



ASSESSMENT OF THE OPINION AND PRACTICE OF FGM AMONG WOMEN ATTENDING OBSTETRICS AND GYNAECOLOGIC CLINIC OF A.B.U.T.H, KADUNA, NORTH-CENTRAL, NIGERIA: A PROSPECTIVE CROSS- SECTIONAL SURVEY

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ABSTRACT

FGM is widely practiced all over the world and is especially widespread in Nigeria. It has a national prevalence rate of 25% among Nigeria women aged 15-45 years. However, of recent, there has been a decrease in the incidence of FGM and many factors are responsible for this decline. These include sustained campaign against the practice, legislation banning the practice of FGM and increasing level of education and awareness about the complications associated with FGM. This cross-sectional survey in a hospital setting seeks to highlight the trends in the prevalence of FGM. The result of the survey revealed that the prevalence of FGM was 26.3%, down from 39% in a study conducted 5 years earlier in a similar setting. The awareness of FGM was only 29%, which was quite low compared to the 53% reported in the earlier study. The level of educational attainment has a dramatic effect in the reduction and intention to subject their off springs to FGM. The study also revealed that the practice of FGM cuts across religious, ethnic, social and educational status. There is however, a tendency for women with more education to either be indifferent or disapprove of this practice, suggesting that as more women acquire post-secondary education, the practice of FGM will gradually diminish. This downward trend can be further encouraged by discouraging harmful traditional health practices in primary and secondary health institutions where access to women with lower educational attainment is higher. Health care givers who usually have access to more women should also participate more actively in campaigning against the practice of FGM.

INTRODUCTION

Female genital Mutilation (FGM) or Female Genital Cut (FGC) comprises all “all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons” [1]. FGM takes different forms in different societies and is performed for different reasons. The practice often serves as a rite of passage to womanhood or defines a girl or woman within the social norms of that ethnic group or tribe. It is practiced as a cultural ritual by many ethnic groups in Sub-Saharan and

Northeastern Africa, and to a lesser extent in Asia, the Middle East and within immigrant communities elsewhere.

It is typically carried out, with or without anesthesia, by a traditional circumciser using a knife or razor [2]. The age of the girls varies from weeks after birth to puberty; in half the countries for which figures were available in 2013, most girls were cut before the age of five [3]. The practice involves one or more of several procedures, which vary according to the ethnic group. According to WHO classification, there are three types of



GM. Type I which is the milder form clinically involves the removal of all or part of the clitoris and clitoral hood, while type II involves the removal of all or part of the clitoris and inner labia. Type III is the most severe form (infibulation) and it involves the removal of all or part of the inner and outer labia and the closure of the vagina. In this last procedure, a small hole is left for the passage of urine and menstrual blood, and the vagina is opened up for intercourse and childbirth. The health effects depend on the procedure but can include recurrent infections, chronic pain, cysts, an inability to get pregnant, complications during childbirth and fatal bleeding.

The most recent survey is the 2013 Demographic and Health Survey of 7,985 women nationally. This survey estimated that 25.0 percent of the women of Nigeria aged 15-49 years have undergone the procedure. In Kaduna state the prevalence ranges from 45% in one study to 50-70% in other studies [4,5]. The prevalence rate in Zaria is about 39% [6,7].

It is estimated that more than 50% of Nigerian girls/women have undergone the procedure while many more are still being subjected to it every year despite the efforts being made to discourage the practice. Of the six largest ethnic groups, the Hausa, Yoruba, Fulani, Ibo, Ijaw and Kanuri, only the Fulani do not practice any form of FGM. The Yoruba practiced mainly type II and I. The Hausa and Kanuri practiced type II and III, while the Ibo and Ijaw, depending upon the local community, practice any one of the three forms.

Of recent, there is a decrease in the incidence of FGM and many factors are responsible for this decrease. The commonest reason for this decrease is the sustained campaign against the practice, legislation banning the practice of FGM and also increasing level of education and awareness about the complications associated with FGM [7].

Global efforts to end FGM have used legislation to provide legitimacy for project activities, to protect women and to discourage circumcisers and families who fear prosecution. In the 1960s, W.H.O was the first United Nations specialized agency to take a position against FGM. Also the platform of Action, adopted by the Beijing Conference in 1995, called for the eradication of FGM, through the enactment and enforcement of legislation against its perpetrators [8-10].

While recognizing that FGM is an important reproductive health issue, it is also a sensitive topic. There is an increasing body of literature on various aspects of FGM including prevalence, awareness, mode of practice and complications [11-14]. However, studies highlighting the trends in the prevalence of FGM are scanty. It is therefore hoped that this work will give an insight into the impact of the various enlightenment campaign and

legislation aimed at reducing, and if possible, eradicate the practice of FGM.

METHODS

Study setting

Study design: The study was a prospective clinical survey of the prevalence of FGM among women attending the services of the Department of Obstetrics and Gynaecology of Ahmadu Bello University Teaching Hospital, Kaduna, Nigeria. Study Population: The patients who participated in this study, were female patients seen at ABUTH Kaduna. A total of 380 were seen within two weeks of study. It was a total survey of all the women who consented to participate in the study. These patients were from various ethnic backgrounds as Kaduna is a metropolitan area in North-Central, Nigeria. Thus all the major ethnic groups in the country are well represented.

Instrument for data collection: All the women were interviewed with the aid of semi-structured interviewer administered questionnaire and all had full examination of the external genitalia by the investigator and five other doctors who could speak any of the major languages and were adequately trained on how to administer the questionnaire beforehand. The information obtained were the age of the respondents, information concerning knowledge of any personal experience of genital mutilation and complications, and the attitude of the respondents towards the practice of FGM.

Physical examination of the lower genital tract was done by simple inspection of the vulva, perineum and patting the labia to inspect the vaginal introitus. Those women that were found to have any form of genital mutilation were then subjected to more detailed examination, that is, digital and where possible speculum, though evidence of hymenectomy was based on informants knowledge.

Ethical clearance

Ethical clearance was sought and obtained from the Ethical and Scientific Committee of Ahmadu Bello University Teaching Hospital before the commencement of the study. Verbal clearance was also obtained from the respondents before the study and they were assured of confidentiality.

Data analysis

The information obtained were entered into Statistical Package for Social Sciences (version.19) software and analyzed. The results were presented in simple proportions. Statistical analysis for association between the socio-demographic variable and outcome measure were determined using Chi-square (X^2) test with P-value set at 0.05.



RESULTS**Table 1. Socio- Demographic Characteristics of Respondents (n=380)**

Characteristics	frequency	percent
Age group (in years)		
11-20	21	5.5
21-30	170	44.7
31-40	112	29.4
41-50	54	14.2
>50	23	6.1
Religion:		
Islam	205	53.9
Christianity	169	44.5
Others	6	1.6
Tribe:		
Hausa	134	35.3
Yoruba	87	22.9
Igbo	77	20.3
Others	82	21.6
Highest level of Education attained		
Primary	88	23.2
Secondary	161	42.4
Tertiary	66	17.4
Arabic School	60	15.8
None	5	1.3

Comment: Majority (74.1%) of respondents are between the ages 21-40 years. Two hundred and nine (53.9%) are Muslims while 46.1% are Christians. Among the major tribes Hausa's predominates (35.3%) followed by Yoruba (22.9%), Ibos, (20.3%). Other tribes constitutes 21.6% .About 82.9% have one form of formal education, while 17.1% have no formal education (Arabic education (15.8%, none 1.3%).

Table 2. History of female genital mutilation and time of practice

Had FGM	Frequency	Percent
Yes	100	26.3
No	280	73.7
Total	380	100.0
Time of cutting		
Few days after birth	72	72.0
At puberty	12	12.0
Just prior to marriage	9	9.0
During the first pregnancy	1	1.0
At first child birth	4	4.0
Cannot remember	2	2.0

Table 3. Summary of Attitude and opinion towards FGM by respondents

Attitude towards the practice	Frequency	Percent
Approved	80	21.1
Disapproved	110	29.0
Indifferent	190	50.0
Total	380	100.0
Advise to friends/relative on practice		
Will advise against	267	70.26
Will not advise against	80	21.0
Indifferent	33	8.68



Attitude towards the practice	Frequency	Percent
Approved	80	21.1
Disapproved	110	29.0
Total	380	100.0
OPINION (n=380)		
It is not important for marriage	254	66.8
FGM is a torture not a culture	166	43.7
The practice should continue	57	15.0
Stopping the practice is an improvement for the society	276	72.6
Discussion in the Radio & TV& Newspapers are important to stop the practice	226	59.5

Comment: Above two-fourth (63.5%) of respondents opinioned that FGM is not important for marriage, while 56.5% were of the opinion that stopping the practice is an improvement for the society and 14.25% opinioned that the practice should continue.

Table 4. Test of association.

Variable	FGM		Total (%)	Statistics
	Yes (%)	No (%)		
Age group (years)				$X^2 = 41.498$ dF= 4 p-value= 0.000
11-20	3 (3.0)	18 (6.4)	21 (5.5)	
21-30	31 (31.0)	139 (49.6)	170 (44.7)	
31-40	29 (29.0)	83 (29.6)	112 (29.5)	
41-50	19 (19.0)	35 (12.5)	54 (14.2)	
>50	18 (18.0)	65(1.8)	23 (6.1)	
Total	100 (100.0)	280 (100.0)	380 (100.0)	
Religion				$X^2 = 2.743$ dF= 2 p-value= 0.254
Muslim	58 (58.0)	147 (52.5)	206 (53.9)	
Christian	42 (42.0)	127 (45.5)	169 (44.5)	
Others	0 (0.0)	6 (2.1)	6 (1.6)	
Total	100 (100.0)	280 (100.0)	380 (100.0)	
Educational status				$X^2 = 25.633$ dF= 4 p-value= 0.000
None	11 (11.0)	14 (5.0)	25 (6.6)	
Arabic	18 (18.0)	22 (7.9)	40 (10.5)	
Primary	32 (32.0)	56 (20.0)	88 (23.2)	
Secondary	27 (27.0)	134 (47.9)	161 (42.4)	
Tertiary	12 (12.0)	54 (19.3)	66 (17.4)	
Total	100 (100.0)	280 (100.0)	380 (100.0)	

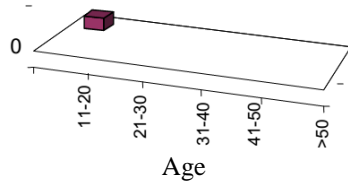
Table 5. The Prevailing attitude of women towards FGM compared with their Educational Status

Educational Status	Total Number of Women Per Educational Status	Number of Women					
		Approve		Indifferent		Disapprove	
		Frequency	Percent	Frequency	Percent	Frequency	Percent
None	117	20	25.8	29	26.4	68	58.0
Primary	83	16	20	25	22.7	42	50.6
Secondary	121	34	48.5	40	36.3	47	38.84
Tertiary	59	10	12.7	14	12.7	35	59.3
Total	380	80	21.0	110	29.0	190	50.0

Comment: The prevailing attitude towards FGM of all the 380 women in the study was investigated; 80 (21.0%) among of the respondents approved of the practice of FGM;110 (29.0%) were indifferent, while 190 (50.0%) disapproved. Among the respondents who approved of FGM practices, those who had attained secondary education constitute the highest proportion, likewise the indifferent groups. On the other hand, among the respondents who disapproved FGM, the illiterate group who probably has never had any form of formal education constitutes the highest proportion.



Figure 1. The Prevalence of FGM by Age Group

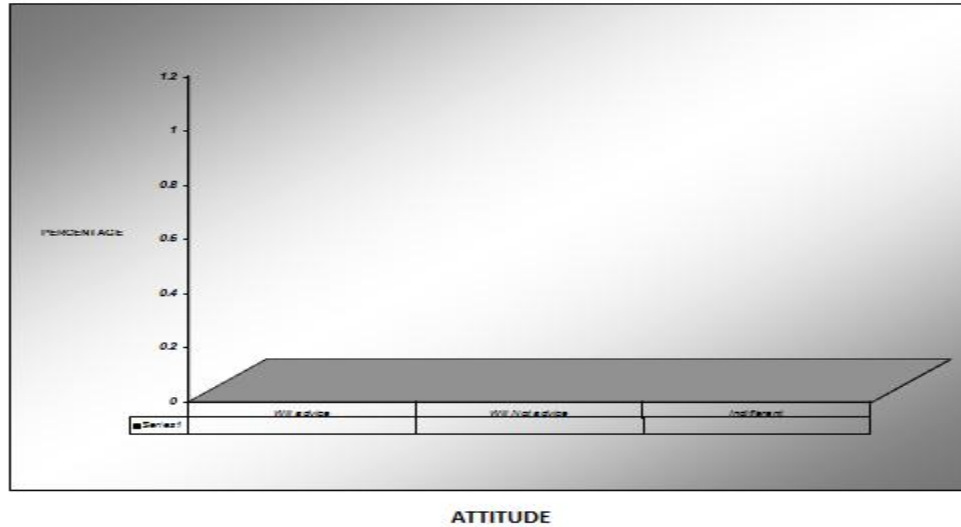


Comment: The age group 11-20 has a very low prevalence (2.88%) while it is uniformly high across other age groups.

Hundred (26.3%) of respondents had history of FGM in the past while 73.7% do not have history of the procedure. Of the hundred respondents who had FGM, majority (72.0%) of them had it few days after birth; followed by those who had it at puberty. Less than half had the procedure just prior to their marriage (9.0%), after first delivery (4.0%), and during their first pregnancy, while

2.0% could not recall the precise time the procedure was carried out on them. There is statistical relationship between the age of the respondents and FGM ($X^2 = 41.498$, $dF = 4$, $value = 0.000$). The educational status is also statistically related to FGM, but there is no statistical relationship between the religion of the respondents and FGM ($p-value = 0,254$).

Figure 2. Respondents Attitude towards Advising Friends/Relatives Not to Perform FGM



DISCUSSION

A total of 380 women were recruited for the study. The women were mainly from the 3 major ethnic groups in Nigeria, Hausa 33.5%, Igbos 19.3%, Yoruba’s 21.8% while the other tribes of Nigeria constituted the remaining 25.5% of the sample.

Muslim respondents constituted 52.3% of the sample, Christians 46.3% while other religious groups constituted 1.3%. The maximum educational level attained by the respondent were tertiary institution, 16.5%, secondary school, 40.3%, primary school 22.0%, Arabic school, 15% and 6.3% had no formal education.

The predominant age group is 20-30 years. This is consistent with a study in Zambia [7]. A total of 100 of the 380 respondents were found to have undergone the procedure, which constitutes 26.3% of the sample, while 73.7% have not undergone the procedure (Table.1). This finding is much lower than the finding in an earlier study conducted in A.B.U.T.H, Zaria about 5 years earlier, which revealed a prevalence rate of 39% in Zaria [6,7], Comparing this with the prevalence recorded in earlier

studies of 45% prevalence for Kaduna State in one study [6], and 50.7% in other studies, and the WHO estimates of about 60% Nigerian female population circumcised, one might conclude that the practice of FGM is gradually declining with age [15-19]. A similar trend was reported in a study from Enugu which revealed a decreasing trend in FGM among Igbo women [20-28].

The Hausas had the highest prevalence by ethnicity (33.1%), followed by the Yoruba (30.21%), Igbo 21.58% and the other tribes (15.12%), Table 1. The high percentage among Hausas can be explained by the fact that, among all the ethnic groups interviewed, they are the only tribe that perform FGM as a curative procedure; it can also be explained by the fact that higher percentage of them were interviewed when compared to the other tribes [29-32].

The prevalence of FGM cuts across various religious groups, Table 1, while 58.27% of those that have undergone the procedure were Muslims, Christians accounted for the remaining 41.73%. This is in close



agreement with some of the earlier studies. FGM was also found to be prevalent among various educational levels with those without any formal education accounting for 10.79% of those that have been mutilated and Arabic education 17.99%, primary school 31.69%, secondary school 27.33% and tertiary schools 12.23%, Table 1. This finding can be explained by the fact that the procedure was performed at an early age when education had no influence. However Chi square test statistic (at $P=0.05$, $V=8$) is equal to 9.49 but the sample result is 34.39. It is therefore obvious that education affects the FGM status of women.

A significant proportion (n=316) of the 380 respondents have heard about FGM most of them were Hausa (28.6%) with the least being the Igbo (21.84%). This is because the population of the study area was predominantly Hausa. The highest proportion of the Hausas in this regard can also be explained by the fact that they have the highest prevalence 33.0% as opposed to the Igbo with prevalence of 21.58%. The minority tribes also vary in their knowledge of FGM. Most of the respondents from Southern Kaduna and the Ebiras essentially have not heard about FGM because it is not practiced in their communities. Among the Urhobos on the other hand, most have heard about FGM because it is ceremoniously practiced in their community.

The awareness of having heard FGM was only 29% which was quite low compared to the 53% reported in an earlier study involving a similar study population⁶. This is possibly because of the age at which it was done, usually in infancy. Moreover until recently, FGM was not openly discussed even in communities where it is practiced. Table IV shows that the role of education is very dramatic. Among the 198 respondents who admitted that FGM was a harmful practice, 63.13% have had post primary education compared to 37.82% whose educational status was below secondary level. This is not surprising because the higher the education the higher the awareness. Chi-Square test statistic (at $P=0.05$, $V=8$) is equal to 15.5 the sample result is 16.66, thus educational status influences the knowledge of the harmful nature of the practice.

The various reasons cited for the practice of FGM also portrayed the fact that the practice was deliberate and purposeful. Table VI shows that the main reason was to reduce sexual desire; this reason cuts across all the major ethnic groups. This closely agrees with another study in which it was reported that FGM was designed to ensure virginity, control the woman's sexuality and to treat nymphomania [33-34]. Another literature had it that all types of FGM interfere to some degree with women sexual response and do not necessarily abolish the possibility of sexual pleasure and climax. Some of the sensitive tissues of the body and the crura of the clitoris are embedded deeply near the pubic symphysis and are not removed when excision of the protruding parts take place. Some studies suggest that apart from the external genitalia, other erogenous zones in the body may become more sensitized

in women with FGM [35-36]. It is important that this fact should be conveyed to the general public as part of the campaign against the continuation of the practice. FGM also has a negative effect on the males, who are the spouses of these women as it is more difficult for the men to attain orgasm or to satisfy their women [34].

The proportion that believed FGM was a religious issue was very low (6.51%) in this study. This shows that religion did not influence most of the respondents as regards to knowledge. It further reveals that FGM has more of cultural undertone than religion. This finding is in agreement with the 1999 NDHS that reported that only 2% of pro-FGM women gave religion as a reason for continuing the practice by contrast, 22% of women opposed to continuing FGM said it was against religion [7].

Only 2.07% of the respondents gave tradition, as a reason while 3.55% said FGM was to make the vagina look better. The issue of making the vagina look better is paradoxical because it is hardly ever exposed. Vaginal cosmesis is virtually unheard of in this part of the world.

The attitude of the respondents on FGM depended on their knowledge, source of knowledge and educational status.

Table V showed that a high proportion of the respondents were anti-FGM. In table VII, 63.5% believed that it was not important for marriage, 69.0% believed that stopping the practice was an improvement for society, 56.5% believe that the media could play a role in stopping the practice. A low proportion 14.25% was of the view that the practice should continue. In another study in Egypt, the proportions were equally high, 94.5% believed that FGM was not important for marriage, 72% believe that abolishing FGM is an improvements for society, 69.1% believe that current discussions in the media are important to ban FGM¹⁵. The finding in this study show that with sustained intensive campaign against FGM more of the women will develop a positive attitude and that will help to stamp out the ugly practice.

Table III displays the attitude of the respondents towards advising friends/relatives not to perform FGM. 70.26% said they would advise against the practice (an active role) as opposed to 21.0% who said no and 8.68% who indifferent (implying passivity). It is hoped that with time and more vigorous campaign those projecting the passive role will tilt to the active side. This will accelerate the liberation of women from the shackles of tradition and these erroneous beliefs. This will gradually lead to reduction in the prevalence and practice of FGM [37].

Age is not a very significant variable as it relates to the choice of the respondents on not performing FGM on their females. Over 70% of the respondents across the various age distributions would not opt for FGM. This may imply that the practice is gradually becoming less popular.

Education plays a vital role in influencing the attitude of the respondents against inflicting FGM on their daughters. In fig. 8, 70.9% of those with tertiary education



said they would not perform FGM on their daughters as opposed to 60% of those with informal education only. Also, among those who would like to carry out the procedure on their daughters those with informal education ranked highest (26.7%) compared to 6.1% of those with tertiary education. In a related study at ABUTH, Zaria, it was reported that a substantial number of women (n=104) said they were going to perform FGM on their daughters, particularly among women with no education (38.0%) as opposed to women with tertiary education (8.0%) [4]. In a related hospital-based study in Lagos, none of the respondents with tertiary education was in favour of FGM while 53.7% of the respondents without tertiary education were in favour of continuing the practice.

Education also affected the attitudes of the respondents that were indifferent about whether they would perform FGM or not on their daughters. 12% of the respondents with no education and 13.3% of those with Arabic education only, were indifferent compared with 8% and 5% for those in the tertiary and secondary education groups, respectively.

Nevertheless, it is good news that there were a high proportion of those who would not perform FGM on their daughter, both among the Muslims (74.2%) and the Christians (86.5%).

The attitude of the respondents towards circumcising the rest of their daughter is quite encouraging. Table VIII show that 72.8% of the respondents will not circumcise the rest of their daughters, as opposed to 6.3% of those who will still circumcise the rest. Only 1.32% was indifferent and 20.3% did not have female child or have circumcised all they have, this finding suggest that the practice is declining.

The timing of Female Genital Mutilation at a very early age is such that an individual has no choice on whether to accept or reject the procedure. This finding is illustrated in Table III with 38% been done in childhood at the age where an individual hardly remembers anything. This is similar to what is obtained in Ethiopia [14]. This is also comparable to a similar study conducted in Lagos, where 78.4% of the circumcisions were done when the victim was a baby, 21.6% were done at puberty and 27.2% at adult level. However, in a few cases, the procedure was carried out as late as at puberty (12.2%), just prior to marriage (8.6%), during the first pregnancy (1.4%), or at first child birth (4%). It is not surprising therefore that majority of the victims (67.62%) do not know who performed the procedure and 63.3% do not know where the procedure was performed and whether there was use of decontaminants, though 8% were aware of the complications they suffered.

Among those who could volunteer this vital information, local barbers were found to be the major culprits of this dehumanizing procedure (12.23%), while traditional birth attendants follow with 7.19%. However, despite the call for demedicalizing the procedure, hospital staff was found to be responsible for 4.32 percent of the

procedure. It was also found that the procedure was mostly performed at home (35.982%) as opposed to 0.72% percent who had it done in the hospital.

The grand mothers were at the forefront in making decision on FGM, as 51.46% of those who practice the procedure recognized them as the perpetrators of the practice. Mothers and fathers also play a vital role, being responsible for 25.44% and 20.47% respectively. In a similar study in Burkina Faso, the fathers (89%) were more likely than the mother and grandmother (56%) to be involved in making the decision to have their girls undergo FGM. This contrasts with the finding in this study. This shows that FGM is a female problem imposed on women; the men appear to be relatively innocent. Emphasis should now shift to self- liberation by the women.

Payment to these who actually perform the FGM is done in various ways as there is one form of remuneration or the other. Thus, the beneficiaries will oppose any attempts to bring an end to the practice. Among those that practice it, 87.77% admitted that money was usually paid for the procedure while others gave food items (8.66%) to the practitioners. Only 2.16% claimed it was done at no cost. Other studies equally show that circumcisers are remunerated in both cash and kind [38-39]. Data from field notes indicate that some of the traditional circumcisers sell the parts, which were removed from the genital, and traditionalists use it to make "good luck" charms for their clients [29]. Such ritual benefits were not recorded in this study. Nevertheless the possibility is not excluded.

CONCLUSION

The practice of FGM cuts across religious, ethnic, social and educational stratum. There is, however, a tendency for women with more education to either be indifferent or disapprove of this practice, suggesting that as more women acquire post-secondary education, the practice of FGM in Nigeria will gradually diminish.

This trend could be further encouraged by special attention to harmful traditional health practices in primary and secondary health institutions, where access to women is facilitated. Also visual information could be posted in maternal health clinics to educate mothers on the dangers of FGM and radio talks could also discuss these topics. Health professionals who usually have access to a lot of women should also participate more actively in campaigning against the practice of FGM.

This study also showed that it is not sufficient to study prevalence of female genital mutilation in the society by simple use of questionnaires and focus group discussions only since a high proportion of the women found to have clinical evidence of female genital mutilation were not aware that they had undergone the procedure. This will suggest that prevalence based on questionnaires and focus group discussion will underestimate the extent of the practice of FGM by over 50%. It is therefore necessary to include clinical assessment in



ascertaining the prevalence of female genital mutilation in order to have a more accurate data on the practice.

Finally, while there is an urgent need to stop the practice of female genital mutilation in communities where it is done, the social mechanism sustaining this practice need to be studied and understood before any meaningful change can be made. This is important having realized that the practice of female genital mutilation is not affected by religion or entirely by educational attainment. The social mechanisms that sustain these practices will certainly be a subject for another research.

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STATEMENT OF HUMAN AND ANIMAL RIGHTS

All procedures performed in human participants were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This article does not contain any studies with animals performed by any of the authors.



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