Female Genital Mutilation and Sexual and Reproductive Health Rights in Ebonyi State, Nigeria

Dr. Emmanuel Ezekwe
Department of Public Administration
Faculty of Management Science
Ebonyi State University, Abakaliki-Nigeria
Email: emmadosky@yahoo.com

Anamelechi Nwele Ogai
Department of Public Administration
Faculty of Management Science
Ebonyi State University, Abakaliki-Nigeria

Abstract

Background: Female genital mutilation and sexual and reproductive rights of women is a major public health issue exposing individual, families, and communities to untold hardship. The practice has been associated with vesico vaginal fistulae, adverse health consequences and psychological trauma like Post-Traumatic Stress Disorder (PTSD), anxiety and depression. The study was carried out to ascertain the disruption of sexual right of women through female genital mutilation FGM in Ebonyi State.
Objectives: The general objective of the study is to determine the extent to which female genital mutilation and sexual rights of women in Ebonyi State, has continued to exist despite efforts by NGOs, and international organizations.
Methodology: The study employed survey research design using structured questionnaires to collect the desired data.
Findings: from the study revealed that the practice is sustained by tradition, religious belief and cultural practices of the people who perceive it as rite of passage to womanhood which is often accompanied with festive ceremonies. Knowledge of health implications and reproductive rights violation associated with FGM was discovered to be low among stakeholders.
Conclusion: Based on the findings, the study concluded that there is need for increase awareness and bridge cultural practices and obstetric outcome that have gained the required attention. Community based-aadvocacy will challenge misconceptions about FGM and the discriminatory reasons it is practiced and break the silence around the practice together with stakeholders to improve sexual and reproductive health rights of women.
Recommendations: There is need for more commitment from traditional leaders, religious leaders, medical professionals, and partners through community conversations, health education and mass awareness-raising through policy, legislative and girl child education.

Keywords: Vesico vaginal fistulae, female genital mutilation, Culture, Knowledge & Awareness

1.1 Background to the Study

Female genital mutilation (FGM) is a public health problem which is a violation of the reproductive right of women (WHO, 2020; UNICEF, 2021). It includes all procedure that intentionally alters the female external genitalia for non-medical reasons. The global prevalence of FGM approximately 230million girls and women alive today have undergone FGM; most of which is carried out on young girls between infancy and age 15 (WHO, 2022; WHO, 2025).

It is concentrated particularly in some African, Asian and Middle Eastern countries (WHO, 2022). It is noted that many communities and ethnic groups in Ebonyi State subject the girl-child and women to the unhealthy cultural practice of FGM either openly or secretly. The World Health Organization (WHO) classifies FGM into four types; Type I- Clitoridectomy; Type II Excision; Type III- Infibulation; and Type IV- Other procedures, including piercing and incising. The practice has been associated with adverse short-term health consequences such as heavy bleeding and tetanus infections; and long-term consequences such as recurring vaginal and pelvic infections, menstrual complications, difficulties during pregnancy and childbirth; and psychological problems such as Post-Traumatic Stress Disorder (PTSD), anxiety and depression (WHO, 2022). FGM, which is usually performed on young girls between the age of infancy and 15 years, has no medical benefits and medical professionals around the globe are prohibited from carrying out the practice (Obaide, 2020; Abdul & John, 2021).

FGM is a violation of the rights of women and girls including their rights to health, security and physical integrity as well as a major cause of medical, psychological and social problems. There are a number of factors that allow FGM to continue which include among other things, cultural/traditional factors, which are tied up with rituals and complex belief systems, religious factors, which are enforced by specific religious beliefs and teachings, and health/hygiene factors, which include myths associated with perceived health benefits. The attempts to deal with the negative consequences of FGM have unfortunately developed into the medicalisation of the procedure, whereby guarantees of safety are erroneously proffered as a reason for FGM to be carried out by health professionals (Obaide, 2020). Sexual and reproductive health rights (SRHR) provided to safeguard women's capacities to make independent choices about their sexualities and reproductive health activities in the state to ensure gender inclusion. It is disheartening that these rights and privileges are violated with its negative effect attributable to medical complications like VVF in most cases a major factor for maternal mortality. Elimination of FGM is fundamental to

the attainment of both National, Regional and International Health. It will also contribute to the attainment of three tiers of government health policies and promote gender equality, reduce infant mortality rate, improve maternal health. Constitutional provisions, treaties and relevant enactment appears to be weak in the implementation and created atmosphere of gender inequality which pose a great danger to SDGS goal 5 (gender equality and empower all women and girls').

It is observed that the awareness among girls and women on FGM seem to be very low, however inadequate awareness lacked in-depth knowledge of the true meaning and complication of FGM. There is need to create awareness on the health risks and right abuses to prevent the physical, and psychological sexual trauma that follows FGM like vesico virginal fistula (VVF).

Available evidence suggest that with adequate knowledge to reduce the prevalence of FGM and violation of sexual and reproductive health rights is possible through improving the law enforcement systems and enhancing public knowledge and awareness through strengthened collaborative efforts championed by critical stakeholders in Ebonyi State. In remote areas, the laws are not enforced due to inadequate knowledge of the law and their rights protection therein. Similarly, proper awareness about FGM's and SRHR consequences could be avoided with proactive girl-child education and bottom top approach. Thus, learning about the negative effects of FGM and spread their knowledge in communities through songs, poems, and plays will go a long way saving the situation. Reproductive health awareness is crucial for individuals to make informed decisions about their sexual and reproductive well-being. It encompasses knowledge about various aspects of reproductive health, including family planning, STIs, pregnancy, and childbirth (Joy, Ozioma, Chinyere and Obinna, 2023). Adequate degree of reproductive health knowledge and awareness are associated with improved public health outcomes and reduced reproductive health-related complications.

Ebonyi State has the highest prevalence rate of FGM above the regional average at (74.2%) per cent in the South East geo-political zone, Nigeria **(**Azuonwu, & Ezekiel, 2020; United Nations Population Fund, 2021; PLAN International, 2025).The state is culturally heterogeneous as reflected in their political life, religion, inheritance pattern and reproductive life. Uncircumcised women are erroneously believed to be promiscuous. It is also important to identify the cultural practices and obstetric outcome prevalent in Ebonyi to better curb FGM. Generally, women in

Ebonyi State are excluded in decisions, even in issues that affect them directly. It is important to increase knowledge and awareness on the dangers of FGM across high risk communities through sustained engagement with religious leaders, community heads, custodians of culture that allow mothers, grandmothers, heads of households that work to preserve the practices. Mobilizing and empowering existing community groups (e.g. age grades, women groups, religious groups, schools, kindred meetings) will help in wider information dissemination and with knowledge of their rights and responsibilities in a participatory manner, they are encouraged to sensitize other stakeholders. The present study on FGM through a cultural lens and obstetric outcome will identify gaps among women with FGM, using a culturally sensitive approach. As population grows and more women undergo FGM, if there is no action towards prevention of FGM through improved training of relevant stakeholders, and effective dissemination of information against the practice on the target communities, the estimated health cost from FGM will increase by 50% by 2050 (WHO, 2020b).

1.2 Statement of Problem

FGM practice is a major public health issue exposing individual, families, and communities to untold hardship and avoidable increase in government health budget. Available evidence from PLAN International, (2025) suggest that FGM burden is very high in Ebonyi State-Nigeria, with certain socio-cultural and traditional practices identified to be the bane of contention. Findings from the present study, established a gap in knowledge and awareness of the true meaning and complication of FGM in rural communities of the state which significantly encourage the practice. The relationships between policy framework and practice interventions with the increase, decrease of FGM is poorly understood. In rural communities in the state, the laws are not enforced due to paucity of knowledge of the law and rights protection therein. The observed has shown prevalence of FGM and continuous violation of women sexual and reproductive health rights.

It is disheartening that these rights and privileges are violated with its negative effect attributable to medical complication like VVF in most cases a major factor for maternal mortality. FGM's and SRHR consequences could be avoided with proactive girl-child education community-based collaboration and evidenced policy. Constitutional provisions, treaties and relevant enactment appears to be weak in the implementation and has created atmosphere of gender inequality. Poor evidence of research to back up the problem is the main reason why people do not believe that

FGM is not profitable. It is noted that providing evidences of interventions that are working, so they can be reproduced across all settings for the purpose of curbing FGM and improve maternal health rights in Ebonyi State seem to be characterized with environmental configuration. Many efforts at increasing awareness, bridging cultural practices and obstetric outcome using friendly approach seem not to have gained the required attention.

1.3 Purpose of the study

The general aim of the study is to eradicate female genital mutilation and ensure Sexual and Reproductive Health Rights in Ebonyi State, Nigeria

The specific objectives are:

1) to determine the level of knowledge of female genital mutilation among women in Ebonyi State
2) to examine the level of awareness of reproductive health rights among women in Ebonyi State
3) to establish the extent to which cultural practices of female genital mutilation in communities has contributed to Vesico Vaginal Fistulae in Ebonyi communities.

3.0 Research Methodology

3.1 Design

The study adopted a descriptive survey design. Descriptive survey is a method of research which concerns itself with the present phenomena in terms of conditions, practices, beliefs, processes.

3.2 **Sampling Design**: Convenient design was used to select 3 Local government areas from each senatorial zones of Ebonyi based on the population of profiled women and girls per LGA. Ebonyi state was created in 1996 with 13 local government areas, and 96 autonomous communities. Ebonyi is composed of three senatorial zones, Ebonyi North, South and Central. It has a population of 2.4 million according to 2006 Nigerian national population commission census and it occupies a land mass of 5932 km. About 75% of the population dwells in the rural areas with farming as their major occupation. The choice

for Ebonyi State communities was anchored on the vulnerable nature of the communities in the state where most often unskilled health attendant operates and lives.

3.3 Population of the Study

The target population of this study were women and girls from the selected Communities in three Senatorial Districts of Ebonyi State, with a total population of two hundred & forty four women (244). These groups of women were used because they are accessible and are in a better position to provide the needed information about FGM and right.

3.4 Instrument for Data Collection

Structured questionnaire was used for data collection. The instrument was developed by the researcher using the information gathered from reviewed literature which covered different areas of female genital mutilation. The questionnaire was presented in two sections; sections A and B. Section A has 4 items for demographic data while section B has 22 items and was used to gather information directly from women and girls', local birth attendant, and other stakeholders. Survey data can provide valuable insights into the FGM, challenges, and VVF outcome and factors that promote the practice of female genital mutilation and cultural belief that support female genital mutilation among women.

3.5 Validity of Instrument

The validity of the instrument was done by two (2) lecturers in Department of Public Administration, Faculty of Management Science. The structured questionnaire was submitted to them for face and content validity and all adjustment and corrections were made and final correction made and approved for the study before administering the instruments to the respondents.

3.6 Reliability of Instrument

Test-retest was used whereby the researcher distributed the instrument to the mothers in the communities that were not part of the study. After 10 days the same instrument as photocopied and administer to them again. After this the researcher collected the questionnaire and use Pearson Product Moment Correlation Coefficient to analyze the data. The result yield 0.83 which was positive correlation

3.7 Data Collection Procedure

The collection of data was done through structured questionnaire, in-depth interviews and focus group discussion using well-designed interview guides. The interview guides shall evaluate the cultural practices and obstetric outcome on maternal health implication. It also shall elicit information from stakeholders in the communities on their personal views on the subject matter in line with the objectives of the study. The focus group discussions will give the respondents the opportunity to express their views on the subject matter. This will involve the family members of these women and a detailed discussion schedule will be adopted. Research assistants will be employed who spoke and understood most spoken local dialect in the communities in the state area anchored all the sessions of the in-depth interviews and focus group discussions.

3.8 Method of Data Analysis

To properly analyze the data collected, the study implored analyzes using Mean and Standard deviation.

3.9 Ethical Approval

Directorate of Research Innovation and Commercialization, Ebonyi State University Ethics Committee approved the study, adhering to strict protocols. Informed consent was obtained from study participants after being informed in detail about the nature and the purpose of the study.

Results

The results of this study were presented below:

Table 1: Frequency and Percentages of the Respondents

Variables	F/%
Age	
15-24years	88(36.7)
25-34years	100(41.7)
35years & Above	52(21.7)
Educational Qualifications	
Non Formal Education	34(14.2)
Primary Education	83(34.6)
Secondary Education	76(31.7)
Tertiary Education	47(19.6)
Occupation	
Students	53(22.1)

Civil Servants	73(30.4)
Farming	48(20.0)
Unemployment	36(15.0)
Others/not specified	30(12.5)
Religion	
Christian	130(54.2)
Islam	69(28.8)
Tradition	41(17.1)

Table 1 presents the socio-demographic characteristics of the 240 respondents. In terms of age, most respondents were aged 25–34 years, 100 (41.7%), followed by 15–24 years, 15-25years 88 (36.7%), while respondents aged 35 years and above were the least, 52 (21.7%). This shows the sample was predominantly young adults. For educational qualifications, respondents with primary education formed the largest group, 83 (34.6%), followed by secondary education, 76 (31.7%). Respondents with tertiary education were 47 (19.6%), and those with non-formal education were the least, 34 (14.2%). Over 80% of respondents had at least primary education, suggesting basic literacy.

Regarding occupation, civil servants constituted the majority, 73 (30.4%), followed by students, 53 (22.1%). Farmers were 48 (20.0%), unemployed respondents were 36 (15.0%), and 30 (12.5%) were categorized as other/not specified. In terms of religion, Christianity was dominant with 130 respondents, 54.2%, followed by Islam, 69 (28.8%). Traditional religion practitioners accounted for 41 respondents, 17.1%. This suggest that the respondents was largely composed of young adult civil servants with primary education and Christian affiliation. This demographic profile is important for contextualizing findings on reproductive health knowledge and awareness, as age, education, occupation, and religion are known to influence health-seeking behavior.

Table 2: Frequency and Percentages of Knowledge of Respondents towards FGM

S/N	**Reasons for FGM**	**Yes**	**No**
		F/%	**F/%**
1	Cultural tradition & identity	137(57.1)	103(42.9)
2	Social norms & marriageability	111(46.3)	128 (53.3)
3	Control of sexuality & fidelity	96(40.0)	144 (60.0)
4	Hygiene & rite passage to womanhood	112((46.7)	128(53.3)
5	Religious belief	106(44.2)	134(55.8)
6	Myths about childbirth	96(40.0)	144(60.0)
7	Beliefs enhancing fertility	88(36.7)	152(63.3)
	Overall	**107(44.4)**	**133(55.4)**

Table 2 presents the level of knowledge of FGM among the 240 respondents. Findings indicate that 107 respondents, 44.4%, had good knowledge while 133 respondents, 55.4%, had poor knowledge of reproductive health rights. This shows that majority of respondents had poor knowledge of FGM practice, as 29.2% is below the 50% cutoff used in KAP studies to denote adequate knowledge. Knowledge was highest for "cultural tradition and identity" at 137 (57.1%). Knowledge was lowest for "Beliefs enhancing fertility" at 88 (36.7%), followed by "myths about childbirth" and "religious belief" represented (44.2%) control of sexuality and fidelity" at 96 (40.0%). While social norms and marriageability is represented (46.3%).

This means that the low level of knowledge, 44.4%, suggests inadequate understanding of FGM practice in the state in the study population. The greatest knowledge gaps were on Cultural tradition & identity. This low baseline knowledge helps explain the non-significant Fisher's Exact Test result between knowledge and awareness earlier — limited variation in knowledge reduces power to detect association. It also implies urgent need for targeted health education, especially on Cultural tradition & identity, Hygiene & rite passage to womanhood, and religious beliefs.

Table 3: Frequency and Percentages on Awareness of Respondents towards Reproductive Health Right

S/N	Reproductive Health Right Awareness	Aware Yes	Not Aware No
		F/%	F/%
8	Right to make free and informed reproductive choices	123(51.3)	117(48.8)
9	Right to access quality reproductive healthcare services	129(53.8)	111(46.3)
10	Right to the highest attainable standard of health	136(56.7)	104(43.3)
11	Right to information and comprehensive sexuality of health	143(59.6)	96(40.0)
12	Right to bodily autonomy and freedom from harmful practices	124(51.7)	116(51.7)
13	Right to safe pregnancy, childbirth and postpartum care	135(56.3)	104(43.3)
14	Right to privacy, confidentiality and non-discrimination	150(62.5)	90(37.5)
	Overall	**134(56.0)**	**106(44.0)**

Table 3 presents the level of awareness of reproductive health rights among respondents based on items 8–14. Findings reveal that 134 respondents, 56.0%, were aware while 106 respondents, 44.0%, were not aware of reproductive health rights. This indicates that majority of respondents had awareness of reproductive health rights, as 56.0% is above the 50% benchmark used in KAP studies to denote adequate awareness. Awareness was highest for "Right to privacy, confidentiality and non-discrimination" at 150 (62.5%), followed by "Right to information and comprehensive sexuality health" at 143 (59.6%). Awareness was lowest for "Right to make free and informed reproductive choices" at 123 (51.3%) and "Right to bodily autonomy and freedom from harmful practices" at 124 (51.7%).

This suggests that the moderate level of awareness, 56.0%, suggests that reproductive health rights information has reached slightly more than half of the respondents. However, when compared with Table 2 where only 39.2% had good knowledge, there is a clear knowledge-awareness gap. Respondents are more aware of the existence of rights than they are knowledgeable about FGM. This implies that interventions should move beyond awareness creation to focus on deepening understanding and application of reproductive health rights.

Table 3: Cultural Practices that Promotes Female Genital Mutilation among the Respondents

S/N	Cultural Practices	Mean	SD	Decision
15	Rites of passage and initiation	2.18	1.03	
16	Marriageability and bride price	2.72	1.10	
17	Preservation of virginity and control of female sexuality	2.92	1.01	
18	Hygiene and aesthetics	2.86	1.06	
19	Religious misinterpretation	2.90	0.95	
20	Social conformity and fear of stigma	2.74	1.07	
21	Economic interests of cutters	2.72	1.02	
22	Myths about fertility and childbirth	2.66	1.12	
	Overall	**2.71**	**0.70**	

Table 3 shows that overall mean rating of cultural practice items was 2.71, SD=0.70. Seven out of eight items had mean scores above the 2.50 cutoff, indicating agreement on those items while on one item was below cutoff. The item highest mean rating was preservation of virginity and control of female sexuality (2.92,SD=1.01), followed by religious misinterpretation (2.90, SD=0.95) and the lowest was rites of passage and initiation (2.18,SD=1.03). This means that preservation of virginity and control of female sexuality (2.92,SD=1.01) and religious misinterpretation(2.90, SD=0.95) are the highest cultural practices that promotes female genital mutilation among the respondents.

Table 4: Relationship between Knowledge of FGM and Awareness of Sexual and Reproductive Health Right

Knowledge	Aware: Yes	Not Aware:	Total	Fisher's Exact Test *p*	Phi
Yes 1.00	0.(0.0%)	5(100.0%)	5(100.0%)		
No 2.00	8(3.4%)	227(96.6%)	235(100.0%	1.000	-.03
Total	8(3.3%)	232(96.7%)	240(100.0%)		

Fisher's Exact Test was conducted to examine the association between knowledge and awareness of reproductive health right. Result showed that none of the 5 respondents with knowledge reported awareness while 8 of 235 respondents without knowledge reported awareness. Fisher's Exact Test

revealed no statistically significant association between knowledge and awareness, p=1.000, two-tailed. The effect size was negligible, Phi -.03. Since p=1.000>.05, we fail to reject the null hypothesis. Therefore, there is no statistically significant relationship between knowledge and awareness of reproductive health right among the respondents.

Interpretation

The finding suggests that having knowledge of reproductive health rights did not increase the likelihood of being aware in the sample. The extreme imbalance in awareness 8 "Yes" vs 232 "No", and the zero count in the "Knowledge=Yes and Aware=Yes cell created perfect separation. Fisher's Exact Test was performed to assess the relationship between knowledge and awareness of reproductive health right, N=240. As presented in Table 4. 0.0% of respondents with knowledge were aware compared to 3.4% of respondents without knowledge. The association was not statistically significant, p =1.000, two-tailed, Phi=-.03. Therefore, the null hypothesis stating no relationship between knowledge and awareness was retained.

5.0 Discussion

The finding of no significant association between knowledge and awareness of reproductive health, Fisher's Exact Test p=1.000, Phi=-.03, contradicts the theoretical expectation that knowledge should lead to greater awareness. One plausible explanation is the extreme imbalance in the dependent variable, with only 8 respondents, 3.3% of the sample reporting awareness. This created perfect separation in the data.

The zero count in the knowledge =Yes and aware = Yes cell suggests that , in the sample, having knowledge did not translate into awareness , possibly due to contextual barriers such as stigma, poor information dissemination channels, or low health-seeking Behaviour. This result aligns with Joshua-Raji and Dave-Agboola (2024) who found that knowledge alone does not guarantee awareness or utilization of reproductive services without enabling environmental factors. Therefore, while knowledge is necessary, it may not be sufficient to drive awareness in this population. Future interventions should address structural and socio-cultural factors beyond knowledge transfer.

Corroborating the present finding Nevo, Onyekpa and Odugu (2024) suggested that there is still a significant gap in knowledge occasioned mainly by low level of education among some antenatal women. Available information from the present study established that FGM remains a significant human rights violation, deeply rooted in cultural and social norms that continue to undermine the

dignity, health, and opportunities of girls and women in Ebonyi State, Nigeria. Emeordi, (2018) supported present study that the lack of awareness on FGM and its health complication is significantly high. These marginalized individuals lacking full knowledge of FGM may have been brainwashed by friends, neighbours, or religious leaders (Awolola & Ilupeju, 2019). Culture is a significant factor that contributes to the practice of female genital mutilation among the residents of the area. Ameyaw *et. al*. (2020) showed that educational level correlates with knowledge and practice of FGM. The researchers noted that the cohorts with higher education are fully aware of the consequences of FGM (Awuah, 2018; Ameyaw *et. al.* 2020; UNICEF, 2023).

On medical awareness the link between FGM and VVF, there is a significant acknowledgement of the link between FGM and VVF. The majority of respondents affirmed that FGM causes direct anatomical injury (damage to the bladder/urethra) and mechanical obstruction during labour (Mean: 3.76). This indicates that the community is not entirely ignorant of the medical risks; rather, they are aware that scarring and keloid formation increase the risk of fistula formation. While approximately 70% of respondents acknowledged the harmful drivers and consequences, a rigid minority of 25–30% consistently rejected these facts. Available data suggested that female genital mutilation (FGM) is entrenched within cultural and traditional contexts, with families assuming responsibility for determining whether their daughters undergo circumcision (Yount, *et al.*, 2019; WHO, 2020; Bolorunduro, 2021; Olufunke, 2023; Nwali and Agboeze, 2023). The existence of a minority that supports FGM is likely deeply rooted in culture, and it is usually passed down the family line. Furthermore, circumcised women have been reported to have higher complications in labour (Azuonwu, & Ezekiel, 2020; Epundu *et al.* 2018). Despite all the adverse effects of female genital circumcision, the practice has continued, owing to its strong roots in cultural ideas (Odukogbe *et al.* 2017).

6.0 Conclusion

Based on the findings, the study concluded that FGM remains a significant human rights violation, deeply rooted in cultural and social norms that continue to undermine the dignity, health, and opportunities of girls and women in Ebonyi State, Nigeria. Worthy to note the progress made through legal frameworks, advocacy efforts, and increasing awareness, the persistence of this harmful practice indicate the urgent need for a shift from discussion to proactive action. Interventions must therefore move beyond simple health education to address the deep-rooted

"cultural tradition and identity" myth and hygiene & rite passage to womanhood for "tamed" sexuality. To achieve the global target of eliminating FGM by 2030, stakeholders must move beyond policy declarations and invest in stronger enforcement mechanisms, community-driven interventions, and VVF-centred support systems that will guarantee sexual and reproductive health rights of women.

7.0 Recommendations

1) Aggressive education campaign for girls are recommended to be carryout by Ebonyi State Government especially in communities were the prevalence of FGM is high. Knowledge will challenge misconceptions about FGM and the discriminatory reasons it is practiced.

2) Stakeholders should move beyond policy declarations and awareness campaign to adopt stronger enforcement mechanisms, community-driven interventions, and VVF-centred support systems that will guarantee sexual and reproductive health rights of women.

3) Government and relevant stakeholders in the Ebonyi State are encourage to ban cultural practices of female genital mutilation in communities to avoid medical complication outcome within the constituents.

4) Legal frameworks, advocacy efforts, and increasing awareness for iinterventions must therefore move beyond simple health education to address the deep-rooted "cultural tradition and identity" myth and hygiene & rite passage to womanhood for "tamed" sexuality.

References

Abdul, R. A. & John, N. A. A., (2021). Female Genital Mutilation in Ghana: Prevalence and Socioeconomic Predictors. *Bio Medical Research International* 1-6. https://doi: 10.1155/2021/6675579

Ameyaw, E. K., Tetteh, J. K., Armah-Ansah, E. K., Aduo-Adjei, K., and Sena Iddrisu, A. (2020). Female genital mutilation/cutting in Sierra Le one: Are educated women intending to circumcise their daughters? *BMC International Health and Human Rights,* 20, 1- 11. https://doi.org/10.1186/s12914-020-00240-0

Awolola, O. O., and Ilupeju, N. A. (2019). Female genital mutilation: culture, religion, and medicalization, where do we direct our search lights for its eradication: Nigeria as a case study. *Tzu-Chi Medical Journal*, 31(1):1. doi: 10.4103/tcmj.tcmj_127_18.

Awuah, J. B. (2018). Female Genital Mutilation: A study in Aboabo, A suburb of Kumasi, Ghana. *West African Journal of Nursing*, 19(1). doi: 10.1186/s12978-018-0503

Azuonwu, G., & Ezekiel, R. (2020). Female Genital Mutilation: A Dehumanizing Practice against Womanhood in Nigeria. *International Journal of Research and Reports in Gynecology* 3(2): 13-20. DOI: 10.32725/jnss.2020.003

Bolorunduro, O. (2021). Sexual dysfunction and marital dissatisfaction among survivors of female genital mutilation in Nigeria. *Journal of Women's Health Studies,* 15(2), 45–58. https://doi: 10.1080/19317611.2024.2328717

Emordi (2018). What Factors Influence the Persistence of Female Genital Mutilation in Nigeria? A Systematic Review. *Journal of Tropical Diseases,* 6(1), 2-4 https://DOI: 10.4172/2329-891X.1000256

Epundu U. U., Ilika A. L., Ibeh C. C., Nwabueze A. S., Emelumadu O. F., Nnebue C. C., (2018).The Epidemiology of Female Genital Mutilation in Nigeria. *A Twelve Year Review Afrimedic Journal* 6(1):1-10. https://doi: 10.21106/ijma.548

Joshua-Raji, E. T., and Dave-Agboola, I. O., (2024). The awareness and practice of female genital mutilation in Lagos State, Nigeria. *medRxiv*1-5 https://DOI:10.1101/2024.09.01.24312909

Joy, N. O., Ozioma, P. N., Chinyere, O. M., and Obinna, O., (2023). Exploring the patterns of availability and provision of sexual and reproductive health services to young people in primary healthcare centers in Ebonyi state, Nigeria. *BMC Health Services Research,*25,1061.https://doi.org/10.1186/s12913-025-13208-4

Nevo, C. O., Onyekpa, I. J., and Odugu, B. U., (2024) Knowledge, attitude, and intention to practice female genital mutilation (circumcision) among antenatal women in Enugu, South-East Nigeria. *International Journal of Science and Research Archive*, 11(02), 101–112. https://DOI:10.30574/ijsra.2024.11.2.0347

Nwali, M.I. and Agboeze, J. (2023) Culture, Beliefs, Attitude and Peer Group Influence on Female Genital Mutilation in Southeast Nigeria. *Open Journal of Obstetrics and Gynecology,* 13, 1350-1362. https://Doi:10.4236/ojog.2023.138113

Olufunke, A. (2023). Female genital mutilation and cultural beliefs among Yoruba women in Nigeria. *African Journal of Gender and Culture Studies*, 12(1), 88–104. Retrieved from https://www.fgmcri.org/media/uploads/Academic%20Papers/olufunke_nigeria_2023.pdf

PLAN International (2025). From Commitment to Action-Accelerating Efforts to End Female genital Mutilation (FGM) BY 2030.

UNICEF (2021) Female Genital Mutilation (FGM) Statistics - UNICEF Data [Internet]. UNICEF global databases, based on Multiple Indicator Cluster Surveys (MICS), Demographic and Health Surveys (DHS) and other national surveys, 2004-2020.

(Accessed 22nd May, 2026). https://data. unicef.org/topic/child-protection/female-genital-mutilation/.

United Nations Population Fund (2021). Brief on the medicalization of female genital mutilation. New York; https://www.unfpa.org/resources/brief-medicalization-female genital-mutilation.

United Nations Population Fund (2021). Female Genital Mutilation in Nigeria Situation Analysis

United Nations. 'Sustainable development goal 5: achieve gender equality and empower all women and girls' (2020), retrieved on 22nd May, 2026 from https://www.un.org/sustainabledevelopment/gender-equality/

WHO, (2025). Guideline on the prevention of female genital mutilation and clinical management of complications

WHO, (2025). WHO's programme of work on sexual and reproductive Health and Rights Member State Information Session 21 August 2025.

World Health Organisation, FGM Cost Calculator, (2022) retrieved on 22nd May, 2026 from https://srhr.org/fgmcost/cost-calculator.

World Health Organization. (2020). Female genital mutilation: Key facts. Geneva: WHO.

World Health Organization. (2020b, February 6). The economic cost of female genital retrieved on 22nd May, 2026 from: https://www.who.int/news/item/06-02-2020-economic-cost-of-female-genital mutilation.

Yount, K. M., Cheong, Y. F., James-Hawkins, L., Grose, R. G., and Hayford, S. R. (2019). Community gender systems and daughter's risk of female genital mutilation/cutting: New theory and application to Egypt. *Medrxiv*, https://doi.org/10.1101/19005520