Female Genital Mutilation in Ovia South-West Local Government Area of Edo State and Its Implication to Social Work Pratice

By

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Abstract

Despite global concerns, awareness, and campaigns against Female Genital Mutilation (FGM), prevalence remains high in most countries of the globe, especially in Africa. This study set out to explore female genital mutilation in Ovia South-West Local Government Area of Edo State and its implication to social work. Examine the experiences women have after female genital mutilation in Ovia southwest local government area of Edo state. Examine the effect of female genital mutilation on the health of the women in Ovia southwest Local Government Area of Edo State. Current study investigated the knowledge, attitude, and public perception of FGM of Bini indigenes who reside in Ovia southwest local government area of Edo state, Southern Nigeria. A total of three hundred and ninety-nine (399) participants were recruited from Benin City, Nigeria. An open-ended questionnaire of about the same number (n = 399) was carefully structured, validated, and distributed to participants to ascertain their level of awareness and understanding of the implications of FGM. Sociodemographic data of respondents were also collected and comparisons were made across gender, age, and religious lines on beliefs and practices of FGM. Sections of the questionnaire were subjected to statistical analysis after data collection, results expressed in simple percentages. After careful observation, study found that about 71.4% of the respondents were ill-informed on the cultural norms and principles of FGM in line with global best practices of the World Health Organizations (WHO). However, the study found out that FGM violates the dignity of women in Ovia South-West Local Government Area. This implies that educational health campaigns against FGM could be useful in combating the hazardous implications of FGM on the socio-cultural well-being of the

female child. Continuous education geared towards global best practices in the study area is highly recommended.

Keywords: Care, Female, Genital, Medical, Mutilation,

Background to the Study

Female genital mutilation (FGM) can also be referred to as female genital cutting. In native parlance, it is known as female circumcision. This is the removal of the clitoris of females without anesthesia. This painful practice is done with native instruments by traditional women with crude devices. A few educated parents hired nurses for this purpose when children were just weeks old. FGM serves one purpose: to preserve the cultural traditions that have existed for centuries in a few Third World countries. The World Health Organization defines FGM as "a harmful traditional practice that involves the partial or total removal of external female genitalia or other injuries to female genital organs for non-medical reasons" (WHO, 2023).

According to the Greek historian Agatharchides of Cnidus, female circumcision was first reported in the 2nd century when tribes in Western Arabia (present-day Egypt) were circumcising their daughters (Daniel, 2013). Since then, it has spread southwards to sub-Saharan Africa. Practiced for over twenty centuries-spanning historical epochs, the international community did not take note of the practice until a group of medical personnel reported its harmful effects to World Health Organization WHO officials in a conference hosted in Khartoum, Sudan in 1965. It was not until another medical conference against harmful traditional practices was held in 1979 that WHO officials issued a policy statement condemning the practice as very harmful to the reproductive rights and dignity of females (Althaus, 1997). Similar conferences were held elsewhere in different parts of Africa regarding the consequences of FGM but the practice continued.

Before 1990 when the practice was in vogue, modern women yielded to the influence of their illiterate mothers to mutilate innocent newly born babies and teenage girls who had no choice but to resist or to run away from being grabbed. Those literate women who initially resisted were deceived by their mothers to send their young children for Christmas holidays, only for them to be forcefully

grabbed and mutilated (Communication with a retired Nurse Mrs. Ojonga, 2023 Calabar, Nigeria). Rather than become a beacon of light to lead native people to modernity, some trained medical personnel, notably medical doctors, nurses, and other allied health professionals, were passive and not forceful in condemning FGM practices in their respective communities in Nigeria. Some experienced nurses were even recruited to cut newly born babies for a fee, thus indicating that they were in support of FGM.

Statement of the Research Problem

In recent times, FGM practices are deeply rooted in gender disproportion, and cultural exclusiveness, as well as in the beliefs and practices of purity, restraint, aesthetics, class, and reputation. It acts as a testament for the control of women's libido and sexual desires, promoting fidelity and chastity, and is often encouraged by both women and men (World Health Organization (2016), Moher, Shamseer, Clarke (2015). It has been reported that the major components of African culture, norms, and traditions vary across ethnic enclaves in diverse communities with observed procedures across ages between six and eight, and a few cultures prefer it at birth, menarche, or before marriage (El-Defrawi, Lotfy, Dandsh, Refaat, Eyada, 2001). Female genital mutilation has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, which interferes with the natural functions of girls' and women's bodies. Immediate health risks include hemorrhage, shock, infection, HIV transmission, urine retention, and severe pain. The practice of female genital mutilation is recognized internationally as a violation of the human rights of girls and women.

A major research problem is the lack of numerous publications from social workers on FGM. As a consequence, the perspectives of social workers are lacking, yet the Code of Ethics of Social Work condemns any form of abuse or barbaric actions that are harmful and antithetical to safety and the well-being of everyone. Although Sweileh (2016) compiled an annotated bibliography of over fifty publications on FGM, he did not critique the reasons associated with the procedure. This study intends to examine the effects of female genital mutilation in Ovia south-west Local Government Area of Edo State, Nigeria, and its implication to social work**.**

Objectives of the Study

The aim of this study was to examine female genital mutilation in Ovia Southwest Local Government Area of Edo State and its implication to social work practice. While the specific objectives were to;

1. examine the experiences women have after female genital mutilation in Ovia south-west Local Government Area of Edo State
2. examine the effects of female genital mutilation on the health of the women in Ovia south-west Local Government Area of Edo State

Literature Review

The literature review on female genital mutilation provides valuable insight into the complex socio-cultural dynamics surrounding the practice, and health consequences for women and girls, and the importance of multispectral approaches to combat female genital mutilation, continued research and collaboration among researchers, policy makers, health care provider, and communities are essential to accelerate progress in ending FGM and protecting the rights and well-being of women and girls worldwide. Female Genital Mutilation is the practice, of partially or totally removing the external genitalia of the girls and young women for non-medical reasons (World Health Organisation, 2023). It is illegal in many countries, it can also be defined as the ritual cutting or removal of some or the entire valve, the practice is found in some countries of Africa. It comprises all procedures that involve partial or total removal of the external female genital organ for non-medical reasons. The practice has no health benefits for girls and women and causes several bleeding and problems urinating, and later cysts, infections as well as complications in childbirth and increased risk at newborn death (Daniel, 2013).

Female genital mutilation is harmful due to severe bleeding which has led to hospitalization and at times deaths of some victims (Esho et al, 2017; Althaus, 1997; Okeke, et al, 2012; Tambe, 2023). The transmission of HIV and other infectious diseases may be rife because the instruments and blades are rarely sterilized. These tools are used to mutilate all females without consideration of possible infections. When the instruments are not sterilized, the women are exposed to long-term chronic infections such as Hepatitis B or C or HIV/AIDS (WHO, n. d.). Several studies have revealed the devastating impact of FGM on women's reproductive

health (Sweileh 2015; Shakirat, et al. 2020). For example, labour may become more difficult because some aspects of the reproductive system may be compromised. In addition, the urinary tract may be damaged such that the need for surgery in a process known as infibulation becomes rife (Esho et al., 2017; Gould, 2010; Okeke et al, 2012). For most women, the fear, trauma, and pain associated with coitus can be very lasting (Althaus, 1997). There is also pain while copulating. All the studies show that disinterest in coitus and loss of pleasure remain for life. "Immediate complications of FGM can include severe pain, excessive bleeding (hemorrhage) genital tissue swelling fever infections e.g., tetanus urinary problems wound healing problems injury to surrounding genital tissues shock, and even untimely deaths" (WHO n. d.). Several medical experts have listed other long-term complications too numerous to cite. FGM constitutes a serious problem with ramifications for the reproductive health and coital pleasure of all survivors. The problem is so severe that its impact on all women can be generalized to pain. Most women cannot initiate or easily yield to their husband's frequent sexual demands because the clitoris has been excised; the drive for frequent sexual intercourse is difficult save for procreating children. Consequently, it has adversely impacted their respective husbands who experience inadequate sexual encounters. Some radio programmes have discussed the problems of FGM in marriages. Some disgruntled participants complained about their frustrations and inadequacies with their spouses and urged the practice to end. These assertions were confirmed by Escho, et al (2017) and more recently by O'Neil and Pallitto (2021). Another group of Somali men shared similar complaints about a lack of sexual satisfaction with their mutilated wives. After sexual encounters with girlfriends who were not mutilated, they confessed great enjoyment (O'Neill & Pallitto, 2021).

As repeatedly asserted above, a major disadvantage faced by survivors of FGM is the loss of interest and diminished pleasure in coitus (Ibizugbe, 2023; Onwuzu, 2020; Nyairo, 2013). It can be very difficult and frustrating for men to get their partners interested in coital action. Since men have higher sex drives, they tend to demand sex more often (Esho et al, 2017). Becoming aroused takes longer for FGM survivors; most women lose interest in frequent copulation due to pain and other physiological factors associated with FGM (Onwuzu, 2020; Esho et al, 2017; O'Neil &Pallitto, 2021). Unlike uncut women, they rarely initiate sex or have cravens for

coital acts. Their sexual function is greatly reduced when compared to uncut women in different samples (Nzinga et al, 2021; Nyairo, 2013).

Female Genital Mutilation: A Social Work Perspective

Studies on the role of FGM in Social Work practice are not numerous. A few publications in the European Union and North American countries, where Social Work has a strong presence, could not find publications that discuss the impacts of FGM and how it relates to Social Work practice. Although Berg (1997) gave us her perspective on FGM and Social Work implications in Canada, it is not a contemporary publication. According to the Code of Ethics of Social Work (1996), social workers anywhere in the world ought to be proactive in helping those harmed by barbaric practices. That was why Social workers were tasked with visiting immigrant communities to sensitize them about the dangers of FGM and urge them to report to the police where there is suspicion of FGM (British Association of Social Workers, 2015). This is in keeping with the Code of Ethics of Social Work, which instructs social workers to advocate for the vulnerable, weak, and poor who are experiencing social and cultural violations of their human rights (Workers (2008). The traumatic process of FGM is harmful to the dignity and rights of females due to the possibility of death. Apart from advocacy and education on the harm of FGM, social workers should seek to find out where FGM practices are occurring and report to law enforcement agencies for speedy arrests and prosecution of violators. Social workers advocate for social justice and clamor for the healthy growth of children, safe from harm and any injury, in addition to the eradication of harmful cultural practices under any guise of cultural, religious, or social requirement. As the engineers of social change, it is our responsibility to advocate for changes that prevent violations of the human rights and dignity of our clients and the general public. The Social Work profession views FGM as harmful in the following forms.

Theoretical Framework

The theoretical framework for the study includes Mitchell and Oakley's (Oxford, 1986) feminist theory and Boas' (1942) theory of cultural relativism. Feminist Theory suggests that in a society, gender is the primary organizing characteristic. According to Mugo (1997) feminist theory and its evolution are based on the different experiences of men and women, the oppression of women as an excluded

group within society, and structure of the female oppression as a function of cultural organization (Ropers-Huilman & Winters, 2011). The concept of feminist theory can be applied to FGM/C. According to Article 5 of the Universal Declaration of Human Rights, "No one shall be subjected to torture or to cruel, inhuman, or degrading treatment or punishment". Mugo (1997) described FGM/C, in the name of a ritual, as a form of physical abuse. Baum (2004) stated women, as fundamentally different from men, are subjected to androcentric cultural norms that privilege men and restrict women. The literature on feminism theory, which includes an exploration of the exploitation and oppression of women, coincided with the aim of this study. However, a challenge to this thinking is the consideration of the African worldviews and systems of thought regarding traditional and cultural standards of FGM/C practices (Ropers-Hulman & Winters, 2011).

Thus, feminist theory, alone, could not provide a sufficient framework for exploring the research question of this study. Accordingly, the study used cultural relativism theory in conjunction with feminist theory to create a comprehensive theoretical framework. Cultural Relativism Theory Boas first introduced the concept of cultural relativism in the 1920s. Cultural relativism theory suggests that "cultures each have their values and ways of understanding the world and therefore each ethnic group needs to be understood in its own, culture-specific terms" (Tennekes, 1971). When considered within a cultural context, cultural relativists argue that all customs and institutions are equally valid (Kanarek, 2013). Cultural relativism has been used across many disciplines, especially in the social sciences (Kanarek, 2013). Given the strong cultural context within which FGM/C must be considered, cultural relativism theory provided a strong theoretical foundation for the study. Cassman (2007) suggested in the context of FGC, unless an understanding of the ethnic, cultural, and religious rationales for the practice is considered, the international movement toward the elimination of this practice is unlikely.

Research Methodology

Survey design was appropriate for the study; this is because the study seeks the opinion of various categories of people living in Ovia South West Local Government Area. Survey design was deemed the most appropriate for gathering the data required for the study because it centers on people and their beliefs, opinions, attitudes, motivations, and behaviours. The estimated population of Ovia Southwest Local Government area is 312,608 with 174,536 males and 138,072 females. The total population of people 20 years and above is 201188(Ovia Southwest Local Government Area Statistics Department, 2024), which is the target population for this study. These are people who are residents of Ovia south-west Local Government Area. This is to ascertain a comprehensive report on the impact of early marriage on the child's education in Ovia South-West Local Government Area. This is necessary to target people who are old enough to understand the issue under study. This comprises both males and females irrespective of their educational qualification, socio-economic background, employment status, religious affiliation, marital status, and ethnic affiliation.

The study adopted simple random sampling technique, systematic sampling technique and purposive sampling technique. In selecting people who are residents of Ovia South-West Local Government Area, Communities that make up ovia south-west were identified as thus Iguobazuwa, Udo, Ora, Usen, Umaza, Ugbogue, Siluko, Ofunama. It may not be feasible to cover the above-mentioned communities as a result of funds and time. Hence, simple random sampling technique was used to select two (2) communities (Iguobazuwa and Udo) from the twelve (18) communities listed above. Based on this, lucky-dip method was used to select the communities. To get a sizable number of the respondents, the communities were further divided into streets, using lucky-dip method to select streets numbered A, B, C, and D where systematic sampling was adopted in the selection of households, so that the household was evenly selected. The household would be selected at certain intervals using the "kth" element represented as

$$K = \frac{N}{n}$$

Where k= sampling interval
N= population size
N= sample size

In each of the selected households, at least two adults including the head of the household was selected purposively. To determine the sample size; Solvin'sformula for calculating sample size was adopted. It is represented as thus:

$$n = \frac{N}{(1+N(e)^2)}$$

Where n= sample size
N=Population of the study
E=Degree of freedom
1=Constant

Therefore
N= 201188
E=0.05

$$n= \frac{N}{(1+N(e)^2)}$$

$$n= \frac{201188}{(1+201188\,(0.05)^2)}$$

$$n= \frac{201188}{(1+201188\,)(0.0025)}$$

$$n= \frac{201188}{(1+502.97\,)}$$

$$n= \frac{201188}{503.97}$$

n= 399.2
n= 399
From the analysis above, the sample size was 399

The questionnaires administered were carefully edited, coded, processed, and analyzed with the Statistical Package for Social Sciences (SPSS) version 22.0. Descriptive statistics like simple percentages and tables were used for the analysis of the personal data of the respondents.

In this survey, two aspects of data analysis are used. The first is the general description of the social-demographic distribution of respondents. The second is cross-tabulation of the data gotten from respondents in the section B of the questionnaire in relation to the objectives of the study.

Table 1 Socio-Demographic data of respondents

Variable	Response	Frequency	Percentage %
Age Group	Below 20 years	48	12.0
	20-29 years	91	22.8
	30-39 years	107	26.8
	40-49 years	68	17.0
	50-59 years	57	14.3
	60 years and above	28	7.0
	Total	**399**	**100**
Sex of respondents	Male	191	47.9
	Female	208	52.1
	Total	**399**	**100**
Marital status	Single	94	23.6
	Married	215	53.9
	Divorced	49	12.3
	Separated	41	10.3
	Total	**399**	**100**
Educational attainment	No formal education	65	16.3
	Primary school	115	28.8
	Secondary school	174	43.6
	Tertiary school	45	11.3
	Total	**399**	**100**

Occupation	Farming	20	5.0
	Trading/ Business	36	9.0
	Artisan	103	25.8
	Civil servants	140	35.1
	Unemployed	41	10.3
	Self employed	15	3.8
	Student	44	11.0
	Total	**399**	**100**
Religion Affiliation	Christian	241	60.4
	African Traditional	112	28.1
	Religion	46	11.5
	Islam	**399**	**100**
	Total		
Number in household	One	12	3.0
	Two	24	6.0
	Three	16	4.0
	Four	29	7.3
	Five	84	21.1
	Six	62	15.5
	Seven	59	14.8
	Eight	33	8.3
	Nine	53	13.3
	Ten and above	27	6.8
	Total	**399**	**100**

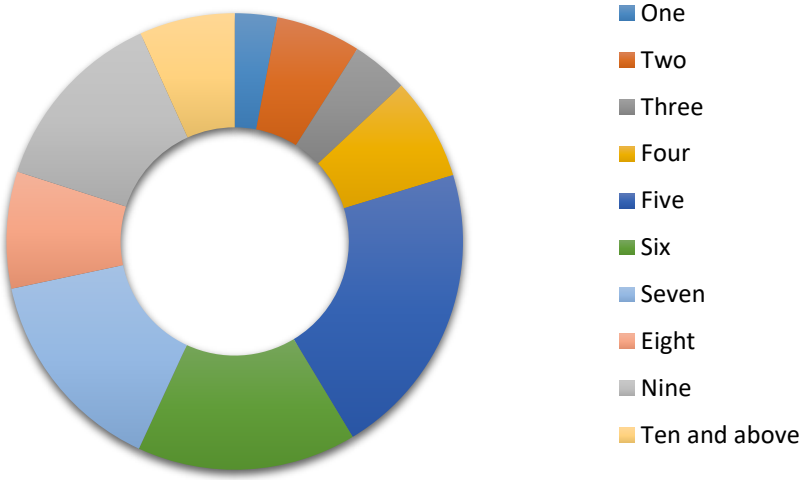
Source: Fieldwork, 2024

The table 1 above showed the age distribution of respondents, the result from the table revealed that 48 of them, representing 12.0% below 20 years; while 91, representing 22.8% are within the age range of 20-29 years. Also 107 of the respondents, representing 26.8% of the entire respondents' falls within ages 30-39 years. However, 68 of them, representing 17.0% are within the age range of 40-49years; 57 of them, representing 14.3% of the respondents fall within ages 50-59years; and also 28 (7.0%) of the respondents fall within ages 60 years and above. Therefore, majority of the respondents who participated in this study fall within ages 30-39 years.

The sex distribution of the respondents. Of the 399 respondents, the result revealed that 208 (52.1%) were females; while 191 of the respondents, representing 47.9% were males. Therefore, it can be said that the majority of respondents in this study are females. The marital status of the respondents. Of the 399 respondents, the result indicated that 215 (53.9%) were married, 94 (23.6%) were single; 49 (12.3%) were divorced; while 41 of them, representing 10.3% were separated. Hence, the majority of the respondents who participated in this study were of the married category.

Number in household:

Fig 4.7. Number in household



Following the result from Table 1 and Figure 1, it revealed that of the 399 respondents, 84 of the respondents representing 21.1% had five (5) members in the household; 62 (15.5%) of them, had six (6) members in the household; 59 (14.8%) of them, had seven (7) members in the household; 53 (13.3%) of them, had nine (9) members in the household; 33 (8.3%) of them, had eight (8) members in the household; 29 (7.3%) of them, had four (4) members in the household; 27 (6.8%) of them, had ten and above members in the household; 24 (6.0%) of them, had two (2) members in the household; 16 (4.0%) of them, had three (3) members in the household; and 12 (3.0%) of them, had one (1) member in the household.

Table 2 Percentage Distribution of the Experiences Women Have After Female Genital Mutilation in Ovia South West LGA

Variable	Response	Frequency	Percentage %
Have you heard of female genital mutilation?	Yes	286	71.7
	No	113	28.3
	Total	**399**	**100**
What experiences do you think women have after female genital mutilation?	Good	114	28.6
	bad	285	71.4
	Total	**399**	**100**
Do you think women after female genital mutilation can experience the following hemorrhages, infections, preterm deliveries?	Yes	285	71.4
	No	114	28.6
	Total	**399**	**100**
Do you think women can experience future infertility due to female genital mutilation?	Yes	285	71.4
	No	114	28.6
	Total	**399**	**100**

Source: Fieldwork, 2024

Table.2. presents the experiences women have after female genital mutilation **in Ovia** southwest LGA. The result indicated that most of the respondents, that is, 286 of them, representing 71.7% believed that women have bad experiences after female genital mutilation. On the other hand, 113 (28.3%) of the respondents that women have good experiences after female genital mutilation. The data above further revealed that 285 (71.4%) of the respondents believe that women after female genital mutilation can experience the following hemorrhages, infections, preterm deliveries, while 114 (28.6%) of them disagreed. From the result above, it suffices to say that women after female genital mutilation can experience the following hemorrhages, infections, and preterm deliveries. The result also revealed that of the 399 respondents sampled in this study, 285 of them representing 71.4% think that women can experience future infertility due to

female genital mutilation; while 114 (28.6%) do not think that women can experience future infertility due to female genital mutilation. Therefore, it is pertinent to say that women can experience future infertility due to female genital mutilation.

Table 3 Percentage Distribution of the Effect of Female Genital Mutilation on Women in Ovia South West LGA

Variable	Response	Frequency	Percentage %
Are there effects that come with female genital mutilation?	Yes	286	71.7
	No	113	28.3
	Total	**399**	**100**
Do you think that Sexual frustration is an effect of female genital mutilation?	Yes	285	71.4
	No	114	28.6
	Total	**399**	**100**
Do you think that threat to family stability is an effect of female genital mutilation?	Yes	285	71.4
	No	114	28.6
	Total	**399**	**100**
Do you think that HIV/AIDS can be contracted through female genital mutilation?	Yes	285	71.4
	No	114	28.6
	Total	**399**	**100**

Source: Fieldwork, 2024

Table 3 presents the effect of female genital mutilation on women in Ovia South-West Local Government Area. The result indicated that most of the respondents, that is, 286 of them, representing 71.7% believed that there are effects that come with female genital mutilation. On the other hand, 113 (28.3%) of the respondents said that there are no effects that come with female genital mutilation. The data above further revealed that 285 (71.4%) of the respondents believe that Sexual frustration can be as a result of female genital mutilation, while 114 (28.6%) of them

disagreed. From the result above, it suffices to say that there are effects that come with female genital mutilation.

The result also revealed that of the 399 respondents sampled in this study, 285 of them representing 71.4% think that female genital mutilation is a threat to family stability; while 114 (28.6%) disagreed to the assertion above. Therefore, it is pertinent to say that female genital mutilation is a threat to family stability. More so, the table also indicate that 285 (71.4%) of the respondents believe that HIV/AIDS can be contracted through female genital mutilation; while 114 (28.6%) of them do not believe that HIV/AIDS can be contracted through female genital mutilation. Hence, it can be said that HIV/AIDS can be contracted through female genital mutilation.

Discussion of Findings

The finding from this study showed that women had very bad experiences after female genital mutilation. This is in tandem with Esho et al, 2017; Althaus, 1997; Okeke, et al, 2012; Tambe, 2023 who asserted that Female genital mutilation is harmful due to severe bleeding which has led to hospitalization and at times deaths of some victims. Findings from the study also showed that female genital mutilation can experience the following hemorrhages, infections, and preterm deliveries in Ovia South-West Local Government Area. This supports the findings of Esho et al, 2017; Althaus, 1997; Okeke, et al, 2012; Tambe, 2023 who went on to assert that There is also pain while copulating. All the studies show that disinterest in coitus and loss of pleasure remain for life. "Immediate complications of FGM can include severe pain, excessive bleeding (hemorrhage) genital tissue swelling fever infections e.g., tetanus urinary problems wound healing problems injury to surrounding genital tissues shock, and even untimely deaths". Other long-term complications have been listed by several medical experts too numerous to cite. FGM constitutes a serious problem with ramifications for the reproductive health and coital pleasure of all survivors. The problem is so severe that its impact on all women can be generalized to pain.

In addition, findings from the study also indicate that female genital mutilation is a threat to family stability. Therefore, it is pertinent to say that engaging in female genital mutilation can later become a threat to family stability, Peltzer & Pengpid,

(2014) pointed out that Unknown to the supporters of FGM, it curbs sexual cravings for every male including their husbands. Victims cannot adjust daily to the sexual demands of their husbands, a trend that leads to anger and frustration among many men. The study further indicated that HIV/AIDS can be contracted through female genital mutilation. Hence, it can be said that HIV/AIDS can be contracted through female genital mutilation. This supports the findings of Sweileh 2015; Shakirat, et al. (2020) that the transmission of HIV and other infectious diseases may be rife because the instruments and blades are rarely sterilized. These tools are used to mutilate all females without consideration of possible infections. When the instruments are not sterilized, the women are exposed to long-term chronic infections such as Hepatitis B or C or HIV/AIDS (WHO, n. d.). Several studies have revealed the devastating impact of FGM on women's reproductive health. For example, labour may become more difficult because some aspects of the reproductive system may be compromised. The finding from this study also revealed that female genital mutilation violates the dignity of women in Ovia South-West Local Government Area, it also shows that it violates the social and cultural rights of women this is in agreement with this assertion in keeping with the Code of Ethics of Social Work, which instructs social workers to advocate for the vulnerable, weak, and poor who are experiencing social and cultural violations of their human rights (Workers (2008). The traumatic process of FGM is harmful to the dignity and rights of females due to the possibility of death. Apart from advocacy and education on the harm of FGM. There is extreme, unending pain for months. Some unlucky victims have bled to death. Although most women survive, they face the trauma of pain during the long recovery. There are other consequences of FGM: pain during copulation, disinterest and inability to enjoy coitus or attain easy orgasms, fear about initiating coitus, and general disinterest in sex unless for procreation (O'Neill &Pallitto, 2021; Nyairo 2013; Nzinga et al, 2021).

Conclusions

Female genital mutilation (FGM) is a practice deeply rooted in Nigerian society, especially in the Southern geopolitical zones of the country. The Northern zones of the country paradoxically have an abundance of the severe forms of FGM being practiced. It is an act that violates womanhood, with negative, far-reaching health, social and economic implications. Despite the reported reduction in prevalence in

the country, a lot more needs to be done to fast-track its elimination, particularly in the area of attitudinal change towards the discontinuation of the practice. Being a practice deeply rooted in culture, change may be slow, but with concerted and well-directed efforts it will surely come.

Eliminating FGM requires a sustainable, community-targeted approach, involving all relevant sectors of the economy such as women's affairs, finance, justice, and health; and relevant organizations such as religious, health professionals, women groups, professional bodies, policymakers, and Non-Governmental Organizations. The involvement of the various women's and religious groups cannot be overemphasized; especially as such groups have shown to be very effective agents of cultural change in the grassroots as evidenced by a study on widowhood practices in Nigeria. Engaging community and religious leaders by helping them understand the need for change is imperative in generating a transformation within the culture. Communities need to develop, strengthen, and support specific actions directed at ending FGM. Sustainability is an essential component of any such approach since the process of culture change is a gradual one. In addition, there is a need for increased and sustained support of the government, key policy/decision makers, the general public, developmental partners, media, and healthcare workers towards curbing the practice; likewise, cultural and religious-sensitive awareness, health education and public dialogue with relevant stakeholders in the communities on the harmful effects of FGM, with emphasis on the rights of women and the illegality of the practice. This will help to foster attitudinal change and encourage discontinuation. There is also a need for the institution and enforcement of appropriate ethical guidelines for medical professionals by the relevant professional organizations, and legal action where and when necessary. This will provide an official platform for other activities against FGM and serve as a discouragement to circumcisers and families fearing prosecution. There should be provision of medical, psychological, and social support to the victims of FGM. This will provide necessary data to monitor trends as well as ensure that resources are appropriately channeled to areas where they are needed.

Implication to Social Work Interventions

Social work can generally be described as scientifically established processes and patterns social workers apply to cases of individuals, groups, and communities. Professional social work organizations both internationally and in the United States specifically oppose FGC. In a statement of "Areas of Critical Concern for Social Work," the IFSW affirmed the position at the United Nations Fourth World Conference on Women, held in Beijing in 1995, which included "genital mutilation" as a discriminatory practice against girls that can affect their "health and well-being" and "have a devastating effect on women's lives" (IFSW, 1999). NASW has taken a similar position, asserting that: The profession…endorses the treaties and conventions as they have evolved that establish that the rights of people take precedence over social customs when those customs infringe on human rights. Ritual genital mutilation is a case in point. NASW endorses the U.N. resolution that women's rights are human rights, no longer simply to be considered civil and political rights (Tessitore & Woolfson, 1997; United Nations, 1993, 1995a, 1995b, as cited in NASW, 1999).

Given the preceding analysis, it is clear that social work values mandate that social workers pursue efforts to eliminate the practice of female genital cutting to secure the physical, emotional, and psychological well-being of women in societies where it is carried out. It is also evident that there is a valid rationale for precipitating cultural change that is consistent with social work values and ethics. However, neither the ethical codes of NASW or IFSW provide social workers with a means of resolving the ethical tension between respect for cultural diversity and the commitment to the individual's right to self-determination. Indeed, NASW specifically states that its code does not provide such guidance: The Code offers a set of values, principles, and standards to guide decision-making and conduct when ethical issues arise. It does not provide a set of rules that prescribe how social workers should act in all situations. Specific applications of the Code must take into account the context in which it is being considered and the possibility of conflicts among the Code's values, principles, and standards. Ethical responsibilities flow from all human relationships, from the personal and familial to the social and professional (NASW, 1999).

Recommendations

Based on the findings from the study, the following recommendations were made:

1. There is a need for sustained public education on Female genital mutilation.
2. Education campaigns by both the public and the private sector and social work professionals on Female genital mutilation prevention need to be intensified.
3. Children should be informed that Female genital mutilation is a crime.

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