora and the majora are stitched together and a hole left to allow the urine and menstrual blood to escape. In a similar vein, Amnesty International (1997) states that Female Circumcision is the removal of all or part if the labia minora and cutting of the majora to create raw surfaces which are then held firm by a collar over the vagina when they heal.

Although the exact origin of Female Genital Mutilation cannot be stated. There are some evidence suggesting that it originated from ancient Egypt (WHO 1996). An alternative explanation is that the practice was an old Africa rite that came to Egypt by diffusion. According to UNICEF (2005) the majority of FGM cases are carried out in 28 Africa Countries. In some countries (e.g Egypt, Ethiopia, Somalia and Sudan), prevalence rate can be as high as 98 percent in other countries such as Nigeria, Kenya, Togo and Senegal, the prevalence rates vary between 20 and 50 percent. It is more accurate however to view FGM as being practiced by specific ethnic group, rather than by a whole country as communities practicing FGM straddle national boundaries.

Until the 1950s FGM was performed in England and the United States as a common treatment for lesbianism, masturbation, hysteria, epilepsy and other so called "female deviances" (Reymond, 2007). In a study in Kenya and Sierra Leone it was revealed that most protestants opposed FGM while majority of Catholic and Muslims supported it continuation. (Ali, 2007). Also there was a direct correlation between a woman's attitude towards FGM and her place of residence, educational background, and work status. (Mohamud, 2008). Demographic and Health Survey indicates that urban women are less likely than their rural counterpart to support FGM. Employed women are also less likely to support it. Women with little or no education are more likely to support the practice than those with a secondary or higher education. Data from the 2004 Sudanese Survey (of women 15 to 49 years old) show that 80 percent of women with no education or only primary education support FGM, compared to only 55 percent of those with Senior Secondary or higher schooling (Ali, 2007).

FGM takes place in parts of the Arabian, Peninsula i.e Yemen and Oman, and is practiced by the Ethiopian Jewish Falachas some of whom have recently settled in Israel. It is also reported that FGM is practiced among Muslim population in parts of Malaysia, Pakistan, Indonesia, and the Philippines (UNICEF 2008). As a result of immigration and refugee movement, FGM is now being practiced by ethnic minority population in other parts of the World such as USA, Canada, Europe, Australia and New Zealand. According to Foundation for Women's Health Research and Development(2002) it is estimated that as many as 6,500 girls are at risk of FGM within U.K every year.

This diffusion has raised the issue of the need for human service provider to get involved in curbing FGM.One such providers are social workers, who by the nature of their training are equipped to stand against injustice and oppression (Zastrow, 2000). FGM according to Idowu (2008) is injustice and

oppression against woman. The procedures in most cases according to Yoder (2003) are carried out by older women with no medical training. Anesthetics are not used and the practice is usually carried out using basic tools such as knives, scissors, scalpels, pieces of glass and razor blades. Often iodine or a mixture of herbs is placed on the wound to tighten the vagina and stop the bleeding. The age at which the practice is carried out varies from shortly after birth to the labour of the first child, depending on the community or individual family.

The reasons for FGM are diverse, often bewildering to outsiders and certainly conflicting with modern western medical practices and knowledge. The justification for the practice is deeply inscribed in the belief systems of those cultural groups that practice it. Custom and tradition are the main justification given for the practice (Muganda 2002).People adheres to this practice because its part of their culture and fulfilling this aspect of culture gives them a sense of pride and satisfaction.

According to Ali (2007) FGM is seen by some people as an essential part of social cohesion and not an act of hate. It is carried out on children because their parents believe it is in their best interest, which is one of the myths of FGM. In some communities where FGM takes place, it is said to be because it is necessary for a woman's honour and pride and uncircumcised woman will stand very little chance of getting married. FGM has also been said to be carried out to safeguard the chastity of a woman before marriage (Johnson, 2008). Some others also use it as a means of controlling and de-sexualizing women and repressing sexual desire thus reducing the chance of sexual promiscuity in marriage on the part of the woman (Johnson, 2008). There are also others who claim that FGM is performed for aesthetics and hygiene Idowu(2008). The practice is carried out as means of purification and ensuring that a woman is clean (UNICEF 2008).

In some societies, the practices is embedded in coming-of-age rituals, sometimes for entry into women's secret society, which are considered necessary for girls to become adult and responsible members of the society (Johnson, 2008). Girls themselves may desire to undergo the procedure as a result of social pressure from peers and because of fear of stigmatization and rejection by their communities if they do not follow the tradition (Behrendt, 2005). Thus in cultures where it is widely practiced, FGM has become important part of the cultural identity of girls and women and may also impart a sense of pride, a coming of age and a feeling of community membership (UNICEF, 2005). FGM is a procedure which causes a number of health problems for woman and girls. There is a great deal of evidence indicating extremely detrimental long and short term health consequences (UNICEF 2002). Although, there are virtually no documentation on the social psychological and psycho-sexual effects of the practice, but it is clear from anecdotal evidence of women's experiences, that FGM affects women adversely in various areas of their lives.

In Nigeria, the practice of FGM is widespread among tribes and religious groups where the milder forms are done except in south-south region where infibulations – the total closing of the vulva is done but usually after age five (Nigeria Demographic and Health survey, 2003). It is done more among the poorly educated, low socio-economic and low social-status groups (ND HS 2003). Although UNICEF (2005) gave the national prevalence of FGM of 61% among Yoruba, 45% among Ibo and 1.5% among Hausa-Fulani ethnic group, this making it a greater problem in southern Nigeria.Edo state is one of the state in southern Nigeria therefore one may assume that FGM also occurs there. However, the authenticity of this claim is not known as there have not been any studies done to check if actually FGM exist in Edo state. This study therefore hopes to determine if FGM actually exist as of today in Edo state or if it was something that happened in the past.

1.2 STATEMENT OF THE PROBLEM

The term Female Genital Mutilation refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organ for non-medical reasons. FGM has known health benefits on the contrary. It is known to be injurious to girls and women in many ways with short and long term health consequences(UNICEF, 2007).

For one to actually appreciate the magnitude of the situation, it will be instructive to consider some data as presented by (WHO 2006). An estimated 100 million to 140 million girls and women worldwide have undergone Female Genital Mutilation and more than 3 million girls are at risk for cutting each year on the Africa continent alone(WHO 2008).

Foundation for women's Health, research and Development (2002) estimates that there are presently 86,000 first generation immigrant and refugee women and girls in the UK who have undergone FGM in their countries of origin with more than 7,000 girls at risk.

The International Federation of Red Cross and Red Crescent Societies reported on 16th August in 2006 that in Cameroon, FGM is carried out in a barbarous manner by traditional midwives with no medical training, without anesthetic and rudimentary instrument. It can give rise to serious complications. Sometimes resulting in death. According to official estimates Cameroon currently has a population of some 17 million, 52 percent of them are women. The United Nations figures suggest that around 20 percent of these women are victims of FGM. An experience that can occur at various ages at birth, during adolescence, just before marriage or even after the birth of their first child.

In Kenya there are report that in spite of the law prohibiting FGM, the practice still persist. According to UNICEF (2007) one third of women between the ages of 15 and 49 had undergone FGM of the country's 42 ethnic groups, only four (thluo, Luhya, Teso, and Turkana) constituting 25 percent of the country's population did not traditionally practice FGM. According to the NGO MaendeleoyaWanawake (Development of Women), the percentage of girls undergoing the procedure were 80 to 90 percent in some district of eastern, Nyanza, and Rift valley provinces.

According to a 2002 World Health Organization's Study, about 60% of the Nigerians total female population have undergone one form of female Genital mutilation or the other. Also a 2001 United Nations development Systems Study reported that 32.7 million Nigeria women have been affected by the same practice. Between 2000 and 2001, a study conducted by the center for Gender and Social Policy Studies. ObafemiAwolowo University, Ile-Ife, Osun State, Nigeria was contracted by the following Organization World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP) the United Nation Population Fund (UNFPA), the Nigeria Ministry of Women's Affairs and the Nigerian Federal Ministry of Health. The study covered 148,000 women and girls from 31 states of the country came out with a revelation that all the four different types of Female Genital Mutilation identified so far, are being practiced in all the ethnic communities in Nigeria except the Fulani Ethnic Group in the North Western part.

Another disturbing trend in this matter is that despite the fact that Nigeria was one of the five countries that sponsored a resolution at the forty-six World Health Assembly calling for the eradication of FGM in all Nations; the practice is still very rampant in the country. Apart from its hazardous health effects, FGM has been known to be one of the most offensive means of violating the fundamental rights of women and female children so recognized by various domestic and international legal instruments (Amos, 2004). Recent

review have suggested that FGM may increase the risk of HIV. Kankiet (2002) reported that Senegalese prostitutes who had undergone FGM had a significantly increased risk of HIV infection when compared to those who had not.

Female genital mutilation is associated with a series of health risk and consequences. Almost all those who have undergone FGM experience pain and bleeding as a consequence of the procedure (Obermeyer, 2005). The intervention itself is traumatic as girls are usually physically held down during the procedure (Chalmer, 2007). Those who are infibulated often have their legs bound together for several days or weeks thereafter (Talle, 2002) other physical and psychological health problems occur with varying frequency.

Based on the foregoing, this study intends to investigate the issues of FGM in Edo state.it seeks to find answers to the question of whether FGM is a myth or reality and to determine if it has relationship with factors like religion and residential location.

1.3 OBJECTIVES OF THIS STUDY

The objectives of the study are as follows:

1. To find out if FGM exist in Edo State
2. To determine if there are differences between those who believe that FGM exist and those who do not believe on its existence
3. To ascertain if FGM as ever existed in Edo State
4. To ascertain the implication of FGM for social work practice in Nigeria
5. To find out if religion has a role to play in the promotion or otherwise of FGM
6. To find out factors that may otherwise influence the existence of FGM

1.4 SIGNIFICANCE OF THE STUDY

This study is significant in two dimensions which are theoretical and practical. Theoretically it is hoped that the outcome of this study will constitute a scientific body of knowledge that will become a point of reference for other scholars who would want to carryout similar research. It will also add to existing knowledge of FGM in southern Nigeria. Practically it is hoped that this study will assist government in re-evaluating existing policies so as to come up with a more realistic programmes and policies towards the eradication of FGM in Edo state and Nigeria in general.

1.5 AREA OF STUDY

The study is on Female Genital Mutilation. The research will be carried out in Edo state .However the researcher decided to focus on Benin City which is the capital of Edo. Benin can be describe as a microcosm of Edo State because all ethnic groups are well represented there. Restricting this study to Benin city was for rigor and want of time .Benin city is made up of three local government areas; namely: Oredo, Egor and IkpobaOkha L.G.A. This constitutes the geographical boundary within which the research will be carried out. Edo State has a population of 3,218, 332 made up of 1,640,461 males and 1, 577, 871 females and a growth rate of 2.7% per annum (NPC, 2006), as well as a total landmass of 19,187 square kilometres, the state has a population density of about 168 persons per square kilometres.

. It is made up of three major ethnic groups; namely the Binis, Esan and Afemai. However the State has a high presence of residents from across the country and the world because of its cosmopolitan tendencies. Benin City the capital has a history of being one of the foremost destinations of Europeans during their exploration of Africa continent many centuries ago. Some of the flash points have remained

enviable tourists’ attraction for the state.

The main ethnic groups in Edo State are: Edos, Afemais, Esans, Owans and Akoko Edos. Virtually all the groups traced their origin to Benin City hence the dialects of the groups vary with their distance from Benin City. The Bini speaking people who occupy seven out of the 18 Local Government Areas of the state constitute 57.54% while others Esan (17.14%) Afemai comprising of Etsako (12.19%), Owan (7.43%), and Akoko Edo (5.70%). However, the Igbira speaking communities exist in Akoko Edo as well as Urhobos, Izons, Itsekiris communities in Ovia North East and South West Local Government Areas especially in the borderlands. Also, Ika speaking communities exist in Igbanke in Orhionmwon LGA.

A lot of communities and indeed the ruling dynasties in all the clans trace their roots to the ancient kingdom of Benin. Cultural similarities are in the areas of religious worships, folk-lore, dances, and festivals, traditional modes of dressing, arts and craft. The political pattern and behaviour are based on a situation where both the monarchical and republican ideas flourished in an integrated manner. The colourful traditional festivals in the state manifest its rich cultural heritage. Critical among these are the Igue and Ekaba festivals done among the Binis and Manhood initiation (age groups) by the Etsako people.

Edo State has a very rich tradition of festivals and masquerades through which the people either appease the various gods and goddesses initiate men and women into age-grades or as a traditional get-together. They include:

The Igue festival ,Ekaba, Ukpe, Irua, Agiele, Adu-Ikukwua, Ebomisi, Eho, Ipihionua, Ugbele, Itakpo, Ofarhe, Emomorhe, Iko, Uzo, Ugozo/Ihiasa, Uba, Egbere, Owere, Ukpako, Oriminyam, Ohonmoimen, Itikiri, Ivhamen/Ororuen, Amekpe,Oto-Uromi,Ighele,andOkpuge-Oro.

1.6 SCOPE OF STUDY

The study is on the myth and realities of female genital mutilation in Edo state. It seeks to find out if FGM truly exist in the state. The entire adult male and female population constitutes the study population out of which a sample of four hundred adult men and women will be used for the study.

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