Female genital mutilation (FGM) and sexual functioning of married women in Oworonshoki Community, Lagos State, Nigeria

John Lekan Oyefara
Department of Sociology, Faculty of Social Sciences, University of Lagos
Akoka, Yaba, Lagos, Nigeria.
E-Mail: oyefara@yahoo.com; loyefara@unilag.edu.ng

Abstract

This article examines the nexus between Female Genital Mutilation (FGM) and three thematic/fundamental areas of women sexual functioning in the study location. These thematic areas are women's sexual desire/initiation, sexual activity and sexual satisfaction/enjoyment. To achieve the objectives of the study, a cross-sectional survey research method was adopted and 350 questionnaires were administered among ever married women. Elicited data were analyzed with the aids of quantitative analytical techniques. Findings of the study reveal that FGM hampered effective and efficient sexual functioning of the women in the study location as circumcised women reported defective sexuality and sexual dysfunctional. Based on these findings, it has been recommended that both state and non-state actors working in the areas of women's reproductive health should develop appropriate intervention programmes to reduce/eradicate the practice of FGM in the study location. This will invariably help the married women to reach orgasm during sexual intercourse.

Keywords: Female Genital Mutilation (FGM), Sexual Functioning, Sexual Desire, Sexual Enjoyment, Lagos State, Nigeria

Résumé

Cet article examine le lien entre les mutilations génitales féminines (MGF) et trois domaines thématiques/fondamentaux des femmes fonctionnement sexuel sur le lieu de l'étude. Ces domaines thématiques sont le désir/initiation, l'activité sexuelle sexuelle des femmes et sexuelle satisfaction/plaisir. Pour atteindre les objectifs de l'étude, une méthode de recherche de l'enquête transversale a été adopté et 350 questionnaires ont été administrés chez les femmes mariées. Des données a suscité ont été analysées avec les aides de techniques d'analyse quantitative. Les résultats de l'étude révèlent que les MGF entravé le fonctionnement sexuel efficace et efficiente des femmes dans le lieu de l'étude que les femmes excisées ont signalé la sexualité défectueux et dysfonctionnement sexuel. Basé sur ces résultats, il a été recommandé que les acteurs étatiques et non étatiques qui travaillent dans les domaines de la santé reproductive des femmes devraient élaborer des programmes d'intervention appropriées pour réduire/éliminer la pratique des MGF dans le lieu de l'étude. Ce sera toujours d'aider les femmes mariées à atteindre l'orgasme pendant les rapports sexuels.

Mots clés: Mutilations génitales féminines (MGF), le fonctionnement sexuel, le désir sexuel, la jouissance sexuelle, l'état de Lagos, Nigeria

Introduction

Sexuality and sexual activities are indisputably, an integral part of demographic analysis from antiquity for obvious reasons. One, the nature and pattern of sexual behavior are strong proximate determinants of human fertility. Two, indiscriminate sexual behavior and uncoordinated sexual life have significant relationships with the level and incidence of morbidity and mortality**,** most especially within the context of sexually transmitted infections (STIs) including human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). Basic knowledge and better understanding of those factors that have direct or indirect relationships with sexual activities of a given population become invariably relevant more importantly in sub-Saharan Africa region for some reasons. One, the region is home to about 70 percent of people living with HIV and AIDS in the world with about 67 percent global share of new infections (UNAIDS, 2013). Two, in the region**,** the issues about sexuality and sexual activities are intricately kept in secrete and are ruled by cultural hegemony and various traditional beliefs.

In sub-Saharan Africa, there are some traditional cultural practices that are inimical to the health and well-being of women in particular and entire society

in general. One of these practices is female genital mutilation (FGM). Consequently, FGM has attracted a lot of interests among scholars, human right activists, feminists and development agencies in recent times because of the associated psychological, social, health, obstetric and sexual consequences of the practice on the affected women, their spouses, members of their immediate families and community in general. Many scholars are of the opinion that FGM is a form of discrimination directed at the female gender. In other words, it is violence against women. Violence against women has been defined as 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). FGM is an act that invariably results in physical, sexual or emotional suffering to the woman. It is an old harmful traditional practice in Nigeria that affects the reproductive health of girls and women. FGM is a rite of passage to womanhood and is performed on female on or before puberty or at the time of marriage (Apena, 1980). It may be performed on girls at a younger age for other reasons such as the celebration of womanhood, preservation of custom or tradition or as a symbol of ethnic identity.

This act of cutting off the healthy genital organs for non-medical reasons is seen by many scholars as a basic violation of the girls' and women's rights to physical integrity. For example, Toubia (1993) believes that female circumcision raises numerous human right issues, including reproductive rights, the protection from violence, women's rights and especially children's rights**;** since most circumcisions take place on girls who are four to ten years of age and have no say in the matter. In some cultures, female circumcision is practiced as early as a few days after birth and as late as just prior to marriage, after the first pregnancy or very close to the delivery of the first child. In Nigeria, FGM is widespread among the various ethnic groups and socio-economic groups and classes and it is usually practice 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 contemporary Nigerian society**,** despite significant increase in level of literacy and other modernization values.

Research findings over the years in the country (Adebayo, 1992; Centre for Gender and Social Policy Studies, 1998; Odimegwu and Okemgbo, 2000; NPC and ICF Macro, 2009) 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. The national data from two recent Nigeria Demographic and Health Survey (NDHS) revealed an increase in the practice of FGM in the country from 19 percent in 2003 to 30 percent in 2008 (NPC and ICF Macro, 2004; 2009). This reality calls for deeper reflections and further studies into FGM practice in Nigeria considering various campaigns, intervention programmes and legislations that had been put in place by various development partners, state and non-state actors against FGM in the past two decades in the country.

Omolade, (1992) argues that FGM is widespread among the various ethnic groups in Nigeria. It is one of the cultural and traditional practices which have not been significantly influenced either by the increase in the level of literacy or of growing modern Muslim and Christian values. According to this scholar, of the six largest ethnic groups in Nigeria – the Yoruba, Hausa, Fulani, Ibo, Ijaw, and Kanuri – only the Fulani do not practice FGM. In other words, it is a practice that is still prevailing. Different reasons have been advanced for the prevalence of the cultural tradition of FGM in the various studies that have been carried out on the subject across Nigeria. The reasons include: socio-cultural, psychological, hygienic, aesthetic and even religious values. For some communities, it is a component of a rite of passage to socially acceptable standard of adulthood**;** while for others it is a nuptial necessity. Yet for others, it is a mark of courage, especially where it is carried out on older people. Whatever reasons are preferred for this practice, it has been medically and scientifically proven that there is no immediate and remote benefit or advantage to the victims of FGM (Ibhawoh, 1999). According to Ibhawoh (1999), FGM is a major human rights issue, not just a health concern. This is because reducing FGM to a health issue only would be like "treating symptoms"; victims only suffer health complications as a consequence of the mutilation.

Emmanuel (1998) described FGM as an extreme example of the general subjugation of women in Africa because it is one, in which the health and welfare of women suffer a long-term adverse effect. It is a practice that has been conclusively described as representing the violation of the human rights of girl children and women. This practice has been recognized as a form of violence against women in the UN Declaration on the Elimination of Violence against Women and in the UN Beijing Declaration and Platform of Action on Women's Rights. These documents and indeed the general trend of human rights discourse, sets FGM in a broader continuum of the violence against women which occurs in all societies in different forms. FGM is seen as one of the manifestations of gender**-**based human rights

violations, which aims to control women's sexuality and autonomy (Adebayo, 1992).

FGM in general terms can thus be described as a traditional practice in which a person, sometimes unskilled or a health worker cuts off parts or whole organs of the female external genitalia. The nature of the 'operation' varies from one country to another and from one ethnic group to another. In Nigeria, it may be performed on neonatal, infant, pubertal, pregnant or post-partum women. There are conventionally three known types of FGM, these according to Hosken (1993), can be group into type 1, 2, and 3. Type 1 is known as clitoridectomy, type 2 is excision, and type 3 is known as infibulations. Considering the cultural context of the practice, this scholar argued that even though there is no theological basis for the practice of FGM, it will be hard to eradicate until we have a better understanding of the cultural beliefs.

Existing evidence revealed that FGM causes permanent, irreparable changes in the external female genitalia. The external female organs encompass the mons pubis, clitoris, labia minora, labia majora, and vaginal opening. All of these organs, collectively known as the vulva, serve important sexual functions (Berg; Denison and Fretheim, 2010). Furthermore, Yang et al (2005) explained that anatomical, histological and MRI-based research has identified five sexually responsive, vascular tissues of the female external genitalia: clitoris, clitoral bulbs, labia minora, urethra, and vestibule/vagina. All were found to engorge during sexual arousal, with the erectile tissue compartments (corpus cavernosum of the clitoris and corpus spongiosum of the clitoral bulbs) having the greatest change in blood volume during sexual arousal and these vascular tissues are important for sexual response. Consequently, the clitoris, with its rich supply of nerve endings, and prepuce form the most consistently erotic area of the female body. Sexual organs in females and males arise from the same embryologic origin. For example, the clitoris is equivalent to parts of the male penis (corpora cavernosa) (Hyde and Delamater, 2006). As reported by Berg et al. (2010) vascular tissue is important in the context of female sexual response. Operations that disrupt or potentially disrupt the female external organs, such as FGM, "can potentially affect sexual functioning by ablating some or all of the genital organs, or their innervation" as well as damage neural innervation. In effect, with FGM, some fundamental structures for sexual stimulation and orgasm have been excised, although not all. In contrast to male circumcision where the foreskin is cut off from the tip of the penis without damaging the organ itself, the degree of cutting and likely harm in FGM is anatomically much more extensive. The main aim of this study is to examine critically the various consequences of FGM on sexual functioning of married women in Oworonshoki community of Lagos State, Nigeria.

Literature Review: Variation and Inconclusiveness

Existing literature on nexus between FGM and sexual functioning of women had been diverse with contradictory opinions. Some of the findings revealed that FGM hampered women sexual activity, while some stated that the practice does not hinder sexual enjoyment of the women. These contradictory findings suggest the need for continue research on the relationships between FGM and sexual activity of women at different micro levels until there is unassailable finding. Among studies that found negative impacts of FGM on women sexuality, Griffith (2005) in a survey report showed that "lack of interest in sex" was the top sexual problem of couples especially on the part of women with FGM. Griffith reported that about one third (1/3) of circumcised women understudy, who are aged 40-60, have sexual difficulties emanating from lack of interest in sex. However, Emmanuel (1998) argues that lack of sexual interest and sexual orgasm or climax are parts of the major aftermaths of female genital mutilation and that lack of sexual interest specifically makes it almost impossible for the women affected to climax or attain sexual orgasm. A study carried out by Idomu (2009) on FGM and sexual fulfillment among women in Delta State reveals that, 600 out of the total 1,230 agreed (40%) that their inability to reach orgasm is directly related to FGM. Furthermore, 480 respondents of the same total (1,230) which accounted for 39 percent agreed that lack of orgasm affects a woman's mental health and emotions, while 49 percent of them agreed that a woman has to have an orgasm in order to be sexually fulfilled. Majority of the women in the study agreed that FGM do affect female sexual desires and attainment of orgasms.

In addition, Mohammed and Ahmed (2000) in their work titled "Defective sexuality and female circumcision; the cause and the possible management", argue that frequency of sex was not affected in lightly circumcised women. However, frequency of sex was markedly affected in the mutilated cases. The scores for sex desire and arousal and for orgasm were especially affected in such cases. The loss of certain clitoris and labia bulk, necessary for orienting the woman towards her genitalia and initiating her interest was responsible for the occurrence of such defects. They advocated for correctional surgery for this to be restored. In consistence with past findings, frequency of sex and sexual satisfaction among both wives and husbands

are positively corrected, but the correlation observed is not as strong as might be expected (Idomu, 2009).

Furthermore, Osinowo and Taiwo (2003) examined the impact of female genital mutilation on marital instability, self-esteem, sexual functioning and marital satisfaction of women. In this study, a total of 99 women drawn from Ajegunle area of Lagos State were examined. They were divided into two groups: circumcised women (N=53) and uncircumcised women (N = 46). Results show that the uncircumcised women significantly reported better sexual functioning and marital satisfaction than the circumcised women. Toubia (1993) argues that there is usually a reduction in or, more frequently, a complete loss of sexual pleasure is not unusual for "circumcised" women. Many African women, having never experienced sexual pleasure themselves, are unaware of the existence of female orgasm. Research reports that when asked about their experiences of sexual pleasure, many of them are bewildered by the question itself. A few reported mild pleasure, and the rare "circumcised" woman reports significant orgasmic experiences. The studies reviewed so far have shown that FGM is a form of gender discrimination and violence directed towards women in order to reduce their sexual desires and restricting their sexual life, whereas men could keep and maintain multiple female partners.

In contrast to the above findings, among 195 immigrated women in northern Europe, 90% of adult women with FGM/C reported that sex gave them pleasure and 69% always experienced orgasm (Catania, et al. 2007). Lightfoot-Klein (1989) found that the majority of her infibulated Sudanese interviewees experienced sexual desire, pleasure and orgasm. Johnsdotter and Essen (2005) reported that most of their respondents stated that they did not have sexual problems and enjoyed sexual relations. This variation was evident also in Abusharaf's study (Abusharaf, 2001): For example, one woman stated "My infibulations did not eliminate my desire to have sex even at this age" while another said "I have to tell the truth: infibulating does not allow women to want sex." Among Eritrean interviewees, sexual satisfaction came from being in tune with their partner and having a loving relationship (Dopico, 2007). In a review of 35 sources by Berg et al. (2010), the results with respect to sexuality were summarized: "while one study … reports that circumcised women are significantly more likely to suffer adverse consequences for sexual enjoyment, other studies that measured sexual activity and pleasure find no significant difference between circumcised and uncircumcised women". Consequently, Obermeyer (2005) concluded that most of the existing studies suffered from conceptual and methodological shortcomings, and the available evidence did not support the hypotheses that FGM destroys sexual functioning or precludes enjoyment of sexual relations. In addition, a critical assessment of existing literature revealed that most of the research questions of the previous studies were not exhaustive in examining the critical thematic issues about the relationship between FGM and women sexual functioning. This article strives to fill this lacuna in knowledge.

Considering the inconclusiveness and contradictory nature of various findings of the existing studies on the impacts of FGM on sexual functioning of affected women, this study seeks answers to the following research questions in the following three thematic and fundamental areas of women sexuality: 1. The effects of FGM on sexual desire/initiation; 2. The impact of FGM on women sexual activity; and 3. The relationship between FGM status and sexual satisfaction/enjoyment of the women. The research questions on the first thematic area are: what is the effect of FGM on the frequency of sexual initiation and whether spouses initiate sex more than the affected women? Whether circumcised women are more likely to nurse fear whenever their spouses call for sex compared with uncircumcised women? Does FGM status affect level of sexual desire of the affected women compared with uncircumcised women? On the second thematic area, the following questions were formulated: What is the effect of FGM on women feeling of pain during sexual intercourse compared with uncircumcised women? What is the impact of FGM status on frequency of sexual intercourse among women in the last 30 days before the survey? Whether circumcised women are more likely to be forced to have sex by their spouses compared with uncircumcised women? Whether childbearing is the main reason for women to engage in sexual intercourse? Questions on the relationship between FGM status and sexual satisfaction/enjoyment, the third thematic area, focused on the following: Whether there is a significant differential between circumcised and uncircumcised women in ever reached orgasm during sexual intercourse? Is there any significant difference between circumcised and uncircumcised women on their level of sexual intercourse enjoyment and finally their level of satisfaction with their sexual life? These questions among other things were examined critically and answered in this article.

Data and Research Methods

Study location

The study location is 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 share boundaries with Bariga Local Council Development Area. The lagoon is situated at the western part of 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, and other ethnic minorities in Nigeria. The community also comprises 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. The traditional ruler – Oloworo of Oworonshoki – upholds and maintains the Yoruba traditions. Oworonshoki is mainly a residential area with highly educated people, averagely educated, and illiterates living in the community. The economic activities of the people include fishing, sand extraction, petty trading, handicrafts and those who engage in the civil service. As a result of this, Oworonshoki is a heterogeneous population with diverse views and beliefs on female genital mutilation. As at 2013, Oworonshoki community has an estimated population of about 202,972 with 111 streets and two geographical distribution into areas/wards A and B as divided by a major road named Oworo Road. The main justification for the selection of Lagos State and Oworonshoki community for the study community was the fact that the incidence of FGM in the State was 53.4 percent far above the national average of 30 percent in 2008 NDHS report (NPC and ICF Macro, 2009). The persistent high rate of FGM in Lagos State despite series of campaigns against the practice in the media, and related sponsored programmes by foreign donors and health talks by health staff during antenatal care suggests the need to examine deeply the cultural roots and consequences of the practice on its immediate victims.

Research design, study population and sample size determination

A non-experimental research design was employed to elicit data on the objectives of the study from the respondents. In the design, cross-sectional survey research method was adopted. Specifically, cross-sectional survey method was used to generate quantitative data. The study population comprised of ever-married women from ages 20 years 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 ages 20 years 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 = $(0.05)^2 = 0.0025$

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

$$= \frac{120{,}960}{377.6855}$$

$$= 320.266$$

= 320.266 respondents.

Therefore N = approximately 320.

Thus, 320 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 percent of the total questionnaires administered.

Sampling Method

To select respondents for the cross-sectional survey, a multistage random sampling technique was adopted. The sampling method adopted was to ensure high degree of representativeness among various social groups in the study community. It is imperative to note that 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 par ward was made to be proportional to the entire population and streets par ward. The third stage consists of numbering and sampling of houses and households in the selected streets. Considering total number of houses and household par street and average of 25 respondents to be sampled par 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, a total of 150 ever-married women were sampled from ward A, while another 200 were sampled from ward B. Thus, 350 ever-married women were sampled for the survey.

Research instrument and data collection

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 actualizing 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 socio-demographic background of the participants. In section two were questions on marital history, while in the third section, questions on issues around female genital mutilation were asked. 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.

Outcome variable

The major outcome variable in this study is the women's sexual functioning. Sexual functioning is a composite variable with a multidimensional measure of nature of sexual response or desire of an individual. A female sexual functioning is said to be dysfunctional if she experienced any one or more of these sexual disorders: i.) low sexual desire (to have diminished libido, or lack of sex drive); ii.) sexual arousal disorder (this is when the desire for sex might be intact, but there is difficulty or inability to become aroused or maintain arousal during sexual activity); iii.) orgasmic disorder (when there is persistent or recurrent difficulty in achieving orgasm after sufficient sexual arousal and ongoing stimulation); and iv.) sexual pain disorder (to have pain associated with sexual stimulation or vaginal contact). In this study, women's sexual functioning has been conceptualized and measured using three multidimensional indicators which are: sexual desire/initiation, sexual activity and sexual satisfaction/enjoyment.

Explanatory variables

The explanatory variable of the study is FGM status of the respondent measured in a dichotomous way: circumcised and uncircumcised.

Study limitations, ethical issues and informed consent

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 certain level of error. In spite of these constraints and limitations, efforts were made to generate both reliable and valid data for the study. Considering the medical and social implications of the topic of the study on the respondents, some ethical factors were considered and implemented during the period of data collection. The first ethical issue is the fact that all respondents were promised total confidentiality of the information provided. In addition, there was an "informed consent" form which each of the respondents read through (and interpreted to the illiterate ones) in order to understand the purpose and objectives of the study and finally signed before the commencement of each interview. Furthermore, respondents were completely anonymous in relation to their responses.

Data processing and analysis

The returned questionnaires were screened and edited possible errors, while open-ended questions were coded. In developing the coding guide for the open-ended questions, each of the responses to the questions was thoroughly and carefully examined. Thereafter, related responses were grouped together and relevant codes were assigned to the thematic responses for proper coding of the

responses. After the coding, the returned questionnaires were entered into computer for further analysis through Statistical Package for Social Sciences (SPSS) version 16.0. Univariate and bivariate statistical analyses were used to examine various research questions and hypotheses.

Results

The findings of the study were presented in the following thematic areas in this section: incidence and prevalence of FGM, sexual desire and initiation among women, women sexual activity, sexual satisfaction/enjoyment among women and cross-tabulation of various sexual functioning indicators with female genital status of the women in the study location. These sub-sections are presented below respectively:

Incidence and Prevalence of FGM

Data on Table 1 involve information on incidence, prevalence of FGM among women in the study location. Respondents were asked about their FGM status, 266 (76.0%) claimed that they were circumcised, while 84 (24%) stated that they were not circumcised. This suggests high prevalence of FGM among the generation of women in the study location. Other probe question was to document the nature of FGM undergone by each of the women that were circumcised. Responses to this question revealed that clitoridectomy predominates among women in the study location. Particularly, 221 (83.1%) of ever circumcised women had clitoridectomy, 29 (10.9%) had excision, while 16 (6.0%) had infibulation

.

Table 1: Percentage Distribution of Respondents by Incidence of FGM

FGM Knowledge, Incidence and Prevalence	Frequency	Percentage
FGM Status of Respondents		
Circumcised	266	76.0
Uncircumcised	84	24.0
Total	**350**	**100.0**
Type of FGM Undergone		
Clitoridectomy	221	83.1
Excision	29	10.9
Infibulation	16	6.0
Total	**266**	**100.0**
Operator of FGM		
Doctor	1	0.4
Trained Health Technician	20	7.5
Nurse/Midwife	209	78.6
Traditional Operator	14	5.3
Don't Know	22	8.3
Total	**266**	**100.0**
Perception on whether FGM is Cultural/Religious		
Religious	1	0.3
Cultural	303	86.6
Both	12	3.4
No Response	34	9.7
Total	**350**	**100.0**
Reason for FGM		
Reduce of Female Sexual Urge and	215	61.4
Promiscuity	13	3.7
Tradition and Custom	52	14.9
Beautification of Female Organ	35	10.0
Prevention of Pre-marital Sex	3	0.9
Others	32	9.1
No Response	**38**	**100.0**
Total		

The operators of FGM in the study location range from Medical Doctors, to Trained Health Technicians, Nurses/Midwives, and Traditional Operators. Specifically, 209 (78.6%) of the FGM were performed by Nurses/Midwives, 20 (7.5%) by Trained Health Technicians, 14 (5.3%) by Traditional Operators, 1 (0.4%) by Medical Doctor, while 22 (8.3%) of ever circumcised women did not know who actually performed FGM for them. Respondents were asked about their opinion on whether FGM is cultural or religious practice, responses to the question on Table 1 revealed that 303 (86.6%) of the women believed that FGM was a cultural practice, 1 (0.3%) stated that it was a religious practice, while 12 (3.4%) claimed that the practice was both religious and cultural. Respondents adduced various reasons for the practice of FGM in the study location. As presented in Table 1, 215 (61.4%) mentioned reduction of female sexual urge and promiscuity, 52 (14.9%) mentioned beautification of female sexual organ, 35 (10.0%) mentioned avoidance of pre-marital sex, 13 (3.7%) mentioned tradition and custom, while 3 (0.95%) mentioned other reasons such as prevention of still birth and keeping women pure. It is important to note that 32 (9.1%) of the respondents did not respond to the question.

Sexual Desire and Initiation among Women

Sexual desire and initiation are not mutually exclusive as one depends on the other. Evidently, desire may invariably engender initiation. Data on Table 2 involve information on sexual desire and initiation among sampled married women in the study location. Specifically, respondents were asked about their frequency of sexual initiation, as presented in the table, married women rarely initiate sex in the study location as only 84 (24%) claimed that they initiate sex very often, 173 (49.4%) initiate sex less often, while 93 (26.6%) had never initiated sex with their spouses. The subsequent probing question revealed that majority of the women wait until their husbands initiate sex. In particular, 258 (73.7%) of the women stated that their husbands initiate sex more compared with their sexual initiation. It is also imperative to note that relatively significant proportion of the women usually nurse fear whenever their spouses call for sex. Specifically, 163 (46.6%) of the women claimed to usually nurse fear whenever their spouses call for sex, while in reality 201 (57.4%) of the women usually have sexual desire.

Table 2: Percentage Distribution of Respondents by Sexual Desire and Initiation

Sexual Desire and Initiation	Frequency	Percentage
Frequency of Sexual Initiation		
Very Often	84	24.0
Less Often	173	49.4
Not at All	93	26.6
Total	**350**	**100.0**
Spouse Initiate Sex More		
Yes	258	73.7
No	92	26.3
Total	**350**	**100.0**
Nursing Fear whenever Spouse Calls for Sex		
Yes	163	46.6
No	187	53.4
Total	**350**	**100.0**
Having Sexual Desire		
Yes	201	57.4
No	149	42.6
Total	**350**	**100.0**

Sexual Activity of Women

This section presents data on four variables on sexual activity of the women. Data on Table 3 show that 169 (48.3%) of the women usually feel pains during sexual intercourse as against 181 (51.7%) of the women that had never feel pains during coitus activities. Feeling of pain during sexual intercourse can demotivate couple from having regular sexual intercourse in the study location. Responses to the question on frequency of sexual intercourse in the last 30 days preceding the survey reveal that slightly above half of the women 176 (50.3) did not have sexual intercourse 30 days before the study. In addition, 75 (21.4%) of the women claimed to have

had sexual intercourse twice in the last 30 days before the survey, while 53 (15.1%) stated that they have had sexual intercourse with their spouses for about four times or more in the last 30 days before the study. Responses to this question revealed that sexual activities between spouses are relatively minimal among couples in the study location. One of the possible explanations for this may not be unconnected with the feeling of pains during sexual intercourse by relatively high number of women in the study location which invariably may result into poor sexual desire among the women.

Table 3: Percentage Distribution of Respondents by Sexual Activity

Sexual Activity	Frequency	Percentage
Feeling Pains During Sexual Intercourse		
Yes	169	48.3
No	181	51.7
Total	**350**	**100.0**
Number of Sexual Intercourse in last 30 days		
None	176	50.3
Twice	75	21.4
Thrice	46	13.1
Four times and above	53	15.1
Total	**350**	**100.0**
Ever Forced by Spouse to Have Sex		
Yes	181	51.7
No	169	48.3
Total	**350**	**100.0**
Engaged in Sexual Intercourse Mainly for Childbearing		
Yes	165	47.1
No	185	52.9
Total	**350**	**100.0**

One of the possible outcomes of poor sexual desire among the women is sexual coercion from their couples. Data on Table 3 reveal that 181 (51.7%) of the women claimed that their spouses had ever forced them to have sexual intercourse in their marital history. In addition, 165 (47.1%) of the women stated that they engage in sexual intercourse mainly for childbearing, while 185 (52.9%) of the women engaged in sexual intercourse for other reasons beyond childbearing. It is imperative to note that those women that engage in sexual intercourse mainly for childbearing are less likely to explore diverse sexual activities that will make them to always desire and enjoy sexual intercourse.

Sexual Satisfaction and Enjoyment among Women

Sexual satisfaction and enjoyment are functions of sexual lifestyle of an individual. Data on Table 4 consist of information on various indicators of sexual satisfaction and enjoyment among women in the study location. The table reveals that 167 (47.7%) of the women had ever reached orgasm during sexual intercourse, while high number and proportion 182 (52.3%) had never reached orgasm during sexual intercourse in their sexual history. Further probing question was asked for those women that reported that they had ever reached orgasm in their sexual history on their frequency of reaching orgasm during sexual intercourse. Responses to this question revealed that only 45 (26.9%) of respondents usually reach orgasm during every sexual intercourse, while 118 (70.7%) usually reach orgasm only once in five sexual intercourse and 4 (2.4%) mentioned that they reach orgasm once in ten sexual intercourse.

On sexual enjoyment, 181 (51.7%) of the respondents stated that they always enjoy sexual intercourse, while 169 (48.3%) mentioned that they do not always enjoy sexual intercourse. It is

imperative to note that sexologists, psychologists and specialists in marital counselling always argue that sexual intercourse should always be enjoyed by both couples in marriage in order to live a fulfilled and blissful marital life. On satisfaction with sexual life, significant high number and proportion of the respondents, 249 (71.1%), stated that they are satisfied with their sexual life, while 101 (28.9) claimed not to be satisfied with their sexual life. Apparently, there are many factors to be considered before an individual can claim to be satisfied with her sexual life more importantly in the study location. Possibly many of the women were satisfied mainly because they were able to conceive and bear children for their husbands not because of their personal enjoyment of the sexual acts.

Table 4: Percentage Distribution of Respondents by Sexual Satisfaction and Enjoyment

Sexual Satisfaction and Enjoyment	Frequency	Percentage
Ever Reached Orgasm During Sexual Intercourse		
Yes	167	47.7
No	183	52.3
Total	**350**	**100.0**
Frequency of Orgasm during Sexual Intercourse		
Every Sexual Intercourse	45	26.9
Once in Five Sexual Intercourse	118	70.7
Once in Ten Sexual Intercourse	4	2.4
Total	**167**	**100.0**
Always Enjoy Sexual Intercourse		
Yes	181	51.7
No	169	48.3
Total	**350**	**100.0**
Satisfaction with Sexual Life		
Satisfied	249	71.1
Not satisfied	101	28.9
Total	**350**	**100.0**

Female Genital Mutilation and Sexual Desire/Initiation among Women

Table 5 consists of cross-tabulations of various indicators of sexual desire/initiation which are dependent variables with FGM status of the women as independent variable. The first examines the effects of FGM on the frequency of sexual initiation among the married women. The findings on the table show a significant relationship between FGM status of women and frequency of sexual initiation in their marriage with $\chi^2 = 101.033$; degree of freedom = 2, $P < 0.01$ and Contingency coefficient (C) of 0.477. Specifically, about 63.1 percent of uncircumcised women compared with 11.6 percent of circumcised women initiate sexual intercourse very often; while about 36.9 percent of uncircumcised women compared with circumcised ones initiate sexual intercourse less often.

Table 5: FGM Status and Sexual Desire/Initiation among Women

Sexual Desire/Initiation among Women	Women's FGM Status			
	Circumcised		Uncircumcised	
	Number	%	Number	%
Frequency of Sexual Initiation				
Very Often	31	11.6	53	63.1
Less Often	142	53.4	31	36.9
Not at All	93	35.0	-	-
Total	**266**	**100.0**	**84**	**100.0**
$\chi^2 = 101.033$; d.f. = 2; P = 0.000; C = 0.477				
Spouse Initiate Sex More				
Yes	227	85.3	31	36.9
No	39	14.7	53	63.1
Total	**226**	**100.0**	**84**	**100.0**
$\chi^2 = 77.288$; d.f. = 1; P = 0.000; C = 0.425				
Nursing Fear whenever Spouse Calls for Sex				
Yes	161	60.5	2	2.4
No	105	39.5	82	97.6
Total	**226**	**100.0**	**84**	**100.0**
$\chi^2 = 86.742$; d.f. = 1; P = 0.000; C = 0.446				
Having Sexual Desire				
Yes	123	46.2	78	92.9
No	143	53.8	6	7.1
Total	**266**	**100.0**	**84**	**100.0**
$\chi^2 = 56.745$; d.f. = 1; P = 0.000; C = 0.374				

It is imperative to note that about 35.0 percent of circumcised women had never initiated sexual intercourse at all in their marital history. This finding suggests that FGM hampers frequency of sexual initiation among women in the study location. There is also a significant relationship between FGM status of the women and their spouses' initiation of sex more. This relationship is significant with $\chi^2 = 77.288$; degree of freedom = 1, $P < 0.01$ and Contingency coefficient (C) of 0.425. In particular, 85.3 percent of circumcised women compared with 36.9 percent of uncircumcised women stated that their husbands initiate sex more than them.

The table further shows significant relationship between FGM status of women and women nursing of fear whenever their spouses call for sex. This relationship is statistically significant with $\chi^2 = 86.742$; degree of freedom = 1, $P < 0.01$ and Contingency coefficient (C) of 0.446. The data show that 60.5 percent of circumcised women compared with only 2.4 percent of uncircumcised women always nurse fear whenever their spouses call for sex. In addition, there is a significant relationship between women FGM status and their desire to have sex. This relationship is statistically significant with $\chi^2 = 56.745$; degree of freedom = 1, $P < 0.01$ and Contingency coefficient (C) of 0.374. In particular, 46.2 percent of circumcised women always had sexual desire compared with 92.9 percent among uncircumcised women.

Female Genital Mutilation and Sexual Activity

This section examines the effects of FGM on sexual activity of women in the study location. As presented on Table 6, FGM has significant relationship with feeling of pains during sexual intercourse. Specifically, 62.0 percent of circumcised women compared with 4.8 percent of uncircumcised reported feeling of pain during sexual intercourse. The relationship is statistically significant with $\chi^2 = 83.848$; degree of freedom = 1, $P < 0.01$ and Contingency coefficient (C) of 0.440. Furthermore, circumcision status of the respondents has significant effect on the frequency of sexual intercourse of the women in the last 30 days before the survey at $P < 0.01$. Specifically, about 62.8 percent of circumcised women compared with 10.7 percent of uncircumcised women did not have sexual intercourse with their husbands in the last 30 days before the survey despite the fact that their husbands were around. This suggests minimal sexual engagement among ever circumcised women compared with their uncircumcised counterparts. It is imperative to note that this low sexual activity

among circumcised women was not with the support of their spouses as about 65.4 percent of circumcised women compared with 8.3 percent of uncircumcised women had ever been forced by their spouses to have sexual intercourse. In addition, about 57.9 percent of circumcised women compared with 13.1 percent of uncircumcised women stated that they engage in sexual intercourse mainly for childbearing. These relationships are significant at $P < 0.01$ with 0.438 and 0.358 Contingency coefficient (C) respectively.

Table 6: FGM Status and Sexual Activity among women

Sexual Activity among Women	Women's FGM Status			
	Circumcised		Uncircumcised	
	Number	%	Number	%
Feeling Pains During Sexual Intercourse				
Yes	165	62.0	4	4.8
No	101	38.0	80	95.2
Total	**266**	**100.0**	**84**	**100.0**
$\chi^2 = 83.848$; d.f. = 1; P = 0.000; C = 0.440				
Number of Sexual Intercourse in the last 30 days				
None	167	62.8	9	10.7
Twice	38	14.3	37	44.0
Thrice	28	10.5	18	21.4
Four times and above	33	12.4	20	23.8
Total	**266**	**100.0**	**84**	**100.0**
$\chi^2 = 72.063$; d.f. = 3; P = 0.000; C = 0.413				
Ever Forced by Spouse to Have Sex				
Yes	174	65.4	7	8.3
No	92	34.6	77	91.7
Total	**226**	**100.0**	**84**	**100.0**
$\chi^2 = 83.298$; d.f. = 1; P = 0.000; C = 0.438				
Engaged in Sexual Intercourse Mainly for Childbearing				
Yes	154	57.9	11	13.1
No	112	42.1	73	86.9
Total	**226**	**100.0**	**84**	**100.0**
$\chi^2 = 51.419$; d.f. = 1; P = 0.000; C = 0.358				

Female Genital Mutilation and Sexual Satisfaction/Enjoyment among Women

Female genital mutilation hampers sexual satisfaction and enjoyment of women in the study location as small proportion of circumcised women compared with uncircumcised women reported that they had ever reached orgasm during sexual intercourse at $P < 0.01$. In particular, as presented in the Table 7, 33.5 percent of circumcised women compared with 92.9 percent of uncircumcised women had ever reached orgasm during sexual intercourse in the study location.

Table 7: FGM Status and Sexual Satisfaction/Enjoyment among women

Sexual Satisfaction/Enjoyment among Women	Women's FGM Status			
	Circumcised		Uncircumcised	
	Number	%	Number	%
Ever reached Orgasm During Sexual Intercourse				
Yes	89	33.5	78	92.9
No	177	66.5	6	7.1
Total	**266**	**100.0**	**84**	**100.0**
$\chi^2 = 90.284$; d.f. = 1; P = 0.000; C = 0.453				
Always Enjoy Sexual Intercourse				
Yes	101	38.0	80	95.2
No	165	62.0	4	4.8
Total	**266**	**100.0**	**84**	**100.0**
$\chi^2 = 83.848$; d.f. = 1; P = 0.000; C = 0.440				
Satisfaction with Sexual Life				
Satisfied	168	63.2	81	96.4
Not satisfied	98	36.8	3	3.6
Total	**226**	**100.0**	**84**	**100.0**
$\chi^2 = 34.422$; d.f. = 1; P = 0.000; C = 0.299				

Other probing questions revealed that 38.0 percent of circumcised women compared with 95.2 percent of uncircumcised women always enjoy sexual intercourse. The relationship is statistically significant with $\chi^2 = 83.848$, degree of freedom = 1, $P < 0.01$ and Contingency coefficient (C) of 0.440. In addition, contrary to their lack of enjoyment of sexual intercourse, significant proportion (63.2%) of circumcised women were satisfied with their sexual lives, although lower than the proportion (96.4%) of uncircumcised women that were satisfied with their sexual lives. It can be deduced from this finding that circumcised women had developed false psychological satisfaction of their sexual lives contrary to their actual life experience.

Summary of Findings, Discussion and Conclusion

This article examines the nexus between female genital mutilation and three thematic/fundamental areas of women sexual functioning in the study location. These thematic areas are: one, sexual desire/initiation; two, women sexual activity; and three, sexual satisfaction/enjoyment of the women. On the first thematic area, the following are the main findings. There is a significant relationship between FGM status of women and frequency of sexual initiation in their marriage. Circumcised women are less likely to initiate sexual intercourse very often compared with uncircumcised women. In fact, significant number of circumcised women had never initiate sexual intercourse at all in their marital history. This finding suggests that FGM hampered frequency of sexual initiation among women in the study location. Consequently, spouses of circumcised women initiate sex more than them. The findings further show significant relationship between female circumcision and women nursing of fear whenever their spouses call for sex. Finally, there is also a significant relationship between women FGM status and their desire to have sex. The circumcised women do have significant less sexual desire compared with uncircumcised women in the study location. In a sententious way, FGM completely distort sexual desire and initiation among women folks in the study location. These findings corroborate Griffith (2005) assertion that about one third (1/3) of circumcised women who were aged 40-60 in his study had sexual difficulties emanating from lack of interest in sex.

On the actual sexual activity of women in the study location, the following are the findings. Majority of circumcised women compared with uncircumcised ones reported feeling of pain during sexual intercourse. A pain is somatic sensation of acute discomfort, thus a painful sexual intercourse invariably will discourage any rational human being from engaging in such an act that brings pain to his/her mortal body. Expectedly, circumcised women in the study location reported less frequent sexual intercourse in the last 30 days before the survey compared with uncircumcised women. This reveals minimal sexual engagement among ever circumcised women compared with their uncircumcised counterparts in the study location. This connotes unhealthy sexual functioning among ever circumcised women in the study location and this is not without consequences to the harmonious conjugal

relationships between affected women and their spouses. In fact significant proportion of circumcised women compared with uncircumcised women had ever been forced by their spouses to have sexual intercourse. In addition, circumcised women compared with uncircumcised women demonstrated poor attitude and reason for sexual intercourse as higher percentage of circumcised women compared with uncircumcised women stated that they engage in sexual intercourse mainly for childbearing, whereas marriage goes beyond mere childbearing. It encompasses other central issues of life such as friendship, companionship and mechanisms to share life burden of which sexual activity plays significant roles among married couples.

Findings on effects of FGM on women sexual satisfaction/enjoyment reveal a pathetic situation in which many circumcised women were living in the study location. This study shows that a small proportion of ever circumcised women had ever reach orgasm during sexual intercourse in their sexual history. Consequently, small number of ever circumcised women compared with uncircumcised women mentioned that they always enjoy sexual intercourse. Finally, small proportion of circumcised women compared with uncircumcised ones, are satisfied with their sexual lives. It can be deduced from this finding that female circumcision has negative effects on and also inimical to sexual functioning of women in the study location. Emmanuel (1998) had argued that lack of sexual interest and sexual orgasm or climax are parts of the major aftermaths of FGM. He stated further that lack of sexual interest specifically makes it almost impossible for the women affected to climax or attain sexual orgasm.

As noted in the introduction, existing national data from the two recent NDHS in Nigeria revealed an increase in the practice of FGM in the country from 19 percent in 2003 to 30 percent in 2008 (NPC and ICF Macro, 2004; 2009). This worrisome reality calls for deeper reflections on this traditional practice in the country considering its effects on women sexual functioning in their matrimonial homes and the multiplier effects of this on marital harmony and general wellbeing of Nigerian society. The practice is seemly rooted in the Nigerian culture and the mechanisms to be adopted to change culture usually tend to be multi-dimensional and intensive considering the hegemonic power of culture. Thus, a grass-root approach that will permeate and penetrate all existing social structure in the country will be ideal to tackle such an age long problem. In doing this, the existing modern social institutions in addition to the traditional ones should be integrated and used to serve as institutions for change**:** A change in orientation, in perception, in attitude and behaviour**,** in relation to the practice of FGM among women in the country. Specifically, the modern educational structure and religious institutions in addition to the traditional institutions**,** including the traditional rulers who are the custodians of the tradition**,** should be fully engaged in the battle against the practice of FGM in the country. The nature of engagement must be systemic and should be bottom-top approach that will be internal**,** rather than the existing superficial imposing top-to-bottom form that is categorized as external. This strategy**,** if properly designed and implemented will reduce**,** if not eradicate the practice within the shortest time**;** and Nigerian women will thus be able to enjoy the full potentiality of their sexual functioning in their matrimonial homes.

About the Author:

Dr. John Lekan Oyefara has a B.Sc. in Demography and Social Statistics from Obafemi Awolowo University, Ile-Ife, Nigeria. In addition, he obtained a M.Sc. and Ph.D. in Sociology from the University of Ibadan, Nigeria. He specializes in Demography and Population Studies. His areas of research include fertility, mortality, migration, nuptiality, family planning, gender studies, public, family and reproductive health including HIV/AIDS. He has worked for over fifteen years in the development sector with local and international organizations in Nigeria. He was a visiting senior lecturer at the Department of Demography and Social Statistics, Faculty of Social Sciences, Obafemi Awolowo University, Ile-Ife, Nigeria in 2014. He is currently a senior lecturer in the Department of Sociology, Faculty of Social Sciences, University of Lagos, Nigeria.

References

Abusharaf, R.M. (2001): "Virtuous Cuts: Female Genital Circumcision in an African Ontology." Differences 12(1):112-140.

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

Apena, A. (1980): Female Circumcision in Africa and Problem of Cross Cultural Perspectives in Africa. London: Dorling Kindersley Book.

Berg, R.C.; Denison, E. and Fretheim, A. (2010): Psychological, social and sexual consequences of female genital mutilation/cutting (FGM/C): a systematic review of quantitative studies. Report from Kunnskapssenteret nr 13−2010. Oslo: Nasjonalt kunnskapssenter for helsetjenesten, 2010.

Catania, L.; Abdulcadir, O.; Puppo, V.; Verde, J.B.; Abdulcadir, J. and Abdulcadir, D. (2007):

"Pleasure and orgasm in women with female genital mutilation/cutting (FGM/ C)." Journal of Sexual Medicine 4(6):1666-1678.

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

Dopico, M. (2007): Infibulation and the orgasm puzzle: Sexual experiences of infibulated Eritrean women in rural Eritrea and Melbourne, Australia. In: Hernlund Y, Shell-Duncan B, (eds.) Transcultural Bodies: Female genital cutting in global context. London: Rutgers University Press. Pp. 224-247.

Emmanuel, B. (1998): Women's Rites versus Women's Rights: A Study of Circumcision among the Ketu Yoruba of South-Western Nigeria. New York: Africa World Press.

Griffith, R.W. (2005): "The Metabolic Syndrome and Sexual Problems" in Women Health and Age [Internet] http://www.healthandage.com/public/health-center/29/article/3013/The-Metabolic-Syndrome-and-Sexual-Problems-in-Women.html.

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

Hyde, J.S. and Delamater, J.D. (2006): Understanding Human Sexuality. 9th ed. Boston: McGraw Hill.

Ibhawoh, B. (1999): Between Culture and Constitution: The Cultural Legitimacy of Human Rights in Nigeria. Copenhagen: The Danish Centre for Human Rights.

Idowu, I.A. (2009): Female Genital Mutilation among Women in Tertiary Institutions in Delta State, Nigeria, in Nwagwu, H.O.; O.A. Moronkola and D.O. Akintunde (eds.) Women Issues in Nigeria. Ibadan: Royal People (Nigeria) Ltd.

Johnsdotter, S. and Essen, B. (2005): "It Is Only a Tradition: Making Sense of Swedish Somalis' Narratives of Female Circumcision and Avoiding Submission to Hegemonic Political Discourse." Critical Social Policy 25(4):577-595.

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

Lightfoot-Klein, H. (1989): "The sexual experience and marital adjustment of genitally circumcised and infibulated females in the Sudan." Journal of Sex Research 26(3):375-392.

Mohammed, T. and Ahmed, S.M.A. (2000): Defective Sexuality and Female Circumcision: The Cause and the Possible Management. Faculty of Medicine, Cairo University, Cairo University, Cairo, Egypt.

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

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

Obermeyer, C.M. (2005): "The consequences of female circumcision for health and sexuality: An update on the evidence." Culture, Health & Sexuality 2005; 7(5):443-461.

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

Omolade, O. (1992): Unending Harmful Tradition Shrouded in Secrecy: Female Genital Mutilation. Ibadan: Royal People Publishers.

Osinowo, H.O. and Taiwo, A.O. (2003): "Impact of Female Genital Mutilation on Sexual Functioning, Self-esteem and Marital Instability of Women in Ajegunle." Ife Psychologia, 11 (1), 123-130.

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

Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO) (2013): AIDS Epidemic Update: May, Geneva, pp. 13-18.

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

Yang, C.C.; Cold, C.J.; Yilmaz, U.; and Maravilla, K.R. (2005): "Sexually Responsive Vascular Tissue of the Vulva." British Journal of Urology International 97(4):766-772.