OBSTETRIC AND MARITAL CONSEQUENCES OF FEMALE GENITAL MUTILATION (FGM) IN METROPOLITAN LAGOS, NIGERIA.

John Lekan **OYEFARA**
Department of Sociology
Faculty of Social Sciences
University of Lagos
Akoka, Yaba, Lagos, Nigeria.
Tel. 08023599623
All correspondences to: oyefara@yahoo.com or loyefara@unilag.edu.ng

ABSTRACT
This article examines the relationships between FGM practice and obstetric complications/marital harmony among ever-married women in Lagos metropolis, Nigeria. A cross-sectional survey was carried out, and a quantitative analytical technique was used in analysing the data. Findings of the study reveal that women who have undergone FGM are more likely than uncircumcised women to experience obstetric complications such as obstetric hemorrhage, obstetric tears/lacerations, cesarean section and prolonged labour. Comparative analysis revealed that obstetric hemorrhage is highly common across the three forms of the FGM. However, women with infibulation seem to be more likely than women with clitoridectomy or excision to experience obstetric tears, while prolonged labour is more common among women with excision. On the marital effects of FGM, women who had undergone FGM are more likely than uncircumcised women to experience marital disharmony due to sexual problems. On the basis of these findings it is recommended that campaigns against FGM should be intensified and various stakeholders sensitised about its obstetric and marital consequences.

Key Words: **Female Genital Mutilation, Obstetric Complications, Marital Harmony, Lagos Metropolis, Nigeria.**

INTRODUCTION
Safe motherhood and reduction of maternal morbidity and mortality are central concerns and targets of the Millennium Development Goal-5 (MDG-5). Paradoxically and sympathetically too, in spite of great oil wealth and more than two decades into the war against maternal deaths, Nigeria still has one of the worst maternal mortality statistics in the world. With a maternal mortality ratio of 545 per 100,000 live births, Nigeria loses about 145 women of childbearing age everyday. A woman's chance of dying from pregnancy and childbirth in Nigeria is 1 in 13 (National Population Commission (NPC) [Nigeria] and ICF Macro (2009). The maternal mortality ratio represents the risk associated with each pregnancy, that is, the obstetric risk (World Health Organization, 2008). Of all the causes of maternal death which have been identified and addressed in the country, traditional practices seem not to have been holistically treated. Some of these traditional practices are Female Genital Mutilation (FGM) or Female Circumcision (FC), food taboos, teenage/child marriage and other practices that are detrimental to the reproductive health of women.

At the global level, FGM has been perceived as a form of discrimination directed at the female gender. In other words, it is violence against women. Violence against women is any act-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women including threats of such acts of coercion, or arbitrary deprivation of liberty, whether occurring in public or private life (United Nations General Assembly, 1981). The World Health Organisation (WHO) conceptualised FGM as all procedures which involve partial or total removal of the external female genitalia and/or injury to the female genital organs whether for cultural or any non-therapeutic reasons (World Health Organization, 1994). It is one of the major causes of maternal death in sub-Saharan Africa. For instance, it was reported that in areas of Sudan where antibiotics are not available, it was estimated that one-third of the girls undergoing FGM die (Women's Policy Inc., 1996). Conservative estimates suggest that, more than one million women

in Central African Republic (CAR), Egypt, and Eritrea, the only countries where such are available, experienced adverse health effects from FGM. One-quarter of women in CAR and 1/5 of women in Eritrea reported FGM-related complications. Where medical facilities are ill-equipped and emergencies arising from the practice cannot be treated, the devastating effects may be costly. Thus, a child who develops uncontrolled bleeding or infection after FGM may die within hours (Koso-Thomas, 1987). The World Health Organisation (WHO) reported that most of the girls and women that had undergone FGM live in East and West Africa, and parts of the Arabian Peninsula. Although, some live in Asia, some are however found in immigrant population groups, living in Europe, USA, Canada, Australia and New Zealand (World Health Organization, 2001). In Nigeria, FGM is widespread among the various ethnic groups and socio-economic groups and classes and it is usually practiced for cultural, religious, and ritual purposes, often as part of initiation rite into womanhood. It is one of the cultural and traditional practices that persist in the contemporary Nigerian society despite significant increase in the level of literacy and other modernisation values. Research findings over the years in the country (National Population Commission (NPC) [Nigeria] and ICF Macro, 2009; Adebayo, 1992; Centre for Gender and Social Policy Studies, 1998; Odimegwu and Okemgbo, 2000; Sai, 1995; National Population Commission (NPC) [Nigeria] and ORM Macro (2004) revealed that many Nigerians still practice FGM on a daily basis. In fact, millions of young girls in the country have been circumcised and many more thousands are still waiting to be circumcised. Worrisome national data from two recent Nigeria Demographic and Health Survey (NDHS) revealed an increase in the practice of FGM in the country from 19 per cent in 2003 to 30 per cent in 2008 (National Population Commission (NPC) [Nigeria] and ICF Macro, 2009). This reality calls for deeper reflections and further studies into FGM practice in Nigeria and its association with obstetric and other psychosocial issues among women in the country.

According to one report (Koso-Thomas, 1987), women who have undergone FGM are twice as likely to die during childbirth and are more likely to give birth to a still born child than other women. He argues further that obstructed labour can also cause brain damage to the infant and complications for the mother. Basically, there are three major conventional forms of FGM identified by scholars in the literature. The first one is called ***clitoridectomy***, which is the least severe form of the practice. It involves the surgical removal of the prepuce or the hook of the clitoris leaving the clitoris itself and the posterior larger part of the minora. The second one is referred to as ***excision*** which consists of the removal of the clitoris along with parts of the labia minora or all of it. The third type is called ***infibulation*** and is considered the most severe form of the practice. It involves the removal of the clitoris, the labia minora and the adjacent medial part of labia majora in their anterior two-third. What makes it infibulation is that the two sides of the vulva are then stitched together (generally using thorns, catcuts or a paste of egg, sugar and gum arabic leaving an opening of the size of a pin head to allow for the flow of urine and menstrual blood (Centre for Gender and Social Policy Studies, 1998; Odimegwu and Okemgbo, 2000; Toubia 1993; Dawit, 1994; Rahman and Toubia, 2000). The degree of cutting is much more extensive and often impairs a woman's sexual and reproductive function (Rehman and Toubia, 2000). The three forms of FGM still exist in the six-geopolitical zones of Nigeria, but there is a variation in the nature, pattern and prevalence of each of them across the regions (National Population Commission (NPC) [Nigeria] and ICF Macro, 2009; National Population Commission (NPC) [Nigeria] and ORM Macro, 2004).

It should be noted that complications are common and can lead to death. In the report by Hosken (Hosken, 1993), the highest maternal and infant mortality rates in the globe are in FGM–practicing regions of the world. The actual number of girls who die as a result of FGM in Nigeria is not known due to poor statistics in the country but this claim becomes a fact when the level of maternal and

infant mortality is considered in the country. Considering the possible nexus between FGM status and a woman's sexuality/reproductive health, this article seeks answers to the following research questions: What are the relationships between the FGM status and the experience of obstetric complications among married women in the study location? Are there any significant differences in the patterns of obstetric complications experienced by the women based on the nature of FGM they have? Is there any relationship between the FGM experience and marital harmony among the married women? These questions among others form the focus of this article.

Obstetric Complications: Conceptual Issues and Measurements

Obstetric complications include disruptions and disorders of pregnancy, labour and delivery, and complications during the early neonatal period. Complications can have short- and long-term effects on the mother and child (Gibbs et al. 2008). Each year, approximately eight million women around the world suffer from pregnancy-related complications (Lewis, 2004) and over 300,000 die in childbirth (Hogan et al. 2010). Four major obstetric complications among others were identified by the respondents in the study location. These are obstetric hemorrhage, obstetric tears/lacerations, cesarean section, and prolonged labour. In a larger perspective, obstetric hemorrhage refers to heavy bleeding during pregnancy, labour, or immediately after birth, however, in this study; it has been conceptualised as such bleeding occurring only during labour and the post-partum period as reported by the respondents. It has been noted in the literature that, the main causes of bleeding during labour include uterine rupture and separation of the placenta from the wall of the uterus before birth and post-partum hemorrhage is usually defined as the loss of greater than 500 ml of blood in relation to vaginal delivery (Gibbs et al. 2008). Obstetric tears/lacerations involve overstretching of the vagina during childbirth which in turn may cause tearing of tissues in the vagina, perineum and/or anus. As noted by these experts (Gibbs et al. 2008) perineal lacerations during vaginal childbirth are usually classified into four categories according to the severity of trauma in the following ways: 1st degree tear: laceration only of the fourchette and superficial perineal skin or vaginal mucosa; 2nd degree tear: laceration extends beyond fourchette, perineal skin and vaginal mucosa to perineal muscles and fascia (but not to the anal sphincter); 3rd degree tear: laceration of fourchette, perineal skin, vaginal mucosa, muscles, and anal sphincter; and 4th degree tear: laceration of fourchette, perineal skin, vaginal mucosa, muscles, anal sphincter, and rectal mucosa.

Cesarean section is the delivery of a fetus by surgical incision through the abdominal wall and uterus. Usually, women deliver their baby through the birth canal, i.e. they have a vaginal birth. But there are cases when a cesarean section is necessary for the safety of the mother and/or the baby. In the general case, cesarean sections are performed because of problems that arise during labour (emergency/unplanned cesarean), but a cesarean section can also be elective (planned). Whether unplanned or planned, a cesarean section is the delivery of a baby through a cut (incision) in the mother's belly and uterus, rather than through the birth canal (Gibbs et al. 2008). Prolonged labour is the fourth obstetric complication mentioned by the respondents. Normally, labour is a series of strong, repeated muscle contractions which push the baby out of the uterus and into the birth canal. As explicated and conceptualised by these authors (Gibbs et al. 2008), the duration of labour varies from woman to woman, but it is usually shorter in women who have given birth before than women who are giving birth for the first time. Typically, labour is considered prolonged when the baby is not born after approximately 20 hours of regular contractions, or 18 to 24 hours of regular contractions.

RESEARCH METHODS

Background information of study location

The study location is the Oworonshoki community in Kosofe Local Government Area (LGA) of Lagos State, Southwestern Nigeria. Oworonshoki is located within the mainland part of Lagos State. Up north, the study location shares boundaries with Bariga Local Council Development Area. The lagoon is situated at the western part of the Oworonshoki community while it shares boundaries with Ifako and Ogudu at the east and south respectively. Oworonshoki can be linked through land and water transport systems. The lagoon connects Oworonshoki and Lagos Island together. The study location has as its inhabitants people from various ethnic and religious groups which include Yoruba, Ibo, Hausa, including other ethnic minorities in Nigeria. The community also consists of Muslims, Christians and Traditional worshippers as there are mosques, churches, and shrines in the area. It is important to note that Oworonshoki is owned and predominantly occupied by the Yoruba. Oworonshoki is mainly a residential area with highly educated people, averagely educated, and illiterates living in the community. As at 2013, the Oworonshoki community had an estimated population of about 402,972 with 111 streets and two geographical distribution spanning into areas/wards A and B as divided by a major road named Oworo road.

Study population and sample size determination

The study population comprised of ever-married women from age 20 and above in the study location. In order to have a representative sample size for the cross-sectional survey, a statistical formula for the estimation of representative sample size designed by Krejcie and Morgan (1970) was adopted. The formula is denoted as:

$$\text{Sample Size} = \frac{\chi^2 NP(1-P)}{d^2(N-1) + \chi^2(1-P)}$$

Where:

N = Population size (estimated population of ever-married women from age 20 and above in the study location = 150,000)

P = Prevalence rate of FGM in Nigeria in 2008 women which was 30.0% (P=0.30)

χ^2 = is the table value of Chi-Square @ *d.f*. = 1 for desired confidence level of 0.05 which is 3.84

d = is the degree of accuracy set at 0.05

d^2 = $(0.05)^2 = 0.0025$

$$= \frac{3.84\ (150{,}000)\ (0.30)\ (0.70)}{0.0025\ (150{,}000-1) + (0.30)\ (0.70)}$$

$$= \frac{120{,}960}{375.2075}$$

= 322.381

= 322.381 respondents.

Therefore N = approximately 322.

Thus, 322 respondents came out to be a representative sample of the estimated population. However, a total of 360 questionnaires were administered considering expected cases of invalid questionnaires due to incomplete response, inconsistency in the responses or a total "no" response from the respondents. At the end of the questionnaire administration, a total of 350 questionnaires were found usable for the study. Thus, the non-responses and incomplete responses constitute about 2.8 per cent of the total questionnaires administered.

Sampling method

To select respondents for the cross-sectional survey, a multistage random sampling technique was adopted. It is imperative to note that the Oworonshoki community consists of two wards (i.e. ward A and B) and 111 streets. The multi-stage random sampling technique adopted involves a total of four stages before eligible respondents were selected for the study. Stage 1 involves strategic sub-division of the community into two existing geo-political wards A and B. The two wards were included in the study and formed two strata from where the sample was drawn. In the second stage, a systematic random sampling method was used to select 14 streets from the two wards for the study. Specifically, 6 streets were randomly sampled from ward A, and 8 streets were also randomly sampled from ward B. The number of streets sampled per ward was made to be proportional to the estimated population and streets per ward. The third stage consisted of numbering and sampling of houses and households in the selected streets. Considering the total number of houses and household per street and an average of 25 respondents to be sampled per street, a sampling interval was developed for each street to guide the random sampling of eligible respondents in each of the streets. The fourth and final stage of the multistage sampling method was the sampling of the respondent in each of the identified houses and households at stage three. In case of plural eligible respondents per household, simple random method was used to select one respondent per household. In all, for the valid returned questionnaires used in the analysis, a total of 150 ever-married women were sampled from ward A, while another 200 were sampled from ward B. it is imperative to note that the women were interviewed alone without the presence of their husbands. Thus, 350 questionnaires were found to be valid returned instruments for further analysis.

Research instrument, data collection and variables

A questionnaire was developed to elicit data from respondents. The questionnaire was designed in such a way that adequate information was collected on the research questions with a view to actualise the purpose and objectives of the study. Specifically, the questionnaire consists of 68 questions that were sub-divided into eight subsections. Section one consists of questions on the socio-demographic background of the participants. Section two focuses on questions on marital history, while the third section borders on questions on issues of female genital mutilation. Section four consists of questions on sexual initiation. Questions on sexual activity and sexual satisfaction were asked in section five and six respectively. Section seven and eight consist of questions on fertility history and marital harmony of the respondents respectively. The fieldwork activities of the study were carried out between July and September in the year 2012. Eight female research assistants were recruited and trained in addition to the principal researcher to conduct the study. The two major outcome variables in this study are obstetric complications and marital harmony, while the explanatory variable is the FGM status of the respondents.

Study limitations

The major constraint of the study was the fact that many of the women were not ready to be interviewed due to their claims that they were very busy with their economic activities. In addition, the women had poor memory about the exact time they were circumcised. It is important to note that human history is prone to some certain level of error. In spite of these constraints and limitations, efforts were made to generate both reliable and valid data for the study.

Ethical approval and informed consent

Considering the medical and social implications of the topic of the study on the respondents, ethical approval was obtained from the Ethical and Research Review Committee of the University of Lagos Teaching Hospital, Idi-Araba, Lagos, Nigeria. Informed written consent was taken from all the respondents after full explanation of the nature, purpose, and all procedures used for the study. Confidentiality was maintained throughout the study period. Furthermore, respondents were completely anonymous in relation to their responses.

Data processing and analysis

The adopted research design and method produced mainly quantitative data for the study. Consequently, quantitative methods of data analysis were used in the study. The returned questionnaires were screened and edited for possible errors, while open-ended questions were coded. After the coding, the returned questionnaires were entered into the computer for further analysis with the use of the Statistical Package for Social Sciences (SPSS) version 16.0. It is imperative to note that the quantitative research method seeks to statistically appraise observable behaviour with a view to providing a coherent explanation to its findings. Thus, the analysis of the collected data was done at two levels: i) univariate analysis, and ii) bivariate analysis. The univariate analysis consists of frequency distributions, percentages and modes, while bivariate analysis involves the use of chi-square (χ^2) to examine relationships between outcome variable and various explanatory variables.

RESULTS

Obstetric Complications: Prevalence and Nature

Information on the nature and prevalence of obstetric complications among women in the study location can be seen on Table 1. According to the table, 178 (50.9%) of the respondents had experienced obstetric complications in the study location. Among women that had experienced obstetric complications, obstetric hemorrhage has the highest prevalence rate with 85.4 per cent, followed by prolonged labour (7.9%), obstetric tears/lacerations (4.5%) and cesarean section (2.2%) respectively.

Table 1: Percentage distribution of respondents by prevalence and nature of obstetric complications

Variables/categories	Frequency	Percentage
Ever experienced complications during childbirth		
Yes	178	50.9
No	172	49.1
Total	350	100.0
Nature of obstetric complications		
Obstetric hemorrhage (OH)	152	85.4
Obstetric tears/lacerations (OT/L)	8	4.5
Cesarean section (CS)	4	2.2
Prolonged labour (PL)	14	7.9
Total	178	100.0

Female Genital Mutilation and Obstetric Complications

The nexus between the FGM status and obstetric complications was examined at two different interconnected levels/steps in this study. The first level looked into the dichotomous experience of obstetric complications between women who have undergone FGM and their counterparts who are uncircumcised, while the second step interrogates the intra-differentials in the nature of obstetric complications experienced by women with different forms of FGM. The results of the first

step can be seen on Table 2. As shown, 65.0 per cent of women who have undergone FGM compared with 6.0 per cent of uncircumcised women had experienced obstetric complications. This difference is statistically significant with *χ^2= 89.174; df=1; P < 0.01 and contingency coefficient of 0.451.*

Table 2: Percentage distribution of respondents by FGM status and obstetric complications

Variables/categories	Ever experienced obstetric complications		Chi-square
	Yes *N (%)*	No *N (%)*	
FGM status			89.147**
Circumcised	173 (65.0)	93 (35.0)	
Uncircumcised	5 (6.0)	79 (94.0)	
Total	178 (50.9)	172(49.1)	

***p < 0.01; df=1; contingency coefficient=0.451*

Data on the second step that probed into the nature of obstetric complications by different forms of FGM can be seen on Table 3. As shown on the table, 91.0 per cent of women who have undergone clitoridectomy, 78.6 per cent of women with infibulation and 50.0 per cent of women with excision reported obstetric hemorrhage. Howbeit, 14.3 per cent of women who have undergone infibulation and 2.7 per cent of women with clitoridectomy had experienced obstetric tears/lacerations. Furthermore, 41.7 per cent of women with excision, 7.1 per cent of women that have undergone infibulation and 4.8 per cent of women with clitoridectomy had experienced prolonged labour, while 8.3 per cent of the women who had undergone excision, and 1.4 per cent of women with clitoridectomy had experienced caesarean section. The observed difference is statistically significant with *χ^2= 31.147; df=6; P < 0.01 and contingency coefficient of 0.391.* It is imperative to note that the Contingency Coefficients of the two tested propositions ranged between 0.391 and 0.451. This suggests that women FGM status accounts only for about 39.1% - to - 45.1% of the obstetric complications among women in the study location. There are other 54.9% explanatory factors causing obstetric complications among women in the study location which other studies can explore.

Table 3: Distribution of respondents by type of FGM and nature of obstetric complication

Variables/categories	Nature of obstetric complication				Chi-square	*N (%)*
	OH	OT/L *N (%)*	CS *N (%)*	PL *N (%)*		
Types of FGM					31.147**	
Clitoridectomy	132 (91.0)	4 (2.7)	2 (1.4)	7 (4.8)		
Excision	6 (50.0)	- -	1 (8.3)	5 (41.7)		
Infibulation	11 (78.6)	2 (14.3)	- -	1 (7.1)		
Total	149 (87.1)	6 (3.5)	3 (1.8)	13 (7.6)		

***p < 0.01; df=6; contingency coefficient=0.391*

Female Genital Mutilation and Marital Harmony

This section examines the nexus between the FGM status and marital harmony among women in the study location. As shown on Table 4, 13.2 per cent of women who have undergone FGM compared with 3.6 per cent of uncircumcised women had marital disruption. This difference is statistically significant with *χ^2= 6.062; df=1; P < 0.05 and contingency coefficient of 0.130.* The major reasons for misunderstanding with their spouses among circumcised women are sexual intercourse (59.8%) and money (32.7%), while among uncircumcised women, money (57.1%) and in-laws (36.9%) are major factors of misunderstanding with spouse. The differences are statistically significant with *χ^2= 123.500; df=4; P < 0.01 and contingency coefficient of 0.511.*

Table 4: Percentage distribution of respondents by FGM status and marital disruption

Variables/categories	Women' FGM status: Circumcised N (%)	Uncircumcised N (%)	Chi-square
Ever had marital disruption			6.062*
Yes	35 (13.2)	3 (3.6)	
No	231 (86.8)	81 (96.4)	
Major reason for misunderstanding with spouse			123.500**
Sexual intercourse	159 (59.8)	3 (3.6)	
Money	87 (32.7)	48 (57.1)	
In-laws	7 (2.6)	31 (36.9)	
Religion	8 (3.0)	1 (1.2)	
Others	5 (1.9)	1 (1.2)	
Involvement of third party to settle misunderstanding			37.994***
Yes	121 (45.5)	7 (8.3)	
No	145 (54.5)	77 (91.7)	

** p<0.05; **p < 0.01; ***p < 0.001*

Table 4 further reveals that 45.5 per cent of women who have undergone FGM compared with 8.3 per cent of uncircumcised women involved third party to settle misunderstandings with their spouses. This difference is statistically significant with $\chi^2 = 37.994$; *df=1; P < 0.01 and contingency coefficient of 0.313.* The Contingency Coefficients of the three tested propositions ranged between 0.130 and 0.511. This suggests women's FGM status accounts only for about 13.0% -to- 51.1% of those factors that affect marital harmony. There are other 50.0% explanatory variables affecting marital harmony which other studies can explore in the study location.

DISCUSSION

This article examined the relationships between FGM practice and obstetric complications among ever-married women in Lagos metropolis, Nigeria. In addition, it delved into the effect of the practice of FGM on marital harmony among couples in the study location. Findings of the study reveal that women who have undergone FGM are more likely than uncircumcised women to experience obstetric complications such as obstetric hemorrhage, obstetric tears/lacerations, cesarean section and prolonged labour. Detailed comparative analysis revealed that obstetric hemorrhage is highly common across the three forms of FGM with the highest occurrence among women that had undergone clitoridectomy, followed by infibulation and excision respectively. Furthermore, women with infibulation are more likely than women with clitoridectomy to experience obstetric tears/lacerations, while prolonged labour is more common among women with excision compared with women with infibulation and women with clitoridectomy. Finally, women who had undergone excision reported a high level of caesarean section compared with women who had undergone clitoridectomy.

A critical question that is needed to be asked is the understanding of the mechanisms by which FGM may lead to the observed adverse obstetric outcomes. As experts explicate in a meta-analysis (Berg and Underland, 2013), the most plausible pathway as documented in the literature is the inelastic scar tissue of the mutilated. FGM is generally performed on girls under the age of ten, and healing from any type of cutting inevitably involves varying amounts of scar formation. Further, scar tissue consists of mature collagen. The highest concentration of collagen is found in tissues subjected to recurrent incision and healing. Such scar tissues are less elastic and have a decreased tensile strength, compared to undamaged tissues. It follows that a likely mechanism through which FGM may increase the risk of obstetric complications is the increase in scarring of perineal and vulval tissues found in women with FGM. Such scarring increases the possibility of tearing and hemorrhage during labour, even when appropriate episiotomy is performed. These authors further revealed that female genital tissues that have been cut is subjected to greater tears/lacerations during parturition and may interfere with the progress of labour. Additionally,

they suggested that damage to the vagina, internally and externally through obstructions such as stenosis and retention cysts following FGM may compromise a normal vaginal delivery, including prolongation of labour.

FGM also has significant effects on marital harmony among couples in the study location. Specifically, women who had undergone FGM are more likely than uncircumcised women to experience marital disharmony. In particular, women who had undergone FGM are more likely than uncircumcised women to have experienced marital disruption. Furthermore, probing question revealed that women who had undergone FGM compared with uncircumcised women gave sexual intercourse as a major reason for misunderstanding with their spouses. In addition, women who had undergone FGM compared to uncircumcised women are more likely to involve a third party to settle misunderstandings with their spouses. The results of this study reveal that sexual intercourse among couples in marriage serves as an important internal mechanism for conflict resolution between husband and wife. On the basis of empirical evidence discovered in this study, it is essential for the Nigerian government and various development partners working in the country most especially WHO and other organs of the United Nations to scale-up existing strategies and put additional various interventions in place to reduce the incidence of FGM practice among women and girls in the country. This will invariably impact positively on maternal health on one hand, and improve marital harmony on the other.

REFERENCES

Adebayo, C.O. (1992). *Female Circumcision and Other Dangerous Practices to Women's Health issues in Nigeria.* U.K: Pearson Education International.

Berg, R.C. and Underland, V. (2013). *Obstetric Consequences of Female Genital Mutilation/Cutting (FGM/C). Report from Kunnskapssenteret No. 6-2013.* Oslo: Norwegian Knowledge Centre for Health Services.

Centre for Gender and Social Policy Studies (1998). *Report of Baseline Survey of Positive and Harmful Traditional Practices Affecting Women and Girls in Nigeria*. Ile-Ife: Obafemi Awolowo University.

Dawit, S. (1994). African Women in the Diaspora and the Problem of Female Genital Mutilation. *ASA Women's Caucus Newsletter.*

Gibbs, R.S., Karlan, B.Y., Hanley, A.F., and Nygaard, I. (2008). *Danforth's obstetrics and gynecology. 10th Ed*. New York: Lippincott, Williams & Wilkins.

Hogan, M.C., Foreman, K.J., Naghavi, M., Ahn, S.Y., Wang, M., and Makela, S.M. (2010). Maternal Mortality for 181 Countries, 1980-2008: A Systematic Analysis of Progress towards Millennium Development Goals. *Lancet 375:*1609-23.

Hosken, F.P. (1993). *The Hosken Report: Genital and Sexual Mutilation of Females, Fourth Edition*. Lexington, Massachusetts: Woman's International Network News.

Koso-Thomas, O. (1987). *The Circumcision of Women: A Strategy for Eradication*. London: Dotesios Ltd.

Krejcie, R.V. and Morgan, D.W. (1970). Determining Sample Size for Research Activities, *Educational and Psychological Measurement 30*:607-610.

Lewis, G. (2004). *Beyond the Numbers: Reviewing Maternal Deaths and Complications to make Pregnancy Safer.* Geneva: World Health Organisation.

National Population Commission (NPC) [Nigeria] and ICF Macro (2009). *Nigeria Demographic and Health Survey 2008*. Abuja, Nigeria: National Population Commission and ICF Macro.

National Population Commission (NPC) [Nigeria] and ORC Macro (2004). *Nigeria Demographic and Health Survey 2003.* Calverton, Maryland: National Population Commission and ORC Macro.

Odimegwu, C.O. and Okemgbo, C.N. (2000). Female Circumcision and Sexual Activity: Any Relationship? *UNILAG Sociological Review, 1,* 159-176.

Rahman, A. and Toubia, N. (2000). *Female Genital Mutilation: A Guide to laws and Policies Worldwide.* New York: Zed Books Limited.

Sai, F. (1995). *Socio-Cultural and Legal Practices and Gender Equity, Adam and Eve and the Serpent*. Accra: The Ghana University Press.

Toubia, N. (1993). *Female Genital Mutilation: A Call for Global Action, 2nd edition.* New York: Women Ink.

United Nations General Assembly (1981). *Convention on the Elimination of all Forms of Discrimination against Women (CEDAW).* New York: United Nations.

Women's Policy Inc. (1996). *Female Genital Mutilation in Women's Health Equity Act of 1996: Legislature Summary and Overview.* Women's Policy Inc. p. 48.

World Health Organisation (1994). *Female Genital Mutilation Information Kit*. Geneva, Switzerland.

World Health Organisation (2001). *A Systematic Review on Health Complications of Female Genital Mutilation including Squelae in Childbirth.* Geneva, Switzerland.

World Health Organisation (2008). *Factsheet, Maternal Mortality, Department of Making Pregnancy Safer*. Geneva, Switzerland.

Conflict of interest

The author has no conflict of interest in the authorship and publication of this contribution.