FEMALE GENITAL MUTILATION AND THE DEVELOPMENT OF THE GIRL CHILD IN AKPABUYO LOCAL GOVERNMENT AREA OF CROSS RIVER STATE, NIGERIA

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ABSTRACT
The main thrust of this study was to examine female genital mutilation and the development of the girl child in Akpabuyo Local Government Area of Cross River State, Nigeria. The specific objective of the study was to: examine female genital mutilation (FGM) and psychological development of the girl child in Akpabuyo LGA; explore female genital mutilation (FGM) and social development of the girl child in Akpabuyo LGA. and to ascertain how female genital mutilation (FGM) affects physical development of the girl child in Akpabuyo LGA. The variables under the specific objectives of the study were further used to form the research questions and hypotheses. Extant literatures were reviewed in line with the topic under study. The social learning and symbolic interactionism theories were used as the theoretical framework for this study. The study adopted survey research design where research questionnaire was used as the main instrument of data collection. The questionnaire containing 3 items questions designed in both open and closed ended questions and administered to the respondents. 120 questionnaires were administered and 20 were invalid while 100 valid questionnaires were used for the analysis. Comprising of 50 males and 50 females, who were selected from the projected population of 2016 in the study area, twenty respondents each were selected from five

wards using the simple random samplings. The two null hypotheses were rejected, two hypotheses were tested at 0.05 level of significance thus revealing that; there is a significant relationship between female genital mutilation and psychological development of the girl child, there is a significant relationship between female genital mutilation and social development of the girl child, and there is a significant relationship between female genital mutilation in the study area. Based on the findings of the study, it was recommended amongst others that there is need for public enlightenment programmes by social workers to combat mass ignorance as well as public and intense awareness on psychological, social and physical health of the female children as well as severe penalty for those still involved in the practice of female genital mutilation in our society.

Introduction

Female genital mutilation (FGM), also known as female circumcision (FC), but more recently as female genital mutilation/cutting (FGM/C) according to the World Health Organization (WHO, 2021) has occurred in many forms in all society of the world. It is practiced in more than 28 countries in Africa and a few scattered, communities worldwide (WHO, 2012). Its' burden is seen in Nigeria, Egypt. Mali. Eritrea, Sudan, and Central Republic and Northern part of Ghana where it has been an old traditional, religious and cultural practice of various ethnic groups (WHO, 2006). The highest prevalence rates are found in Somalia and Djibouti where female genital mutilation is virtually universal (Rahman & Toubia, 2016).

Female genital mutilation/cutting is widely practiced in Nigeria with its large population. Nigeria has the highest absolute number of cases of FGM in the world accounting for the estimated 115-130 million circumcised worldwide WHO, 2012). FGM/C is the collective name given to several different traditional practices of the cutting of female genitals (Newmam and Weissbrodt, (2010). The procedure is commonly performed on girls anywhere between the ages of four and twelve years of age as a rite of passage to womanhood (Rahman & Toubia, 2016). However, in some cultures, it is practiced as early as a few days after birth and late as just prior to marriage or after the first pregnancy. Girls may be circumcised alone or with a group of peers from their community and the reason for it are complex, related to other and woven into the beliefs and values communities uphold (Okeke, Anyaehie & Ezenyeaku, 2013 cited in Nnana, Abonor, Tiku. & Rita 2024).

FGM/C is widely recognised as a violation of human rights of children which is deeply rooted in cultural beliefs and perceptions over decades and generations with no easy task for change (WHO, 2012, Okeke, Anyaehie&Ezenyeaku, 2013). It also reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against women. Since, it is nearly always carried out on minors, it violates the rights of children to physical integrity, the right to health, security and cruel, inhuman or degrading treatment and the right to life when the procedure results in death (WHO, 2021). It denies children including women security, personal liberty and the right to health (Momoh, 2017). Female genital mutilation entails the total or partial cutting away of the female external genital organs with razors, ceremonial knives, or blades under non-hygienic conditions without anaesthesia. It is usually performed on girls ranging in age from 1 week to puberty (Ladjali, Rattray &Walder, 2019). FGM is a traditional practice in which the external female genitalia is partially or totally incised or excised for a non-

therapeutic reason, usually without the consent of the individual (Akinsulure-Smith & Chu, 2017).

In Nigeria, similar rates (36%) were reported by women, while 45% of men supporting continuation of the practice agreed with this statement. FGM was believed to be proof of a girl's virginity, thereby improving the marriage prospects of unmarried girls who have undergone the procedure. In Cote dTvoire, "improved marriage prospects" was cited by 36% of women favoring continuation of the practice once married. FGM is also believed by some communities to ensure that a woman is faithful and loyal to her husband. For example, 51 % of women in Egypt believe that FGM prevents adult (Yirga, Kassa, Gebremichael & Aro, 2012). This perception has no scientific justification and hampers women's self-determination in the area of sexuality. Furthermore, it has health-related consequences and complications on the health such as severe pain, shock, injury to adjacent organs, broken bones, severe bleeding, acute urinary infection, tetanus even death. Others are chronic pain, difficulties with micturition and menstruation, pelvic infection leading to infertility and prolong and obstructed labour during childbirth (Campion, 2017). Given such health issues and complication witnessed in children, one is tempted to ask why the practice is still continuing. Could it be that, there is lack of knowledge regarding the development of the girl child and the health consequences associated with this practice, as well as the law against the practice? It is on this note that the present study intends to investigate female genital mutilation and the development of the girl child in Akpabuyo Local Government Area of Cross River State, Nigeria.

Statement of the Problem

The phenomenon of female genital mutilation (FGM), despite its ills, is still being practiced and passed on to younger generation in Nigeria. This is partly due to the fact that FGM is perceived to be functional and a worthwhile tradition that upholds family honour, promotes moral values and ensures sexual chastity among young girls and women. The practice of FGM has remained a global and scholarly concern due to its adverse implication on the development of the girl child (Adeyemo, Omisore and Asabi, 2012 cited in Nnana, Isaac& Blessing 2023). This harmful practice not only affects children in Africa and Middle East, where it has been traditionally carried out, but also touches the lives of children in grant communities in industrialized countries. Although, concerned advocacy work over recent decades has generated widespread commitment to end this practice, success in eliminating FGM/C has been limited with some significance exceptions (Gruenbaum, 2021). It describes a range of procedures, often involving partial or total' excision of the external female genitalia that are carried out for non-medical reason. FGM/C has attracted increased attention and strong international opposition in recent years. It breaches international human rights law, in particular the United Nations Convention on the Rights of the Child, and has been criminalized in much of the world, including many African countries in which it is traditionally practiced. Female genital mutilation (FGM) is an established cultural practice in over 30 countries. It carries a high risk of health issues on the children (Campion, 2017).

Worldwide, estimated 1.30million children have undergone the practice at least 2miliion girls a year are at risk of undergoing some form of the procedure (ICCPR, 2009). In Africa, about 3 million girls are at risk of FGM annually (WHO, 2002). In Nigeria, subjection of children to obscure traditional practices is legendary. FGM is an unhealthy traditional practice inflicted on girls and women in Nigeria, an estimated 20-40 million children are currently living with the consequences of FGM (Akpuaka, 2016). The practice is inevitably causing death and serious ill health and is unequivocally destroying sexual pleasure. It is perceived as a common and rampart practice in the study area with serious health consequences and permanently affect those children's sexuality during adulthood (Campion, 2017).

The procedure has no health benefitsfor children. Adverse consequences of FGM are shock from pain and hemorrhage (Verzin, 2015). Infection, acute urinary retention following such trauma, damage to the urethra or anus in the struggle of the victim during the procedure making the extent of the operation dictated in many cases by chance (Hathout, 2010). Chronic pelvic infection, acquired gynatresia resulting in hematocolpos, vulval adhesions, dysmenorrhea, retention cysts, and sexual difficulties with anorgasmia. Other complications are implantation dermoid cysts and keloids and sexual dysfunction (Akpuaka, 2016). Obstetric complications include perineal lacerations and inevitable need for episiotomy in infibulated paturients. Others are defibulation with

bleeding, injury to urethra and bladder injury to rectum, and purperial sepsis. Prolonged labor, delayed 2nd stage and obstructed labor leading to fistulae formation, and increased perinatal morbidity and mortality have been associated with FGM (Yoder & Khan, 2017).

The consequences of female genital mutilation on the development of the girl child also include: psychological and physiological, short- and long-term complication varied due to the method in which the procedure is performed, social and physical. Primary infections include staphylococcus, urinary tract, excessive and uncontrollable pain, hemorrhaging, human immunodeficiency virus (HIV), Chlamydia trchmatis, Clostridium tetani, herpes simples' virus (HSV). Hence, this study seeks to examine female genital mutilation (FGM) and the development of the girl child in Akpabuyo Local Government Area of Cross River State, Nigeria.

Literature Review

(i) Concept of female genital mutilation

An estimated 1.00 to 140 million girls and women in the world today have undergone some form of female genital mutilation, and 2 million girls are at risk from the practice each year (Dorkenoo, 2011). FGM includes a range of practices involving the complete or partial removal or alteration of the external genitalia for nonmedical reason (Boyle, 2005). Prior to the adoption of the term FGM, the practices were referred to as female circumcision. This procedure may involve the use of unsterilized, makeshift or rudimentary tools such as special knives, scissors, razors, or pieces of glass (Okeke, Anyaehie, & Ezenyeaku, 2012cited in Nnana, Tangban, Willie & Rita, 2023).

The operation is usually performed by an elderly woman of the village specially designated this task, who may also be a traditional birth attendant (TBA). The procedure may take 15 to 20 minutes, depending on the skill of the operator, the extent of excision and the amount of resistance put up by the girl child. The wound is dabbed with anything from alcohol or lemon juice to ash, herb mixtures, porridge or cow dung, and the girl's legs may be bound together until healing is completed (Toubia, 2016). The age at which girls are undergo FGM varies widely, depending on the ethnic group or geographical location. The timing of FGM procedure is often flexible even within communities, either because it is not tied to any particular ceremony, or because people's belief in its ceremonial significance has died away. The procedure may be carried out on infant girls, during childhood or adolescence, at the time of marriage, at a woman's first pregnancy, or even whilst in labour (Dorkenoo, 2011).

Female genital mutilation (FGM) is defined by the World Health Organization (WHO, 2012) as all procedures which involve partial or total removal of the external female genitalia and/or injury to the female genital organs, whether for cultural or any other non-therapeutic reasons. Female genital mutilation or female circumcision is the collective name given to several different traditional practices that involve the cutting of female genitals. The term FGM is reserved to describe ritualistic practices where actual cutting and removal of sexual organs takes place (Toubia, 2016). It is estimated that worldwide more than 100,000,000 women alive today have undergone FGM (Dorkenoo, 2011). The practice occurs across religious and economic lines and is practiced primarily in Africa, with particularly high prevalence rates in sub-Saharan African countries. The practice of FGM also can be found in the Middle East (for example, in Egypt), and there are reports that a form of FGM is practiced in Malaysia and Indonesia among some Muslim populations. It also is practiced by Bohra Muslims of India, Pakistan, and East Africa.

FGM/C varies from country to country, tribes, religion, and from one state and cultural setting to another, and no continent in the world has been exempted (Odoi, 2015 cited in Nnana, Tangban, Tiku & Abonor 2023). In most parts of Nigeria, it is carried out at a very young age (minors) and there is no possibility of the individual's consent (Hathout, 2019). Type I and Type II are more widespread and less harmful compared to Type III and Type IV. In Nigeria, there is greater prevalence of Type I excision in the south, with extreme forms of FGM prevalent in the North (UNICEF, 2011). Practice of FGM has no relationship with religion. Muslims and Christians practice it, but it is more widely spread in Christian predominated parts of Nigeria (UNICEF, 2011).

According to World Health Organization (2012), FGM practiced in Nigeria is classified into four types such include, Clitoridectomy or Type I (the least severe form of the practice): these

involves the removal of the prepuce or the hood of the clitoris and all or part of the clitoris. In Nigeria, this usually involves excision of only a part of the clitoris. Type II or sunna is a more severe practice that involves the removal of the clitoris along with partial or total excision of the labia minora. Type III (infibulation) is the most severe form of FGM. It involves the removal of the clitoris, the labia minora and adjacent medial part of the labia majora and the stitching of the vaginal orifice, leaving an opening of the size of a pin head to allow for menstrual flow or urine. Type I and Type II are more widespread but less harmful compared to Type III (Odoi, 2015).

Economics reasons: Viewing FGM/C from an economic angle, for the practitioners, it serves as an income earner and for some families it is used to improve the marriage prospects of young girls. In some societies, it is used as a kind of social stratification. mechanism with those who have been circumcised perceived to be at a higher status than others and is a prerequisite for the right to inheritance (W.H.O, 2012).

Female genital mutilation and psychological development of the girl child

The range of health issues on children associated with FGM is wide and some are severely disabling. Female Genital Mutilation/Cutting (FGM/C) is a harmful traditional practice with severe psychological health complications, deeply rooted in many Sub-Saharan African countries (Adriana, Suiberto, Miguel, & Isabelle, 2011). The psychological effects of FGM/C depend on the type of the procedure performed, experience of the circumciser and the social atmosphere at the time the cutting is performed (Gage &Rossem, 2016). These effects are due to psychological trauma of the painful procedure, sense of humiliation and being betrayed by parents, use of physical force by those perforating the procedure, negative genital image, lack of sense of ownership of their bodies, devastating sexual life, infertility and vesico vaginal fistulae (Boyle, 2015).

Children/women with type III FGM/C have a more distressing psychological complication in relation to sexual problems and infertility with a documentedinfertility rate of 30% (,44). psychological disturbances, low libido, apareunia or dyspareunia, chronic pain, dysmenorrhea, gynaetresia, cryptomenorrhoea, vaginal fistulae, labial agglutination, hypertrophic scar/keloids, clitoral retention cysts, dermoid cysts, vaginal lacerations during coitus, straining at micturition, genital tract lacerations, especially during vaginal delivery, obstructed labour, increased rate of caesarean delivery and postpartum haemorrhage, psychiatric diagnosis, suffer from anxiety, somatization, phobia, and low self-esteem). However, our meta-analyses for anxiety, somatization, depression, and hostility failed to reach significance and were marred by high heterogeneity (Cottingham &Kismodi, 2019 cited in Nnana, 2023).

Female genital mutilation and social development of the girl child

FGM/C posed a serious ill challenges on the social life of the female children. The social consequences include loneliness, isolation, death, posttraumatic stress disorder (PTSD), anxiety disorders, panic disorders, inhibition, depression and. suppression of feeling and thinking and sometimes attempted suicide (Klein, Helzner, Shayowitz, Kohlhoff, & Smith-Norowitz, 2018). Others health issues includes; maternal prolonged maternal hospitalization, low birth weight, prolonged, labor, obstructed labor, and increased frequency, scratching and piercings) to be included and lower the internal validity. Moreover, patients with FGM were givenpreferential treatment (i.e., extended hospital stays and extra examination time (Chibber, El-Saleh, & El Harm, 2011)

Genital mutilation is commonly performed when girls are young and miinformed and is often preceded by acts of deception, intimidation, coercion, and violence by parents, relatives and friends that the girl has trusted. Girls are generally conscious when the painful operation is undertaken as no anaesthetic or other medication is used (Adam, Bathija, Bishai. Bomienfant, Darwish, Huntington & Johansen, 2015). They have to be physically restrained because they struggle. In some instances, they are forced to watch the mutilation of other girls. This can lead to social problems. For some girls, mutilation is an occasion marked by fear, submission, inhibition and the suppression of feelings. The experience is a vivid landmark in then mental development, the memory of which never leaves them. Some girls are ready to express the humiliation, inhibition and fear that have become part of their lives as a result of enduring genital mutilation. Others find it

difficult or impossible to talk about their personal experience, but their obvious anxiety and sometimes tearfulness reflect the depth of their emotional pain. Girls may suffer feelings of betrayal, bitterness and anger at being subjected to such an ordeal, even if they receive support from their families immediately following the procedure. This may cause a crisis of confidence and trust in family and friends that may have long implications. It may affect the relationship between the girl and her parents, andmay also affect her ability to form intimate relationships in the future, even perhaps with her own children Cole-Ceesay & Cherian (2019).

Some female children have reported disturbances in their eating and sleeping habits, and in mood and cognition. Symptoms include sleeplessness, nightmares, loss of appetite, weight loss or excessive weight gain, as well as panic attacks, difficulties in concentration and learning, and other symptoms of post-traumatic stress. As children grow up, many develop feelings of incompleteness, loss of self-esteem, depression, chronic anxiety, phobias, panic. Many children suffer in silence, unable to express their pain and fear. Girls who have not been excised may be socially stigmatized, rejected by their communities, and unable to many' locally, which may also cause psychological trauma (Walraven, Scherf, West, Ekpo, Paine, Coleman. Bailey, & Morison, 2015 cited in Nnana& Lilian, 2024).

Female genital mutilation and physical development of the girl child

The range of complications associated with FGM is wide. Physical health issues of FGM on female children are severe pain due to the operation being performed with crude instruments and without anaesthetic. In medical settings where theanaesthetic is available, it is difficult to administer anaesthetic as the clitoris is - "highly vascular- organ with a dense concentration of nerve end (Gambia MultipleIndicator Cluster Survey, 2015). Multiple painful injections are required toanaesthetize the area completely. Injury to the adjacent tissue of urethra,vagina, perineum and rectum can result from the use of crude instruments, or because the operator is ignorant of the anatomy and physiology of the female external genitalia, has poor eyesight or a careless technique, or may be operating in poor light. Such injury is especially likely if the girl is struggling because of pain and fear. (Elmusharaf, Elhadi&Almroth 2016 cited in Nnana O. O., & Lilian O. U. 2024). Damage to the urethra can result in incontinence. Haemorrhage excision of the clitoris involves cutting the clitoral artery which has a strong flow and high pressure. Packing, tying or stitching to stop bleeding may not be effective and this can lead to haemorrhage. Secondary haemorrhage may occur after the first week as a result of sloughing of the clot over the artery due to infection. Cutting of the labia causes further damage to blood vessels and Bartholin glands. Haemorrhage is the most common and life session, others physical complications may include, difficulty in passing urine can occur as a result of damage to the urethral opening or scarring of the meatus.

Recurrent urinary tract infection. Infection near the urethra can result in ascending urinary tract infections. This is particularly common following type III mutilation, when the normal flow of urine is deflected and the perineum remains constantly wet and susceptible to bacterial growth. Stasis of mine resulting from difficulty in micturition can lead to bladder infections. Both types of infection can spread to the ureters and kidneys.

The role of social work in curbing female genital mutilation

Social work as a profession is known for intervening at the individual, group and community level in assisting then clients. (Twikirize, Asingwire, Omona, Luanga&Kafuko, 2013). Social workers can assist individuals, families and communities in the process of changing their behaviour and practice as regards FGM. by promoting education against its practice. Social workers also encourage health care workers to provide knowledge and understanding of the practice. They engaged in mobilization of youth, women, elders and leaders to work to eliminate the practice. Social work must play the role of facilitating the introduction of by-laws against FGM practice at community level. Involving individuals, families and communities in the prevention of FGM means working with them towards changing their beliefs, values and attitudes towards the practice, integrating education and counselling against FGM into day to day nursing and midwifery practice, identifying influential leaders and other key individuals and groups within the community with whom you can collaborate and could be used as change agents,

visiting individual people or groups in the community, awareness raising in communities of problems associated with the tradition as appropriate and establishing small focus groups for discussions (Twikirize et al, 2013). These discussions should be interactive and participatory, allowing the people themselves to do most of the talking, assisting the people to think through the practice of FGM and its effects on psychological, social and physical health of children. They also identify resources within the community that could be used in the prevention programme, suggesting strategies for changing practice, example, a culturally acceptable alternative ceremony to mark the rite of passage and teaching children and women as well as the entire community, problem solving skills and supporting individuals and families to cope with the problems of FGM and with adjusting to change (WHO, 2012).

Social work can influence the media by playing an important role in breaking the silence around FGM/C and bringing the issue into the public realm. Also provide media with accurate, up to date information regarding FGM/C and strengthening media operators' skills to disseminate this information can contribute to the abandonment of the practice because lack of knowledge of FGM/C is a major obstacle preventing many media professionals from discussing the issue (UNICEF, 2011). The involvement of opinion leaders, including traditional leaders, political figures, religious chiefs and intellectuals has had an important role in raising awareness within communities where there is a strong perception that the practice of FGM/C is required by Islam, by engaging religious leaders in public discussion will essential element in raising awareness of this practice, disassociating it from religious considerations and creating an enabling environment for change (Yoder & Khan, 2017).

Theoretical framework

i) Social learning theory

The theory was propounded by Albert Bandura in 1977. The theory posits that learning would be exceedingly laborious if people had to rely solely on the effects of their own actions to inform them on what to do. Fortunately, most human behaviour is learned observationally through modeling. From observing others, one forms an idea of how new behaviours are performed and on later occasions this coded information serves as a guide for action (Bandura, 1977). Bandura argued that people learn and acquire new information, attitude and behaviour by watching, listening and observing other people. Through socialization, people are exposed to various types of female genital mutilation (FGM) and practice them effectively. The theory is considered relevant to the study because of its usefulness in explaining and. understanding the practice of FGM and its benefits.

Bandura opined that observation like watching someone talk, listening, behave in a certain way, either in radio, television or live (face to face) can be effective form of learning for people. The fundamental assumption of these theory states that new behaviours are learned either by watching or modeling the behaviours of other and direct experience (Bandura, 1977). That if an individual sees the behaviour of a model rewarding; the person will tend to copy the reward behaviour. As individuals watch television, listen to radio and read books or literature on FGM,they can acquire knowledge associated with it and have better opportunity of practicing it.

ii) Symbolic interaction theory

Symbolic Interaction theory has John Dewey Thomas and George Herbert Mead as its major proponents in (1981). The basic idea of this theory is that people act towards things on the basis of the meaning those things have for them. These meanings are derived from social interaction with others and modified through the interpretation they use in dealing with things encountered (Okeibunor&Anugwom, 2002). These meanings are also created from interactions people have in sharing the interpretation symbols. Therefore, through symbols of interaction, the populace would be made aware of the so called benefits of female genital mutilation (FGM) and decide to copy. There are some assumptions of this theory that people live in a symbolic world as well as in a physical world. Individuals learn about themselves based on how people react to their own behavoiur.

They believe that human beings spend a great time interpreting their own conduct or action and that of others and strive to make sense of the circumstances in which they find themselves. The theory views human beings as attempting to make practical adjustments to their

surroundings. This theory gives insight into the assumption that the reactions of people towards social issues are based on their interpretation.

Methodology

The researcher adopted a survey design because it permits the researcher to obtain useful data in a short period of time from a sample as well as generalization of research results to the entire population of the study. Anikpo, 1986; Obikeze, 1990). Obikeze (1990). This study is to assess the extent of female genital mutilation and health of female children in the Akpabuyo L.G.A of Cross River State. Nigeria.Akpabuyo is a Local Government Area (LGA) of Cross River State, Nigeria. It is located in the Southern Senatorial District with headquarters at Ikot Nakanda. It became autonomous on Tuesday 27th August 1991, following its creation from the former Odukpani Local Government Area. It has an area of 1,241 km2 and a population of 271,395 at the 2006 census. Akpabuyo Local Government Area lies between latitude 4° 5' and 5° 40' and longitude 8° 25' and 8° 32 East. It lies within the vegetation belt of southern and shares a boundary with Akamkpa LGA, the Republic of Cameroon, Bakassi LGA, and Calabar South to the North, East. South and West respectively. National Population Commission of Nigeria (web), National Bureau of Statistics (web)

It consists of 10 (ten) Council Wards, namely: Idundu/Anyananse, Atimbo East, Atimbo West, Ikot EdemOdo, Eneyo, Ikot Nakanda, Ikot Eyo, Ikang North, Ikang South and Ikang Central. The major ethnic groups are the Efiks, Quas and Efuts. The major languages spoken are Efik and English, while all the major ethnic groups share a common cultural and ancestral heritage.

In carrying out this study, the researcher used a sample size of 100 respondents both men and women from 18years and above derived from the projected population of 2016 in the study area. A multi-stage sampling technique which entails selection of wards, streets, households and respondents was employed. Akpabuyo L.G.A is made up of ten wards. The researcher used simple random sampling (SRS) by (balloting) to select five wards. All the entire recognize streets in each ward was computed with the aid of street index from the town planning office. From the total numbers of streets in each wards, five streets were selected through a systematic random process which gave us a total of twenty-live streets. The researcher selected two buildings per a street with the used of simple random sampling and got a total of fifty buildings. Through a simple random process and with the dip and shuffle method, two respondents from 18years and above from each of the building was selected. These give us a total of 100 respondents used for the study.

The two major instruments used for data collection were primary and secondary sources. The researcher administer 100 questionnaires to the respondents and explanations were made on how to fill them. Also, Chi-square, (x2) statistical analysis were apply in calculating the relationships existing between them. This is presented below:

$$X^2 = \frac{(O - E)^2}{E}$$

Where:

X^2 = Chi square

Z = Summation

O = Observed frequency

E = Expected frequency

Findings

The analysis was based on views of the respondents from the questionnaires. Out of a total of 120 questionnaires collected from the respondents 20 were tendered invalid because they were not properly completed. 100 questionnaires were however duly completed and used for analysis.

Table 4.2.1: Distribution of respondents by sex

Sex	No. of respondents	Percentage (%)
Male	60	60
Female	40	40
Total	100	100

Source: Field work. 2024.

Table 4.2.1 above shows that out of 100 respondents; males were 60 and female 40.

Table 4.2.2: Distribution of respondents by age

Age	No. of respondents	Percentage (%)
18-29	40	40
30-40	44	44
4land above	16	16
Total	100	100

Source: Field work, 2024.

Table 4.2.2 above shows that the numbers of respondents with 18-29 years were 40,30-40 years were 44, and 41 years and above were 16 respectively representing 100%respondents.

Table 4.2.3: Distribution of respondents by marital status

Marital status	No. of respondents	Percentage (%)
Single	32	32
Married	20	20
Separated	32	32
Divorce	10	10
Widowed	6	6
Total	100	100

Source: Field work, 2024.

Table 4.2.3: Distribution of respondents by marital status

Marital status	No. of respondents	Percentage (%)
Single	32	32
Married	20	20
Separated	32	32
Divorce	10	10
Widowed	6	6
Total	100	100

Source: Field work, 2024.

Table 4.2.3 above shows that out of the 100 respondents, 32 were singles, 20 were married, 32 were separated, 10 were divorce and 6 respondents were widows representing 100% respondents

Table 4.2.4: Distribution of respondents by occupation

Occupation	No. of respondents	Percentage (%)
Fanning	2	2
Trader	34	34
Civil/public servant	12	12
Student	36	36
Others	16	16
Total	100	100

Source: Field work, 2024.

Table 4.2.4 above shows that 2 respondents were farmers, 34 respondents were traders 12 respondents were civil/public servants, 36 respondents were students and 16 were others representing 100% respondents.

Table 4.2.5: Distribution of respondents by educational qualification

Educational qualification	No. of respondents	Percentage (%)
No formal education	10	10
Primary education	20	20
Secondary education	40	40
Tertiary education	30	30
Total	100	100

Source: Field work, 2024.

Table 4.2.5 above shows that 10 respondents had no formal education, 20 respondents had primary education, whereas 40 respondents had secondary

Table 4.2.6: Distribution of respondents by religious affiliation

Religious affiliation	No. of respondents	Percentage (%)
Christianity	92	92
Islam	2	2
African Traditional religion	4	4
Others	2.	2
Total	100	100

Source: Field work, 2024.

Table 4.2.6 above shows that 92 respondents represent Christianity, 2 respondents were Islam, 4 respondents practice African traditional religion and 2 respondents were others madding it up 100% respondents.

Hypothesis one

H0: There is no significant association between female genital mutilation and psychological development of the girl child

Hi: There is a significant association between female genital mutilation and psychological development of the girl child

NOTE: Number 1.3 question in the questionnaire was used to test the hypothesis one.

Decision rule: Accept Ho if X2 > 5.991, otherwise rejects Ho and accept Hi instead at level of significance = 0.05 and degree of freedom (df) =(r-l) (c-1) = (3-1) (2-1) =2.

Table 4.3.1: Chi-Square distribution of respondents

Responses	No of respondents		Row total
	Male	Female	
A	10	6	16
U	12	10	22
D	38	24	62
Total	60	40	100

Since calculated value of 1.36 is less than calculated value of 5.991 at 2df, therefore, Ho is rejected and Hi is accepted which states that, there is a significant association between female genital mutilation and psychological development of the girl child in Akpabuyo LGA

Hypothesis two

H0: There is no significant association between female genital mutilation and social development of the girl child

Hi: There is a significant association between female genital mutilation and social development of the girl child

Table 4.3.2: Chi-Square distribution of respondents

Responses	No of respondents		Row total
	Male	Female	
A	58	40	98
U	2	0	2
D	0	0	0
Total	60	40	100

NOTE: Number 19 question in the questionnaire was used to test the hypothesis two.

Decision rule: Accept Ho if X2 > 5.991, otherwise rejects Ho and accept Hi instead at level of significance = 0.05 and degree of freedom (df) =(r-l) (c-1) = (3-1) (2-1) =2.

Since calculated value of 1.36 is less than calculated value of 5.991 at 2df, therefore, Ho is rejected and Hi is accepted which states that, there is a significant association between female genital mutilation and social development of the girl child

Since calculated value of 1.36 is less than calculated value of 5.991 at 2df, therefore, Ho is rejected and Hi is accepted which states that, there is a significant association between female genital mutilation and physical development of the girl child in Akpabuyo LGA

Hypothesis One: Statistical Computation of Chi-square to table 4.3.1

Cells	Fo	Fe	Fo-Fe	$(Fo-Fe)^2$	$(Fo-Fe)^2$
A	44	39.6	4.4	19.36	0.488
B	22	26.4	-4.4	19.36	0.733
C	10	12	2	4	0.333
D	10	8	2	4	0.5
E	6	8.4	2.4	5.76	0.685
F	8	5.6	2.4	5.76	1.028
Total	-	-	-	X^2 =	3.767

Expected choice

a) 66x60 =39.6
b) 66x40 = 26.4
c) 20x60 = 12
d) 20x40 = 8
e) 14x60 = 8.4
f) 14 x 40 = 5.6

Hypothesis Two: Statistical Computation of Chi-square to table 4.3.2

Cells	Fo	Fe	Fo-Fe	(Fo-Fe)2	$(Fo-Fe)^2$
A	58	58.8	-0.8	0.64	0.0108
B	40	39.2	0.8	0.64	0.0163
C	2	1.2	0.8	0.64	0.5333
D	0	8	-0.8	0.64	0.8
E	0	0	0	0	0
F	0	0	0	0	0
Total	-	-	-	X^2 =	1.36

Expected choice

a) 96x60 = 58.8
b) 98 x40 = 39.2
c) 2x60= 1.2
d) 20x40 = 8
e) 0x60 = 0
f) 0x40 = 0

Discussion of the Findings

Hypothesis One

There is no significant relationship between female genital mutilation and psychological development of the girl child in Akpabuyo LG A. This result is in agreement with the view of Cottingham &Kismodi (2019). They argued that female genital mutilation has a long-lasting effect on psychological health of female children such that complication in relation to sexual problems and infertility with a documented infertility rate of 30% (,44). psychological disturbances, low libido, apareunia or dyspareunia, chronic pain, dysmenorxhoea, gynaetresia, cryptomenorrhoea, vaginal fistulae, labial agglutination, hypertrophic scar/keloids, clitoral retention cysts, dermoid cysts, vaginal lacerations during coitus, straining at micturition, genital tract lacerations, especially during vaginal delivery, obstructed labour, increased rate of caesarean delivery and postpartum haemorrhage, psychiatric diagnosis, suffer from anxiety, somatization, phobia, and low self-esteem). However, our meta-analyses for anxiety, somatization, depression, and hostility failed to reach significance and were marred by high heterogeneity. Others researches says, effects are due to psychological trauma of the painful procedure, sense of humiliation and being betrayed by parents, use of physical force by those performing the procedure, negative genital image, lack of sense of ownership of their bodies, devastating sexual life, infertility and vesico vaginal fistulae (Boyle, 2015).

Hypothesis Two

There is no significant relationship between female genital mutilation and the social development of the girl child in Akpaboyu LGA. Data gotten from the field reveals that female genital mutilation socially affect the female children in the study area. The result of this hypothesis is in consonance with the idea of (Walraven, Scherf, West, Ekpo, Paine, Coleman, Bailey, & Morison, 2015). They believed that those children who experience this practice reported disturbances in their eating and sleeping habits, and in mood and cognition. Symptoms include sleeplessness, nightmares, loss of appetite, weight loss or excessive weight gain, as well as panic attacks, difficulties in concentration and learning, and other symptoms of posttraumatic stress. As children grow up, many develop feelings of incompleteness, loss of self-esteem, depression, chronic anxiety, phobias, panic. Many children suffer in silence, unable to express their pain and fear. Girls who have not been excised may be socially stigmatized, rejected by their communities, and unable to marry locally, which may also cause psychological trauma, others social consequences include loneliness, isolation, death, posttraumatic stress disorder (PTSD), anxiety disorders, panic disorders, inhibition, depression and suppression of feeling and thinking and sometimes attempted suicide (Klein, Helzner, Shayowitz, Kohlhoff, & Smith-Norowitz, 2018).

Conclusion

This study sought to explore female genital mutilation and. the development of the girl child in Akpabuyo L.G. A of Cross River State, Nigeria. From the study, it can be seen that psychological, social and physical health of the female children are associated with the practice of female genital mutilation. The result is in agreement with the view of (Adriana, Suiberto, Miguel, & Isabelle, 2011). That the psychological effects of FGM/C depend on the type of the procedure performed, experience of the circumciser and the social atmosphere at the time the cutting is performed and are very traumatic. Boyle (2015) says these effects are due to psychological trauma of the painful procedure, sense of humiliation and being betrayed by parents, use of physical force by those performing the procedure, negative genital image, lack of sense of ownership of their bodies, devastating sexual life, infertility and vesico vaginal fistulae.

Cole-Ceesay & Cherian (2019) believe that it makes the female children to physically restrained because they struggle. In some instances, they are forced to watch the mutilation of other girls. This can lead to social problems. For some girls, mutilation is an occasion marked by fear, submission, inhibition and the suppression of feelings. The experience is a vivid landmark in their mental development, the memory of which never leaves them. Some girls are ready to express the humiliation, inhibition and fear that have become part of their lives as a result of enduring genital mutilation. Others find it difficult or impossible to talk about their personal experience, but their obvious anxiety and sometimes tearfulness reflect the depth of their emotional pain. Girls

may suffer feelings of betrayal, bitterness and anger at being subjected to such an ordeal, even if they receive support from their families immediately following the procedure. This may cause a crisis of confidence and trust in family and friends that may have long term implications. It may affect therelationship between the girl and her parents, and may also affect her ability to form intimate relationships in the future, even perhaps with her own.

Finally, researchers like Oduro, Ansah, Hodgson, Afful, Baiden, Adongo & Adongo (2016) opined that the practice may obstruct the vaginal orifice, leading to dysmenorrhoea (painful menstrual period). Following infibulation, scarring can be so extensive that it prevents penile penetration and may cause sexual and psychological problems. Abscess. Deep infection resulting from faulty healing or an embedded stitch can cause an abscess, which may require surgical incision. Cysts and abscesses on the vulva. Implantation dermoid cysts are the commonest complication of infibulation.

Recommendations

The following recommendations are made;

a) The general public should be made aware of the psychological, social and physical effects of female genital mutilation on the health of female children in the study area.
b) There should be public enlightenment programmes by social workers to combat mass ignorance and public awareness on the right to freedom fromall forms of female genital mutilation on the female children in the study area and the general society at large.
c) Intense awareness should be created among teachers and school managers using seminars, workshops and training programmes about the danger of female genital mutilation.
d) Teaching profession should be professionalized to ensure that there is no one teaching as a second-best option, this would ensure that people in this profession really see it as their contribution to society's development.
e) Penalty for those who still practice this barbaric act on the children should be severe enough to deter other perpetrators.
f) Encouraging early disclosure, timely and appropriate intervention when female genital mutilaton does occur to reduce recurrence and ultimately promote desistance (tertiary prevention).
g) A comprehensive prevention framework that targets (potential) offenders, (potential) victims, specific situations, and relevant ecological (peer, family, organizational, and neighborhood) systems, across all three prevention levels, provides the best armory against the practice

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