

## FEMALE GENITAL MUTILATION: ATTITUDE AND PRACTICES AMONG WOMEN IN OKADA COMMUNITY, EDO STATE

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### ABSTRACT

In Africa, an estimated 3 million girls are at risk of Female Genital Mutilation (FGM) annually. This study assessed attitude and FGM practices in Okada Community, Edo State, to help develop programs and interventions to curtail this harmful cultural practice. A community based descriptive cross sectional study was conducted involving interviewer administration of semi-structured questionnaires to 325 consenting women in Okada Community. Data was analysed using SPSS version 21.0 statistical software, with statistical significance set at  $p < 0.050$  and 95% confidence interval. The respondents studied had mean age of  $22.78 \pm 9.30$  years. Awareness of FGM was 96.6%(314) while 268 (85.3%) had negative attitude towards FGM. The prevalence of FGM was 28.7% (90), age group of respondents (OR=0.157; 95%CI=0.028-0.869;  $p=0.034$ ) and attitude towards FGM (OR=0.115; 95%CI=0.056-0.235;  $p < 0.001$ ) were identified as significant predictors influencing FGM practices in the study area. FGM is still a common cultural practice and there is need for a well-coordinated approach engaging relevant stakeholders to curtail this harmful cultural practice.

### Introduction:

Female genital mutilation (FGM) also known as female genital cutting (FGC) comprises 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<sup>1</sup>. This practice is mostly carried out by traditional circumcisers, who often perform other central and crucial roles in communities, such as attending to childbirths<sup>1,2</sup>. An estimated 100–140

million girls and women worldwide are currently living with the consequences of FGM<sup>2,3</sup>. In Africa, it is estimated that 3 million girls are at risk of FGM annually<sup>3</sup>. Medicalization of FGM is becoming a common practice with an estimated 18% of FGM globally reported to be performed by health care providers<sup>1,2</sup>. Female Genital Mutilation is recognized internationally as a violation of the human rights of girls and women, it violates an individual's rights to health, security and physical integrity, the right to be free from any form of torture and cruelty, inhuman or degrading treatment, and the right to life when the procedure results in death<sup>1-5</sup>.

Female Genital Mutilation is widely practiced in Nigeria, and contributes nearly one-quarter of the global FGM estimates<sup>4</sup>. In Nigeria, the highest prevalence of FGM is reported among adult women in Southern than Northern

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### KEYWORDS:

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Nigeria, paradoxically Northern region of Nigeria reports more extreme forms of the practice<sup>4,6</sup>. The national prevalence rate of FGM in Nigeria is 25% among adult women, with varying prevalence of 49%(South East), 47.5%(South West), 25.8%(South South),20.7% (North West), 9.9% (North Central),2.9% (North East)reported across the respective geopolitical zones<sup>6</sup>. The prevalence of FGM is highest among females whose mothers were circumcised and 64% of women in Nigeria who have been circumcised wish that FGM should be discontinued<sup>6</sup>. This is based on FGM being considered as a practice against their religion (22%); associated with medical complications (21%), painful personal experience (10%), and the view that FGM is a violation against dignity of women (10%)<sup>3,6</sup>. Despite, the aforementioned there is still considerable support for the practice in Nigeria especially in areas where it is deeply rooted in local tradition<sup>4,6-8</sup>. Advocates of FGM have based it on the premise that it is a needful initiation rite for inducting young girls into womanhood; to ensure virginity, curb promiscuity and or to protect and promote female modesty and chastity<sup>6,9</sup>. Other reasons cited include that it helps prevent mother and child from dying during childbirth and interestingly for legal reasons (denial to inherit property if not circumcised)<sup>6,10</sup>.

Nigeria ratified the Maputo protocol and was one of the countries that sponsored the resolution at the 46<sup>th</sup> World Health Assembly in 1993 calling for the eradication of FGM in all Nations, but there has been no federal law against FGM until just recently May 2015; as is obtainable in France, Canada, Belgium, Ghana, Sweden, and United Kingdom

among others<sup>11</sup>. In Edo State the only reported legislative bill against FGM was in late 1999, making it punishable under the law for any person or group of persons to be engaged in the act of FGM with a fine and or 6 months imprisonment as penalty; despite this legislative bill its enforcement has been poor<sup>12</sup>. This study was therefore carried out to assess attitude and practice of FGM among women of reproductive age in Okada, Edo State, to help develop programs and interventions against this harmful cultural practice.

### **Materials and Method:**

A community based descriptive cross sectional study design was utilized for this study.Okada (an evolving rural township) the administrative headquarters of Ovia North East Local Government Area (LGA) of Edo State, it is 100 km (90minutes travel time by car) from Benin City,with an estimated population of 30,000 people. Okada is bordered by Okha village to the east, Iguomo village to the west, Owen village and Uhen village to the north and south respectively. Majority of the indigenes are Benin while other tribes Esan, Igbo, Hausa, Yoruba, Efik, Etsako, Ijaw and Urhobomake up the minority group. Christianity is the predominant religion; others include Islam and African Traditional Religion. The main sources of livelihood for indigenes include farming, trading and timber lumbering. Okada host several educational and health institutions such as Igbinedion University and Igbinedion University Teaching Hospital (IUTH), Police station and barracks, the Local Government secretariat headquarters, a primary health care centre, a town hall, market, a magistrate court etc and some financial institution among others.

This study was carried out over a 3 month period from May to July 2014; with sample size of 325 women of reproductive age (15-49 years) calculated using Cochran formulae<sup>13</sup> for descriptive study based on the 2013 NDHS FGM national prevalence of 25% among women of reproductive age(15-49 years)<sup>6</sup>. A cluster sampling technique was utilized to recruit women of reproductive age using existing political division of Okada community into two clusters (i.e Okada East and Okada West respectively). A cluster (Okada West) was then selected by balloting; within the selected cluster eligible respondents were subsequently recruited to participate after an initial cluster population census. Pretested semi-structured questionnaires were interviewer administered to respondents after obtaining written informed consent. The questionnaire comprised questions on socio-demographic characteristics of respondents, awareness of FGM, attitude and FGM practices. Data collected were sorted for completeness coded, entered and analysed using SPSS version 21.0 statistical software with statistical significance set at  $p < 0.050$  and 95% confidence interval.

Attitude towards FGM was assessed based on a composite point scoring system addressing 7 attitudinal questions towards female genital mutilation, a point score of "1" was assigned to every correct response to every positive and negative question respectively; while a point score of "0" to every incorrect response to every negative and positive question respectively, thus making a total point score of 7. A percentage attitudinal score of 49.9% and less (i.e "0-3 points") was graded as having negative attitude towards FGM while percentage attitudinal score of 50.0% and above (i.e

"4-7 points") was graded as having positive attitude towards FGM. Finally practice of FGM was assessed to mean any respondents reporting to have had any part of their external genitalia cut prior to commencement of the study.

**Ethical Consideration:** Ethical and Institutional Approval was obtained from Edo State Ministry of Health, Ovia North East Local Government Council, Okada while written informed consent was obtained from individual respondents before commencement of study

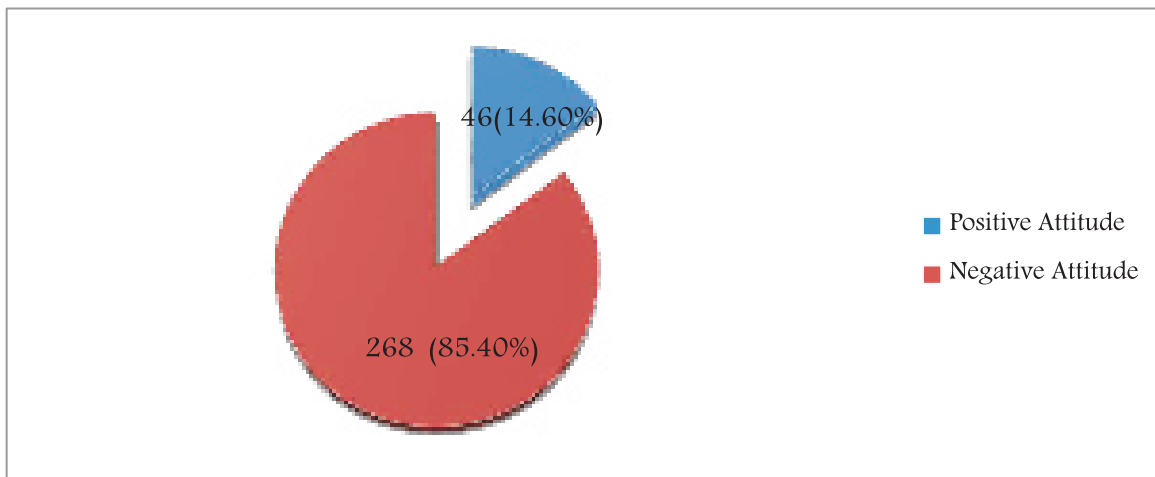
### Results:

Three hundred and twenty five women of reproductive age participated in the study, with mean age of  $22.78 \pm 9.30$  years. Christianity 309(95.1%) was the predominant religion followed by Islam 11 (3.4%) with least being African Traditional Religion 5(1.5%). In relation to occupation, 205(63.1%) were students,32(9.8%) artisans, 28(8.6%) teaching, 24(7.4%) trading, 17(5.2%) nursing, 14(4.3%) secretaries and lastly 5(1.5%) farming. In relation to actual employment status majority 236(75.2%) were unemployed while 78 (24.8%) employed. In relation to marital status,257(79.1%) respondents were single, 61(18.8%) married, 4(1.2%) widowed, 2(0.6%) separated and finally 1(0.3%) divorced. In relation to ethnic groups, Benin 118 (36.3%) was the predominant ethnic group, followed by Yoruba 51(15.7%), Esan 50 (15.4%), Igbo 39 (12.0%), Urhobo 34 (10.5%) and others 33(10.2%) consisting of Ijaw, Efik, Igala and Ogoja. In relation to educational status; 145 (44.6%) had completed primary education, 107 (32.9%) had completed tertiary, 70 (21.5%) had completed secondary education while 3(0.9%) had no formal education.

**APPENDIX**

**Table 1.** Awareness and source of information on Female Genital Mutilation (FGM) among women in Okada, Edo State (n=325).

Variable	Frequency	Percent (%)
<b>Awareness on FGM</b>		
Yes	314	96.6
No	11	3.4
<b>Source of Information (n=314).</b>		
School	155	49.4
Family	124	39.5
Friends	56	17.8
Social Media	41	13.1
Others	2	0.6



**Figure 1.** Percentage Attitudinal score of respondents towards Female Genital Mutilation (n=314)

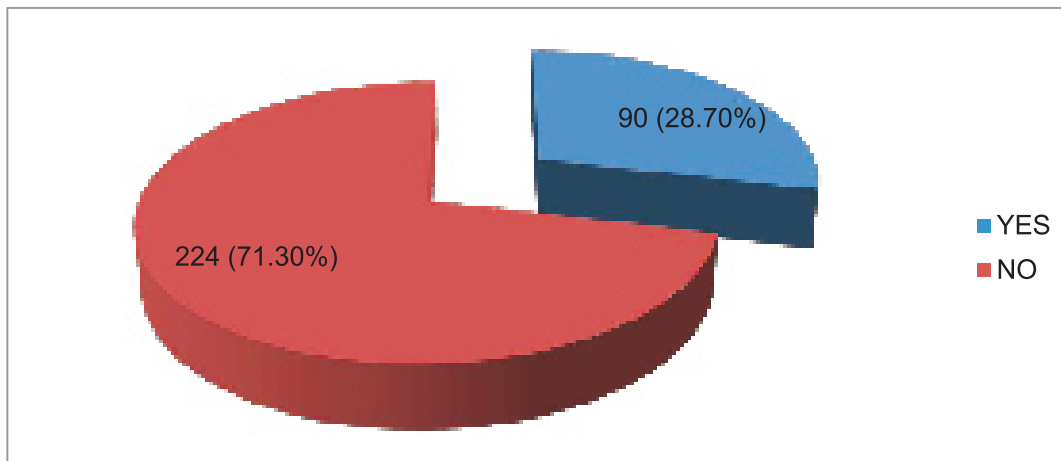


Figure 2: Practice of Female Genital Mutilation among women in Okada Community, Edo State (n=314)

**Table 2: Female Genital Mutilation (FGM) Practices among women in Okada, Edo State (n=90).**

<b>Practice Variable</b>	<b>Frequency</b>	<b>Percent (%)</b>
<b>Place where FGM was carried out.</b>		
Home	36	40
Traditional Home	30	33.3
Health Facility	24	26.7
<b>Person that carried out FGM.</b>		
Doctor	14	15.6
Nurse/Midwife	25	27.7
Traditional Birth Attendant	61	67.7
<b>History of FGM among siblings</b>		
Yes	88	97.8
No	2	2.2
<b>Age group of Respondents during FGM (Years)</b>		
0-5	75	83.4
6-10	3	3.3
11-15	5	5.6
16-20	3	3.3
21-25	4	4.4
<b>Opinion to stop FGM among those Circumcised(n=90)</b>		
Yes	49	54.4
No	41	45.6
<b>Opinion to stop FGM among those not circumcised(n=224)</b>		
Yes	211	94.2
No	13	5.8

**Table 3: Factors associated with attitude towards female genital mutilation (FGM) among women in Okada, Edo State.**

Variable	Attitude Towards FGM		Test Statistic	<i>p</i>	OR	95%CI
	Negative Freq.(%)	Positive. Freq.(%)				
<b>Age Group(Years)</b>						
15-24	174(82.1)	38(16.1)	Fishers Exact =5.174	0.140		
25-34	63(91.3)	6(8.7)				
35-44	21(91.3)	2(8.7)				
≥ 45	10(100.0)	0(0.0)				
<b>Educational Status</b>						
None	3(75.0)	1(25.0)	$\chi^2=12.810$	0.005		
1 <sup>o</sup> Completed	109(79.0)	29(21.0)				
2 <sup>o</sup> Completed	58(84.1)	11(15.9)				
3 <sup>o</sup> Completed	98(95.1)	5(4.9)				
<b>Marital Status</b>						
Single	213(84.9)	38(15.1)	Fishers Exact =0.783	0.610		
Married	51(87.9)	7(12.1)				
Others	4(80.0)	1(20.0)				
<b>Employment Status</b>						
Unemployed	198(83.9)	38(16.1)	$\chi^2=1.602$	0.206		
Employed	70(89.7)	8(10.3)				
<b>Religion</b>						
Christianity	260(86.4)	41(13.6)	Fishers Exact =7.465	0.013		
Islam	6(75.0)	2(25.0)				
ATR	2(40.0)	3(60.0)				

**Table 4. Factors associated with female genital mutilation practices (FGM) among women in Okada, Edo State**

Variable	Practice of FGM		Test Statistic	P	OR	95%CI
	No (%)	Yes (%)				
<b>Age Group(Years)</b>						
15-24	161(75.9)	50(24.1)	$\chi^2=19.224$	<0.001	0.270	0.045-1.614
25-34	49(71.0)	20(29.0)			0.157	0.028-0.869
35-44	12(52.2)	11(47.8)			0.236	0.038-1.462
≥ 45	2(20.0)	8(80.0)			1	
<b>Educational Status</b>						
None	2(50.0)	2(50.0)	$\chi^2=5.109$	0.127		
1 <sup>o</sup> Completed	107(77.5)	31(22.5)				
2 <sup>o</sup> Completed	44(63.8)	25(36.2)				
3 <sup>o</sup> Completed	71(68.9)	32(31.1)				
<b>Marital Status</b>						
Single	195(77.7)	56(22.3)	$\chi^2=25.202$	<0.001		
Married	26(44.8)	32(55.2)				
Others	3(60.0)	2(40.0)				
<b>Employment Status</b>						
Unemployed	174(73.7)	62(26.3)	$\chi^2=2.657$	0.103		
Employed	50(64.1)	28(35.9)				
<b>Religion</b>						
Christianity	214(71.1)	87(28.9)	fishers exact =0.193	> 0.999		
Islam	6(75.0)	2(25.0)				
ATR	4 (80.0)	1(20.0)				
<b>Attitude towards FGM</b>						
Negative	208(77.6%)	60(22.4%)	$\chi^2=35.222$	<0.001	0.115	0.056-0.235
Positive	16(34.8%)	30(65.2%)			1	



In terms of awareness on FGM, 314 (96.6%) respondents were aware while 11(3.4%) were not, with 155(49.4%) and 124 (39.4%) reporting school and family respectively as their predominant sources of information (See Table 1 in appendix). In relation to composite attitudinal score towards FGM (See Figure 1 in appendix), 268 (85.3%) respondents had negative attitude towards FGM while 46 (14.7%) had positive attitude towards FGM. In terms of actual practice of FGM, 224(71.3%) reported no previous history of FGM while 90 (28.7%) had FGM carried out on them. Among those who had FGM, the mean age for FGM was  $4.12 \pm 1.17$  years, with 75(83.4%) being in the (0-5 years) age group; in relation to the desire to discontinue FGM 257 (81.8%) of respondents were of the opinion that FGM should be stopped while 54 (18.2%) wanted the practice to continue. (See Figure 2 and Table 2 in appendix).

In relation to factors associated with composite attitudinal score towards FGM (see Table 3 in appendix) bivariate analysis identified religion ( $p=0.013$ ) and educational status of respondents ( $p=0.005$ ) as significant factors associated with respondents attitude towards FGM while marital status ( $p=0.610$ ), age group of respondents in years ( $p=0.140$ ), employment status ( $p=0.206$ ) and level of knowledge on FGM ( $p=0.223$ ) were not. Multivariate analysis did not identify any significant predictor for the composite attitudinal score towards FGM among respondents studied.

Furthermore, in relation to factors associated with practice of FGM (see Table 4 in appendix) bivariate analysis identified age group in years ( $p<0.001$ ), marital status ( $p<0.001$ ) and attitude towards FGM ( $p<0.001$ ) as significant

factors associated with practice of FGM while educational status ( $p=0.127$ ), employment status ( $p=0.103$ ), religion ( $p=0.999$ ) and level of knowledge of FGM ( $p=0.087$ ) were not. Finally, multivariate analysis subsequently identified age group in years ( $OR=0.157$ ;  $95\%CI=0.028-0.869$ ;  $p=0.034$ ) and attitude towards FGM ( $OR=0.115$ ;  $95\%CI=0.056-0.235$ ;  $p<0.001$ ) as significant predictors influencing FGM practices among respondents studied.

### Discussion

This study identified a high level of awareness of FGM (96.6%) among women studied. This high level of awareness may be due to FGM being a common cultural practice in the study area, as respondents studied may have been victims of FGM themselves and or witnessed it being carried out. This finding is similar to reports from the 2013 NDHS that revealed a high level of awareness on FGM among women of Reproductive age in Nigeria<sup>6</sup>. Furthermore, the high awareness of FGM in this study could also be due to a high proportion of students among study respondents, possibly due to the study area accommodating several public and private primary and secondary schools in addition to a university; this was buttressed in school and family reported as predominant source(s) of information on FGM. In addition, the increasing attention FGM has received over the years corroborated by increasing education of the girl child might be contributory. This high level of awareness on FGM has been similarly reported in previous studies conducted in Jos (94.6%)<sup>14</sup>, Kano (90.0%)<sup>15</sup>, and in the 2013 NDHS<sup>6</sup>. This high level of awareness on FGM could be well harnessed as a strong tool to mobilize support against FGM practice through sustained sensitization and

reinforcement on the negative health and related consequences associated with FGM. It has been well reported that Female Genital Mutilation has no known health benefits for girls and women but has been increasingly associated with several adverse consequences such as severe pain, shock from pain of procedure, hemorrhage, infection, injury to adjacent tissues, adhesions, difficulty in child birth. Other genitourinary complications include, urinary incontinence, recto-vaginal fistulae, vesico-vaginal fistulae etc, in addition to the risk of human immunodeficiency virus infection, other blood borne viral infections and the psychological trauma associated with the procedure and possible marital disharmony due to frigidity and painful sexual intercourse associated with FGM<sup>1-5, 8, 12, 16-24</sup>.

This study also identified that majority of respondents studied had negative attitude towards FGM. This study further identified a significant association between age of respondents in years and attitude towards FGM, with negative attitude towards FGM identified to correspondingly increase with increasing age in years of respondents and vice versa. This observation is a positive development since findings from this study also identified a significant increase in prevalence of FGM among older respondents compared to younger respondents and vice versa. The implication is that FGM is becoming less prevalent and fashionable among the younger generation of females. This development in the near future may form a very strong platform towards eradicating this harmful traditional practice through effective information, education and communication strategies, with appropriate mobilization of the girl child,

women and significant others in our communities on the need to abolish this harmful cultural practice. This is important since perpetrators of this harmful cultural practice are mainly women. In relation to religion, respondents who practiced Christianity had significantly a higher proportion of negative attitude towards FGM when compared to those practicing Islam and African traditional religion; this could be related to high proportion of respondents studied practicing Christianity in the study area relative to others. Further multivariate analysis failed to identify religion as a significant predictor for attitude towards FGM. Among the respondents studied only 19.4% of the respondents studied were in favour of the practice continuing. This finding on continuance of FGM is similar to report from Jos (15.8%), Kano (16.2%) Northwest Nigeria<sup>14-15</sup> and South-South Nigeria (11.1%)<sup>6</sup>. This finding on continuance of FGM was lower and in contrast to findings reported in Edo State (26.9%) and Nigeria (36%)<sup>6</sup>, from Ibadan (67%) and Lagos (37.6%) in Southwest Nigeria<sup>25</sup> and Eritrea (60%)<sup>26</sup>. It was also identified in this study that a higher proportion of respondents who experienced FGM were in support of continuance of the practice in comparison to all study participants, this was also noticed in the 2013 NDHS<sup>6</sup> report. This clearly demonstrates cultural and geographical influences on the practice of FGM in the study area and by extension in Nigeria. The southwest region<sup>4-5</sup> of Nigeria is reported to have a high prevalence of FGM hence the higher percentage in favour of continuation of the practice compared to the findings from this study.

The prevalence of FGM in this study was 28.6%. This finding is similar to the 2013 NDHS national prevalence of

25.0%<sup>6</sup> and those from Kano, Northwest Nigeria (23.3%)<sup>15</sup>, Ghana (30%)<sup>27</sup> and Jos, Nigeria (31.3%)<sup>14</sup>. Furthermore, the prevalence of FGM identified in this study is lower than those reported from Eritrea (90%)<sup>26</sup>, Somalia (98%)<sup>28</sup>, Port-Harcourt, Nigeria (53.2%)<sup>29</sup>, South West Nigeria (53.0%)<sup>30</sup>, 49.6% in Abakaliki, Eastern Nigeria<sup>31</sup> and Edo state prevalence of 41.6%<sup>6</sup>,

This finding although encouraging shows that FGM is still a common cultural practice in Edo State, thus reflecting the deep cultural dimension to FGM, this point have been buttressed in previous studies<sup>4,7-10</sup>. It is important to note that the prevalence of FGM among respondents increased significantly with increasing age grouping of respondents and vice versa, older respondents who are more likely to be married compared to those in younger age groups, were more likely to have experience FGM and vice versa. This trend reveals a decreasing trend in the practice of FGM, particularly among younger respondents, possibly due to increased awareness campaign against FGM as a harmful cultural practice over the years, with increasing agitation against the practice among women groups in Edo State. If this decreasing trend continues we may be on track to eradicating FGM in the near future, this is possibly the reason why majority of respondents studied had significantly negative attitude towards FGM. The finding that majority of the respondents had FGM at a very early age calls for increasing vigilance as the trend to carry out this harmful act has shifted to infants and the young girl child (0-5 years) who are a vulnerable groups who are not aware of the effects and complication associated with, less likely to resist the pressure of

being circumcised and are subject to the decision of their parents and caregivers; this is a violation of the right of the child and must be very strongly condemned. This important finding is similar to the 2013 NDHS<sup>6</sup> report on age of FGM for Edo State and Nigeria but in contrast to findings from neighbouring Delta State where it is more frequently carried out at puberty, prior to or during marriage rites<sup>6</sup>. In relation to persons that performed female circumcision in this study, traditional birth attendants (TBA) performed most of the procedures (56.2%), while 43.8% was by health care practitioners. Similarly, in Nigeria the practice of FGM is largely in the domain of TBA/traditional healers as shown by 2013 NDHS report where 64% of FGM were carried out by traditional circumcisers<sup>6</sup>, studies are now reporting increasing engagement of health professionals in this act<sup>12,29</sup>. It is obvious that medicalization of FGM is becoming a common occurrence in both the study area and by extension in Nigeria, the World Health Organisation (WHO) frowns at this development<sup>1-2</sup>.

While medicalization of FGM may improve the condition under which it is performed, it violates principles of professional health ethics and does not address violation of women's right<sup>3,14</sup>. There is currently no scientific evidence to supports the procedure and practice as no proven health benefit or otherwise associated with this practice have been reported rather increasing literature abound on several health complications associated with the practice and in extreme cases death of the victim<sup>1-5, 8, 12,16-24</sup>. Medicalization of FGM must be seriously discouraged if we are to make substantial progress in eradicating FGM in Edo State and Nigeria in general.

## **Conclusion**

This study identified high level of awareness of FGM. Majority of respondents studied had negative attitude towards FGM. FGM remains a common traditional practice in the study area. There is need for well-coordinated interventions involving all relevant stakeholders especially in affected communities to make relevant enforcement against the practice.

**Limitation of Study:** The findings of this study were based on self-report, so it was not possible to validate the claims made by respondents in the course of questionnaire administration. Also recall bias might influence the validity of the findings. Finally, qualitative research involving in-depth interviews and focused group discussions would have enriched research findings.

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**Competing Interest:** We wish to state that this study is free of any competing interest and was fully sponsored by the Authors.

## **References**

1. World Health Organization: Female Genital Mutilation; An Overview. Geneva: World Health Organization: 1998.
2. UNICEF. Female Genital Mutilation/Cutting: a statistical overview and exploration of the dynamics of change, 2013.
3. World Health Organization. Eliminating Female Genital Mutilation: An interagency statement. Geneva: World Health Organization: 2008.
4. UNICEF. Children's and Womens right in Nigeria: A wake up call. Situation Assessment and Analysis. Harmful Traditional Practice (FGM) Abuja NPC and UNICEF Nigeria. 2001:195–200.
5. Okeke TC, Anyaelue USB, Ezenyeaku CCK: An overview of FGM in Nigeria. *Ann Med Health Sci Res.* 2012 Jan–Jun; 2 (1):70-3
6. National Population Commission (NPC). Nigeria and ICF International. Nigeria Demographic and Health Survey 2013, Abuja, Nigeria and Rockville, Maryland, USA: NPC and ICF International. 2014
7. Adegoke P. Ibadan University Humanist Society. Female Genital Mutilation: An African Humanist view. 2005 Nov
8. Odoi AT. Female genital mutilation. In: Kwawukume EY, Emuveyan EE, editors. *Comprehensive Gynaecology in the Tropics.* 1st ed. Accra: Graphic Packaging Ltd; 2005. pp. 268–78.
9. Assaad MB. Female circumcision in Egypt: social implications, current research, and prospects for change. *Stud FamPlann.* 1980 Jan; 11(1):3-16.
10. Worsley AJ. Infibulation and female circumcision: a study of a little-known custom. *ObstetGynaecol Br Emp.* 1938; 45: 686-91.
11. African Commission on Human and Peoples Right (n.o). ACHPR Protocol to the African Charter on Human and Peoples Right on the Rights of Women in Africa. Adopted by the 2<sup>nd</sup> ordinary session of the Assembly of the Union on 11<sup>th</sup> July, 2003. Maputo
12. Onuh SO, Igberase GO, Umeora OIJ, OkogbeninSA, Ofoide VO, Agakiki EP. Female Genital Mutilation: Knowledge, attitude and Practice among Nurses. *J.Natl. Medscape.* 2006; 98(3):409-14.
13. Cochran WG. *Sampling techniques* (3rd ed.). 1977. New York: John Wiley & Sons
14. Dattijo LM, Nyango DD, Osagie OE. Awareness, perception and practice of

- female genital mutilation among expectant mothers in Jos university teaching hospital Jos, North-central Nigeria. *Niger J Med.* 2010 Jul-Sep; 19(3):311-5
15. Abubakar I S, Ilyasu Z, Kabir M, Uzoho C C, Abdulkadir MB. Knowledge, Attitude and Practice of Female genital cutting among antenatal patients in Aminu Kano Teaching Hospital, Kano. *Niger J Med* 2004;13: 254-8
  16. Okonofua FE, Larsen U, Oronsaye F, Snow RC, Slinger TE. The association between FGC and correlatives of sexual and gynaecological morbidity in Edo State, Nigeria. *Br. J. Obstet. Gynaecol.* 2002.; 109: 1086-96..
  17. UNDP/UNFPA/WHO/World Bank. Female Genital Mutilation-New Knowledge spurs optimism. *Progress in Sexual and Reproductive Health Research* 2006; 72.
  18. WHO study group on female genital mutilation and obstetric outcome. Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. *Lancet* 2006; 367:1835-41.
  19. Klouman E, Manorgi R, Klepp KI .Self-reported and Observed Female Genital Cutting in Rural Tanzania: Associated demographic factors, Human Immunodeficiency virus and sexually transmitted infections. *Trop. Med. Intl. Health.* 2005; 10(1):105-15.
  20. Akpuaka FC. Vulval adhesions following female circumcision in Nigeria. *Postgrad Doct Afr.* 1991;13:98-9.
  21. Oduro AR, Ansah P, Hodgson A, Afful TM, Baiden F, Adonge P. Trends in the prevalence of FGM and its effects on delivery outcome in the Kassena-Nankana District of Northern Ghana. *Ghana Medical J.* 2006 ;40 (3):87-92.
  22. Larsen U, Okonofua FE. Female circumcision and obstetric complications. *Intl. J. Gynaecol. Obstet.* 2002; 77: 581-88.
  23. Ibekwe PC. Physical and psychological sequelae of Female Genital Mutilation: A case report. *Niger. J. Med.* 2004;13(3):293-298.
  24. Osifo DO, Evboumwan I. Female Genital Mutilation among Edo People: The complications and patterns of presentation at the paediatric surgery unit, Benin City. *Afr. J. Reprod. Health.* 2009;13(1):17-25.
  25. Odunjinrin OMT, Akintoye CO, Oyediran MA. A study on female genital mutilation in Nigeria. *W Afr J Med* 1989; 8(3):183-192
  26. National Statistics and Evaluation Office (NSEO) [Eritrea] and ORC Macro. Eritrea Demographic and Health Survey 2002. Calverton, MD: National Statistics and Evaluation Office and ORC Macro; 2003
  27. Adongo P, Akeongo P, Binka F, Mbacke C. Sociocultural factors that influence the practice in Kassena-Nankana District, Ghana. *Afr J Reprod Health* 1998;2(2):21-4
  28. World Bank. Female Genital Mutilation/Cutting in Somalia. Washington, DC: World Bank; 2004
  29. Ugboma H A A, Akani C I, Babatunde S. Prevalence and medicalization of Female Genital Mutilation. *Niger J Med* 2004;13 (3):250-253.
  30. Adeokun LA, Oduwale M, Oronsaye F, Gbogboade AO, Aliyu N, Wumi A, et al. Trends in Female Circumcision between 1933 and 2003 in Osun and Ogun States, Nigeria (A Cohort Analysis). *Afr J Reprod. Health.* 2006; 10(2):48-56.
  31. Ibekwe PC, Onoh RC, Onyebuchi AK, Ezeonu PO, Ibekwe RO. *Journal of Public Health and Epidemiology.* 2012; 4(5):117-22