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# Culture, Beliefs, Attitude and Peer Group Influence on Female Genital Mutilation in Southeast Nigeria

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## Abstract

**Background:** Female Genital Mutilation is still practiced in Ebonyi State in Southeast Nigeria, despite the complications that follows it and government legislation against the practice. **Aim:** To determine the impact of Culture, Beliefs, attitude and Peer Group Influence on the persistence Female Genital Mutilation practice in the State especially in the rural areas. **Materials and Methods:** Qualitative study that used Focused Group Discussion and In-depth interviews for data collection. Those willing and given consent were recruited into the group discussion according to age, marital status, educational level and their location in the state. In-depth interviews were used with the Stake Holders, Opinion Leaders, Traditional Rulers and the Clergy. **Result:** A total of 454 participants were recruited from the 13 local government areas of Ebonyi State but only 420 (92.5%) participated. The age ranges of participants were 25 to 35 years for single males and females while the married participants male and female were aged 35 to 70 years. One hundred single females (23.8%) and 94 single males (21.4%) participated while 97 (23.1%) married women and 95 (22.6%) married men participated. Out of the 26 health workers recruited only 22 (5.2%) participated. Four traditional rulers, 4 women leaders, 4 youth leaders and 2 clergy 12 (2.9%) in number had in-depth interviews. All the participants had knowledge of FGM and its practice. Rural health workers are getting more involved. 'Female Genital Crushing' is replacing actual cutting. The participants all agreed there is no benefit and the practice should stop. **Conclusion:** Female Genital Mutilation is secretly practiced and is getting replaced by "Female Genital Crushing" perpetrated by rural health workers as well as mothers, fathers, traditional birth attendants and the peer group playing a major role with low knowledge of the Law against Female genital mutilation.

**Keywords**

Female Genital Mutilation, Culture, Beliefs, Attitude, Peer Group Influence

## 1. Introduction

Female genital mutilation involves partial or total removal of the external female genitalia or other injury to the female genital organ for cultural, religious or other non-therapeutic reasons [1] [2]. This has long been practiced in different parts of the world. The origin is not known but was first discovered in ancient Egyptian mummies in 200BC [3]. World Health Organization (WHO) in 1996 estimated that between 100 and 140 million girls and women worldwide were living with female genital mutilation and every year about three million girls are at risk [1].

In some African countries including Nigeria the practice is still going on despite the fact that it has been recognized as a major reproductive health problem and dehumanizing practice especially in the developing countries like ours. It is gender-based discrimination and circle of poverty is encouraged and reinforced by the practice [4]. UNICEF in 2022 estimates that 140 million women and girls aged between 15 and 49 years are living with female genital mutilation [5]. The prevalence is different among the African countries, ranging from 1% in Cameroun to 90% and above in Somalia, Guinea and Djibouti. In Nigeria the prevalence is about 20% among this age group [6] but up to 50% over all national prevalence which is the highest absolute number of women living with genital mutilation in the world [1]. Ebonyi State ranked third across the States in Nigeria between 2017 and 2019 with about 75% of the residents engaging in this obnoxious practice [7] despite long period of campaign and legislation by government to eradicate the practice. A hospital-based study in Ebonyi State in 2012 reported the prevalence of 49.6% [8]. The practice violates fundamental human right, reproductive right as well as breach the integrity and personality of women [9] [10].

All the types of female genital mutilation (1 - 4) were identified with obstetric outcomes. Pinhole introitus at delivery due to infibulation (type 3) or with vaginal atresia due to introduction of chemicals or salts to the vagina (type 4) or due to unintentional vaginal or vulva atresia as a result of infection or further scaring (types 1 and 2) [11].

No benefit has been identified with female genital mutilation but there are lots of complications which include Obstetric, gynaecological, dermatological and infectious diseases that follows the practice [9] [12]. There may be haemorrhage, infection (including HIV), retention of urine, genital organ swelling, infertility, dysmenorrhea, urinary incontinence, dysuria and poor flow of urine. Obstetric complication may present with difficult or inadequate antenatal and intrapartum vaginal assessment and catheterization, perineal tear, performance of episiot-

omy, postpartum haemorrhage, prolonged obstructed labour and fistula formation leading to increased maternal and foetal morbidity and mortality. The practice is also associated with sexual dysfunction shown by dyspareunia, difficult arousal, anorgasmia, vaginal dryness, un-satisfaction and psychological problem [4] [9]-[21].

The practice is maintained due to social and family pressure transmitted from generation to generation. Individual, economic, socio-demographic, religious and cultural factors play a role in the continuation of the practice [22] [23]. Done for different reasons like getting married, social acceptance, to safeguard virginity and suppress sexual desire thus remains a cultural practice. Alternative rites of passage were suggested as an important strategy for eliminating this harmful practice [18] [24]. In six African countries studied, the estimated annual cost of female genital mutilation and related obstetric complications amounted to $3.7 million [25] [26].

Few studies have been done on Female Genital Mutilation situation in Ebonyi State which are mainly hospital-based. This study seeks to get to the grassroots of the communities and ascertain the influence of culture, beliefs, attitude and peer group influence on Female Genital Mutilation and how best to eradicate this obnoxious practice among our people.

## 2. Methodology

This was a qualitative study carried out in Ebonyi State, using a focused group discussion and in-dept interview. Ebonyi is one of the 36 states in Nigeria that was created in 1996 out of the South eastern states in Nigeria. The State is made up of 13 local government areas one urban and one semi-urban and the rest mainly rural. Some Development centers were carved out of the main Local Government Areas to encourage rural development. The National Population Commission, reported the population of 2.1 million people and a land mass of 5932 km, however the State Government in the year 2020, estimated the population of about 4.3 million people and a land mass of 5935 km based on extrapolation from 2005 population census. The people of Ebonyi State are predominantly (about 75%) [27] rural dwellers with subsistent farming as their major occupation.

The recruitment was by individual signed informed consent. Information was given out through the Officer in Charge (OIC) of the major health care centre in the area about the visit by medical experts to address them with free medical check. During the programme, those that gave consent were recruited into the study according to their Age, Sex, Marital status and knowledge of the subject to be discussed. The study protocol and what is going to be discussed were explained to them and those that signed informed consent were recruited into the study. They were also given the option to opt out at any time if they do not wish to continue. The unmarried males aged between 25 and 35 years had their group discussion different from the unmarried female of the same age group. The same

was done for the married men aged between 35 and 70 years as well as the female. This selection was done this way to have a fair representation of those who are knowledgeable in the matter to be discussed as well as their culture and tradition. This segregation was done to prevent domination of the discussion by a particular group, so that everyone could freely express their mind about the practice. The other groups of participants were carefully selected traditional rulers, women leaders youth leaders and the clergy which we considered are important stake holders and opinion leaders as well as the custodians of the peoples' culture. These groups had In-depth Interviews. The health workers' recruitment was done during training of health workers on Maternal and New-born care courses.The health workers were recruited because of several reports of immediate complications like severe hemorrhage which had to be managed in the tertiary hospitals as a result pear group organized FGM carried out by some health workers without the knowledge of their parents. The participants were however assured of privacy and confidentiality.

The focused group discussions were carried out in different sessions. A total of 39 sessions were carried out. Each session consisted of at least 8 participants with a moderator and an assistant. During the sessions the group of participants were guided by the moderator who introduced Female Genital Mutilation as a topic for discussion and helped the group to participate in a lively and natural discussion among themselves. The group participants were allowed to agree or disagree with each other so that it provides an insight into what the group thinks about Female Genital Mutilation, the range of opinion and ideas, misconceptions, Culture, Belief, Peer Group Influence and the variation that may exists between the communities in terms of beliefs and their experiences and practices. In-depth Interviews were mainly conducted for different opinion leaders like the Traditional Leaders, Women leaders, Youth leaders and the Clergy. Inclusion criteria were those who signed informed consent to participate and were assured of confidentiality. The exclusion criteria were any person closely working with the government team on eradication of Female Genital Mutilation and other Harmful Practices.

Questions asked included if they have heard about Female Genital Mutilation? What it means? How they got to know about it? How it is practiced in their locality? Why was it practiced? Is it still practiced in their locality? Who practices it? What is the role of the peer group in the practice of it? Any known benefits in the practice of Female Genital Mutilation? Awareness of any complication associated with this practice? Should it be stopped or encouraged for their opinion? What should be done to stop this practice? Awareness of any law against Female Genital Mutilation? If they (female participants) were mutilated themselves and Why? If there is anything they want to add to all that was discussed? Round sitting position adopted for participants. All seated in open field under a shed or suitable office where available. Introduction of participants, the moderator and assistant were done. Ground rules were established and the purpose of the discussion was once more said and confirmation of consent to participate gotten

again. The questions and answers session now followed and conclusion. Those that do not understand English especially the elderly uneducated ones had the questions interpreted in their local dialect.

Recording each session was done with a small tape recorder. The assistant moderator also took down note in a format to help with reporting the discussion.

The moderator ensured even participation, careful wording of the key questions, maintaining a neutral attitude and appearance, and summarizing the session to reflect the opinions evenly and fairly.

Each session lasted an hour. At the end of each session, the moderators took time to educate the participants on areas that appeared to be confusing, especially as regarding the Law against Female Genital Mutilation.

Recorded discussions were transcribed. Categories or themes across the entries for each question were developed. A summary of findings for each subcategory noting similarities and differences across were done. Results were presented in tables and simple percentages.

## 3. Ethical Issues

Ethical approval for the study was obtained from the Alex Ekwueme Federal University Teaching Hospital, Abakaliki, Ebonyi State. Informed consent was obtained from the participants and were given the option to opt out at any time if they do not wish to continue. The participants were also educated on the harmful nature or complications of the practice at the end and they all agreed to discourage the practice in their communities since there is no benefit.

## 4. Results

A total of 454 participants were recruited from the 13-local government areas of Ebonyi State. A total of 420 (92.5%) participated while 34 declined after the second explanation of the purpose of the program saying they are busy and there was no financial benefit/entertainment. Ninety four unmarried males (21.4%) aged between 25 to 35 years participated in the Focused Group Discussion (FGD) while 95 (22.6) married men aged between 35 to 70 year participated in the FGD also. A total of 100 unmarried females (23.8%) aged 25 to 35 years and 97 married women (23.1%) aged 35 to 70 years also participated. Out of the 26 health workers recruited only 22 (5.2%) participated while 4 said they are not willing to continue. Others which consisted of 4 traditional rulersaged 70 years and above, 4 women leadersaged 60 years and above, 4 youth leaders aged 40 years and above and 2 clergy men (aged 50 years) making a total of 12 (2.9%) had in-depth interviews (Table 1). All the percentages in parentheses are based on the total number of participants.

### 4.1. Knowledge of Female Genital Mutilation

Virtually all the participants have knowledge of the existence of Female Genital

**Table 1.** Focused group discussion/in-depth interviews across the 13 local government areas in Ebonyi State.

| Serial number | Group | Age range | Number | Method | Percentage |
|---|---|---|---|---|---|
| 1. | Unmarried female | 25 - 35 | 100 | FGD | 23.8 |
| 2. | Unmarried male | 25 - 35 | 94 | FGD | 22.4 |
| 3. | Married women | 35 - 70 | 97 | FGD | 23.1 |
| 4. | Married men | 35 - 70 | 95 | FGD | 22.6 |
| 5. | Health workers | 25 - 55 | 22 | FGD | 5.2 |
| 6. | Others | 40 - ≥70 | 12 | In-depth interview | 2.9 |
| | Total | | 420 | | 100% |

FGD: Focused Group Discussion.

mutilation. Majority of them heard about it from the community, their grandmothers/mothers and elderly women at a very young age. Some also heard it from their peers, at school, over the radio/television and from the hospitals. Many of the participants, especially the older girls and married women had Female Genital Mutilation done on them and some can describe how it is done. Some had witnessed it done on other girls, some on their sister.

## 4.2. Practice

During the procedure, the girl is naked and lying down with her legs spread wide apart and restrained by people. Part of the genitals especially the clitoris and labia minora is cut with a razor blade or "AGUBA" (a small sharp knife) which was also used for shaving the hair those days. The procedure can be done early in life, as early as 1 - 8 days of life, or as soon as breast development begins but can be done any time from 10 years and above or when the girl is about getting married. The one done during marriage is an elaborate and colorful display of affluence and wealth, dances and other cultural displays. Most of the time this one is done in group and each suitor and family trying to outwit the other. The participants agreed that Female Genital Mutilation is still being practiced in the state mostly in the rural areas. The practice was carried out by elderly women, traditional birth attendants and surprisingly some health workers. Most of the sporadic cases that presented with heavy bleeding in the tertiary hospitals during the period of this study were done by health workers and organized by the peer group.

In Table 2 below, we see that culture and tradition is the major reason for this practice. Hundred percent of the married men agreed it is their culture and tradition passed down to them by their ancestors. In the same vain 96% of the

**Table 2.** Reasons for the practice.

| Group | Age | Reasons | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Culture and tradition | For marriage | Reduce Promiscuity or infidelity | Reduce sexual urge | Avoid difficult delivery | Peer group influence | stigmatisation | Beautify the vulva |
| Single girls | 25 - 35 | 80 | 50 | 10 | 50 | 20 | 60 | 40 | 5 |
| Single boys | 25 - 35 | 90 | 10 | 50 | 5 | 10 | 10 | 3 | 0 |
| Married women | 35 - 70 | 92 | 75 | 80 | 80 | 70 | 3 | 90 | 30 |
| Married men | 35 - 70 | 95 | 90 | 80 | 70 | 60 | 0 | 0 | 10 |
| Health workers | 25 - 55 | 20 | 10 | 2 | 15 | 0 | 18 | 7 | 0 |
| Traditional Rulers | ≥70 | 4 | 4 | 4 | 4 | 3 | 0 | 0 | 3 |
| Women leaders | NA | 4 | 4 | 2 | 2 | 1 | 0 | 2 | 0 |
| Youth leaders | 40 | 2 | 2 | 0 | 0 | 0 | 0 | 1 | 0 |
| Clergy | NA | 2 | 2 | 0 | 0 | 0 | 2 | 2 | 0 |

NA: Not Applicable.

unmarried males also alluded to that. Eighty percent of the unmarried female and 92% of the married women also attributed it to culture. Hundred percent of both the traditional, women leaders as well as the clergy also alluded to culture as the main reason for the practice while 50% of the youth leaders agreed it is practiced for culture. Fifty percent of the unmarried female believe it is an important marriage rite, 82% of the married women agreed with that while while 95% of the married men also have that same believe. Fifty three percent of the unmarried males believe it reduces infidelity, 82% of the married women and 84% of the married men also share the same opinion. Fifty percent of the unmarried female believe it reduces sexual urge, 82% of married women and 74% of married men also share the same opinion. Seventy two percent of married women and 63% of married men believe it reduces difficult labour. Sixty percent of the unmarried female had peer group influence as a reason while 40% said they were stigmatized by their peers. Ninety three percent of the married women were stigmatized while 31% believe that it beautifies the vulva. The table also showed peer group influence and stigmatization as major reasons for the perpetuation of the practice among young girls. Most of the single males still believe it is their culture and reduces infidelity and flirting or promiscuity when the lady

gets married.

### 4.3. New Practices

During the discussion some participant mentioned an alternative to genital cutting which is replacing the old practice. This they said is because the government and the health workers are saying that it is not good. The alternative is what they described as massaging the clitoris between the thumb and the fingers with the aim of reducing the size and prominence. This is a process by which the clitoris or the labia minora or both are forcefully squeezed between the fingers and the thumb until the size or prominence is reduced. This can be done by the girls' fathers, mothers or other elderly relatives. This is started as early as possible and done over a long period (up to two months or more). Vaseline, powder or other chemicals are used. They called the procedure genital massaging but we thought this could actually mean "crushing" the clitoris or external genitalia with the fingers. Some admitted that the Clitoris disappears if done well. We did not find any reference in our literature search as regards this practice. This practise is perpetuated to avoid the actual cutting because of government campaigns against the practise of Female Genital Cutting in the State and as a result of ignorance as they believe that the complications that follow actual cutting may not be associated with the new method.

### 4.4. Complications of FGM

Heavy bleeding was the commonest complication mentioned by the participants. 2 particular participants became emotional and said they watched their sisters bleed to death after the procedure before they could get help. Others are coital difficulty/pain, inability to deliver their baby (obstructed labor), infertility, infections, excessive pains, leakage of urine from the prolonged obstructed labor following genital mutilation. Some mentioned amenorrhea as part of the complication as well as transmission of HIV since there use the same instrument for many people without sterilization. Those that were mutilated were more likely to have obstructed labor which there attributed to other causes than FGM like punishment from the gods for wrong doing. They were also more likely to have genital/perineal laceration as well as episiotomy during child birth. Dyspareunia was also commoner among them.

### 4.5. Benefit

Minority of the participants especially the older ones mentioned easy delivery as a benefit associating increased caesarean section rate to those that are not circumcised (FGM).

The majority however felt that there are no benefits. The Clergy particularly frowned at the fact that the practice is still ongoing secretly. They said it is like man trying to help the Almighty God in His creation and that it should be stopped immediately.

### 4.6. Awareness of Law against Female Genital Mutilation

About 92.9% of the participants were not aware of any law against Female Genital Mutilation. The few that were aware of the existence of the law (mainly the health workers) does not know the content of the law.

### 4.7. Strategies to Eliminate Female Genital Mutilation

Many suggested information disseminations particularly in the rural areas where this practice is still ongoing secretly. Information about the complications that follow Female Genital Mutilation should be made known to the public especially in the rural areas. The use of jingles condemning the practice in all the local dialects in the state was suggested by many. The use of Media (Radio, Television and the social media) to educate the people was also suggested. Significant number suggested reward for those that will report those that are still practicing it secretly. Many advocated for the demerits of the practice to be part of the discussions during August meeting as a good avenue for disseminating information.

Others mentioned enforcing the anti-FGM Law making an example of any defaulter as this will serve as a deterrent to others. Others suggested the use of clergy men to keep passing the information in the Churches as they are held at high esteem, respected and obeyed by their followers/members. Dramatization of the complications associated with FGM should be played continuously and should be translated to the different dialects in the state. Empowering the women generally and particularly those their livelihood depends on circumcision was suggested by some of the participants. The town unions, the women organizations and different opinion leaders should also act as agents of change in this regard.

## 5. Discussion

The study has revealed to an extent why the practice of Female Genital Mutilation has continued to thrive despite all the effort made and resources expended for its eradication. This practice involves an elaborate ceremony especially when done during marriage. There is show of wealth and affluence or popularity by the family and or the suitor. The families, the girls and their suitors look forward to it. Sometimes it is done in group with different colorful cultural displays and dances and the girls adorned in different colors too. During this ceremony, each family and grooms tries to outwit the other in the show of wealth affluence and popularity. These should be taken into consideration in effort to stop the practice.

All participants knew about Female Genital Mutilation (FGM) as procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. The majority of the participants in our study believe that the procedure has no health benefits for girls and women. Few of the elderly among them however still believe that it makes labor easier and faster. Their opinion

may be based on the believe then that prolonged and or obstructed labor experienced by some parturients is as a result of infidelity or unfaithfulness to one's husband and visitation of the anger of the gods for this or other wrong doing. They were educated on causes of prolonged obstructed labor making them understand that Female Genital Mutilation is one of the causes. Female Genital Mutilation (FGM) is encouraged by uninformed mutilated women themselves with strong support and backing of domineering uninformed men. Many have died as a result of this procedure as shown by two participants who watched their sisters bleed to death before they could get to where they could get help. It is believe that as long as the practice is done to keep the women for that single man in her life, no amount of death or complication was believed to be associated with FGM. The participants however confessed how bad they felt to have encouraged this practice after seeing that there was no benefit for the circumcised over the uncircumcised female. Experience of FGM has shown increased short- and long-term health risks to women and girls and is unacceptable from a human rights and health perspective. While in general there is an increased risk of adverse health outcomes with increased severity of FGM. Some of the single males still would want to get married to a circumcised girl to decrease their sexual urge and cub infidelity.

It is worrisome that education seems not to have changed the perception of the Female Genital Mutilation. This is because the health workers instead of discouraging circumcision are taking over the procedure. This may be due to financial gain, less pain with the use of local anesthesia and seems to be less associated with immediate complication. However, the two cases that were referred to the tertiary hospitals in the state secondary to severe hemorrhage during the period of this study were done by health workers. The study also revealed high level of peer group influence on the practice now especially on the unmarried girls. There is stigmatization between the circumcised and the uncircumcised girls. The circumcised encourage and arrange for it without the knowledge of their parents. This is done in order to belong. The two cases mentioned was organized by the peer groups, their parents got to know about it while they were admitted in the hospital. The discussion also revealed a new or emerging practice to replace the actual cutting. This they described as massaging but we describe it in this study as "Clitoral or Genital Crushing". This is carried out by the child's mother or father and is started as early as possible. It is done for months until the clitoris disappears. This may be due to increased campaign against genital cutting. This practice is also dehumanizing and has the same outcome and complication of the actual cutting and can be regarded as child abuse.

Our study showed very low awareness of the presence of the anti-FGM law. This may be due to non-enforcement of the law by the government or its agencies. There is also no for a where the law is discussed in the public domain. The punishment prescribed by the law now is no longer tenable and should be amended. Many may be ready to pay the little fine involved and go on to carry

on the practice.

Finally, the participants agreed that this practice was meant to have a positive rather than a negative effect on the girl but has been shown to have nothing positive. There are no health benefits to FGM and it is recognised internationally as a human rights violation.

## 6. Conclusion

Female Genital Mutilation is still going on secretly in a number of the communities and rural health workers are increasingly getting involved in the practice. The actual cutting is getting replaced by what we described as "Female Genital Crushing" due to ignorance of the fact that it has the complications as the actual cutting and to avoid being punished by the government. There is low awareness of the Law against Female genital mutilation in the state.

## 7. Limitations

Though the sample size may give to an extent a reasonable picture of FGM and its practice in the state, it may not be the true representation of FGM and the practice in the state.

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## Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

## References

[1] World Health Organization (1996) Female Genital Mutilation: Report of a WHO Technical Working Group, Geneva.

[2] World Health Organization (2008) Eliminating Female Genital Mutilation: An Interagency Statement. Geneva.

[3] El Dareer, A.A. (1983) Epidemiology of Female Circumcision in the Sudan. *Tropical Doctor*, **13**, 41-45. https://doi.org/10.1177/004947558301300114

[4] Ruiz, I.J., Martinez, M.P. and Bravo Mdel, M. (2015) Impact of Female Genital Mutilation on the Millennium Goals. *Revista Gaúcha de Enfermagem*, **36**, 254-261. https://doi.org/10.1590/1983-1447.2015.esp.56724

[5] United Nations International Children's Emergency Fund (UNICEF) (2022) Towards Ending Harmful Practices in Africa: A Statistical Overview of Child Marriage and Female Genital Mutilation.

[6] United Nations International Children's Emergency Fund (UNICEF) (2022) UNICEF Global Database 2022, Based on DHS, MICS and Other National Surveys from 2004-2021.

[7] (2020) National Orientation Agency Ebonyi State Chapter.

[8] Ibekwe, P.C., Onoh, R.C., Onyebuchi, A.K., Ezeonu, P.O. and Ibekwe, R.O. (2012) Female Genital Mutilation in Southeast Nigeria: A Survey on the Current Knowledge and Practice. *Journal of Public Health and Epidemiology*, **4**, 117-122. https://doi.org/10.5897/JPHE11.194

[9] Junqari, S.B. (2016) Female Genital Mutilation Is a Violation of Reproductive Right of Women: Implication for Health Workers. *Health & Social Work*, **41**, 25-31. https://doi.org/10.1093/hsw/hlv090

[10] Sauer, P.J. and Neubauer, D. (2014) Female Genital Mutilation: A Hidden Epidemic (Statement from the European Academy of Paediatrician). *European Journal of Pediatrics*, **173**, 237-238. https://doi.org/10.1007/s00431-013-2126-0

[11] World Health Organization (2000) A Systematic Review of the Health Complications of Female Genital Mutilation, Including Sequelae in Childbirth. WHO/FCH/WMH/002.

[12] Farage, M.A., Miller, K.W., Tzegai, G.E., Azuka, C.E., Sobel, J.D. and Ledger, W.J. (2015) Female Genital Cutting: Confronting Cultural and Health Complications across the Lifespan. *Women's Health*, **11**, 79-94. https://doi.org/10.2217/WHE.14.63

[13] Galukande, M., Kamara, J., Ndabwire, V., Leistey, E., Valla, C. and Luboga, S. (2015) Eradicating Female Genital Mutilation and Cutting in Tanzania: An Observational Study. *BMC Public Health*, **15**, Article No. 1147. https://doi.org/10.1186/s12889-015-2439-1

[14] Bogale, D., Markos, D. and Kaso, M. (2014) Prevalence of Female Genital Mutilation and Its Effect on Women's Health in Bale Zone, Ethiopia: A Cross-Sectional Study. *BMC Public Health*, **14**, Article No. 1076. https://doi.org/10.1186/1471-2458-14-1076

[15] Jones, H., Diop, N., Askew, I. and Kabore, I. (1999) Female Genital Cutting Practices in Burkina Faso and Mali and Their Negative Health Outcomes. *Studies in Family Planning*, **30**, 219-230. https://doi.org/10.1111/j.1728-4465.1999.00219.x

[16] Egwuatu, V.E. and Agugua, N.E.N. (1981) Complications of Female Circumcision in Nigerian Igbos. *British Journal of Obstetrics and Gynaecology*, **88**, 1090-1093. https://doi.org/10.1111/j.1471-0528.1981.tb01758.x

[17] Dirie, M.A. and Lindmark, G. (1992) The Risk of Medical Complication after Female Circumcision. *East African Medical Journal*, **69**, 479-482.

[18] Ballesteros Mesequer, C., Almansa Martinez, P., Pastor Bravo Mdel, M. and Jimenez Ruiz, I. (2014) The Voice of Women Subjected to Female Genital Mutilation in the Region of Murcia (Spain). *Gaceta Sanitaria*, **28**, 287-291. https://doi.org/10.1016/j.gaceta.2014.02.006

[19] Alsibiani, S.A. and Rouzi, A.A. (2010) Sexual Function in Women with Female Genital Mutilation. *Fertility and Sterility*, **93**, 722-724. https://doi.org/10.1016/j.fertnstert.2008.10.035

[20] Catania, L., Abdulcadir, O., Puppo, V., Verde, J.B., Abdulcadir, J. and Abdulcadir, D. (2007) Pleasure and Orgasm in Women with Female Genital Mutilation/Cutting. *The Journal of Sexual Medicine*, **4**, 1666-1678. https://doi.org/10.1111/j.1743-6109.2007.00620.x

[21] Elneil, S. (2016) Female Sexual Dysfunction in Female Genital Mutilation. *Tropical Doctor*, **46**, 2-11. https://doi.org/10.1177/0049475515621644

[22] Reig Alcarez, M., Siles Gonzalez, J. and Solano Ruiz, C. (2014) Attitude towards Female Genital Mutilation: An Integrative Review. *International Nursing Review*, **61**, 25-34. https://doi.org/10.1111/inr.12070

[23] Setequ, T., Lakew, Y. and Deribe, K. (2016) Geographic Variation and Factors Associated with Female Genital Mutilation among Reproductive Age Women in Ethiopia. *PLOS ONE*, **11**, e0145329. https://doi.org/10.1371/journal.pone.0145329

[24] Puppo, V. (2017) Female Genital Mutilation and Cutting: An Anatomical Review and Alternative Rites. *Clinical Anatomy*, **30**, 81-88. https://doi.org/10.1002/ca.22763

[25] Adam, T., Bathija, H., Bishai, D., *et al*. (2010) Estimating the Obstetric Cost of Female Genital Mutilation in Six African Countries. *Bulletin of the World Health Organization*, **88**, 281-288. https://doi.org/10.2471/BLT.09.064808

[26] Okonofua, F.E. (1998) Female Genital Mutilation: The Shame of Our Nation. *Women's Health Forum*, **3**, 1-2.

[27] Umeora, O.U. and Egwuatu, V.E. (2010) The Role of Unorthodox and Traditional Birth Care in Maternal Mortality. *Tropical Doctor*, **40**, 13-17. https://doi.org/10.1258/td.2009.080207