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FEMALE GENITAL MUTILATION AND SOCIO-CULTURAL IMPLICATIONS IN NIGERIA

Florence Foluso AWOSAN
Crisis Management Department,
Nigeria Security and Civil Defence Corps, Sokoto State Command
fawosan@yahoo.com

and

Samuel Opeyemi IROYE
Department of Peace Studies and Conflict Resolution
National Open University of Nigeria
lifelinesamuel@yahoo.com

ABSTRACT

Female Genital Mutilation (FGM) is a practice that is prevalent around the world with an estimate of about two hundred million women and girls being affected globally, and among which are about twenty million women and girls in Nigeria alone thus, constituting about 10% of the global total. FGM has been recognized as a major factor for the sustained oppression of women and girls in Nigeria in view of its huge impact on the development and economic growth of girl-child and women in the country. This study aims to examine the practice, attending crises and probable prevention of female genital mutilation in Nigeria. A systematic review method was employed in this research and the findings show that the procedure is very prevalent in Nigeria, it is driven largely by socio-cultural factors and has adverse effects on the physical, psychological, and social wellbeing of the victims. Although, several efforts have been made towards eradicating "FGM" in Nigeria, its success is being hampered by several factors among which is the non-uniformity of the application of relevant laws within the nation which thus creates a lacuna in the enforcement procedures. Thus, the high prevalence of FGM, and the dire consequences of the procedure on the girl-child and women in Nigeria made the writer to underscore the need for a strategic community sensitization on the dangers associated with the practice and to also advocate that the government should ensure the vigorous application and enforcement of relevant laws against such practices generally in Nigeria.

KEYWORDS: Female genital mutilation, cultural beliefs, consequences, Prevention

INTRODUCTION

The burden of Female Genital Mutilation (FGM) is disproportionately high in the developing countries of the world (WHO, 2021). In essence, FGM has become one of the most common forms of Gender Based Violence (GBV) or violence against women and girls in the developing countries. According to the World Health Organization (WHO), an estimated three million girls are at risk of undergoing FGM every year, and majority of them are forced to undergo the procedure before the age of 15 years (WHO, 2021). FGM is a traditional practice that has been found to be very harmful, and it involves the partial or total removal of external female genitalia or other injury to female genital organs for non-medical reasons (WHO, 2021). The Subjection of girls and women to this archaic traditional practice is very common in Nigeria; and it has become widely recognized as a violation of human rights. Unfortunately, FGM is deeply rooted in cultural beliefs and perceptions which have passed from one generation to the other and lasted for many decades and has become very difficult to eradicate (UNICEF, 2001).

In Africa, FGM is practiced in twenty-eight countries, with some of the highest prevalence rates in West African countries such as Sierra Leone, Gambia, Burkina Faso and Mauritania (Sipsma, Chen, Ofori-Atta, Ilozumba, Karfo, and Bradley 2012; WHO, 2011). Children between the ages 0 and 15 years are most at risk, and it is estimated that in Africa alone, 91.5 million females aged 10 years and above have been mutilated (WHO, 2011; WHO, 2012). Certain societies carry out this act on their girls as infants while others do so during childhood, often as a rite of passage to adulthood or during marriage. In some other cultures, FGM is performed on pregnant women or on corpses of dead women (Nour, 2008; Garba, Muhammed, Abubakar, and Yakasai, 2012). As of 2013, Nigeria, with a population of over 69 million women, had a national prevalence of 25% (Nour, 2008). Majority (82.0%) of these mutilations occurred before the age of five years, a period when these children can neither give informed consent nor understand why they are being cut (NPC and ICF International, 2014).

There is still considerable support for the practice in areas where it is deeply rooted in local tradition, and this is of serious concern (UNICEF, 2001). Although, several attempts have been made to eradicate the practice through legal and other means, it has remained over the years.

The ramifications of FGM affect the girl for the rest of her life and result in many health problems (i.e., extended bleeding, problems with urination, cysts, infections, and complications during childbirth). Aside from health-related, ethical, and moral consequences of FGM, it has been estimated by the World Health Organization that the annual cost of obstetric complications is more than $3.7 million. However, rationalization of genitalia mutilation persists; the people conducting the procedure do not believe they are doing harm. The eradication of FGM as a public health initiative is imperative to ensuring that newborn females and youth do not undergo this traumatic ordeal. Moreover, immigrant populations arriving in developed countries, particularly the United States (U.S.), present a particular obstacle in the full-global abolition of female genital mutation as many seek to continue their cultural traditions Goldberg. et. al., 2016).

Analytical method of research using systematic review was employed in carrying out this work, and it negates the operation of the "theory of promiscuity" upon which such contentious cultural practice is built and based. The belief behind the "Theory of promiscuity" is that women are likely to be motivated to live immoral lifestyles if their genitals are still intact and not ruptured by circumcision. Thus, this process known as Clitoridectomy is believed to help diminish sexual sensation for women. It is often posited that FGM reduces sexual urge in a girl and uncircumcised girls are believed to be promiscuous, will initiate sex early and will have high rate of sexual activity (Odimegwu and Okemgbo, 2000; NPC, 2008). It is also believed that this practice reduces the female sexual demands on her husband and thus the men can guaranty the paternity of their children most especially from their wives.

Cultural beliefs regarding female genital mutilation

The origin and significance of female genital mutilation (FGM) is shrouded in secrecy, uncertainty and confusion (Odoi, 2005). The ritual has been so widespread that it could not have risen from a single origin, and people generally regarded it as a tribal traditional practice that has to be protected; and as a superstitious belief being practiced for preservation of and purification, family honor, hygiene, esthetic reasons, protection of virginity and prevention of promiscuity, modification of sociosexual attitudes (countering failure of a woman to attain orgasm), increasing sexual pleasure of husband, enhancing fertility and increasing matrimonial opportunities (Odoi, 2005).

The cultural and traditional components of FGM vary between ethnic enclaves. The procedure is routinely carried out between the ages of six and eight with a few cultures preferring to cut at birth, menarche, or before marriage (Islam and Uddin, 2001; Morison, Dirir, Elmi, Warsame and Dirir, 2004). Mutilation is more often undergone alone, but can occur in groups, using same instruments on more than 40 women (Islam and Uddin, 2001; Morison, Dirir, Elmi, Warsame and Dirir, 2004; Odukogbe, Afolabi, Bello, and Adeyanju, 2017). In the Somali culture the procedure is almost always performed in a ceremonial manner accompanied by music, food, and gifts. The operators can range from "circumcisers" (religious leaders) with no medical training to midwives and birth attendants. The tools used include knives, clippers, scissors, or hot objects (Nour, 2015). A sterile environment is not feasible to attain in the cast majority of cases, and no medical anesthetics are available; the wound is sewed with crude instruments such as thorns. When infibulation takes place, thorns or stitches may be used to hold the two sides of the labia majora together and the legs may be bound together for up to forty days (Population Reference Bureau, 2013; Abu Dai, 2000). The healing process is aided by ointments and compounds made of herbs, milk, eggs, ashes, sugar, or animal excrement, which is thought to facilitate healing.

Girls undergoing the procedure have varying degrees of knowledge about what will happen to them. Girls are encouraged to be brave and not to cry during the procedure lest it

will bring shame onto their family (Morison et al., 2001). Only women are allowed to be present at the ceremony. In some cultures, girls will be told to sit beforehand in cold water to numb the area and reduce the likelihood of severe bleeding (Morison et al., 2001). However, no steps are taken to reduce the pain (Morison et. al., 2001).

Female Genital Mutilation in Nigeria

Female genital mutilation (FGM) is widespread in Nigeria. Some socio-cultural determinants have been identified as supporting this practice. FGM is still deeply entrenched in the Nigerian society where critical decision makers are grandmothers, mothers, women, opinion leaders, men and age groups (WHO, 2007). FGM is an extreme example of discrimination based on sex. Often used as a way to control women's sexuality, the practice is closely associated with girls' marriageability (Mackie, 1996). Mothers chose to subject their daughters to the practice to protect them from being ostracized, beaten, shunned, or disgraced (Yoder and Khan, 2007). FGM was traditionally the specialization of traditional leaders' traditional birth attendants or members of the community known for the trade.

There is, however, the phenomenon of "medicalization" which has introduced modern health practitioners and community health workers into the trade (WHO, 2007). The term medicalization of FGM is used to describe the practice of FGM by health care providers, whether in the private, public or home setting. While most of the practice of FGM is perpetuated by traditionalists (circumcisers, barbers, birth attendants), the involvement of medical professionals has also been noted. In 2011, 17% of all FGM in Nigeria was carried out by medical personnel, especially nurses /midwives (Population Reference Bureau, 2014). The perception of FGM as being harmless, 'good' or less risky when performed by professionals have been put forward as reasons for the practice of medical FGM (Onuh et. Al., 2006). Medical FGM has come under severe criticism by the WHO as the involvement of medical professionals may serve to justify the practice, as well as contravene fundamental medical ethics. The WHO is strongly against this medicalization and has advised that neither

FGM must be institutionalized nor should any form of FGM be performed by any health professional in any setting, including hospitals or in the home setting (WHO, 2016).

FGM practiced in Nigeria is classified into four types (WHO, 2008, Okeke, et. al., 2012) as follows:

i. Clitoridectomy or Type I (the least severe form of the practice): It 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;
ii. 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 I and Type II are more widespread but less harmful compared to Type III and Type IV;
iii. 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;
iv. Type IV or other unclassified types include introcision and gishiri cuts, pricking, piercing, or incision of the clitoris and/or labia, scraping and/or cutting of the vagina (angrya cuts), stretching the clitoris and/or labia, cauterization, the introduction of corrosive substances and herbs in the vagina, and other forms.

In Nigeria, of the six largest ethnic groups, the Yoruba, Hausa, Fulani, Ibo, Ijaw, and Kanuri, only the Fulani do not practice any form of FGM 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, 2005). 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. In Nigeria, there is greater prevalence of Type I excision in the south, with extreme forms of FGM prevalent in the North. 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, 2001).

The practice of FGM in Nigeria is widespread and varies from one geopolitical zone, state and ethnic group to another. The highest prevalence of FGM is reported from the Southern geopolitical zones of the country, among the Yoruba and Igbo ethnic groups. Although the commonest types practiced in Nigeria are types I and II, the other types of FGM (types III and IV) are also carried out, particularly in the northern parts of the country (NPC and ICF International, 2014; NBS and UNICEF, 2017).

According to the 2013 National Demographic and Health Survey (NDHS), Nigeria has a national prevalence of 25%, an improvement from the 30% reported in the preceding 2008 survey (NPC and ICF International, 2014; NPC and ICF International, 2009). The Multiple Indicator Cluster Surveys (MICS) [NBS and UNICEF, 2017] also show a gradual decline from 26% reported in 2007 and 27% in 2011, to 18% as reported in 2016. While there are difficulties in the direct comparison of data across surveys due to differences in the methodology applied during the data collection processes, these results still remain valid clues to the fact that positive change is taking place. This decline is further evidenced by the fact that girls 15- 19 years of age are less likely to have undergone FGM than older women (NPC and ICF International, 2014; NPC and ICF International, 2009). The reasons for the reduction in prevalence may not be unconnected to the global push for the elimination of FGM, noted to have begun in the late 1990s (Adeokun et. al., 2006; UNICEF, 2013). These efforts were driven by several international debates on the topic occurring about the time, notably the Convention on the Elimination of all forms of Discrimination against Women in 1979, World Conference on Human Rights in 1993, International Conference on Population and Development in 1994 and the World Conference on Women in 1995 (Adeokun et al., 2006; UNICEF, 2013).

Consequences of Female Genital Mutilation

Violation of fundamental human right

FGM is recognized worldwide as a fundamental violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes and constitutes an extreme form

of discrimination against women. It involves violation of rights of the children and violation of a person's right to health, security, and physical integrity, the right to be free from torture and cruel, inhuman, or degrading treatment, and the right to life when the procedure results in death. Furthermore, girls usually undergo the practice without their informed consent, depriving them of the opportunity to make independent decision about their bodies. In essence, FGM has become one of the most common forms of Gender Based Violence (GBV) or violence against women and children. An estimated 100–140 million girls and women worldwide are currently living with the consequences of FGM (WHO, 2000). In Africa, about 3 million girls are at risk for FGM annually (WHO, 2008). Despite the increased international and little national attention, the prevalence of FGM overall has declined very little (Yoder and Khan, 2007).

Effect FGM on health and childbirth

The consequences of FGM have both physiological and psychological complications; including short- and long-term complications (Chibber et al., 2011). The method in which the procedure is performed may determine the extent of the short-term complications (Morison, 2011). If the process was completed using unsterile equipment, no antiseptics, and no antibiotics, the victim may have increased risk of complications. Primary infections include staphylococcus infections, urinary tract infections, excessive and uncontrollable pain, and hemorrhaging (Ivazzo et al., 2013). Infections such as human immunodeficiency virus (HIV), *Chlamydia trachomatis*, *Clostridium tetani*, herpes simplex virus (HSV) 2 are significantly more common among women who underwent Type III mutilation compared with other categories (Ivazzo et. al., 2013). As the short-term complications manifest, mortality risk increases because of the limited health care available in low-income economies. While data on the mortality of girls who underwent FGM are unknown and hard to procure, it is estimated that 1 in every 500 circumcisions results in death (Reyners, 2004). The belief that the procedure produces protective factors against sexually transmitted infections (STIs), much like male circumcision, was disproved in a case-control study conducted in Sudan (Ivazzo et.

al., 2013). After the area heals, victims suffer the long-term consequences of the abuse through both physiological and psychological complications and substantial complications during childbirth (Bishai et. al., 2010).

One of the most common long-term complications is the development of keloid scar tissue over the area that has been cut. This disfiguring scar can be a source of anxiety and shame to the women who had FGM. Neuromas may develop because of entrapped nerves within the scar leading to severe pain especially during intercourse. First sexual intercourse can only take place after gradual and painful dilation of the opening left after mutilation. Other side complications include cysts, haematocolpos, dysuria and recurrent urinary infections, and possible infertility. Childbirth for infibulated women presents the greatest challenge, as maternal mortality rates are significantly higher because of complications that arise during labor. During delivery, infibulated women (i.e., genitals have been closed tightly) are cut in the perineum area so that the baby can be delivered safely (Chibber, et. al., 2011).

Effect of FGM on psychological wellbeing

FGM is often a very traumatic experience for victims. Traditional circumcisers typically use crude implements with questionable levels of sterility such as knives, razor blades, scissors and shards of broken glass (WHO, 2012). There have been reports of inhumane treatment such as being held down and cut without any form of anaesthesia and having the legs and thighs of the circumcised bound for a long time to ensure proper healing of the wound (Nour, 2008). Self- esteem issues sometimes manifested by a 'feeling of incompleteness' have also been documented (Ezenyeaku, 2011). Posttraumatic stress disorder (PTSD), anxiety, depression, neuroses, and psychoses are common delayed complications that are associated with FGM (Rushwan, 2000). In developing countries, these conditions regularly go unrecognized and if left untreated, may lead to mental concerns later in life.

FGM as a cause of marital conflict

One of the dire consequences of FGM is its being a cause of marital conflict. As girls grow up and marry, the sexual disfunction caused by FGM may put stress on their marriages; and over

the long term, FGM can leave serious psychological scars. Girls and women who experience it may suffer anxiety, depression, memory loss, sleep disorders and post-traumatic stress disorders (PTSD) (Bishai et al., 2010). These have serious consequences on the ability of the women affected to perform their marital functions, particularly not being able to have intimate relationship with their husbands as a result of the pains they experience anytime they tried to do so. This could cause serious marital conflict which could result to domestic violence or intimate partner violence (including economic violence, psychological violence, emotional violence, sexual violence and physical violence (which could result to serious physical injuries and even death). Other common consequences include separations and divorce, particularly if the source of the conflict is not identified and addressed early enough, because in many instances the couples concerned of feel shy let other people (including their family members) know that the frequent conflicts they are experiencing in their marriage are majorly due to issues related to intimate relationships.

Effect of FGM on the economy

The financial burden posed by FGM is huge, as medical costs, especially that related to management of the complications weigh heavily on families and health care systems. A study in South East Nigeria (Ezenze, et. al., 2007) estimated the cost of managing the post mutilation complications per girl child in a pediatric clinic to be about US $120; a huge amount for Nigerian families considering that many live on less than the national minimum wage of 18,000 naira (US $50). In a study to estimate the obstetric cost of FGM in some countries including Nigeria, it was shown that the number of years of life lost per incident case of FGM in 15-45 year-old women increases progressively from type 1 to 111 (Adam et al., 2010).

5.0 Prevention of female genital mutilation

It is true that tradition and culture are important aspects of any society in helping to mold the views and behavioral patterns of the society. Few treatment options exist for victims of FGM (Behrendt and Moritz, 2005; Foldes, et. Al., 2012). Psychological and emotional support is available from therapist and support groups that specialize in PTSD (Behrendt and

Moritz, 2005; Foldes et. Al., 2012). These support groups are often located in urban areas or near ethnic enclaves that have high risk of FGM. In addition, defibulation, a surgical process that attempts to reconstruct the labia by undoing the initial mutilation, is available at specialty hospitals throughout the world. However, many times the procedure has mediocre results and can result in additional complications. Additionally, the cost of the surgery is not always covered by insurance, thereby causing a financial deterrent (Behrendt and Moritz, 2005; Foldes et. al., 2012).

Foldès et. al. (2012), conducted a study at St. Germain Poissy Hospital, France, from 1998 to 2009, assessing the immediate and long-term outcomes of reconstructive surgery (Behrendt and Moritz, 2005). Employing a prospective cohort study design, they followed 2938 women who had been operated on, from surgery to one-year follow-up. Prior to surgery, all patients filled out a questionnaire about tier demographic characteristics and preoperative pain at the mutilation site (Behrendt and Moritz, 2005). Subsequently, patients underwent surgery to restore both clitoral anatomy and function. In addition, for infibulated patients, defibulation preceded surgery in order to restore vaginal function. Patients were all discharged two days following surgery, returned for a two-week follow-up, and told to return in a year's time; a follow-up rate of 29% was achieved (Behrendt and Moritz, 2005).

A multidisciplinary approach is needed to tackle this deep-rooted legendary practice of FGM. There is a need for legislation in Nigeria with health education and female emancipation in the society. The process of social change in the community with a collective, coordinated agreement to abandon the practice "community-led action" is therefore essential. With improvement in education and social status of women and increased awareness of complications of FGM, most women who underwent FGM disapprove of the practice and only very few are prepared to subject their daughters to such harmful procedures (Odoi, 2005).The more educated, more informed, and more active socially and economically a woman is, the more she is able to appreciate and understand the hazards of harmful practices like FGM and

sees it as unnecessary procedure and refuses to accept such harmful practice and refuses to subject her daughter to such an operation.

Several actions have been taken at the global level and the national level in Nigeria to eliminate female genital mutilation. In 2008, the 61st World Health Assembly called upon member states to institute actions aimed at preventing and eliminating FGM, as well as provide support for victims (WHO, 2008c). The WHO is working with professional organizations as well as the United Nations (UN) system to achieve this goal. Several UN agencies, notably the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA), have been in the forefront of the fight against FGM. In conjunction with UNICEF and the United Nations Educational Scientific and Cultural Organization (UNESCO), the WHO in 2010 launched a global "de-medicalization campaign" strategy; aimed at coordinating the efforts of policy makers in government, parliamentarians, international agencies, professional bodies, associations, community leaders, religious leaders and Non-Governmental Organizations in the fight against medical FGM. In 2007, the UNFPA and UNICEF together launched the 'Accelerating Change'; a partnership which is the main tool of the United Nations against FGM (UNFPA and UNICEF, 2014) This collaboration has recorded tremendous progress in fast-tracking the elimination of FGM across several African countries using cultural and rights sensitive strategies.

Other UN agencies have issued joint statements geared towards the elimination of FGM (United Nations, 2014). At the 47th World Health Assembly more than two decades ago, Nigeria resolved to eliminate FGM. This was further reinforced in 2012, when the country joined other African nations to sponsor the Anti-FGM Resolution at the 69th session of the UN General Assembly (United Nations, 2012). In 2013, the National Policy and Plan of Action for the Elimination of FGM in Nigeria was also formulated and approved. The Nigerian government has also sponsored the conduct of various surveys on FGM, and a federal law against FGM was passed in May 2015. Several Nigerian states such as Edo, Ogun, Cross-River, Osun, Bayelsa and Rivers have also outlawed the practice. National ministries,

departments and agencies involved in the anti-FGM war include the Federal Ministries of Women Affairs and Social Development, Information and Communication, Justice, Health, as well as the National Human Rights Commission.

However, despite the increased international and little national attention, the prevalence of FGM overall has declined very little (Yoder and Khan, 2007). FGM is not required by any religion and there is no scientific evidence that women who have been mutilated are more faithful or better wives than those who have not undergone the procedure (WHO, 2007), as it is very clear that there is no single benefit derived from FGM.

Conclusion and Recommendations

Female genital mutilation is a practice deeply rooted in the 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 affairs, finance, justice, health; and relevant organizations such as religious, health professionals, women groups, professional bodies, policy makers 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 through 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 need for increased and sustained support of the government, key policy/decision makers, 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 serves as a discouragement to circumcisers and families fearing prosecution. There should be provision of medical, psychological and social support to the victims of FGM. More research into the perception and practice of FGM in Nigeria should be done. This will provide necessary data to monitor trends as well as ensure that resources are appropriately channeled to areas where they are needed.

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