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RESEARCH ARTICLE

The Role of Educational Level in the Practice of Female Circumcision in Oredo LGA of Edo State, Nigeria

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Abstract

Background: The aim of this study was to determine the role of educational level in the practice of Female Circumcision in Oredo Local Government Area of Edo State, Nigeria. Nigeria ranks third in the global burden of FGM and Southern Nigeria, which Edo State is in, has the highest national prevalence. Infection, bleeding, infertility, and death are some of the complications of FGM. Due to its harmful outcomes, in 1999, Edo State banned FGM and in 2015 the Government of Nigeria enacted a law banning FGM.

Methods: This was a descriptive cross-sectional study of 200 male and female respondents, aged 15 years and above. The questionnaire was interviewer – administered, data was analysed using SPSS statistical software and Chi – Square statistical method to measure the significant relations.

Results: The current practice of FGM in Oredo LGA was placed at 34% and support for FGM ban was 66.5%. Only 19% of the male respondents insisted on marrying a circumcised woman, and 26% of them will not their circumcised daughter. There were statistically significant associations between support for discontinuation of FGM and educational level; male respondents that are willing to circumcise of their daughter and level of education; respondents with at least one daughter that are willing to circumcise their next daughter and level of education and awareness of fight against FGM and educational level respectively.

Conclusion: An effective recipe for FGM eradication must include good proper and education for all; to at least the secondary level.

Keywords: Female circumcision, FGM/FGC, Support for FGM, Education, Oredo, Edo state

1. Introduction

Female Genital Mutilation (FGM), also known as Female Genital Cutting (FGC) is the removal of part or all the external genitalia of a female [1]. These external genitals include the labia, fatty tissue over the pubic bone, the clitoris, the urethral and vaginal openings. Due to the supposed similarity to male circumcision, it is often called female circumcision.

The extent of cutting can be so extensive; that it impairs a woman's sexual and reproductive functions [2]. In 1995, the World Health Organization (WHO) categorized FGM into four wide categories [3].

- I: The removal of the clitoral hood with or without removal of part or the entire clitoris.
- II: Excision of the clitoris along with part or of the labia minora.
- III: The tightening of the vaginal opening with formation of a masking seal by trimming and readjusting either or both the labia minora and the labia majora, with or without excision of the clitoris.
- IV: Unclassifiable and may not include removal of tissue. It can also be defined as every harmful incision to the female genitalia for non-medical reasons. Typical examples include: incising, piercing, scraping, pricking the clitoris, ripping

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Table 1. Respondent's awareness and knowledge of FGM.

Variables	Category	Frequency (%)
Awareness of FGM	Aware	153 (76.5)
	Not aware	47 (23.5)
Knowledge of female circumcision	Have Knowledge	151(75.5)
	Have no Knowledge	26 (13)
	No response	23 (11.5)
Reasons for practice of FGM	Reduce promiscuity	137 (68.5)
	Traditional belief	38 (19)
	No response	25 (12.5)
Knowledge of harmful effect of FGM	Have knowledge	106 (53)
	Have no Knowledge	74 (37)
	No response	20 (10)
Harmful effect known ***	Infection	80 (40)
	Decrease in sex drive	8 (4)
	Difficulty in childbearing	9 (4.5)
	Others (bleeding, painful sex and death)	103 (51.5)

n = 200

*** Multiple answers

There is a high awareness level of FGM practice (76.5%) in Oredo Local Government Area (LGA) of Edo State. Half (53%) of the respondents had knowledge of its harmful effects on girls and women and 68.5% reported that the reason for the practice is to reduce promiscuity in girls and women.

or tearing and burning or scarring of the vagina [4].

FGM is typically limited to the removal of the clitoris and trimming of the labia minora in Nigeria.

It is practiced currently in about 28 countries across the African continent; but is not common in either Southern Africa or in the nations of North Africa, except for Egypt [5]. In Africa, FGM is practiced mostly in Sub Saharan countries stretching from Senegal in the West to Somalia in the East. In the Middle East, it is commonly practiced in Yemen, and in some parts of south-east Asia. In

Table 2. Respondent's knowledge of current practice and support for FGM.

Variables	Category	Frequency (%)
Current Practice of FGM in Oredo LGA	FGM still practiced	68 (34)
	FGM not practiced anymore	29 (14.5)
	No response	103 (51.5)
Support for FGM	Support	36 (18)
	Do not support	133 (66.5)
	No response	31 (15.5)
Reasons for support/ non -support of FGM	Can cause infection	34 (17)
	The practice is irrelevant	80 (40)
	Tradition	10 (5)
	Reduce promiscuity	22 (11)
	No response	54 (27)

The respondents believe that the practice of FGM is low (34%) and a high percentage (66.5%) do not support the continuation of this practice. Many respondents didn't support the practice because they believe it is now irrelevant (40%) and susceptibility to infection (17%).

Table 3. Knowledge of fight against FGM.

Variables	Category	Frequency (%)
Aware of fight against FGM	Aware	128 (64)
	Not aware	51 (25.5)
	No response	21 (10.5)
Aware of bill against FGM	Aware	56 (28)
	Not aware	121 (60.5)
	No response	23 (11.5)
Effect of bill on practice of FGM	Bill has effect	32 (16)
	Bill has no effect	102 (51)
	No response	66 (33)
Reasons given for effect of bill	Health providers banned from performing FGM	9 (4.5)
	Practice has reduced	10 (5)
	FGM still persist	25 (12.5)
	No enforcement of law	17 (8.5)
	Lack of publicity of bill	16 (8)
	No response	123 (61.5)

The anti-FGM campaign level was high, 64% of correspondents were aware of the fight against the practice of FGM. Similarly, they were mostly aware of the anti-FGM bill, however the effect of the bill is reported to have no effect by 51% of respondents.

North America, Europe, and Australia; reports shows that it is still practiced among immigrants [6]. It is estimated by WHO that at least 100 million girls and women alive have experienced some form of FGM [7]. Sometimes, it is in the form of initiation rite, other times for aesthetical reasons, and also it can be connected to virtue or sensuality [8].

The practice of FGM is an extreme type of gender discrimination and is often used to control women's sexuality [9].

In Nigeria, FGM is widely practiced and the country accounts for about one-quarter of the estimated 115–130 million women circumcised globally [10]. As such, Nigeria ranks third in the global burden of FGM [11].

The practice of FGM is still entrenched in the Nigeria society because of its social culture, where critical decisions are made by matriarchs in the family, opinion leaders, age and men groups [12].

Table 4. Prevalence of FGM among female respondents and their daughters.

Variables	Category	Frequency (%)
Prevalence of circumcised female respondents	Circumcised	40 (32.8)
	Not circumcised	71 (58.2)
	No response	11 (9)
Prevalence (respondents with circumcised daughters)	Have a circumcised daughter	15 (22.7)
	Have no circumcised daughter	23 (34.8)
	No response	28 (42.4)

A third of the female respondents were victims of FGM and only 15% of these respondents had their daughter/s circumcised.

Table 5. Association between support for discontinuation of FGM and educational level of respondents.

Educational level	Support FGM	Do not support FGM	Total
No formal education	4	5	9
Primary education	4	4	8
Secondary education	21	68	89
Higher education	7	56	63
Total	36	133	169

Critical value 7.81 P- Value 0.0000008 Degree of freedom 3 Chi square 31.12.

This is statistically significant, so reject null hypothesis and accept the alternate which is the higher the level of education, the lesser the support for FGM.

There was statistically significant relationship between the level of education and support for discontinuation of FGM practice and this shows that, the higher the respondents' educational level, the more the support for FGM to be discontinued.

Mothers will rather subject their daughters to the practice in order to protect them from being ostracized, maltreated, shunned, or stigmatized [13,14].

Traditionally, FGM was carried out by members of the community known for the trade or traditional birth attendants. Over time, community health workers and health practitioners got involved in the practice, a term called “medicalization of FGM” was coined for it. The WHO has strongly opposed the medicalization of FGM and warns against the practice and institutionalization.

The highest prevalence of FGM in Nigeria, is reported in Southern Nigeria. Edo state is in the South and is part of the South–South geo-political zone of the country. Benin city is the capital of Edo State and Oredo Local Government Area (LGA) is the administrative seat of this LGA and is also the most populated LGA in the state.

Table 6. Association between male respondent's willingness to circumcise their daughter and level of education.

Educational level	Will circumcise	Will not circumcise	Total
No formal education	6	3	9
Primary education	4	3	7
Secondary education	6	27	33
Higher education	4	25	29
Total	20	58	78

Critical value 7.81 P- Value 0.00148118 Degree of freedom 3 Chi square 15.43.

This is statistically significant, so reject null hypothesis and accept the alternate which is the higher the level of education of the male respondents, the less they are willing to circumcise their daughter.

There was statistically significant relationship between the level of education of male respondents and their willingness to circumcise their daughter and this shows that, the higher the male respondents' educational level, the more they are unwilling to circumcise their daughter.

Table 7. Association between female respondents with at least one circumcised daughter that is willing to circumcise their next daughter and level of education.

Educational level	Will circumcise	Will not circumcise	Total
No formal education	6	0	6
Primary education	4	4	8
Secondary education	1	7	8
Higher education	4	12	16
Total	15	23	38

Critical value 7.81 P- Value 0.01537897 Degree of freedom 3 Chi square 10.41.

This is statistically significant, so reject null hypothesis and accept the alternate which is the higher the level of education of respondents with at least one living daughter, the less they are willing to circumcise their daughter.

There was statistically significant relationship between the level of education of female respondents with at least one circumcised daughter and their willingness to circumcise their next daughter and this shows that, the higher the female respondents' educational level, the more they are unwilling to circumcise their next daughter.

A 1999 survey revealed that the prevalence rate of FGM in Edo State was 88%. The National lowest prevalence rates were recorded in Akwa-Ibom (South), Kebbi (North) and Adamawa (North) states, while the highest (89%) was recorded in Ekiti State (South) [15].

Customary, FGM is a pubertal rite of passage for the Ibos of Abakiliki, while it is a pre-marital rite for the Isokos of Delta State and the Hausas in the Northern States of Nigeria. Whereas, it is performed at infancy and early childhood by the majority of Yorubas' in the West, Enugu and Edo States.

The practice of FGM outdates many religions including Christianity and Islam. The practice however, cuts across various religious settings and ethnicities.

FGM has no known health benefits and victims of this practice suffer the complications it brings in

Table 8. Association between awareness of fight against FGM and educational level of respondents.

Educational level	Aware	Not aware	Total
No formal education	8	8	16
Primary education	12	6	18
Secondary education	70	25	95
Higher education	38	12	50
Total	128	51	179

Critical value 7.81 P- Value 0.000049115 Degree of freedom 3 Chi square 17.77.

This is statistically significant, so reject null hypothesis and accept the alternate which is the higher the level of education, the higher the awareness of fight against FGM.

There was statistically significant relationship between the level of education and awareness of ant-FGM campaign and this shows that, the higher the respondents' educational level, the more they are aware of the fight against FGM.

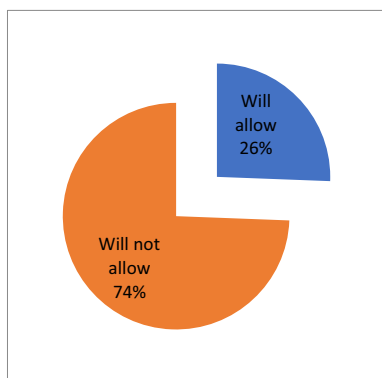


Fig. 1. Male respondents that will allow circumcision of their daughter(s). Most of the male respondents were not willing to have their daughters circumcised.

silence. The consequences and complications of FGM are significant and broadly they include infection, damage to local structures, bleeding, infertility, and even death. These are usually presented in the forms of acute urinary retention, wound infection, tetanus, re-current infection, fatal bleeding [16,17], complications during delivery and possible transmission of HIV [13,18]. Psychologically, the consequences include anxiety disorders and post-traumatic stress disorder. There is reported rise in fetal and neonatal deaths as an outcome of FGM and an increased need to revive infants whose mothers had been excised [13], the infants are four times more likely to have adverse health consequences [19]. A study of obstetric consequences showed that circumcised women were over three times more likely to have a difficult labour, obstetric haemorrhage was double fold [20], and perinatal deaths could be increased by one or two in all deliveries of 100 [21].

Record shows that FGM victims experience significantly lower sexual quality-of-life that those who were not circumcised, as their sexual function is adversely affected [22].

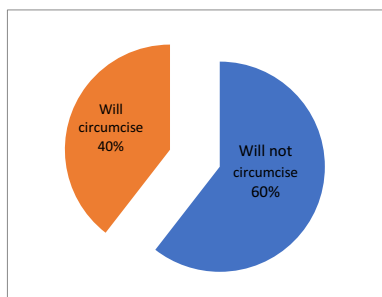


Fig. 2. Female respondent's with at least one living daughter that are willing to circumcise their next daughter. A large percentage (60%) of female respondents with a least a daughter was not willing to circumcise their daughters.

Due to the cultural and sensitive nature of FGM, governments have been reluctant to address the practice. In 2002, a commitment to end FGM by 2010 was agreed upon by over 70 Heads of State at the UN General Assembly Special Session on Children. February 6th of every year was thereafter declared “the International Day of Zero Tolerance of Female Genital Mutilation” for UN-sponsored awareness to end the practice.

For a long time, Nigeria had no law banning the practice of FGM. In 2015, a law termed “the Violence Against Persons Prohibition (VAPP)” was enacted, which “seeks to eliminate female genital mutilation and all other forms of gender-based violence.” However, the VAPP act applies only to the Federal Capital Territory (FCT) of Abuja and it is up to the discretion of each of the 36 states of Nigeria to domesticate the legislation in its territory [23].

Presently, only 19 states have domesticated this act, following the lead of the FCT. So heavy is the burden of FGM in Southern Nigeria that, 12 of its’ 17 states (Abia, Akwa Ibom, Anambra, Delta, Ebonyi, Edo, Enugu, Imo, Ogun, Ondo, Osun and Oyo states) have VAPP bill assented by their various executives, whereas 7 out of the 19 Northern states (Bauchi, Benue, Borno, Jigawa, Kaduna, Kwara and Nassarawa states) have done same [24]. Although FGM is now illegal in Nigeria, it is still prevalent.

Prior to the VAPP enactment in 2015, Edo State had since banned the practice by enacting a legislative bill in 1999, making it punishable for any person or persons to be engaged in the act of FGM with a penalty of fine and/or 6 months imprisonment. This bill is however, hardly enforced [17]. In 2021, Edo state assented the VAPP into law.

2. Methodology

This study was carried out in Oredo Local Government Area (LGA) of Edo State, Nigeria. The seat of Oredo local government is Benin City. The local government has an area of 249 km², comprising of twelve (12) wards; named Ward 1 through 12 and has a population of 374,515, made up of male 188,895 and female 185,620 at 2006 census.

A descriptive cross-sectional study design was used. The study was carried out among males and females aged 15 years and above in the local government area.

2.1. Sample size determination

The sample size was determined using the following equation as described by Naing et al. [25].

$$n = \frac{Z^2 p(1-p)}{d^2}$$

where n = sample size

z = statistics for a level of 95% confidence interval = 1.96

p = 88% Edo State FGM prevalence rate [15].

d = precision (allowable error) = 5%

$$n = \frac{(1.96)^2 * 0.88 * (1 - 0.88)}{(0.05)^2} = 162$$

162 samples.

Attribution rate = 10% of 162 samples.

= 178 samples.

The minimum sample size for this survey is 178, therefore 200 respondents were used in the survey.

Multistage sampling method was used. Five (5) wards were randomly picked from the twelve wards. They were wards 2, 3, 5, 7 and 11.

Thereafter, three (3) streets were randomly picked from each ward with the aid of the local government map.

Thereafter, forty respondents were interviewed in each chosen ward from all three streets.

Questionnaire was used in this survey; it was designed based on the aim and objectives of the study. The pretested questionnaire which composed of both open and closed ended questions, was interviewer administered after obtaining informed consent from respondents.

Data collected was sorted and analysed using SPSS statistical software and then Chi – Square statistical method was used to measure the significant relations between various categories with a 95% confidence interval (CI) and P-value of 0.05.

3. Discussion

This study showed that people are very aware of the practice of FGM (76.5%) in Oredo Local Government Area (LGA) of Edo State (See [table 1](#)). Similar studies have shown a high awareness level of FGM in the state [26] and among undergraduates in the University of Benin, FGM awareness was 91.79% [27]. This isn't unexpected as a study had shown that the state had a prevalence rate of 88% [15].

The current practice of FGM was placed at 34%, this is not high when compared with the state prevalence rate ([table 2](#)). This is probably because Oredo LGA is an urban area, most populated LGA in the state, and comprise of many different tribes, high educational level and enlightenment. A previous study had reported that the prevalence of FGM

in Edo State is much higher in the rural areas when compared to the urban areas [28].

There was substantial support for the practice of FGM to stop (66.50%), still probably due to urban effect ([table 3](#)). In the neighbouring LGA of Egor, a study had also showed a high level of support to end the practice [28]. Similarly, a study in South East Nigeria showed 82.30% support for FGM ban [18].

The male respondents were very supportive of the ban of the practice, only 19.00% insisted on marrying a circumcised woman (see [Fig. 1](#)). People were quite aware of the campaign against the practice of FGM (64.00%), this could be as a result of the various campaigns carried out the state government and its parastatals (Edo State Ministries of Women Affairs and Social Development and Health respectively) and several Non-Governmental Agencies operating in the state.

The prevalence rate of FGM among respondents was 32.80%, this is commensurate with decline in the practice and urban effect as well ([table 4](#)). Considerable differences in urban/rural practice and prevalence of FGM has been reported in Ethiopia (68.50%/75.50%) and Kenya, Sudan however reported a contrary data of higher prevalence in urban areas [29].

The prevalence rate of FGM among daughters of respondents was low at 22.70%, ([Fig. 2](#)). A mother's own circumcision status can be a significant influence on the likelihood of supporting or opposing FGM.

There were statistically significant associations between support for end of FGM and educational level; male respondents permitting circumcision of their daughter and level of education; respondents with at least one living daughter that are willing to circumcise their next daughter and level of education and awareness of fight against FGM and educational level respectively (see [tables 5-8](#)).

Several studies have showed that the educational attainment of women and even men has a crucial role in ending the practice of FGM. [30-33] This is a good justification, education improves the well-being of people, their health and civil involvement. The combination of these and the implementation of anti-FGM projects is a recipe for total eradication of FGM in Oredo LGA, Edo State, Nigeria and the world at large.

Ethical considerations

Ethical and Institutional Approval was obtained from Edo State Ministry of Health and Oredo Local Government Office. Informed consent was obtained

from all respondents before administration of questionnaires. All respondents were interviewed separately, and appropriate measures were taken to assure confidentiality of information.

Limitation of study

Findings were based on self-reporting, and this is difficult to validate. There was potential for response bias and respondents could conceal information.

Conflicts of interest

None.

References

- [1] WHO female genital mutilation: report of a technical working group. vol. 17–19. Geneva: World Health Organization; July 1995. p. 9.
- [2] Toubia N. Female genital mutilation: a call for global action vols. 5 – 47. New York: Rainbo; 1995.
- [3] WHO, UNICEF and UNFPA. Female genital mutilation: a joint statement. Geneva: World Health Organisation; 1997. p. 7.
- [4] UNICEF. <http://www.childinfo.org/areas/fgm/profiles.php>. Data from preliminary report.
- [5] Shell D, Bettina S, Ylva H. The medicalisation of females “circumcision”, harm promotion or reduction of a dangerous practice? *Social Sciences and Medicine* 2000;52:1018–25.
- [6] United Nations Children’s Fund Female Genital Mutilation/ Cutting: A statistical exploration. New York: UNICEF; 2005.
- [7] World Health Organisation. ‘Female genital mutilation’, fact sheet No. 241 (June 2000). Accessed 21 February. 2010, 21:00, <http://www.who.int/mediacentre/factsheets/fs241/en/>.
- [8] Gruenbaum Ellen. The female circumcision controversy: an anthropological perspective. Philadelphia: University of Pennsylvania Press; 2001. p. 102.
- [9] Mackie G. Ending footbinding and infibulation: a convention account. *Am Socio Rev* 1996;61:1009.
- [10] UNICEF. Children’s and Women’s right in Nigeria: a wake up call. Situation assessment and analysis. Harmful traditional practice (FGM) Abuja NPC and UNICEF Nigeria. 2001. p. 195–200.
- [11] UNICEF 2013. Female Genital Mutilation/Cutting: a statistical overview and exploration of the dynamics of change. <https://data.unicef.org/resources/fgm-statistical-overview-and-dynamics-of-change/>.
- [12] WHO elimination of FGM in Nigeria plot 617/618 diplomatic drive, central district Abuja. Family Health Department, Federal Ministry of Health Phase II Federal Secretariat Abuja; 2007 Dec.
- [13] WHO. Female genital mutilation complicates births: WHO collaborative prospective study in six African countries. *Lancet* 2006;367:1835–41.
- [14] UNICEF 003. Overview of FGM/Cutting. Nigeria FGM/ Cutting country profile. UNICEF Nigeria DHS. vol. 2.
- [15] Research and Marketing Services (RMS). *The prevalence of female circumcision in Nigeria*: fact sheet. Nigeria: RMS Media Services Lagos; 1999.
- [16] Oduro AR, Ansah P, Hodgson A, Afful TM, Baiden F, Adong P, et al. Trends in the prevalence of female genital mutilation and its effect on deliver outcome in the Kassena – Nankana district of Northern Ghana. *Ghana Med J* 2006; 40(3):87–92.
- [17] Onuh SO, Igbarese GO, Umeora OJ, Okogbenin SA, Ofoide VO, Agariki EP. Female genital mutilation: knowledge, attitude and practice among Nurses. *J. Natl. Medscape* 2006;98(3):409–14.
- [18] Ibekwe Perpetus C, Onoh Robinson C, Onyebuchi Azubike K, Ezeonu Paul O, Ibekwe Rosemary O. Female genital mutilation in Southeast Nigeria: a survey on the current knowledge and practice. *J Publ Health Epidemiol* 2012;4(5):117–22.
- [19] Kaplan A, Forbes M, Bonhoure I, Utzet M, Martín M, Manneh M, et al. Female genital mutilation/cutting in the Gambia: long-term health consequences and complications during delivery and for the newborn. *Int J Womens Health* 2013;5:323–31.
- [20] Berg RC, Underland V. The obstetric consequences of female genital mutilation/cutting: a systematic review and meta-analysis. *Obstet Gynecol Int* 2013;2013:496564.
- [21] Banks E, Meirik O, Farley T, Akande O, Bathija H, Ali M. Female Genital Mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. WHO study group on female genital mutilation and obstetric outcome. *Lancet* 2006;367(9525):1835–41.
- [22] Andersson SH, Rymer J, Joyce DW, Momoh C, Gayle CM. Sexual quality of life in women who have undergone female genital mutilation: a case-control study. *BJOG* 2012;119(13): 1606–11.
- [23] Violence against persons (prohibition) act, 2015, laws of the federation of Nigeria. Accessed on 14/May/23 at 14:20, [https://en.wikipedia.org/wiki/Violence_Against_Persons_\(Prohibition\)_Act_2015](https://en.wikipedia.org/wiki/Violence_Against_Persons_(Prohibition)_Act_2015).
- [24] Naing L, Winn T, Rusli BN. Practical issues in calculating the sample size for prevalence studies. *Arch Orofac Sci* 2006;1: 9–14.
- [25] Marchie Lucy C. Knowledge of consequences and attitude towards female genital mutilation in Edo state. 2008. p. 4.
- [26] Unubun Odegua R. Awareness of FGM among undergraduate students of University of Benin. Benin City. May 2002. p. 34.
- [27] Abimbola Adebimpe ALLEN. Prevalence and challenges of female genital mutilation (FGM) in Edo state, Nigeria. *International Journal of Innovation and Scientific Research* 2014;9(1):70–7.
- [28] Okpara TA, Udensi CJ, Okwunze C. The effect of legislation on FGM in egor LGA of Edo state. 2008. p. 47.
- [29] UNICEF. The state of the world’s children. Women and children. The double dividend of gender equality. 2007. Accessed 5 August. 2010, February:12, <http://www.unicef.org/sowc07/docs/sowc07.pdf>.
- [30] Satti A, Elmusharaf S, Bedri H, Idris T, Hashim MSK, Suliman GI, et al. Prevalence and determinants of the practice of genital mutilation of girls in Khartoum, Sudan. *Ann Trop Paediatr* 2006;26:303–10.
- [31] Almroth L, Almroth-Berggren V, Hassanein OM, Hadi NE1, Al-Said SSE, Hasan SSA, et al. A community-based study on the change of practice of female genital mutilation in a Sudanese village. *Int J Gynecol Obstet* 2001;74:179–85.
- [32] Snow RC, Slanger TE, Okonofua FE, Oronsaye F, Wacker J. Female genital cutting in southern urban and peri-urban Nigeria: self-reported validity, social determinants and secular decline. *Trop Med Int Health* 2002;7:91–100.
- [33] Klouman E, Manongi R, Klepp K. Self-reported and observed female genital cutting in rural Tanzania: associated demographic factors, HIV and sexually transmitted infections. *Trop Med Int Health* 2005;10:105–15.