

ASSESSMENT OF THE EFFECTS OF FEMALE GENITAL MUTILATION IN OGBOIN CLAN, BAYELSA STATE, NIGERIA

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ABSTRACT

Background/Objectives: Female genital mutilation poses great danger to the health of women and girls wherever it is being practiced. It is a major health problem with many physical and psychological consequences. The health implications of female genital mutilation have been documented all over the world. This study aims at assessing the effects of female genital mutilation among the victims in Ogboin Clan. The broad objective is to assess the effects to determine the level of intensity of each effect on the victims in the clan. **Materials/Methods:** A descriptive survey design was used. A total of 100 samples were obtained by snowball and accidental/haphazard sampling techniques based on the inclusive criterion of having undergone female genital mutilation. A structured five point modified Likert scale questionnaire was used to obtain the data. Result is presented in tables and analyzed in simple percentages. The arithmetic mean was used to evaluate the effects of the mutilation. **Results:** The major findings of this study is that haemorrhage (80.00%), perineal laceration (69.80%), chronic pain (68.60%), scar/keloid (65.80%), shock (56.60%), infection (51.00%) and internal bleeding (51.00%) are the effects of female genital mutilation with the highest prevalence among the victims in Ogboin Clan. **Conclusion:** Female genital mutilation has left severe health effects on the victims of this practice in Ogboin Clan. It was strongly recommended that the law banning female genital mutilation in Bayelsa State, Nigeria should be strictly enforced, and the Bayelsa State Ministries of Information and Orientation, and Women Affairs and Social Development should step up advocacy to educate the parents on the need to stop subjecting their daughters to the act.

Keywords: Female, Genital Mutilation, Ogboin Clan, Bayelsa State.

1. INTRODUCTION

Female genital mutilation (FGM) is defined as the removal of all or parts of the female genitals for non-medical reasons (Alcaraz, Gonzalez & Ruiz 2013). It includes all procedures for the partial or total removal of the external parts of the female genitalia, or injury to the female genital organs for non-therapeutic reasons (Kaplan, Hechavarria, Bernal & Bonhoure 2013; Bogale, Markos & Kaso 2014). It is considered a very harmful traditional practice found in many cultures all over the world, performed on girls from infancy to young adulthood. It is a surgical operation carried out mainly for the purpose of conforming to cultural expectations (Bogale, Markos & Kaso 2014). It is a practice with severe consequences for the health and well-being of girls and women (Naguib 2012).

According to some studies (Bogale, Markos & Kaso 2014; Kaplan, Hechavarria, Bernal & Bonhoure 2013), there are four types of female genital mutilation. Type I involves the removal of the clitoral prepuce, type II is the excision of the entire clitoris and the adjacent parts of the

region, type III is called infibulation which consists of the removal of the whole clitoris, the whole of the labia minora and the medial parts of the labia majora. Type IV involves all other harmful procedures performed on the female genitalia for non-medical reasons. But whatever type that is performed holds consequences that undermine the health and well-being of girls and women.

The World Health Organization (2008) says female genital mutilation is performed in families, communities and cultures all over the world for various reasons. But for whatever reason it is performed it falls within the ambit of belief that ensures the girl conforms to key social norms relating to sexual restraint, femininity, respectability and maturity. The act is regarded as part of normal culture so much so that any parent whose daughter has not undergone female genital mutilation is considered very negligent (Naguib 2012).

The practice of female genital mutilation is considered a critical component in the process of socialization in the communities that practice it. It is a key practice in distinguishing between the sexes as necessary opposites in the community. It is linked with the important values of a sense of community and sex complementarity. It is a rite of passage that proves the girl is a virgin and has now attained adulthood. She has received all the necessary teachings that will make her a good wife. She is now considered clean, pure and healthy enough for marriage. It is a tradition rooted in the culture of the communities that practice it. (Kaplan, Hechavarria, Bernal & Bonhoure 2013; Naguib 2012). According to Klein, Helzner, Shayowitz, Kohlhoff & Smith-Norowitz (2018) it is this sense of tradition surrounding the act that has made it difficult for the eradication.

The act is normally performed by traditional practitioners in the communities such as traditional birth attendants and those who perform circumcision. They perform the mutilation more often than not in a non-sanitary, unhygienic environment without the administration of anesthetics using unsterilized razor blades and knives (WHO 2008). In some communities, ointments and compounds made of herbs, milk, eggs, ashes, sugar, a mixture of butter, earth and cow dung and are normally used to treat the wound (Klein, Helzner, Shayowitz, Kohlhoff & Smith-Norowitz 2018). But recently the act has been medicalized by being performed by trained health professionals in some communities. This has now lifted it out of the traditional environment into the realm of orthodox medicine (Ibrahim, Oyeyemi & Ekine 2013; Bogale, Markos & Kaso 2014; Naguib 2012).

According to Kaplan, Hechavarria, Bernal & Bonhoure (2013) female genital mutilation is practiced all over the world including Europe, the USA and Australia, but more in Africa and the Middle East. It is estimated that communities in 28 countries in Sub-Saharan Africa practice it. WHO (2008) estimates that 140 million women and girls in the world have been victims of one form of female genital mutilation or the other, and each year 3 million girls are subjected to or at the risk of being subjected to this harmful custom. WHO (2008) continued that over 66,000 women in England and Wales have undergone female genital mutilation, and 32,000 girls under the age of 15 years are at the risk of becoming victims. Documents from the European Parliament cited by the WHO suggested that more than half a million girls in the European Union are at the risk of undergoing female genital mutilation (Chung 2016).

Prevalence rates for countries in Sub-Sahara are very high being countries hosting communities that traditionally perform female genital mutilation. It is 92.3% in Ethiopia, 81.2% in Sierra Leone, 77% in Mauritania, 75.6% in Gambia, 34% in Nigeria, 98% in Somalia, 93% in

Djibouti, 89% in Eritrea. Iran records 55.7%. It is prevalent in different degrees in different regions in Africa, but it is generally believed that prevalence rate is about 91% (Naguib 2012). Even in Nigeria there is regional variance in prevalence. According to the Nigeria Demographic and Health Survey (NDHS) report of 2008, it ranges from 2.7% in the North-East to 53.4% in the South-West. In Bayelsa State it is 25.9% (NDHS 2008; Ibrahim, Oyeyemi & Ekine 2013). Kaplan, Hechavarria, Bernal & Bonhoure (2013) added that in all countries the prevalence rate is higher in rural areas than urban centres. In Ogboin Clan in Southern Ijaw Local Government Area of Bayelsa State, female genital mutilation has been commonly practiced from generations back. Even presently it has been observed to being practiced not just in the small communities but even in the principal communities of Amassoma, Amatolo and Otuan. The type commonly performed here is the type III.

Alcaraz, Gonzalez & Ruiz (2013) say female genital mutilation is a major health problem with many physical and psychological consequences. The health implications of female genital mutilation have been documented all over the world (Kaplan, Hechavarria, Bernal & Bonhoure, 2013; Naguib, 2012; Bogale, Markos & Kaso 2014). Even in Bayelsa State HIV/AIDS, haemorrhage, difficult delivery, scar/keloid, clitoral cyst, tetanus infection and perineal laceration are commonly identified health conditions arising from female genital mutilation (Ibrahim, Oyeyemi & Ekine 2013). Other documented effects in various parts of the world includes shock, infections, chronic pain, fibrosis, primary infertility, psychological trauma, high mortality rate, sepsis, death, painful sexual intercourse, urinary and menstrual problems, high risk of cervical cancer. Female genital mutilation poses great danger to the health of the women and girls wherever it is practiced. But according to Obermeyer (2005) in many cases the association of female genital mutilation with some health consequences has not been significantly established statistically. And even where they are established the intensity of the various effects even among the same population varies significantly (Ismail, Abass and Bahloul 2017).

What has been observed however among these studies that have variously documented the effects of female genital mutilation is that the sample has often been drawn from doctors, nurses and other health practitioners who conducted the exercise, whose knowledge of the effects and their intensity is not firsthand and is often based on perception. These studies hardly incorporate the knowledge of the victims. There exists a knowledge gap of the intensity of the effects from the perspective of the victims. This study is aimed at assessing the identified effects in Ogboin Clan from the perspective of the victims.

Ogboin clan is part of the Ijaw ethnic group in the River Niger Delta located in Bayelsa State, Nigeria. It is situated between the River Nun and a tributary of the Forcados River, between the bifurcation linking the two rivers at Sabagreia on the River Nun through Egbedi and Amassoma on the River Forcados. Fishing and farming are the traditional occupations of the people of the clan. But a substantial portion now works in the formal and informal sectors around the clan and the state.

Their customs are akin to those of other clans of the central Ijaw ethnic group spanning entertainment, sports, economy, political organizations, social structure, religious observations, paternal authority and inheritance structure. Many of these practices are changing in content and procedure due to various factors over time, but the sense of tradition remains strong among them. The Bayelsa State owned Niger Delta University is located in Amassoma one of the principal communities in Ogboin clan.

2. MATERIALS/METHODS

We adopted a descriptive survey design. The population of study is the entire female population of Ogboin Clan in Southern Ijaw Local Government Area of Bayelsa State, Nigeria. According to the National Population Commission of Nigeria, the projected population for the clan is 4,899 as at December 2014, 63% of which is female. The sample size is 100. This was purposively determined to be at least 10% of the female population which is considered statistically significant. We stratified Ogboin Clan into Amassoma, Amatolo and Otuan, the three principal communities that make up the clan. Each area contributed 40, 30, 30 samples respectively to make up the total sample. The sample was drawn by snowball, and accidental/haphazard sampling techniques since an enabling sampling frame of victims of female genital mutilation in the clan does not exist. The process was guided by inclusive criterion of having experienced female genital mutilation. A structured and modified Likert questionnaire scaled to 5 points was used to collect primary data. It collected demographic information as well as data on the variables. The 5 points are **Very high Extent, High Extent, Low Extent, Very Low Extent and N/A**. After ethical consideration was satisfied, we served the questionnaire to the identified victims of female genital mutilation throughout Ogboin Clan. It was served on face to face basis. Result is presented in tables and analyzed in simple percentages. The arithmetic mean was used to assess and evaluate the data.

3. RESULT

TABLE I. PRESENTATION OF DEMOGRAPHIC DATA

S/NO.	ITEMS	FREQUENCY	PERCENTAGE (%)
1.	AGE		
	20 – 24	26	26%
	25 – 29	14	14%
	30 – 34	10	10%
	35 – 39	23	23%
	40 – 44	10	10%
	45 – 49	10	10%
	50 ⁺	7	7%
	TOTAL	100	100%
2.	EDUCATIONAL QUALIFICATION		
	NO FORMAL EDUCATION	10	10%
	FSLC	29	29%
	WAEC/NECO/GCE	54	54%
	ND/BACHELORS	7	7%
	MASTERS/DOCTORATE	-	-
	TOTAL	100	100%
3.	AGE WHEN GENITAL WAS MUTILATED		
	Birth – 9	33	33%
	10 – 15	48	48%
	16 – 20	9	9%
	21 – 25	10	10%
	26 – 30	-	-
	31 ⁺	-	-
		TOTAL	100

4.	YEAR OF MUTILATION	18	18%
	1971 – 1980	35	35%
	1981 – 1990	22	22%
	1991 – 2000	15	15%
	2001 – 2010	10	10%
	2011 – 2015	-	-
	2016 ⁺	100	100%
	TOTAL		
5.	WHO DID THE GENITAL MUTILATION	-	-
	Doctor	3	3%
	Nurse	-	-
	Other Health Worker	29	29%
	Native Midwife	68	68%
	Local Circumciser	100	100%
	TOTAL		
6.	WAS THE REASON EXPLAINED TO YOU	22	22%
	YES	78	78%
	NO	100	100%
	TOTAL		

This table shows that age brackets 20 – 24 and 35 – 39 have slightly higher percentages than the other age brackets with 26% and 23% respectively. Age bracket 50⁺ recorded the least at 7%. On educational qualification we have the highest frequency of 54% in WAEC/NECO/GCE. This is followed by FSLC with 29% and ND/BACHELORS having just 7%. We can also see that 48% of the sample had their genital mutilated when they were within age 10 – 15, followed by birth – 9 with 33%. Age 26⁺ recorded nil. Year of mutilation shows that the highest record of 35% appeared in 1981 – 1990. 10% is the least occurring between 2011 – 2015. The table shows also that local circumcisers mutilated 68% of the genitals, 29% by native midwives and 3% by nurses. We see also that the reason for mutilation was explained to only 22%.

TABLE II. ASSESSMENT OF EFFECTS OF FEMALE GENITAL MUTILATION

VHE – Very High Extent, **HE** – High Extent, **LE** – Low Extent, **VLE** – Very Low Extent, **N/A** – Not Applicable.

VARIABLES	VHE (4)	H E (3)	LE (2)	VLE (1)	N/A (0)	TOTAL	X	%X	EVAL UATI ON
SHOCK	25	43	22	10	-	100	2.83	56.60	HE
INFECTIONS	21	26	40	13	-	100	2.55	51.00	HE
CHRONIC PAINS	53	37	10	-	-	100	3.43	68.60	HE
FIBROSIS	-	5	17	24	54	100	1.07	21.40	VLE
PRIMARY INFERTILITY	-	-	22	53	25	100	1.22	24.40	VLE
PSYCHOLOGICAL	-	30	39	31	-	100	1.99	39.80	LE
TRAUMA	-	-	-	-	100	100	0.01	00.02	VLE
HIGH MORTALITY RATE	-	27	43	29	1	100	1.97	39.40	LE
SEPSIS	-	-	-	-	100	100	0.01	00.02	VLE
PAINFUL SEX	10	19	13	36	22	100	1.81	36.20	LE
URINARY & MENSTRUAL PROBLEMS	-	-	-	-	100	100	0.01	00.02	VLE
CERVICAL CANCER	-	-	-	-	100	100	0.01	00.02	VLE
HIV/AIDS	21	41	10	10	18	100	2.55	51.00	HE
INTERNAL BLEEDING	-	10	10	32	48	100	1.30	26.00	VLE
DIFFICULT DELIVERY	34	62	3	1	-	100	3.29	65.80	HE
SCAR/KELOID	-	-	-	-	100	100	0.01	00.02	VLE
CLITORIDAL CYST	-	10	20	23	47	100	1.40	28.00	LE
TETANUS INFECTION	61	28	10	1	-	100	3.49	69.80	HE
PERINEAL LACERATION	100	-	-	-	-	100	4.00	80.00	VHE
HAEMORRHAGE									

Evaluation Marks: VHE: 76% - 100%, HE: 51% - 75%, LE: 26% - 50%, VLE: 01% - 25%.

A criterion mean of **2.00** was established as an average to assess the variables. A grand mean of **1.73 (34.60%)** was also established indicating a general low level of effect of female genital mutilation on the victims in the clan. 1 item was assessed to be of **Very High Extent**, 6 items were assessed to be of **High Extent**, 4 items at **Low Extent** and 8 items at **Very Low Level**.

4. DISCUSSION

All age brackets appeared in the sample. This means that the practice has been going on for a very long time in the clan. It also means that the practice has been continuous. This shows mutilation of female genital to be a traditional practice in the clan which has been passed on from generation to generation. The studies of female genital mutilation of Bogale, Markos & Kaso (2014) in Ethiopian society and Naguib (2012) in Egypt stated that this act is traditional in all the communities that practice it, and is systematically performed on all females. It is seen as a cultural requirement for all females to make them eligible for marriage and motherhood. The educational qualifications of the respondents show that both the educated and uneducated have passed through the experience. This further shows the act to be an encompassing and accepted custom. The absence of masters and doctorate degree holders in the sample may not necessarily signify that ladies of that educational status did not experience it when they were young. It could rather be the product of the small population of females with those qualifications in the community.

Considering age at which the genital mutilation was done, the absence of the age bracket 26 years and above shows that this practice is done on the victims as early as possible. The large proportion of the respondents (81%) undergoing the act on or before age 15 shows the practice conforms to observations of the act in other studies (Bogale, Markos & Kaso 2014; Kaplan, Hechavarria, Bernal & Bonhoure 2013; Naguib 2012). These studies stated that female genital mutilation is performed on females from infancy to young adulthood. Kaplan, Hechavarria, Bernal & Bonhoure (2013) was more definite that in Gambia the act is performed on girls between age 7 and 15 years.

The year of mutilation shows that the act is commonly performed on females in the clan every year. Every year appeared in the sample from 1971. That we have respondents within 2011 – 2015 shows that the act has not abated. It is still being seriously practiced. From observation we know that it is a tradition steeped in the early history of these settlements. In an earlier study of this phenomenon in Bayelsa State Ibrahim, Oyeyemi & Ekine (2013) stated that female genital mutilation is still actively practiced in communities in the state. Even the 25.9% prevalence rate computed for the state as late as 2008 (NDHS 2008) shows it is now a modern phenomenon.

We can also see from table I that medicalization of this act has started but has not taken root in Ogboin clan. Only 3% was performed by nurses. Ibrahim, Oyeyemi & Ekine (2013); Naguib (2012) and Bogale, Markos & Kaso (2014) had stated earlier that the act has been medicalized in some communities. This means it is now being increasingly performed by trained medical personnel (doctors, nurses and midwives etc.). This gives the act the look of a normal medical procedure instead of the air of traditionally harmful act it has always been associated with. It should be noted that the study of Ibrahim, Oyeyemi & Ekine (2013) was based on perception of the act by medical personnel in Bayelsa State, but medicalization is negligible in this study. A huge 97% of the respondents said theirs were mutilated by native midwives and traditional circumcisers.

We can also see that many undergo the process without really knowing why it was necessary to mutilate their genital. Only 22% percent of the respondents said they were told the reason. We think that part of it is due to the nature of the concept of tradition itself. In all human communities customs are passed down from generation to generation, without the need for their perpetuation (tradition) ever explained. Female genital mutilation is seen just like any other custom in the communities that practice it.

So they do not see the cause to explain the reason to the victims just as they do not see the reason to explain the necessity of other cultural practices. Klein, Helzner, Shayowitz, Kohlhoff & Smith-Norowitz (2018) had stated that in most cases the reason for the mutilation is not told the victims. Another explanation could be that at the time of mutilation many of the victims were too young to understand the reason for the act, as many underwent it in their infancy. It is likely that the small percent that received explanation for the act are those who subjected themselves to it at comparatively older age due to peer or community pressure (Kaplan, Hechavarria, Bernal & Bonhoure 2013).

We can see from table II that the result of the assessment of the effects produced only haemorrhage (excessive bleeding) to be of Very High Extent. The scores show that all respondents experienced haemorrhage. This is understandable as the act of female genital mutilation involves the cutting off of tissues from a living body. Blood is expected to gush out in large quantity during the act under all normal circumstances. All studies of the effect of this

act have always listed haemorrhage as one of the commonly observed effects of female genital mutilation. WHO (2008), Kaplan, Hechavarria, Bernal & Bonhoure (2013), Bogale, Markos & Kaso (2014) and Kaplan, Hechavarria, Martin & Bonhoure (2011) did not just see it as any other effect, but as a primary, immediate, direct and life-threatening effect. Kaplan, Hechavarria, Martin & Bonhoure (2011) stated that the excessive bleeding in some cases continues long after the act and puts the victim under anemic condition. The WHO (2008) report even clarified that the postpartum haemorrhage is even more severe and continues much longer in the life of some of the victims.

Of the effects assessed to be of High Extent chronic pain (68.60%), scar/keloid (65.80%) and perineal laceration (69.80%) had the highest prevalence. The respondents experienced these effects more than others. The victim of female genital mutilation suffering from severe and chronic pain is natural as a response of the body to external stimulus. Whatever instrument that is used (razor blade, knife, etc) will cause great pain to the victims. WHO (2008) and Naguib (2012) said because of the limited level of medicalization of the act in the communities that practice it, administration of anesthetics is virtually absent in the procedure. The victims bear the full intensity of the pain from the mutilation.

We can understand why shock is always considered a primary effect of this act. The immediate severe pain the victims go through often leads to shock. The prevalence level of shock (56.60%) in this study is even considered comparatively low as other studies have concluded that the level of shock on each victim is so high that many do not come out of it for a long time. The victims in this environment may be are not associating what they felt at the time of the mutilation with shock or have better body constitution to withstand the severe pain. This could be the reason why Ibrahim, Oyeyemi & Ekine (2013) did not even list it among their findings. It has been observed that the female genital mutilation type III is the one commonly performed in Ogboin Clan. The type III is called infibulation which consists of the removal of the whole clitoris, the whole of the labia minora and the medial parts of the labia majora (Bogale, Markos & Kaso 2014). This means that during the procedure apart from cutting off the clitoris completely, a lot of cutting and scraping of the whole area adjoining the clitoris are done. This explains why perineal laceration reflects strongly (69.80%) in the sample. This agrees with Bogale, Markos & Kaso (2014) who lists it as a primary effect.

It is a surprise that in this study, infections as effect of female genital mutilation barely made it to High Extent. It came out as a weak (51.00%). Bogale, Markos & Kaso (2014), WHO (2008) and Kaplan, Hechavarria, Bernal & Bonhoure (2013) all listed infections particularly tetanus as serious effect of the act. This is because of the unsterilized instruments used in performing the procedure and the unsanitary environment where they do it. This is in addition to the mixture of some unhealthy substances they use in treating the wound. It is possible that the victims do not have enough knowledge to associate some infections they suffer with the act. Kaplan, Hechavarria, Martin & Bonhoure (2011) reached a similar assumption when considering infections in their study of the magnitude of the effects on the victims in Gambia. This we think also accounts for the weak (51.00%) High Extent of internal bleeding, and Low Extent (28.00%) of tetanus infection.

It is common to see scars of different levels of thickness forming at the mutilated spots among the victims. It reflects in this study as High Extent (65.80%). It has always been listed by other studies (Orchid Project n.d) as a primary effect.

Apart from tetanus infection, the other effects that reflect Low Extent are psychological trauma (30.80%), sepsis (30.40%), and urinary/menstrual problems (36.20%). The low prevalence of urinary/menstrual problems in the study area may be because it is not an immediate effect. It is considered by other studies as secondary effect. WHO (2008) listed it alongside child delivery complications under secondary effect. But sepsis and psychological trauma are primary effects yet in this study they have low prevalence. The low prevalence by some degrees agrees with Ibrahim, Oyeyemi & Ekine (2013) who did not acknowledge it in their findings.

Table II shows fibrosis (21.40%), primary infertility (24.40%), difficult delivery (26.00%), high mortality rate (0.02%), painful sex (0.02%), cervical cancer (0.02%), HIV/AIDS (0.02%) and clitoridal cyst (0.02%) are the effects assessed to be of Very Low Extent. The Very Low Extent assessment of fibroid does not agree with general clinical observations in Bayelsa State and the findings of Ibrahim, Oyeyemi & Ekine (2013) and Kaplan, Hechavarria, Bernal & Bonhoure (2013). Clinical observations have shown high prevalence rate of fibroid in Bayelsa State, and the cited studies listed it as effect of high prevalence among victims of female genital mutilation. Not all cases of fibroid in the state could be traced to this act, but the assessment could be that many victims may not know they have fibroid, or may not have established the link between the fibroid condition and the female genital mutilation.

This may also explain the low assessment of primary infertility which has a causal link with fibroid and difficult delivery. The assessment outcome in the case of HIV/AIDS could be understood from the point that many people including the victims of female genital mutilation have not had the courage to go for a test. Even those who have tested positive may not admit it due to the strong social stigma and isolation associated it. The disagreement with the high prevalence of HIV/AIDS (69.5%) in Ibrahim, Oyeyemi & Ekine (2013) is because that study tested the knowledge and observations of medical personnel and not that of the victims as this study did.

1. It is strongly recommended that the law against female genital mutilation in the state should be enforced strongly by the relevant law enforcement agencies.
2. Bayelsa State Ministries of Information and Orientation, and Women Affairs and Social Development should step up advocacy campaigns educating the parents on the need to stop subjecting their daughters to this harmful act.

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