FEMALE GENITAL MUTILATION AND ITS IMPLICATIONS

Benedicta N. Agu (Ph.D)[1], *Olaoluwa S. Agbaje (Ph.D)[2],
[1,2,] Department of Public Health,
Madonna University Elele, Rivers State

Abstract
Female genital mutilation is one of the public health problems that is endangering the life and well-being of female in developing countries of the world. The paper reviewed the concept of FGM, defining it as cutting off part or whole of girl clitoris and some other part of her sex organ whether for cultural or any non-therapeutic reason. Reasons for female genital mutilation: FGM is practiced for cosmetic purposes; or as a sign of maturity. It may also be done to desensitize the clitoris thereby reducing libido and promiscuity, to prevent immorality, preparing female for marriage, increase cleanliness, to prevent labia hypertrophy, to improve fertility, to give more pleasure to the husband (by tightening the vagina), for religious rite and obligations. Specifically, this paper outlined the physical, psychological and social health (bioethical) implication of FGM as a public health problem. It has dangerous health implications because of the unsanitary conditions in which it is generally practiced. In addition, it is a fundamental violation of human rights because it is carried out at a very young age when there is no possibility of the individual consent and mutilated/cut infants, girls and women face irreversible lifelong health risks, among other consequences. Finally, measures for eradicating the practices of FGM were recommended, among which are capacity building of rural women through health education and advocacy.

Keywords: Female Genital Modification, Forms, Advocacy, Implications, Eradication

Introduction

Female genital mutilation and its origin were shrouded in mystery. It is complex and ancient. It is difficult to say where female genital mutilation originated from and how it was being performed originally. Onuzulike (2006) was of the opinion that female genital modification has been in practice for more than 2,000 years ago, and it is still being widely practiced. She perceived female circumcision as a ritualistic sexual mutilation of female genital organ that dates back to the fifth century B.C. This traditional practice is a social as well as a health issue that affects the physical and mental wellbeing of the women who undergo it.

According Ahmed (1996) more than eighty million women in Africa and around the world have been affected by the practice. He also, reported that the practice was common in many parts of the world, including Nigeria. Continuing, World Health Organization (1998) opined that over 135 million women and girls have been affected worldwide as of 1997. The report further showed that female genital mutilation has been in practice mostly in African countries north of the equator and the-middle-East. Concern was equally expressed that female genital mutilation exist in the United States of America, Europe and other western countries by immigrants from these countries.

In recent times, the story is different in most developing countries of the world as females are subjected to genital mutilation under the guise of conforming to traditional beliefs and societal norms. Onuzulike (2006) opined that the generic "female mutilation victims are over 80 per cent in countries like Sierra-Leone, Sudan, Somalia, Ethiopia and other African countries where infibulation or pharaonic circumcision and excision are still widely practiced. Female mutilation has been discovered to be a serious health hazards for the girl-child or woman, inflicting pain, trauma and body injuries (American Academy of Paediatrics, 1998). Female genital mutilation could be carried out in infancy, early childhood, at puberty, short before marriage, during first pregnancy and even on the uncircumcised dead.

FGM is the partial or total removal of the external female genital or other injury to female genital organ for cultural, religious or other non-therapeutic reason (Smith Jones, Kieke & Wilcox 2000). The clitoris is a specialized sexual organ of the female and although only the highly sensitive glands and part of the shaft is visible externally part of the body and the two crura are embedded behind the symphysis pubis. This means that in most types of Female Genital Modification a substantial amount of clitoral tissue may still be intact unless the whole clitoris has been dissected out and avulsed from its

insertion in the public bone. Because of the erectile nature of the spongy tissue of the clitoris and labia minora they both have a high pressure and dense and concentrated marking the clitoris and labia highly sensitive to stimulation as well as to pain. The cutting is therefore extremely painful and often results in long term residual pain and discomfort in the area of the scar.

A classification of female genital mutilation was first drawn up at a technical consultation in 1995 (WHO, 1996b). An agreed classification is useful for purposes such as research on the consequences of different forms of female genital mutilation, estimates of prevalence and trends in change, gynaecological examination and management of health consequences, and for legal cases. A common typology can ensure the comparability of data sets. Nevertheless, classification naturally entails simplification and hence cannot reflect the vast variations in actual practice. As some researchers had pointed out limitations in the 1995 classification, WHO convened a number of consultations with technical experts and others working to end female genital mutilation to review the typology and evaluate possible alternatives. It was concluded that the available evidence is insufficient to warrant a new classification; however, the wording of the current typology was slightly modified, and sub-divisions created, to capture more closely the variety of procedures (WHO & UNICEF, 2006). WHO's (1995) classification of Female genital mutilation has four major types, namely:

1. **Clitoridectomy**: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
2. **Excision**: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
3. **Infibulation**: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
4. **Other**: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

WHO's (2007) modified typology of FGM include:

1. **Type I**: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy). When it is important to distinguish between the major variations of Type I mutilation, the following subdivisions are proposed: Type Ia, removal of the clitoral hood or prepuce only; Type Ib, removal of the clitoris with the prepuce.
2. **Type II**: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). When it is important to distinguish between the major variations that have been documented, the following subdivisions are proposed: Type IIa, removal of the labia minora only; Type IIb, partial or total removal of the clitoris and the labia minora; Type IIc, partial or total removal of the clitoris, the labia minora and the labia majora.
3. **Type III**: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). When it is important to distinguish between variations in infibulations, the following subdivisions are proposed: Type IIIa: removal and apposition of the labia minora; Type IIIb: removal and apposition of the labia majora.
4. **Type IV**: Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization

The procedures for FGM can cause severe bleeding and problems urinating, and later cysts, infections, infertility as well as complications in childbirth and increased risk of newborn deaths. More than 125 million girls and women alive today have been cut in the 29 countries in Africa and Middle East where FGM is concentrated (UNICEF, 2013). FGM is mostly carried out on young girls sometime between infancy and age 15. FGM is a violation of the human rights of girls and women. The choice of the particular method of FGM is depended on the person performing the operation. Female genital mutilation is usually carried out by traditional practitioners often lay persons with only rudimentary training. Different operation instrument are used in performing the operation in different countries of the world. However, the most commonly use operating instrument are small sharp knife, razor blade,

dwarf blade, sugar, herbs mixture and extracts from vegetable among others, were used for individual females modifications at different ages and time.

The age at which female child is circumcised varies from tribe to tribe. It can be performed as early as the 8th day of life as in Igbo lands of Nigeria and Ethiopia 3 – 4 years old as in Somalia, around puberty as in part of Edo and Delta State at Nigerian, Peru and Sierra-Leone. Besides, FGM can be performed shortly after marriage as in mosaic or later after child bearing as in Guinea (Odinini & Odediran, 2001; Owumi, 2003).

The obnoxious practice of FGM has been given many reasons which include: prevention of immorality, preparing female for marriages, to ensure cleanliness, to prevent Labia hypertrophy, to improve fertility, to give more pleasure to the husband (by tightening the vagina orifix) for religious rites and obligation (Onuzulike, 2006). Depending on why it is practiced; the procedure is occasionally justified on the basis of tradition, religious rite of passage health assurance of virginity before marriage and marital fidelity. The justification for the motives and function of FGM are at first glance bewildering often conflicting and always at odds with biological fact (Elchala, 2004). Religion is central to the lives of many women and this is usually manipulated to control their sexuality. It is important to note that female genital modification or mutilation is not required. Equally, there is no scientific evidence that women who have been genitally mutilated are more faithful and better wives than those who were not circumcised (WHO, 1999).

Traditionally too, Uhaegbu (1999) reported that "Ibo and Yoruba people of Nigeria believe that circumcision is a traditional way of checking women from flaring. Some Yoruba's go further to believe that uncircumcised female have problem during child birth as the clitoris disturbs the easy passage of the baby. These are all fallacies and go to prove right, the evidence of backwardness of developing countries. There is no medical attendance of benefits resulting from female genital mutilation. Rather medical experts have spoken against the practice especially, with regard to the health hazards; it poses to women's reproductive health (Onuzulike, 2006). Various forms of female genital mutilation can create severe hazard and complication for the young girl or the women. Such complications may occur immediately after the practice, months or even year afterward and such problem may occur due to the fact that the operation is performed in an unhygienic environment with unsterilized crude instrument and by unskilled non-medical practitioner. Circumcised women have very tiny vaginal opening because of stitching together of the vulva.

Smiths, Jones and Willcox (1997) were of the opinion that narrowing of the vaginal opening following circumcision make the conjugal consummation of marriage relationship painful, difficult, uncomfortable and sometime impossible following such irritation, some husbands may end up battering their wives for lack of co-operation and frigidity. Naturally, the skin of the vulva and vaginal canal is soft and elastic. This also allows for expansion during childbirth. Infibulations reduces vagina opening and these conditions may predispose the circumcised women to obstetric problems. Such problems include epistomy and delayed second stage of labour. Effects of epistomy include: liability to bleeding, infection, septicemia and delayed healing. Hosken (2001) opined that in the process of circumcision, many little girls bleed to death because Chimps operation must have cut into dorsal artery of the clitoris. The area cut during circumcision is meant to tear off during delivery, because scar tissue is not elastic. Delayed labor may lead to impaired circulation, foetal brain damage, visco-vaginal fistula (VVF) and still birth. Medical experts define visco-vaginal fistula (VVF) as a situation where a young woman's bladder is damaged during labor. The woman following such damaged would be unable to control her urinary tract resulting in her passing urine uncontrollably. This would cause some social problems for the woman because she would be emitting a strong foul smell, which often keeps her and those around her uncomfortable. The external genitalia of the female child may become distorted especially in Pharaonic type. Winkel (1997) posited that the possibility of distortion occurs because, healing is usually by fibrosis.

Complications of Female Genital Mutilation

In the local context within which most FGM traditionally occurs several short and long term complications have been reported. Most short term complications occur because of unsanitary operating conditions botched procedures by inexperienced circumcisers or inadequate medical services once a complication occurs. In the short-term, profuse bleeding is common due cutting of the high-pressure clitoral vessels. Shock can also occur from loss of blood combined with extreme pain- when

the procedure is performed without anaesthesia. These conditions have sometimes been fatal. Infection of varying degrees from superficial wound infection to septicaemia is also common. Urinary retention from pain and inflammation as well as direct obstruction (in Type III) often occurs in the first days (Onuzulike, 2006). More so, The Inter-Africa Committee (2000) outlined the various complications of Female Genital Mutilation which may be visible and directly related to circumcision, these include:

Ulcer: Vulva ulcers under the hood of skin of infibulated women have been reported. The conditions may be caused by Urea Crystals precipitated from Urine trapped under the hood, forming small stones.

Sebaceous and inclusion (dermoid) cyst: Cysts resulting from embedding of the skin fold in the scar or a sebaceous cysts from the skin fold in the scar or a sebaceous cyst from the blocking of the sebaceous gland duct are one of the most common complication of all types of FGM woman may present with these early or when they are size of a pea or after they have grown to the size of a tennis ball or a grapefruit.

Keloid: Many circumcised women have dark skin which is known for its increased tendency to form Keloid scar growth. Moreover, the keloidal scar growth sometimes becomes so large that it causes difficulties during intercourse or possible obstruction during delivery.

Neuroma: The clitoral nerve may get trapped in the scar fibrous tissue of the scar following clitoridectomy. This may result in an extremely sharp pain over the fibrous swelling anteriorly. The pain may be aggravated by the rubbing of under-wear or during intercourse. The neuroma may be felt as a small pebble under the mucosa.

Onuzulike (2006) opined that the complications of FGM include physical health risks such as:

Infection: Women who undergo such practices are at risk when unsterilized black razor, knives or other sharp objectives likes “Omani” are used. Some of the commandment infections are tetanus, septicaemia and staphylococcal infection even though local gin is used to douche the area, local herbs and sometimes animal faeces are used to dress the wound. Ascending infections can lead to secondary infertility.

Stricture formation: Following this procedure, the wound tends to heal but poorly with the resultant stricture formation. The formation leads to difficult deliveries and dysperunia (painful sexual intercourse) in some who were predisposed, develop hypertrophied scar.

Labour problems: The ease of childbirth is far from reality after an introital stenosis and therefore in labour, a generous episiotomy has to be done to widen the introitus. This also leads to more haemorrhage as the episiotomy often than not is given on the scar tissue and delayed second stage of labor as a result of the scar tissue to stretch. Some emotional health implications were also explained by Onuzulike (2006) and these include:

Frigidity: If this develops, the sexual life of the lady is ruined due to the continuous tension or contraction of the smooth muscles of the stricture involved.

Divorce: As there is freedom of marriage to any other community or society, the woman is divorced due to the scarring of the vaginal introitus, dysparennias possible, leading to frustration as experience might be traumatic but subsequent experience might lead to a sense of helpless such as instability and divorce.

Guilt feeling: Failure to adequately and appropriately fulfill the requirements of womanhood could lead to a mark of guilt feeling and as tendency to delusion of unworthiness due to a sense of deprivation. The woman will suffer from sense of inferiority complex.

Suicidal tendency: Due to the feeling of unworthiness, she may give up the struggle and prefer to die to end the helplessness in sexual life.
Depression: Due to inability to perform her function as a wife (sexually), that is, as maximum sexual excitement cannot be derived with the manipulation of these areas, the circumcised female is thus deprived full sexual gratification and this will lead to behavioural aberration. The depression can be due to implication such as vesico vagina and recto vagina fistulae. When a young lady or a girl starts licking urine or faeces, it leads to depression and even suicide. These vesico vaginal fistula (VVF) and Recto vaginal fistuta (VVF) result from injuries to dorsal nerve of the clitoris, deinfibulation and reinfibulation and the baby's head exert constant pressure on the urethra and bladder (Ichita, 2007). Finally, in order to understand the damage by FGM and potential clinical complication that may arise from the mutilation and healing process a close look at the functional anatomy and histology of the clitoris, labia minora and majora is necessary.

Implications of FGM

FGM does irreparable harm. It can result in death through severe bleeding, pain and trauma and overwhelming infections. It is routinely traumatic. It has dangerous health implications because of the unsanitary conditions in which it is generally practiced. Education has been identified as an indispensable instrument for national development. Education stands out as process of teaching training and learning to improve knowledge and to develop skills (Nnajieto, 2005). Health Education can be used to inform women about the psychological, social health damage and disruption of social life resulting from Female Genital Cutting besides the dangers inherent in performing the procedures in unsanitary conditions, which makes the victims susceptible to infections

According to The Explorer (1997), education is one of the vital means of fighting FGM. Through health education, women and girls can learn the facts about FGM and share it with their relations and friends. Also, through health education efforts to secure the co-operation and understanding of leaders in the community including women who have undergone the procedures themselves when highlighting the dangers of FGM will be achieved. Furthermore, advocacy to protect all women and young girls from harmful practices should be included in existing programme to reach women e.g. health centre and antennal clinic (The Explorer, 1997). The health education programme on FGM should be designed in such a way that it would disseminate scientifically sound information, change people's misconception and behaviours in relation to FGM with aim of discarding such inimical practice.

Furthermore, FGM is a fundamental violation of human rights because it is carried out at a very young age when there is no possibility of the individual consent. FGM is a fundamental violation of the rights of children and women as outlined in numerous international conventions including Convention on the Rights of the Child and the Convention on the Elimination of all forms of Discrimination against Women. It is an infringement on the physical and psychosexual integrity of women and girls. It is discriminatory and violates:

1. the rights to equal opportunities in life;
2. the right to the highest attainable standard of health;
3. the right to freedom from all forms of physical and mental violence, injury or abuse;
4. the right to be protected from traditional practices prejudicial to children and women's health;
5. the right to make decisions concerning reproduction - free of discrimination, coercion and violence;
6. the right to freedom from prejudices and all other practices that are based on the idea of inferiority or superiority of either of the sexes or in stereotyped roles for men and women.

Due to children's vulnerability and their need for care and support, human rights law grants them special protection. One of the guiding principles of the Convention on the Rights of the Child is the primary consideration of "the best interests of the child". Parents who take the decision to submit their daughters to female genital mutilation perceive that the benefits to be gained from this procedure outweigh the risks involved. However, this perception cannot justify a permanent and potentially life-changing practice that constitutes a violation of girls' fundamental human rights.

The Convention on the Rights of the Child refers to the evolving capacity of children to make decisions regarding matters that affect them. However, for female genital mutilation, even in cases

where there is an apparent agreement or desire by girls to undergo the procedure, in reality it is the result of social pressure and community expectations and stems from the girls' aspiration to be accepted as full members of the community. That is why a girl's decision to undergo female genital mutilation cannot be called free, informed or free of coercion. This apparent situation in Nigerian societies demands drastic measures such as mass education of the public especially staunch proponents of FGM such as TBAs, custodians of customs and traditions, religious leaders and traditional/community leaders where this harmful practice is prevalent. Through implementation of valid health education programme particularly at the hotspots of FGM in the country, FGM can be successfully eliminated.

Ways of Eradicating FGM

FGM remains a widespread scourge and a community felt need of women the world over the problem with FGM practice is that the opposition to it is silent. Most people concerned are skeptical about responding to the practice itself. Others find it not convenient to discuss about it or campaign against it at all. Based on the Nigerian context, individuals can be divided into three categories, they include: People that practice it and admit openly that they do it; People who did not discuss it but continue the modification in secret; and those who do not do it and are against to hear that there is such practice (Hiersh, 1998).

Based on these controversies, most African parents give birth to female children and circumcise them. Considering numerous health hazards associated with female circumcision, it becomes necessary to formulate mobilization strategies for the prevention and eradication of the obnoxious practice (Onuzulike, 2006). According to her, mobilization is one of the ways of eradicating the obnoxious practices of FGM. Citing, Mysters (1995), Sanderson (1999) and Onuzulike (1997) opined that the following agencies and groups should be actively involved in waging war against FGM.

1. Ministries, Departments and Government Agencies/Institutions.
2. All cadres of health workers at Federal, State, Local Government Area level.
3. Opinion Leaders in the communities who can help in bringing about desired positive concepts and changes.
4. Non-governmental Organizations (NGOs), Religious Organization as well as Social and Civil Organizations.

Specifically, the family should be the primary institution to be mobilized for the prevention and the eradication of female circumcision, since through the family the child sees and interprets the world around him as he acquire characters, socialize, develop personality, receive health and education. The family could sometimes consist of the members of a household, which may include father, mother and child or children. It may be a one parent family with only mother or father or extended family. Family health education is very important, in other to trained the family members on the need for maternal and child health care services. Through this education, the promotion, maintenance, protection, and where necessary; the restoration of the social, physical and mental wellbeing of the parents and their children will be achieved (Hiersh, 1998).

Also, family health education should be given priority in the society and culture; for through it learners will be exposed to sensitive issues such as sex education, family planning and the controversial FGM or circumcision. Effectiveness of this health education will help in the wiping out misconceptions, inhibiting, baseless fears and superstitious beliefs surrounding female circumcision. There is need to include family health courses in the curriculum of medical, and allied personnel as well as in secondary schools and tertiary institutions. Such courses, programmes will help students in studying the harmful effects of female genital modification.

Communication strategy is another important tool for mobilization. Media houses should be used in disseminating information on the danger inherent of female circumcision at the grass-route. Such public enlightenment campaign should be timed properly, may be during the festive periods or resting period. The target area should include an antenatal clinics, post natal clinics, infant welfare clinics. Efforts should be made to disprove the claim that female genital mutilation stern promiscuity.

Women Organizations should also be used in educating both the rural and urban women about the dangers effects of FGM in order to opposed or eliminate it to this end regard. Seminars and workshops should be periodically organized at the national, State, local and even village levels. There is also the need to promulgate laws necessary to forbid FGM. The production of the local educational

and instructional materials should be used to enlighten the public on damaging effects of FGM practice. The materials include model, flannel graphs and slides with view.

Family planning should be made available at the urban and rural settings. The traditional birth attendants should be trained in the modern midwifery and taught the techniques of modern family planning and family education. Attempts should be made to provide adequate management of the psychological consequences of FGM.

Conclusion

Female genital mutilation (also called "female genital cutting" and "female genital mutilation/cutting") refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. Female genital mutilation has no known health benefits. On the contrary, it is known to be harmful to girls and women in many ways. First and foremost, it is painful and traumatic. The removal of or damage to healthy, normal genital tissue interferes with the natural functioning of the body and causes several immediate, intermediate and long-term health consequences. There is no possibility of the individual consent while mutilated/cut infants, girls and women face irreversible lifelong health risks, among other consequences. FGM has dangerous health implications because of the unsanitary conditions in which it is generally practiced. The practice also violates the rights to health, security and physical integrity of the person, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

Decades of prevention work undertaken by local communities, governments, and national and international organizations have contributed to a reduction in the prevalence of female genital mutilation in some areas. However, despite some successes, the overall rate of decline in the prevalence of female genital mutilation has been slow. Therefore, it becomes imperative to strengthen work for the elimination of this inimical practice, which is essential for the achievement of many of the Millennium Development Goals. Health education programmes, advocacy and capacity building of rural women and TBAs would to a large extent facilitate the eradication of FGM.

Recommendations

1. Strengthening the health sector response: guidelines, training and policy to ensure that healthcare professionals can provide medical care and counselling to girls and women living with FGM.
2. Increasing advocacy: developing publications and advocacy tools for national, regional and local efforts to end FGM within the country.
3. The federal, state and local governments should enact and enforce laws that will discourage harmful cultural practices such as FGM in Nigeria.
4. Government and communities should establish rehabilitative homes to cater for the victims of FGM.
5. Development of alternative sources of income for circumcisers.

References

Adnelman, S. L. (1990). *The new home medical encyclopedia*. New York: Grolier Incorporated.

Ahmed, C. (1996, 10th March). Circumcision is responsible for high mortality, says WHO's boss. *The Guardian*, pp.35.

Akalazu, J. (1992). *The horrors of female circumcision* (June 15th). Nigerian Statesman p.10

Akinwusi, A. (2004). *Contemporary issues and researches on adolescents*. Ibadan: Royal People (10igenal) Ltd.

American Academy of Pediatrics (1998). Female genital mutilation. *Pediatrics, 102* (1), 153-156.

Dorkenoo, E. (2001). *Female genital mutilation*. The practice and its prevention. London: Forward Minority Right Publication.

Elchalal, V., Ben, A.B., Gillis, R., & Brezezinski, A. (1997). Ritualistic female genital mutilation: Current states and future outlook. *Obstet-Gynaecology Survey 52 (10*), 643-651.

Hiersh, L. (1998). Giving up Harmful practice, not cultural passage, Advocate for youth issues at a glance. *Hyperlink Publishers 5 (1)*, 7-18.

Hosken, P. F. (1991). *The Hoskea Report*: *Genital and sexual mutilation of female*. USA:

Women International Network (win).
Ichita, R.I. (2007). *Awareness of health implications of female genital cutting among women in Ovim, Isikwuato LGA, Abia State*. Unpublished Project Report, Department of Public Health, Madonna University, Elele Campus, Rivers State.
Inter-Africa Committee (2000). *Female genital mutilation in monograph sense on harmful and beneficial practices in Nigeria.*
Mysters, A.R. (1995). Circumcision, its nature and practice among some ethnic group in southern-Nigeria. *Second Science and Medicine 21* (5), 581- 588.
Odjinri, T., Akintoye, C. & Oyediram, P. (2001). *A study on female circumcision in Nigeria*. A Publication of Medicine Department of College of Medicine, University of Lagos
Onuzulike, N. M. (2005). *Healthy living and national development.* Owerri: On Publishing House W/B Housing Estate.
Onuzulike, N. M. (2006). *Issues in Health*. Owerri: Megassoft Publishers.
Owumi, B. E. (2003). *Asocio- cultural analysis in female circumcision among the urhobo. A study of the Okpe people of Delta State*. A project submitted to Inter-African Committee.
Procter, P. (2000). *Longman Dictionary of Contemporary English*. Great Britain: Pitman Press.
Sanderson, L.P. (1999). *Against the mutilation of women: The suffering against the unnecessary suffering*. London: Athacoc Press.
Smith, J., Jones, W.K., Keike, B.J., & Wilcox, A. (2000). *Female genital mutilation and female circumcision. Who is at risk in the USA?* Centre for Disease Control and Prevention: Atlanta.
The Explorer (1997; April/June). Female genital mutilation: A violation on girls' rights. *Citizenship to Leadership Training Centre, Nigeria 5 (3)*, 11218.
The Minority Right Group Report-MRGR (1993). *The practical encyclopedia of sex and health.* United States: Fireside Press.
The Federal Ministry of Health (2003). *2003 Nigeria Demographic Health Surveys*. Abuja: FMoH
Thomas, I M. (1998). *The work of Nigeria National Committee of infibulations and excision.* Female Circumcision Proceeding of the International Seminar on F.C. 13-16th June, 72-72.
UNICEF (1998). *Two million girls a year mutilated.* The Progress Nation, New York: UNICEF.
UNICEF (2013). *Female Genital Mutilation/Cutting: a statistical overview and exploration of the dynamics of change*. New York: UNICEF
Ugwu, A.B.C. (1997). *Development psychology and education*. Enugu: Royal Printing Company, #1b Moore Avenue, Ogui, Enugu.
Uhaegbu, V. (1999, April 12). Female circumcision: An evil inflated on womanhood. *Punch, 28*, 12.
Umar, A. M. (1993; February 16). *The danger in circumcision*. The vanguard.
Winkel, E. (1995). A Muslim's perspective on female circumcision (Editorial). *Women's Health 23 (1)*, pp.1-7.
Werner, I. (1995). *Where there is no doctor: A village healthcare handbook for Africa*. Kaduna: Katsina Publishers.
World Health Organization (1993). Where do we go from here? *WHO Chronicle 39 (3)*, pp. 98-103.
WHO (1996b). Female genital mutilation. *Report of a WHO technical working group, Geneva, 17−19 July 1996*. Geneva: World Health Organization.
World Health Organization (1998)."*Female genital mutilation.* A report of a technical grows. Geneva 101.
World Health Organization (1999)."*Female genital mutilation.* A report of a technical grows. Geneva 101.
World Health Organization (1999).*Traditional practice affecting women's health.* An overview Geneva: WHO Publication.
WHO & UNFPA (2006). *Towards the elimination of female genital mutilation: A training manual for the affected countries in the Eastern Mediterranean Region*. Cairo: World Health Organization Regional Office for the Eastern Mediterranean.

Appendix A

Figure 1: TBA performing FGM
Source: http://www.middle-east-info.org/league/somalia/fmgpictures.htm