ISSN-0795-073X

IFE
RESEARH PUBLICATIONS IN
GEOGRAPHY
Volume 14, 2016

Differentials and Determinants of Genital Mutilation among Girls Child in Nigeria

[a*]TITILAYO Ayotunde, [a]ASA Sunday Soladoye,
[a]OLAOYE-OYESOLA Oludare John, & [b]ANUODO Olakitan Oludare
[a]Deparment of Demography and Social Statistics,
Obafemi Awolowo University, Ile-Ife, Nigeria
[*]**Email: liasuayotunde@gmail.com**

[b]Department of Sociology, Bowen University, Iwo, Nigeria.

Abstract

Many negative female reproductive and poor general women health outcomes have been associated with Female Genital Mutilation (FGM). Nonetheless FGM was still being practiced in many societies. The aim of the paper was to examine the differentials and investigate the significant socio-demographic predictors of occurrence of FGM in Nigeria based on the2008 and 2013 Nigeria Demographic and Health Survey (NDHS) datasets. Data were analyzed using descriptive and inferential statistical techniques. The study indicated that the practice of FGM for girl children declined from 30.5% in 2008 to 14.2% in 2013. The practice was however prevalent in rural areas than urban areas. The study also showed that religion, location and socio-demographic and economic factors influenced the FGM practice. The study concluded that although record had shown progress in reduced FGM, nationwide, the practice was still prevalent in the rural communities. It therefore recommended intensive education at the rural communities, and the help of religious leaders in creating awareness among those who practiced it on religious justification.

Keywords: Girls child, Female genital mutilation, Demographic and Health Survey

Introduction

Female genital mutilation(FGM)refers to all procedures involving partial or total removal of the external female genital and/or injury to the female genital organs, whether for cultural or any other non-therapeutic reasons (WHO, 1998). The practice of FGM, in its diverse form, has been in existence among the Phoenicians, Hittites and Ethiopians as early as the fifth century BC (Taba, 1979). More than 136 million females had suffered from the negative consequences of FGM and many more young girls and grown up ladies are still at greater risk of this unpleasant experience every year most especially in African countries (Mcleary, 1994; UNICEF, 2005).FGM is a worldwide practice with diverse justifications (Ladjali, Rattray and Walder, 1993). The practice was well pronounced among some ethnic groups in Australia, Western Brazil, Easterrn Mexico and Peru (Elchalal, Ben-ami and Brzezinski, 1999; Magoha and Magoha, 2000) and among immigrant populations of France, United Kingdom and the United State (PRB, 2010). The practice cut across all socio-economic strata and has no religious

boundary; it was among many religions and faiths of the world (PRB, 2010; Mitike and Deressa, 2009).

In sub-Saharan African countries, Somalia recorded the highest prevalence rate in the practice of FGM as at year 2008 (WHO, 2008) while Nigeria was ranked the highest by UNICEF in 2001 (UNICEF, 2001). Studies also showed that the practice of FGM is still well common in Nigeria, though with diverse regional variations (Odimegwu and Okemgbo, 2000; NPC and Macro, 2004; 2009). A good proportion of girls and women of all the six geo-political entities of Nigeria still live with the experience of different forms of FGM (NPC and Macro, 2004; 2009). With a national prevalence rate of 41%, a regional variation was observed in Nigeria with the highest prevalence rates in south-south, followed by south east and south west and the lowest rates among the northern sub-region of the country (Okeke, Anyaehie and Ezenyeaku, 2012).

Going by the debates and arguments on FGM there is no consensus among researchers and practitioners on the practice and perpetration of FGM. While some researchers have argued for the continuation of the age long traditional act others have argued against the acting, tagging it a 'harmful act' (e.g.Verzin, 1975; Gallard, 1995; Mcready, 1996; Carr, 1997Ibhawoh, 1999; Magoha and Magoha, 2000;Oyefara, 2015). Researchers who are against the act have argued that it caused complications ranging from those that are immediate like slight blood loss, painful menstruation, haemorrhagic shock to long lasting issues such as painful sexual intercourse or dyspareunia, reactive depression, urinary retention, recto-vaginal among others as part of the negative consequences of FGM (Gallard, 1995; Mcready, 1996; Magoha and Magoha, 2000). Apart from the opinion that FGM is a form of discrimination directed at the female population (United Nations General Assembly, 1981). It has been observed as an old harmful traditional practice that affects the reproductive health and rights of girls and women (Ibhawoh, 1999; Oyefara, 2015).

Many other writers and traditionalists are advocating for the continuation of FGM in order to protect the tradition and culture of the land. They believe that all efforts must be done to protect culture and tradition. In their own right, they lay emphasis on FGM as a socio-cultural practice which has its own religious and traditional values and will always refer to that in their argument for the continuation of FGM. The practitioners mentioned family honour, protection of virginity, chastity, virtue, modification of socio-sexual attitudes and increasing matrimonial opportunities as some of the cultural reasons why FGM has been in place and should continue to exist (Worseley, 1938; Carr, 1997; Elchalal, Ben-ami and Brzezinski, 1999).

Socially, practice of FGM has been traced to many initiation rites and ceremonies. In such societies that engage in FGM as a social rite, they have the belief that FGM changes the social status of women from being ordinary to higher and recognized women in the society (Adinma, 1997) and as a rite of passage from childhood to womanhood (Apena, 1980; Oyefara, 2014). Secondly, the practice and procedure of FGM has been supported or justified as a cure for sexual deviations such as control masturbation, achievement of orgasm, sexuality and nymphomania (Duffy, 1989; Eke, Kanu and Nkanginieme, 1999).

It was widely believed that circumcised girls and women would be less promiscuous than their counterparts who never went through the procedure of circumcision (Odimegwu and Okemgbo, 2000; NPC and Macro, 2009). On another note, ignorance at times has led many to perform FGM on the girls' children, while some ignorantly believed that if clitoris is not cut off it could grow long enough like penis between women's legs (Sayed, Abd el-aty and Fadel, 1996).Some erroneously thought and believed that the practice of FGM is universal and that everybody is circumcised (Magoha and Magoha, 2000), therefore they and their girls have to be circumcised.

Given the review of the literature on FGM, the following four assertions are made:

1. That FGM is a traditional practice with severe health consequences and life threatening act for girls and women and it is a structural inequality and violates universally recognized human-rights principles of equality and non-discrimination (UNICEF, 2005).
2. That FGM should be globally abolished in the same manner other anachronistic global traditional and cultural practices have been stopped (Davies, 1992; Magoha and Magoha, 2000).
3. That FGM as a tribal traditional practice and our custom is a good tradition which may appear senseless or destructive from the standpoint of others, they have meaning and fulfill a function for those who practice them and have to be protected, as a superstitious belief practiced for preservation of chastity, virtue and purification (Verzin, 1975; Carr, 1997; UNICEF, 2005).
4. That a multidisciplinary approach is needed to tackle the deep-rooted legendary practice of FGM in Nigeria as stated by Okeke, Anyaehie and Ezenyeaku, (2012).

Objectives

The objectives of this study are to (i) examine the differentials in the prevalence of FGM of girls' child between 2008 and 2013, and (ii) investigate the significant socio-demographic predictors of occurrence of FGM in Nigeria.

Materials and Methods

Data

This study uses data extracted from the nationally representative 2008 and 2013 Nigeria Demographic and Health Surveys (NDHS) (National Population Commission (NPC) [Nigeria] and ORC Macro (2009, 2014). (being the only two of the NDHS series that sought information on FGM in the country) in examining the trend and differential of FGM across the six geo-political zones of the country as well as socio-demographic and environmental determinants or circumstances surrounding the act of FGM.

The 2008 and 2013 NDHS were follow-up-surveys of the 1990, 1999, and 2003 NHDS. While the 2008 series contained 33,385 women (respondents), that of 2013 consisted of 38,948 women of reproductive ages 15-49 years. Sequel to the aim of designing measure for the levels, patterns, and trends of demographic, health and socio-economic indicators, the two NDHS datasets provide up-to-date information on the population, health and socio-economic situation of the country. Specifically, NDHS questionnaire collected information on the maternal, child and household health, socio-economic and demographic characteristics, and individual birth history, among others. Although the total national respondents for 2008 and 2013 NDHS were 33,385 and 38,948 respectively, the present study will limit the sample for the study to those that responded to question G108 (Number of daughter circumcised) which was 11,324 and 26,293 weighted sub-sample of the total sampled population (33.9% and 67.5% of the total sampled population respectively). This was with the assumption that those were the respondents that ever had female children among the total sampled population (see Figure 1). Response to question G108 ranges from 0 (didn't circumcised any girl child) through 9 (total number of circumcised girl child).

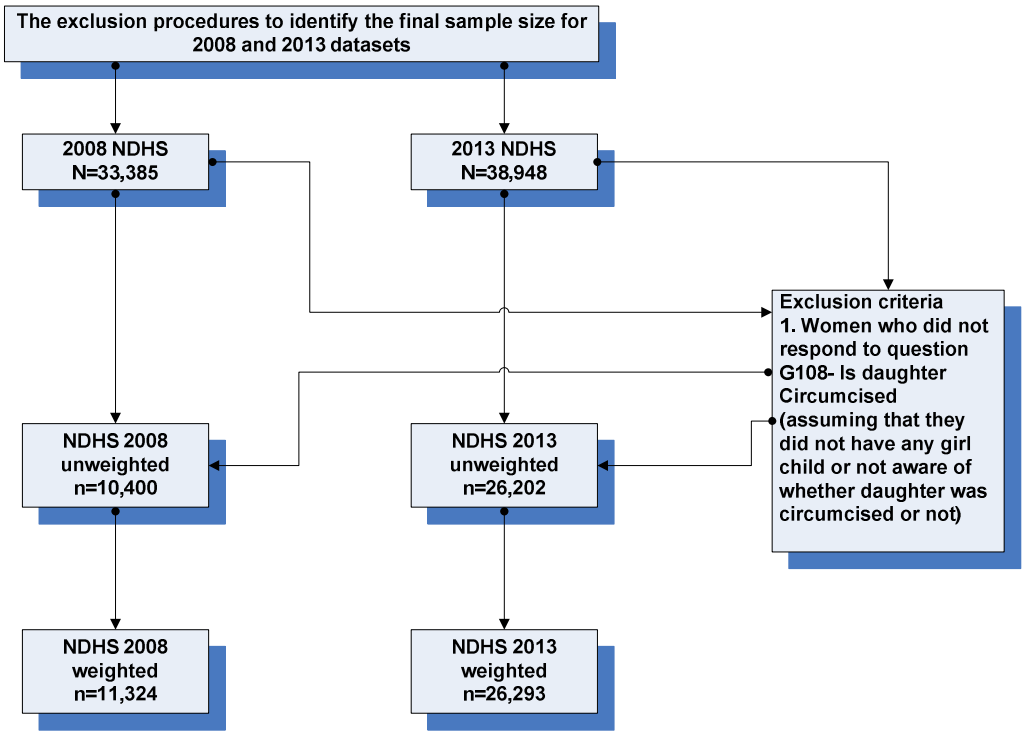

Figure 1.Framework showing selection and exclusion procedures for final sample for the study. (Adapted from Worku, Tessema and Zeleke, 2014)

Methods

With the aid of Statistical Package for Social Scientists (SPSS) version 20 and Microsoft Excel, the analyses of the study's objectives were based on pure descriptive and inferential statistics. Three levels of statistical analysis were employed. The univariate analysis revealed the percentage distribution of all the variables, the bivariate analysis was employed to examine the trend of FGM between the two surveys and differentials within the individual independent variables. In addition, cross tabulations were used to express the trend of FGM of daughters between the two surveys. The relationship between the dependent and independent variables were further examined using bivariate and multivariate binary regression techniques in order to determine the predictive factors of FGM. Binary logistic regression was employed in the study because of the dichotomous nature of the dependent variable.

Dependent variable

The main dependent variable for the study was female genital mutilation status by daughters in Nigeria. This was obtained from the responses to the question on whether or not their daughter(s) was(were) circumcised. The question that was asked during the survey was, "Has your daughter been circumcised?" or has any of your daughters been circumcised? The possible answers were either yes or no. As such, the outcome variable was categorized into two: women whose daughter(s)was/were not circumcised (coded as 0) and women whose daughter(s)was/were circumcised (coded as 1).

Independent variables

The independent variables for this present study are current age of women, region of residence, place of residence, religion, respondents' education attainment, wealth status, partner's educational level, is

respondent circumcised, respondent's attitude towards FGM and attitude towards gender-based violence were applied to examine probable socio-demographic and environmental circumstances surrounding the act of FGM. These variables were selected for inclusion in the analysis based on their significance in previous studies or on their hypothesized association with FGM (see for instance Kolawole and van de Kwaak, 2010; Steinmetz, 2012; Olubayo-Fatiregun, 2014).

The classifications/categorizations for the study are as follows: Age of respondents (15-19, 20-24, 25-29, 30-34, 35-39, 40-44 and 45-49); Type of place of residence (Urban and Rural); Region of residence (North Central, North East, North West, South East, South West and South South); Educational attainment (No education, Primary, Secondary and Higher); Religion (Christian, Islam and Traditional), Is respondent circumcised (Yes and No); Respondent's attitude towards circumcision (Continued, Stop and Undecided); Wealth Status (Poor, Middle and Rich);Partner's educational level (No education, Primary, Secondary and Higher) and Attitude towards gender-based violence (Non-tolerant and Tolerant). The attitude of women towards gender-based violence is measured through 5 variables as follows: wife's beating is justified when (1) women goes out without telling the husband (ii) women neglects the children (iii) women argues with husband (iv) women refuses to have sex with husband (v) women burns food. Responses to these questions were categorized as yes, no and don't know. In this study, women's attitude towards gender-based violence was recoded into 2 categories – non-tolerant and tolerant. Women having non-tolerant attitude are grouped as those who said no to all the above questions, those who said yes to anyone were grouped as having tolerance attitude, likewise those women who said don't know to any or all the questions were grouped as tolerant too, since it is believe that women should not be beaten up due to any reason especially those mentioned above.

Results

Characteristics of the study respondents

The socio-demographic and environmental characteristics of the sampled population were presented in Table 1. The ages of respondents of the two datasets showed similar pattern of distribution. The proportion of respondents interviewed increases with age from 15-19 to 25-29 and then decreases afterwards. The mean ages of the respondents were 34 and 30 years for the 2008 and 2013 datasets respectively. The population aged 25-29 years consist the highest proportion of respondents in the two datasets (20.0% and 18.7% for 2008 and 2013 datasets respectively). An examination of the pattern of distribution of respondents' age between 15 and 34 years depletes young population. The age distribution of the sub-samples was a true reflection of the general age distribution of the country (the country is characterized as a youthful population). While more than half of the sub-sampled respondents in 2008 were Christian, a little above fifty percent were Muslims in the 2013 survey. Respondent's place of residence in the two surveys showed that majority (59% and 53% in 2008 and 2013 datasets respectively) were rural dwellers.

The 2008 and 2013 sub-samples showed a different pattern in the case of respondents' region of residence. It skewed towards the southern region in 2008 dataset while the three regions in the northern part of the country had majority of the sub-sample population in 2013 dataset. Although there was an improvement in secondary and higher educational attainment among respondents from 2008 to 2013 (from a total of 41.3% to 47%) but generally, educational attainment of respondents in both surveys revealed that higher proportion of the respondents had low educational attainment. The wealth status of respondents revealed that more people are becoming improvised with 30 percent in poor category in 2008 and 35 percent in 2013. Majority of respondents' partners had low level of education in both surveys. The proportion of respondents' partners who attained higher education dropped to 44% in 2013 from 48.1% in 2008.

Table 1 further showed that, there was a decline in the prevalence of FGM among respondents and daughter within the five year survey line (2008 to 2013). More than six in every ten respondents wanted the act of FGM stopped and majority of the respondents in the two surveys (57% and 66% in 2008 and 2013 respectively) were also not well favourably disposed to gender-based violence in Nigeria.

Table 1:Percentage distribution of characteristics of the respondents, 2008 and 2013 Nigeria Demographic and Health Surveys

Characteristics	Year of Survey	
	2008	2013
Age		
15-19	2	15.4
20-24	10.1	16.6
25-29	20	18.7
30-34	19.9	15
35-39	18.6	13.6
40-44	15.1	10.3
45-49	14.3	10.4
Place of residence		
Urban	40.7	47.2
Rural	59.3	52.8
Region of residence		
North Central	7.9	7.4
North East	9.5	12.4
North West	19	32.2
South East	15.4	14.2
South South	28.2	14.5
South West	19.9	19.3
Educational level		
No education	31.6	35.8
Primary	27.1	17.2
Secondary	31.5	35.6
Higher	9.8	11.4
Religion		
Christianity	58	47.9
Islam	40	51.3
Traditional & Others	1.9	0.8

Characteristics	Year of Survey	
	2008	2013
Wealth Status		
Poor	29.5	34.9
Middle	19.1	17.2
Rich	51.3	47.9
Partner's education		
No education	26.1	37.1
Primary	25.8	18.9
Secondary	32.5	28.8
Higher	15.6	15.2
Is respondent circumcised		
Yes	52	39.3
No	48	60.7
Daughter circumcised		
No	30.5	14.2
Yes	69.5	85.8
Attitude towards FGM		
Continue	22.4	23.2
Stop	62.9	64.7
Undecided	14.7	12
Attitude towards GBV		
Tolerance	42.7	34.5
Non-tolerance	57.3	65.5
Total sample (N)	11,324	26,293

Source: NDHS 2008 and 2013

Differentials in FGM practices by selected characteristics of mothers, 2008 and 2013 Nigeria Demographic and Health Surveys

This section of the paper presents the differentials in female genital mutilation in Nigeria between 2008 and 2013. As shown in Table 2 and Figure 2, there is a significant drop of 16.3% (percentage point difference) in the prevalence of FGM of daughters over the five years study period (a drop from 31% in 2008 to 14% in 2013). The differentials (variation) in FGM of daughters by respondents' characteristics as shown in Table 2 reveals major drop among some categories of socio-demographic and environmental variables than some other ones. For instance, both youngest and oldest age groups had major drop (25.1 and 28.5 percentage point differences) in FGM practices than their other counterparts. The other major drop in the prevalence of FGM of daughters were observed among urban dwellers (17% point difference), residents of South South and North West (34.4% and 22.5% point differences), Muslim and traditional faith believers (20% and 20.8% point differences), respondents who were rich (19.1% point difference). Differentials in FGM by respondents' educational attainment and that of their partners follow the same pattern with almost the same percentage point differences among all the categories and those with higher educational level contributing much less (11.3% and 7.6% point differences among respondents and partners respectively) to the drop. Although, there was an increase in the prevalence of FGM of daughters among respondents who never experienced FGM (-1.7% point difference) but never the less, major decrease in FGM of daughters was also observed among respondents who ever experienced FGM themselves (27.6% point difference). Respondent's attitude towards the practice of FGM also indicated decrease of FGM of daughters among all the three categories but interestingly, major drop were observed among those who supported continuation of FGM and those who were not sure of their position on whether FGM should continue or stop (39.7% and 27% point differences). Another major drop of prevalence of FGM of daughters was witnessed among those respondents that were not tolerance of gender-based violence (18.7% point difference).

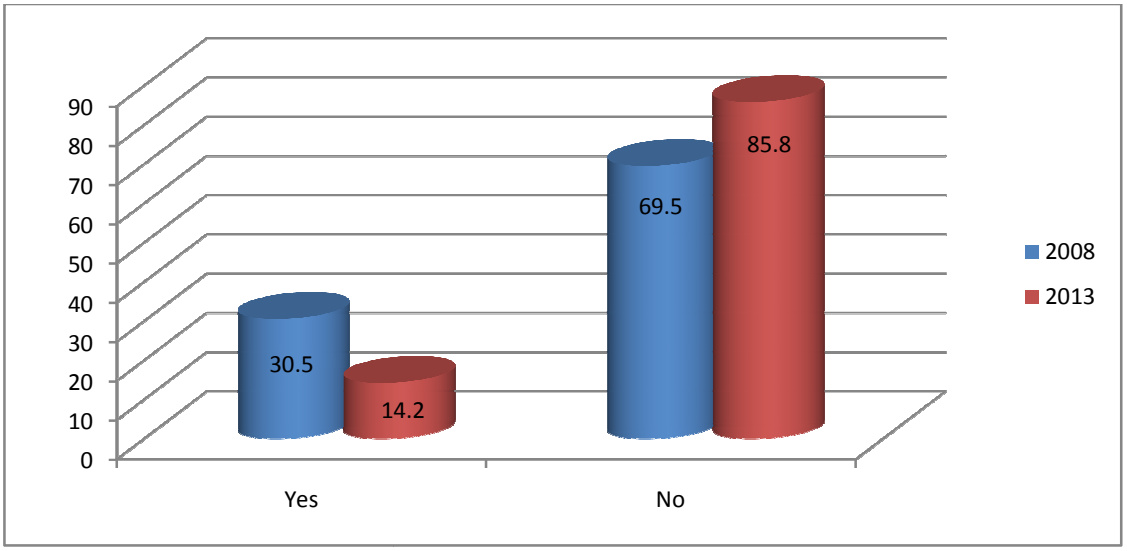

Figure 2: Percentage distributions of differentials in FGM of daughters, 2008 and 2013

Table2: Differentials in female genital mutilation of daughters by selected characteristics of mothers, 2008 and 2013 Nigeria Demographic and Health Surveys

Characteristics	NDHS 2008 n=11,324	NDHS 2013 n=26,293	Percentage point difference in FGM
Age			
15-19	28.4	3.3	25.1
20-24	25.9	10.0	15.9
25-29	25.8	15.5	10.3
30-34	25.2	19.9	5.3
35-39	30.6	19.9	10.7
40-44	35.5	18.7	16.8
45-49	42.7	14.2	28.5
Place of residence			
Urban	28.2	11.2	17.0
Rural	32.1	16.8	15.4
Region of residence			
North Central	21.0	7.5	13.5
North East	5.7	5.2	0.5
North West	46.4	23.9	22.5
South East	31.0	11.6	19.4
South South	38.5	4.1	34.4
South West	19.3	15.7	3.6
Educational level			
No education	37.1	21.3	15.8
Primary	33.5	17.3	16.2
Secondary	25.8	8.6	17.2
Higher	15.9	4.6	11.3
Religion			
Christianity	23.9	7.9	16.0
Islam	40.0	20.0	20.0
Traditional & Others	34.1	13.3	20.8
Wealth Status			
Poor	33.7	20.7	13.0
Middle	30.9	14.0	16.9
Rich	28.5	9.4	19.1
Partner's education			
No education	37.2	21.8	15.4
Primary	34.7	19.9	14.8
Secondary	28.7	15.2	13.5
Higher	17.8	10.2	7.6
Is respondent circumcised			
Yes	56.0	28.4	27.6
No	2.9	4.6	-1.7
Attitude towards FGM			
Continue	76.1	36.4	39.7
Stop	11.8	6.4	5.4
Undecided	40.7	13.7	27.0
Attitude towards GBV			
Tolerance	28.9	16.3	12.6
Non-tolerance	31.7	13.0	18.7
Total	30.5	14.2	16.3

Source: NDHS 2008 and 2013

Determinants of Female Genital Mutilations

The relationship between FGM and socio-economic characteristics were further examined using bivariate and multivariate regression analyses. The results of these analyses are presented in Table 3.

The bivariate logistic regressions indicate that in 2008, age, geopolitical zones, maternal education, religion, wealth status, paternal education, circumcision status of the mother, attitude towards FGM and attitude towards GBV are significantly related to FGM experience of daughters ($p<0.05$). Furthermore, the results of the multivarite logistic regressions indicate that the odds of FGM of daughters are significantly higher for girl child whose mothers reside in North West region (1.86), whose mother's partner had less than higher educational attainment and more interestingly, daughters whose mothers were favourably disposed to continuation of FGM (2.73) (Table 3).

In a bid to cross check the socio-demographic and environmental determinants of FGM of daughters as observed in 2008 dataset, we performed a separate binary logistic regression on 2013 NDHS dataset. Results presented in Table 3 confirmed age of respondents, region of residence and respondent's circumcision status as having significant ($p<0.05$) odds in determining FGM experience of girl child in Nigeria. The 2013 dataset further showed mother's educational attainment, religion and wealth status as other socio characteristics that determine daughter's FGM experience. Furthermore, according to 2013 dataset, there was significant higher odds FGM of daughters among women aged 25-44 years (1.72) than other age groups; among not well to do (poor (1.40) and middle (1.33) class), Muslim (2.86) who resided in North West (1.54) and who had less than higher education (1.05) (Table 3).

Age of respondents is one of the factors influencing FGM in Nigeria. In 2008, women in the different age groups had significant lower odds of having their daughters circumcised than women in 45-49 age group. A different pattern is noticed in the 2013 dataset. Women in 25-29, 30-34, 35-39, 40-44 had 72%, 124%, 114%, and 65% higher odds of circumsizing their daughters than women who were in the age category 45-49. The odds ratios increase with increasing age of the respondent probably reflecting the predominance of the practice among older women.The prevalence of FGM depends on the region of residence. In 2013 women residing in North Central, North East, South South had respectively 36%, 50% and 55% lower odds of having their daughters circumcised than women residing in South West.

Another factor that greatly influences FGM in Nigeria is the level of education of women. The adjusted odds ratio of the 2008 dataset showed that women with no education, primary education and secondary education had respectively 40%, 38% and 28% higher odds of carrying out FGM on their daughters than those with tertiary education. The same pattern is noticed in the 2013dataset, women with no education, primary education and secondary education respectively had 86%, 96% and 51% higher odds of having their daughters circumcised than women with higher education.

The two datasets revealed the same pattern of women whose partners had no education, primary education and secondary education having higher odds of circumsizing their daughters than those with tertiary education. Wealth status is another factor influencing FGM in Nigeria. In 2013 poor women and women in middle income category had 40% and 33% higher odds of having their daughters circumcised than rich women.FGM is also influenced by Religion. Table 3 indicates that in 2013, Muslim women and Christian women had 186% and 59% higher odds of performing FGM for their daughters than women practicing traditional and other religion.

Table 3: Final logistic regression model with crude and adjusted odds ratio of daughter circumcision using the 2008 and 2013 Nigeria Demographic and Health Surveys

	2008			2013		
	COR	AOR	95% CI	COR	AOR	95% CI
Age						
15-19	0.40***	0.38***	0.21-0.62	0.21***	0.44***	0.34-0.57
20-24	0.47***	0.21***	0.17-0.28	0.67***	0.95	0.79-1.15
25-29	0.47***	0.30***	0.24-0.37	1.11	1.72***	1.45-2.03
30-34	0.45***	0.30***	0.24-0.37	1.50***	2.24***	1.90-2.65
35-39	0.59***	0.49***	0.40-0.60	1.50***	2.14***	1.80-2.53
40-44	0.74***	0.65***	0.53-0.80	1.39***	1.65***	1.38-1.97
45-49 ®						
Place of residence						
Urban	0.83	0.93	0.81-1.07	0.62***	0.87	0.77-0.98
Rural (R)						
Geopolitical zones						
North Central	0.43***	0.60***	0.46-0.78	0.44***	0.64***	0.51-0.81
North East	0.10***	0.39***	0.26-0.58	0.29***	0.50***	0.39-0.65
North West	1.39***	1.86***	1.48-2.33	1.69***	1.54***	1.30-1.84
South East	0.72***	0.84	0.70-1.02	0.71***	1.02	0.85-1.22
South South	0.38***	0.45***	0.37-0.54	0.23***	0.45***	0.36-0.56
South West ®						
Maternal Education						
No education	3.13***	1.4	1.02-1.92	5.63***	1.86***	1.41-2.46
Primary	2.67***	1.38	1.05-1.81	4.36***	1.96***	1.53-2.53
Secondary	1.85***	1.28	0.99-1.65	1.95***	1.51***	1.20-1.91
Higher ®						
Religion						
Christianity	0.61***	1.39	0.91-2.11	0.56**	1.59	0.98-2.56
Islam	1.29	2.49	1.61-3.86	1.62*	2.86***	1.76-4.66
Traditional & Others ®						
Wealth Status						
Poor	1.28***	1.08	0.89-1.32	2.51***	1.40***	1.18-1.65
Middle	1.12*	1.01	0.85-1.21	1.56***	1.33***	1.14-1.55
Rich ®						
Paternal Education						
No education	2.73***	1.33*	1.01-1.74	2.46***	0.95	0.771-1.17
Primary	2.46***	1.50***	1.18-1.89	2.20***	1.05	0.87-1.28
Secondary	1.86***	1.37**	1.10-1.71	1.58***	0.95	0.79-1.13
Higher ®						
Is respondent ircumcised						
Yes	0.02***	0.04***	0.03-0.04	0.12***	0.11***	0.10-0.13
No ®						
Attitude towards FGM						
Continue	4.65***	2.73***	2.28-3.26	3.61***	2.45	2.11-2.84
Stop	0.19***	0.25	0.21-0.30	0.43***	0.49	0.42-0.57
Undecided ®						
Attitude towards GBV						
Tolerance	1.14**	0.98	0.86-1.11	0.77***	1.02	0.93-1.13
Non-tolerance ®						

The same pattern is noticed in the 2008 dataset. Circumcision status of the mother greatly influences whether or not the daughter will be circumcised. Both datasets revealed that women who were circumcised had lower odds of having their daughters circumcised than women who are not circumcised.FGM is also influenced by women's attitude towards the practice. In 2013 women who wanted the practice to continue had 261% higher odds of circumsizing their daughters than women who were undecided. Women who wanted the practice to stop had 57% lower odds of having their daughters circumcised than women who were undecided. Similar patterns were also observed with the 2008 dataset. FGM is also influenced by women's attitude towards gender based violence. In 2013 women who were tolerant towards GBV had 14% higher odds of circumcising their daughters in 2008 while 23% had lower odds of performing FGM on their daughters in 2013

Discussion

Female genital mutilation (FGM)is one of the principal harmful traditional cultural practices of gender-based violence. It has been presented over time as inimical to the sexual activity, satisfaction and healthy well-being of women and society at large (Oyefara, 2014; 2015). Hundreds of millions of girls and women have undergone FGM and with the trend of things, many more are still at risk of being circumcised or mutilated.

In an attempt to examine the trend of FGM in Nigeria, the study descriptively and analytically examined the differential/variation of FGM among daughters within some relevant socio-demographic strata (current age, place of residence, region of residence, religion, educational attainment, partner's educational level, mother's circumcision status, daughter's circumcision status, mother's attitude towards FGM and finally attitude towards gender-based violence)of women of child bearing age (15-49 years) in the most populous nation of Africa. The use of the last two nationally representative datasets from Nigeria Demographic and Health Survey (NDHS) (being the only of all the NDHS series that contain the variable on FGM in the country) were employed for the study.

Out of the 33,385 and 38,948 total sampled respondents in the 2008 and 2013 NDHS dataset, the study utilized a weighted sub-sample population of 11,324 and 26,293 (which constitute 33.9% and 67.5% respectively of 2008 and 2013 dataset) who responded to question G108 (Is daughter circumcised?). This was with the assumption that those sub-sampled population were the respondents that ever had female children among the total sampled population or who had the awareness of whether circumcision was done or not on their daughter(s) (see Figure 1).

Despite the social and religion attachments to the practice of FGM, the drop of about 13% point difference in the prevalence of FGM of daughters within a period of 5 years (from 52% in 2008 to 39.3% in 2013) was an indication of an on-set of decrease in the practice of FGM. This is in line with reports from other studies (Yoder, Abderrahim and Zhuzhuni, 2004; Oyefara, 2014; PRB, 2014). The age distribution of the two nationally representative sub-samples with a mean age averaging 30 years, with majority having less than higher educational attainment and rural residents revealed a youthful population in the country where majority are not highly educated and most are of rural population.

Differential of prevalence of FGM of daughters between the age groups showed the picture of what happened within a span of at least three decades (15-19 years to 45-49 years). Calculating the ratio between the youngest and oldest age group using 2008 and 2013 data, the results gave 0.65 and 0.21 for 2008 and 2013 respectively. This is an indication from the two datasets that there is a low prevalence of FGM among younger generations than the older generations in the country, which is an indication of declining trend in FGM prevalence in Nigeria. The

declining as found in this study is a pointer to likelihood of FGM gradual discontinuation as reported in other studies (Oyefara, 2014).This result is consistent with findings from other countries that show the incidence of female circumcision being higher among women in the older age groups than the younger ones (Ondiek, 2010; Inungu, and Tou, 2013). Many factors could be responsible for this declining among which are enlightenment, socio-economic empowerment of mothers, gender equity, the yield in the campaign against the act of FGM and many more.FGM was observed as a rural phenomenon with higher prevalence and a lower point difference than urban in 2008 and 2013 datasets.

Religion as a significant determinant found in this study is consistent with findings from other studies in Africa which established the fact that religion remains a major factor influencing whether or not FGM is practiced (Setegn, Lakew, Deribe, 2016)

Wealth index was found to be a significant factor influencing FGM. This is in line with the results of the study conducted in Ethiopia (Setegn, Lakew and Deribe, 2016). The authors however unlike the findings of this study found that women in the richest and richer wealth index categories had higher odds of having experienced FGM as compared to women in the poorest category.

The incidence of FGM which has been observed as a cultural issue than religion and universal in a few countries (Yoder, Abderrahim and Zhuzhuni, 2004) was also proved right with the case in Nigeria. It was observed to be more prevalent in the southern parts of the country than the northern zones except with North West that portray high prevalence than other zones in the northern part of Nigeria. Regional disparities in terms of FGM have also been observed in other countries Ondiek (2010) reported that North Eastern Province has the biggest percentage of women who are circumcised (99%), while Western Province has the lowest proportion of women who have undergone FGM (4%). This is a very good pointer to the hypothesis of culture and tradition in FGM. The mean year of schooling among women which was relatively low in Nigeria revealed a higher proportion of illiterate or semi illiterate of women in the country. The study further showed the existence of highest prevalence of FGM among those women with secondary education and the lowest among those with higher education than any other category of educational level. This was also in line with the findings of Oyefara (2014) which stated that educated women are more likely to discontinue the practice of FGM among their daughters in the nearest future.

Conclusion and Recommendations

Finally, the determinants of FGM in Nigeria, as presented in this study, have policy and programme implications for Nigeria and for other African countries with similar social, cultural and economic conditions. First, the national lobby groups that are working towards eradication of FGM should intensify not only its information, education and communication programmes on the negative aspects of the practice but also, more importantly, adjust their messages to suit local conditions. NGOs and CBOs should help in creating the necessary awareness in the society and organized counseling services for behavioral and attitudinal change. Special focus should be placed on neglected areas (or hard to reach populations) such as rural areas, uneducated women. In order to win the battle all opportunities, namely, the school system, youth associations, religious organisations, traditional leaders, communities and families should be sensitised and educated about the negative effects of FGM.

Given that Nigerian society is largely male-dominated, even with regard to female reproductive health, so men's involvement in the fight against FGM can hardly be over-emphasized. One of the crucial factors that have hindered successful implementation of the sexual and reproductive health is minimal male involvement. Therefore IEC messages should target both men and women. In addition religious leaders should make a religious pronouncement clearly stating and

strongly condemning the practice of female genital mutilation.

Acknowledgements:
The authors gratefully acknowledge National Population Commission (NPoPC) and ICF Macro International, Calverton, Maryland, USA for making available the data for public use. The authors wish to state that views expressed in this article are solely those of the authors and not of data provider.

References

Adinma, J.I.B. (1997). Current status of female circumcision among Nigerian Igbos. *West African Journal of Medicine.* 16: 227-230.

Carr, D. (1997). *Female genital cutting: Findings from the Demographic and Health Survey Programme,* Calverton, Maryland: Macro International.

Davies, J.H. (1992). Female genital mutilation. A practice that should have vanished. *Midvies Chronicle.* 105: 33

Duffy, J. (1989). Clitoridectomy: A nineteenth century answer for masturbation. The truth seeker, free Thinkers Publications, 1:55-56.

Eke, N., Kanu, E.O. and Nkanginieme, M.D. (1999). Female genital mutilation: A global bug that should nor cross the millennium bridge. *Wid. J. Surg.* 23:1082-1087.

Elchalal, U., Ben-ami, B. and Brzezinski, A. (1999). Female circumcision: The peril remains. *Britain Journal of Urology International.* 83: 103-108

Gallard, C. (1995). Female genital mutilation in France. *British Medical Journal.* 1592-1593

.

Ibhawoh, B. (1999). Between culture and constitution: The cultural legitimacy of human rights in Nigeria. Copenhagen: The Danish Centre for Human Rights.

Inungu, J and Tou Y (2013) "Factors associated with female genital mutilation in Burkina Faso"*Journal of Public Health and Epidemiology*Vol. 5(1), pp. 20-28.

Kolawole, A.O.D. and van de Kwaak, A. (2010).A review of determinants of female genital mutilation in Nigeria. *Journal of Medicine and Medical Sciences.* Vol. 1(11): 510-515.

Magoha, G.A.O. and Magoha, O.B. (2000). Current global status of female genital mutilation: A review. *East African Medical Journal.* 77(5): 268-272.

Mcleary, P.H. (1994). Female genital mutilation and childbirth: A case report. *Birth* 21:221-224.

Mcready, N. (1996). Female genital mutilation in the United States. *British Medical Journal.* 313: 1592-1593.

Mitike, G. andDeressa, W. (2009) "Prevalence and associated factors of female genital mutilation among Somali refugees in eastern Ethiopia: a cross-sectional study"*BMC Public Health*, 9:264 doi:10.1186/1471-2458-9-264

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 ORC Macro. (2009). Nigeria Demographic and Health Survey 2003. Calverton, Maryland: National Population Commission and ORC Macro.

National Population Commission (NPC) [Nigeria] and ICF International, 2014. *Nigeria Demographic and Health Survey 2013.* National Population Commission (NPC) and ICF International, Abuja, Nigeria, and Rockville, Maryland, USA.

Odimegwu, C.O. and Okemgbo, C.N. (2000). Female circumcision and sexual activity: any relationship? *UNILAG Sociological Review*. (1):159-176.

Okeke, T.C., Anyaehie U.S.B. and Ezenyeaku, C.C.K. (2012). An overview of female genital mutilation in Nigeria. *Annals of Medical Health Sciences Research.* 2(1): 70-73.

Olubayo-Fatiregun, M.A. (2014). Determinants and Health consequences of female genital mutilation among women of child bearing age in Ife East local Government area of Osun State, Nigeria. *International Journal of Humanities and Social Sciences.* Vol. 4 No. 6(1): 200-205.

Ondiek, CO (2010) "The persistence of Female Genital Mutilation (FGM) and its impact on women's access to education and empowerment: a study of Kuria district, Nyanza Province, Kenya" PhD Thesis submitted in fulfilment of the requirements of the degree of doctor of literature and philosophy in the subject, Sociology, University of South Africa.

Oyefara, J.L. (2014). Female genital mutilation (FGM) and theory of promiscuity: myths, realities and prospects for change in Oworonsoki community, Lagos State, Nigeria. *Genus Journal of Population Science.* 70(2-3):7-33.

Oyefara, J.L. (2015). Female genital mutilation (FGM) and sexual functioning of married women in Oworonshoki community, Lagos State, Nigeria. *African Population Studies.* 29(1): 1526-1540.

Population Reference Bureau (PRB), (2010). Female Genital Mutilation/Cutting: Data and Trends Update 2010. Population Reference Bureau

Population Reference Bureau (PRB), (2014). Female Genital Mutilation/Cutting: Data and Trends Update 2014. Population Reference Bureau

Sayed, G.H., Abd el-aty, M.A. and Fadel, K.A. (1996). The practice of female genital mutilation in upper Egypt. *International Journal of Gynaecology Obstetric.* 55: 285-291.

Setegn T., Lakew Y. and Deribe K. (2016) Geographic Variation and Factors Associated with Female Genital Mutilation among Reproductive Age Women in Ethiopia: A National Population Based Survey. *PLoS ONE* 11(1): e0145329. doi:10.1371/ journal.pone.0145329.

Steinmetz, T. (2012). Empirical determinants of female genital cutting: Evidence from the Gambia. *Master's project, Sanford School of Public Policy,* Duke University.

Taba, A.H. (1979). Female circumcision. In tropical practices affecting the health of women and children. WHO/EMRO Technical Publication no. 2 Alexandra: World Health Organisation 43-52.

UNICEF United Nations Children's Fund. (2005). Female genital mutilation/cutting: A statistical exploration 2005. United Nations Children's Fund.

United Nations General Assembly, (1981). Convention on the elimination of all forms of discrimination against women (CEDAW). New York: United Nations.

Verzin, J.A. (1975). Sequelae of female circumcision. *Tropical Doctor* 5: 163-169.

Worku, A.G., Tessema, G.A. and Zeleke, A.A. (2014). *Trends and Determinants of Contraceptive Use among Young Married Women (Age 15-24) Based on the 2000, 2005, and 2011 Ethiopian Demographic and Health Surveys: A Multivariate Decomposition Analysis.* DHS Working Papers No.

103 ICF International Rockville, Maryland, USA.

World Health Organization (WHO). (1998). Female genital mutilation: An overview. Geneva: World Health Organization.

World Health Organization (WHO). (2007). *Elimination of FGM in Nigeria*. Family Health Department, Federal Ministry of Health Phase II Federal Secretariat Abuja.

World Health Organization (2008) *Eliminating female genital mutilation: aninteragency statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO*. Geneva, Switzerland.

Worseley, A. (1938). Infibulation and female circumcision. A study of little-known custom. *British Journal of Obstetric Gynaecology.* 45: 686-691.

Yoder, P.S., Abderrahim, N. and Zhuzhuni, A. (2004). *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis.* DHS Comparative Reports No. 7. Calverton, Maryland: ORC Macro.