WILL FEMALE GENITAL MUTILATION EVER END? INVESTIGATING FACTORS ASSOCIATED WITH CONTINUATION OF FEMALE GENITAL MUTILATION IN SELECTED ETHNIC GROUPS IN NIGERIA

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BACKGROUND

Female Genital Mutilation (FGM) is a global issue which cuts across almost all the continents of the world. The practice is still persistent though in different magnitude despite well reported information about its side effects which usually call for attention and support in the developing countries. The origin of female genital cutting cannot actually be defined but it started in ancient times. Reference was made to it by a Greek papyrus dated 163 BC (Dike et al 2012). The practice of female genital cutting regrettably occurred in many developing countries where it is anchored in culture and tradition (African Health 2003). FGM is practiced in many communities in Nigeria. In many ethnic groups FGM is a recognized and accepted practice that is considered important for the socialization of women, curbing their sexual appetites and preparing them for marriage (NPC Nigeria and ICF Macro 2009). Some cultures also see it as a cultural rite which prevent new born baby from death in the process of birth and for such it is done during pregnancy shortly before the birth of a baby. This operation is usually done by traditional healers, traditional birth attendants, midwives, and sometimes medical practitioners, mostly in Egypt and Sudan and in some part of Nigeria. FGM is usually done in poor hygienic environment. The process involves partial or total removal of external female genitalia for

cultural, religion or other therapeutic reasons. It is an age long practice which cuts across nations, regions, ethnic groups and socio-economic status.

In February 2010, WHO reported that between 100 million to 140 million girls and women worldwide went through female genital cutting and more than 3 million girls are at risk for cutting each every year on the African continent alone (2011). FGM is generally performed on girls aged 4 to 12, although it is usually performed as early as few days after birth or as late as just before marriage. Typically, traditional excisors have carried out this procedure, but recently a discouraging trend has emerged in some countries where medical professionals are increasingly performing the procedure (Fieldman and Clifton 2010). WHO (2011) has linked FGM to increase in maternal mortality and complications during child birth. Moreover, it is an infringement on the rights and well being of women.

There are different approaches to the process of FGM and each process causes varying effect or damages to the body of individual female. The World Health Organisation (2011), has identified four types of FGM. The first typology is also known as *clitorectomy* and is a process of removing the clitoral hood with or without removal of all or part of the clitoris. The second typology is the *excision and this* involves the removal of the clitoris together with part of the labia *minora*. The third typology is known as infibulations and is sometimes referred to as *pharaonic* circumcision. This is the most painful procedure and the one with the most devastating effect on the one circumcised. It is the removal of the whole clitoris, the whole of the *labia minora* and the media parts of the l*abia majora*. This will cause occlusion of the genitalia leaving only a small space to allow the urine to pass and monthly passage of blood. The fourth typology is unclassified and it includes pricking, piercing or incision of the clitoris and or labia. It also involves stretching of the clitoris, by burning of clitoris and the surrounding tissues in the

vaginal. The pains and agony of FGM exacerbated with the introduction of corrosive substances or herbs into the vagina, which either causes bleeding, tightens or narrows the vagina and constitute future complications for the maternal health of the one who has been circumcised.

Female Genital Mutilation is still a problem till date in Nigeria because of the limited awareness of it consequences. The practice cuts across religious and cultural boundaries and is either done in secret or with fanfare. Victims always display a sense of helplessness and not certain about the dangers associated to it. The health implications of FGC are both immediate and futuristic. These ranges from health implications such as excessive bleeding, severe pain, shock infections urine retention, genital ulcerations, keloid, scar formation, HIV/AIDS/STIs, vesico vaginal fistula (VVF), recto vaginal fistula (RVF) resulting from damage to the urethra/rectum. There are also certain psychological complications where the victims feel incomplete, suffer anxiety, and become depressed, less confident because part of her body has been tampered with because of cultural belief. FGM is also a form of violence against women and girls and infringes on their human rights to integrity as well as attainment of the highest level of physical and mental health. The fact that FGM is usually done at infancy shows that most of its victim are ignorant when it was being carried out on their vaginal. According to World Health Organisation (2006), FGM can be linked to increased complications in childbirth and if not well manage it can lead to maternal mortality.

FGM is an increasing problem in our society that need urgent attention in all the regions and ethnic groups in Nigeria especially in regions or zones that have experienced increase in FGM practices. Since FGM is a practice ingrained in culture and Nigeria is a multi cultural country, there is need to understand cultural differentials in the practice of FGM. This study therefore

examines the variability of FGM continuity or discontinuity among different Zones of the country and the socio-demographic reasons for this relationship.

RESEARCH QUESTIONS

The study provides answers to the following research questions:

- What socio-demographic factors are associated with the practice of Female Genital Cutting among major ethnic groups in Nigeria?
- What is the attitude of women in selected ethnic groups in Nigeria towards FGM continuity?

OBJECTIVES

The objectives of the study are to;

- examine the attitude of women in major ethnic groups in Nigeria towards continuity of FGM practice.
- investigate the socio-demographic factors associated with the practice of FGM among women in selected ethnic groups in Nigeria

BRIEF LITERATURE REVIEW

FGM PRACTICE GLOBALLY AND IN NIGERIA

The origin of FGM practices has been in time without memorial. It began before the advent of Christianity and Islam. Researchers traced to the Egyptian mummies that displayed some characteristics of FGM. Also, an historian (Herodotus) claimed that in the fifth century BC the Hittites and the Ethiopians practiced circumcision. It is also reported that circumcision rites occurred among the early Romans and Arabs. In 1950s, clitoridectomy was practiced in Western Europe and United States to treat 'ailments' in women like epilepsy, masturbation, lesbianism and melancholia. FGM has been talked about in different articles and various researches have dealt with the issues across the continent. Also, UNICEF (2005) proposed that countries be categorised in three groups according to FGC prevalence rates: Group 1, 80% or higher prevalence, e.g. Ethiopia and Somalia, Group 2, 25-79% prevalence, e.g. Senegal and Kenya, and Group 3, 1-24% prevalence, e.g. Nigeria. (Berg et al 2012). Female genital cutting is a violation of human rights of women and girls. It is another subtle way of subjecting women to pain and subjugation. Women and girls are being deprived of their right to their body and it shows gender inequality (UNICEF 2005).

HEALTH IMPLICATIONS OF FGM

Young girls who experienced FGM are exposed to the danger of instant consequences, shock, bleeding, continuous pain, infections and difficulty in passing urine and feces. According to a review of health complications of FGM by (WHO, 2000), some of the identified obstetrical problems, include delay in labour, episiotomies and perineal tears, postpartum hemorrhage, and fetal and maternal death. A study investigated 28,393 women who attended obstetric centers in different African countries, (WHO study group, 2006) concluded that women with FGM were

significantly more likely than those without to have obstetric outcomes such as a caesarean, postpartum blood loss, postpartum hospital delay, low birth weight and inpatient perinatal death (WHO Study Group,2006). Risk seems to be greater with more extensive FGM. Infertility is also another health complication that devastate psychosocial of a woman who is infibulated. It can be as high as 30% MacLeod (1995). Ironically the infibulated scar that should protect girls from being pregnant out of wedlock has become hindrances that prevent them of carrying a child in their womb when married. Several girls who had FGM have reported having difficulties in later married life. It has been discovered that men prefer women who are not circumcised, other studies have found the opposite to be true (Gruenbaum 2006).

INTERVENTIONS

There have been a lot of efforts and interventions to eliminate FGM practice in Africa. Several approach have been used, including a health risk approach, training health workers as change agents, human rights frameworks and the use of comprehensive social development approaches. There are still indications of the effectiveness of some anti-FGM interventions in achieving positive changes in beliefs, behavior, attitudes, knowledge and practices related to FGM but evidence of the appraisal are not systematic. The data collected by Ministry of Health in 2002, shows the prevalence of FGM as follows, South-West Zone: 0.1-93.8%, South-East Zone :4.6-95.4%, South-South Zone 0.2-79.2%, Middle-Belt Zone: 6.9-85.5%, North-East Zone: 3.4-38.8%, North-West Zone: 6.2-76.2%. With the effort of government agencies; like Ministry of Health and National Policy, FGM should have reduced to a minimal level by now. But it is sadden to hear that FGM is still on the increase, according to NDHS (2008); reported that the prevalence of female circumcision reported in the 2003 NDHS was 19 percent, this suggest that FGM have over the past five years. Much of the increase in FGM is due to an observed

prevalence of 20 percent in the North-West Zone in 2008, compare with a prevalence of only 0.4 percent in 2003 NPC Nigeria and Macro (2009).

SOCIAL CONTROL THEORIES OF FGM

Social control theories focus on strategies and techniques of regulating the human behaviour to conform to the rules of the society, family, culture, traditions, norms and beliefs. The stand of the theorist is that everyone has power to deviate, but rather choose to conform to forces controlling their lives and environment they belong. Individual who fails to comply will be at risk of deviance. The concept of social control was propagated by the sociologist E.A Ross. Ross observed that, ones' beliefs, norms and custom have a way of guiding and controlling individual attitude. Social control theory, deals with what is considered deviant, violation of the law. It can be applied as norms, mores, ethics, and customs which all of these aim at controlling and defining behavioural attitude (Alston et al 1995). The implication of this theory in this study is that despite the pain most victims of FGM went through during the cause of circumcision, it is an accepted norm among people and some other custom celebrate oddly. Individual has the power to say 'NO' but saying it shows that the fellow does not share in their belief, even though is painful.

DATA SOURCE AND METHOD

The data source to be used in this study is the 2013 Nigeria Demographic and Health Survey. It is affiliated with National Population Commission (NPC) which is responsible for collecting, collating, analysing, and disseminating population census and survey data at all levels. This set of data is also the latest in the periodic Demographic and Health Survey (DHS) series, which started in Nigeria far back in year 1990. The NDHS gives up-to-date information on background

characteristics of the respondents at national level. The target groups were women age 15-49 years and men age 15-59 years in randomly selected household across Nigeria. The data are also useful because they provide estimates of key indicators for rural and urban areas in Nigeria; the six geo-political zones, the thirty-states and the Federal Capital Territory (FCT). This study will be focusing on women who have experienced circumcision before and their attitude toward future practice. Respondents from the three major ethnic groups in Nigeria (Hausa, Igbo, Yoruba) will be study.

In 2013 NDHS, women individual recode dataset (IR) 38,948 household were sampled, 26,292 women age (15-49) interviewed. The sample size was 38948 women that have knowledge of circumcision, while women who were circumcised from the study were 9,652. Weight was applied so as to regulate representativeness and non-response. The methods of analysis are: Univariate analysis using percentages and frequency distributions, bivariate analysis using chi square, multivariate analysis using logistic regression. Measurement of variables: independents variables; Socio-demographic: age (15-24, 25-34, 35+), education (No education=1, pry=2, secondary +=3), religion (Christian =1, Islam=2, Tradition=3), ethnic group (Yoruba=1, Igbo=2, Hausa=3), place of residence (Urban=1, Rural=2). Outcome variables: Attitude to practice; this is measure by asking the respondents if wish to continue or discontinue the practice of FGC. The responses were "continue or discontinue". Intervening variables: Knowledge; this measure by asking if respondents have heard about the FGM. The responses were "ever heard of FGM", "yes" or "no".

RESULTS AND DISCUSSION

Table 1 shows that the majority of the respondents (34%) were above 35 years of age and the rest categories were a little lower. Most of the women (53%) were rural residents and (47%) had attained secondary school and higher. The highest proportion (48%) of the women were from the richest wealth index and the least from the middle class (17%).

In general, most of the respondents (74%) were currently married and the least are formally married (5%). The highest proportion (51%) were Islam and the least from the traditional (1%). The majority are from the Hausas' (46%) and the Igbo and Yorubas' have the same proportion (27%). The tendency to continue was still high, about (23%) still have interest to continue.

In Table 2, it can be seen that women above age 35 years have highest discontinuity (71%) of FGC in Hausa. This relationship was statistically not significant. Contrary, in Igbo communities, women who are between age group 25-34 who reported highest (80%) discontinuity of FGM and the same age group reported lowest (20%) continuity. It was significant ($p< 0.05$). Also, Yoruba women was similar to Hausas' in this regard, women who are above 35 years reported highest (73%) discontinuity, as well as lowest continuity.

Furthermore, among women who are Hausas' those who had secondary education and higher have highest (77%) discontinuity of FGM, compare to others with low education. This relationship was significant at ($p< 0.05$). While in Igbo, the women who had secondary school and more were highest (79%) who reported discontinuity of FGM. Also in Yoruba, the women who reported discontinuity of FGM were highest (74%) among those who had secondary school and above. This was statistically significant at ($p<0.01$). Among the three ethnic groups, the Yorubas' reported 26% of continuity higher than other two ethnic groups.

The women who are traditionalist reported highest (81%) discontinuity of FGM, followed by Christian (78%) and Islam (70%) in Hausa. This relationship was not significant. In Igbo, women who are Christian and Islam reported highest (79%) discontinuity of FGM, while traditionalist (41%). The traditionalist has highest number of continuity of FGM among Igbo women. The association was highly significant between FGM and religion ($p< 0.01$). More so, among Yoruba women who are Christian reported highest (79%) discontinuity of FGC, followed by Islam (61%) and the Traditional (35%). This was strongly significant ($p<0.01$).

The place of residence, like the Hausas' women in urban areas reported highest (79%) discontinuity, while in rural areas (67%) reported FGM discontinuity. Nevertheless, about 33% still agreed that FGM should continue in rural areas and it was statistically significant ($p< 0.01$). Igbo had (79 %) discontinuity of FGC in urban areas and (76%) in rural areas. Yoruba had 73% of discontinuity in urban and (62%) in rural areas. It was not significant.

Concerning the wealth status of women, the rich reported the highest (83%) discontinuity of FGM among the Hausas' and the poor class reported highest (34%) continuity. It was highly significant ($p<0.01$). The Igbo women reported highest (80%) among the rich, followed by the middle class (76%) and the poor (72%) the discontinuity of FGC. It was a significant relationship ($p< 0.05$). The Yorubas' reported highest (73%) discontinuity among the rich, and highest (44%) continuity among the poor. It also significant at ($p< 0.05$)

More so, the marital status of women in Hausa, for those have been married before either widow or divorced had highest (75%) discontinuity of FGM and those who are currently married had highest (30%) continuity of the practice. It was not significant. The Igbos' who are currently married and those never married had highest (79%) reported discontinuity of FGM and

those formally married had highest (27%) continuity of FGM. It was not significant. Yoruba women who are formally married had highest (75%) discontinuity and those currently married had highest continuity of FGM. This was significant ($p<0.05$)

MULTIVARIATE ANALYSIS RESULT: USING LOGISTIC REGRESSION

*****Model 1

The attitude of women who are Yorubas' were less (OR=0.9982), which means they are 1% less than women who were Hausas' to continue the practice of FGC. This relationship is not statistically significant. Women who were Igbos' have less than (34%) to continue the practice FGC compare to women who were Hausas' and it was statistically significant ($p<0.01$).This show that the Yorubas' and Hausas' women have high tendency of continuity of FGC.

*****Model 2

The continuity of female genital cutting among three major ethnic groups depends on women's marital status, wealth index, education, residence, religion and their age. Regarding residences, women in rural area have 5% tendency less than those in urban to continue the practice of FGC. This was statistically insignificant. Also, the age group of the women has no significant implication has to the continuity of FGC. The odds ratio of age group (35+) is just a little bit higher than the age group (25-34), which is statistically insignificant. Even though the age group (35+) has little bit more likely than other age groups to continue the practice it was still not significant. Regarding women's marital status, there was an increase in the odds ratio of currently married (OR=1.0091) compare to the never married. This relationship was statistically insignificant. The women, who are formerly married, have a very slight decrease in their continuity of female genital cutting and also not significant. The education of women has just

little influence on whether to continue the practice of FGC or not. Women who had no education at all, have almost 9% tendency to continue FGC than those who had secondary education and more. It was not significant. While the women who had only primary education will at (6%) likely practice FGC compare to the women with secondary and higher. Even with that it is slightly significant (p=0.5). More interestingly, continuity of FGC practice has a religion undertone. The Islamic religion has about 91% more than Christianity, to continue the practice of FGC and this relationship was statistically significant (p< 0.01). Similarly, women who are traditional worshipper were three times (OR=3.2085) more likely to practice FGC compare to the Christian and Islam. This relationship was also highly significant (p< 0.01). The classes of wealth have little effect on continuity of FGM practice. The middle class has just little (21%) decrease in continuity of FGC compare to the poor class, yet the relationship was significant (p< 0.05). While the women in the rich class will decrease more than other two categories in the continuity of FGM practice and this is still insignificant.

*****Model 3

This is the third level of logistic regression to establish the significant predictors of FGM practice. The results are shown in the table 5.

The women who are living in the northern part of Nigeria known as 'Hausa' are not likely to practice FGM compare with the Igbos'. The odd ratio is (OR=2.266) and relationship was highly significant (p=0.000). The Yorubas' are more than two times (OR=2.684) likely to continue to practice FGM compare to Hausa. The relationship was also highly significant (p< 0.01). More so, the women from rural areas have about 30% tendency to increase their continuity of FGM practice compare to women who lives in urban areas. The relationship was slightly significant at

($p<0.05$). The age groups 24-34 has the highest (28%) tendency of FGM continuity than other two categories which was not significant. Age group 35 and above have lowest value of odd ratio among the three categories to continue the practice of FGM, which was highly significant ($p<0.01$). Furthermore, the marital status of women has little effect on whether or not to continue the practice. The formally married women have tendency to continue more than the women who have never married. The relationship was insignificant. The women who are currently married will continue the practice more than those who have not married. It was insignificant. Regarding the women who had secondary and higher, has a bit tendency more than those who had 'no education' to continue the practice of FGM. The relationship was not significant. The women who had secondary education and above have higher tendency to continue the practice of FGM compare to the women had only primary education. The relationship was significant ($p< 0.05$). The religion was a predictor of FGM continuity. The women who practice Islam, compare to those in Christianity, were twice (2.1241) more likely to continue the practice of FGM. This relationship was highly significant. Similarly, the women who are traditionalist, compare to those who are Christian have four times more (4.0597) tendency to continue the practice of FGM. The relationship was highly significant ($p< 0.01$). The wealth status of women serves as a predictor to FGM practice. The class of women who are poor have tendency to continue the practice of FGM than the middle class. It was not significant. Similarly, women who are poor have more tendency to continue the practice of FGM than those who are rich (OR=0.6254). The relationship was highly significant.

SUMMARY AND DISCUSSION

From the analysis, most of the respondents (74%) were currently married and the lowest were formally married (5%). Majorities were from Hausas' (45%) and the tendency to continue was

still on a high side (23%). The highest (34%) numbers of respondent were between the age group of 35 years and above. At least 47% of the women finished secondary and higher education while 36% had not been to school at all. The women who were Islam have highest (51%) and the lowest was the traditionalist (1%). Most of them are among the rich (48%) and the lowest was from the middle class.

At a bivariate level of analysis, the factors were significantly associated with discontinuity of FGM among the three ethnic groups are; women's wealth status, residence, education and religion. FGM was more prevalence among the Yoruba ethnic group compare to Hausa and the Igbos' and from poor wealth index, this because Yorubas' has cultural intimacy among themselves and that make it possible to continue the practice. It is interesting to note that Islamic has highest reported (39%) in Yoruba, (40%) in Igbo, (28%) in Hausa who want to continue the practice of FGM. Also, women who lives in urban will discontinue this practice more than those who lives in the rural areas.

The significant predictors of FGM were age of women, wealth index, education, religion and marital status. The women who were 35 years and above have highest discontinuity of the practice of FGM compare to other age groups. Women who never married will not continue the practice of FGM compare to those who are currently married and formally married. Education of women will do a lot good for the discontinuity of FGC practice. According to this study, women who had secondary school and higher will not likely to continue the practice compare to those who had lower education or none. From this study, it was also observed that from all the ethnic groups, Islamic religion (91%) more likely to continue the practice of FGC compare to Christianity, while traditional worshippers three times (OR=4.0597) more than other two religion specify in this study.

However, several limitations of the study merit our discussion. The women who practice traditional religion are not well capture, who had interest also in the continuity of FGC. The paper is limited by inadequate knowledge of women to continue FGC and its implications. Finally, the paper is unable to lay hold completely on causality of FGC continuation among the three ethnic groups.

CONCLUSION

Based on these findings, the paper recommends several interventions: first, mass media publicity of FGCs' danger and it long term effect. It is just of recent that those rear publicity in the television and radio and if this can be intensify, there will be reduction in the continuity in the FGC practice. Also, the ministry of Health will do more by establishing programmes both in Primary Health Centers and government hospitals to facilitate the discontinuity of FGC among women. In addition, it is necessary to promote initiatives that are aimed at preventing FGC continuation. We need programmes that will educate men on the effect and maternal complication attached to this practice. In the future, there is need for further research on relationship of FGC and religion view. It is necessary to explore the reason(s) why FGC is most prevalence among the Yorubas' compare to other ethnic groups.

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APPENDIXES

Table 1: Percentage distribution of socio-demographic variables, knowledge, Attitude by background characteristics to Practice Female Genital cutting

Background Factors	Frequency (26,292)	Percentage (100%)
Independent variables		
Age:		
15-24	8,410.26	31.99
25-34	8.876.83	33.76
35+	9,005.86	34.25
Education:		
No Education	9,421.73	35.83
Primary	4,510.25	17.15
Secondary+	12,360.96	47.01
Religion:		
Christian	12,547.54	47.95
Islam	13,420.70	51.29
Traditional	200.26	0.77
Residence:		
Urban	12,417.58	47.23
Rural	13,875.36	52.77
Wealth Index:		
Poor	9,180.92	34.92
Middle	4,528.83	17.22
Rich	12,583.19	47.86
Marital Status:		
Never Married	5,434.35	20.67
Currently Married	19,476.86	74.08
Formally Married	1,381.73	5.26
3 Ethnic Groups:		

Hausa	7,877.94	45.79
Igbo	4,648.93	27.02
Yoruba	4,676.67	27.18
Dependent Variable		
Attitude:		
Continue	6,065.37	23.07
discontinue	20,227.58	76.93

Table 2: Associations between Female Genital Cutting and the attitude of 3 Major Ethnic Groups

Socio-Demographic	Hausa		Igbo		Yoruba	
	Continue	Discontinue	Continue	Discontinue	Continue	Discontinue
Age:						
15-24	0.3034	0.6966	0.2464	0.7536	0.3185	0.6815
25-34	0.3004	0.6966	0.1963	0.8037	0.2973	0.7027
35+	0.2819	0.7181	0.2109	0.7891	0.2744	0.7256
Chi2(p=value)	2.9888(0.3489)		11.7530(0.0293)		7.4164(0.1481)	
Education:						
No Education	0.3164	0.6836	0.2499	0.7501	0.4769	0.5231
Primary	0.2417	0.7583	0.2499	0.7501	0.3825	0.6175
Secondary+	0.2271	0.7729	0.207	0.793	0.2617	0.7383
Chi2(P=value)	43.3070(0.0018)		9.0832(0.1411)		87.4975(0.0000)	

Religion:						
Christianity	0.2247	0.7753	0.2137	0.7863	0.2152	0.7848
Islam	0.2962	0.7038	0.2147	0.7853	0.3902	0.6098
Tradition	0.1881	0.8119	0.5862	0.4138	0.6539	0.3461
Chi2(P=value)	2.1737(0.3773)		37.1447(0.000)		194.2201(0.0000)	
Residence:						
Urban	0.2149	0.7851	0.2071	0.7929	0.2746	0.7254
Rural	0.3276	0.6724	0.2443	0.7557	0.3732	0.6268
Chi2(P=value)	86.2686(0.0006)		7.4502(0.2845)		36.7021(0.0914)	
Wealth Index:						
Poor	0.3355	0.6645	0.2798	0.7202	0.4665	0.5335
Middle	0.2777	0.7223	0.2423	0.7577	0.4041	0.5959
Rich	0.174	0.826	0.1962	0.8038	0.2746	0.7254
Chi2(P=value)	128.4731(0.000)		26.1920(0.0133)		60.9664(0.0177)	
Marital Status:						
Never Married	0.2849	0.7151	0.2218	0.7782	0.2702	0.7298
Currently Married	0.2979	0.7021	0.2075	0.7925	0.3074	0.6926
Formerly Married	0.248	0.752	0.2741	0.7259	0.2501	0.7499
Chi2(P=value)	2.9450(0.05790)		7.9078(0.1450)		8.4585(0.0537)	

Table 3

Attitude 2	Odds Ratio	t	p>/t/	[95% conf.	Interval]
Igbo	0.6627721	-3.27	0.001	0.5178108	0.8483153
Yoruba	0.9982359	-0.01	0.989	0.7676283	1.298122
Hausa (R)	1.000				
_cons	0.4189447	-10.58	0.000	0.3565011	0.4923256

Table 4: Adjusted odds ratios from logistic regression model examining the effect of female genital cutting on women in major ethnic groups, controlling for background factors.

Attitude 2	Odds ratio	t	p>/t/	[95% conf.	Interval]
Rural	0.9516302	-0.44	0.663	0.7610875	1.189876
Urban (R)	1.000				
25-34	0.9098334	-1.86	0.063	0.8235346	1.005176
35+	0.9141792	-1.59	0.112	0.8183026	1.021289
15-24 (R)	1.000				
Currently Married	1.009117	0.12	0.905	0.8685534	1.17243
Formally Married	0.9463177	-1.48	0.629	0.7561383	1.18433
Never Married(R)	1.000				
No Education	1.089997	0.84	0.399	0.8920211	1.331913
Primary	1.05928	0.60	0.548	0.8776242	1.278536
Secondary+ (R)	1.000				
Islam	1.91226	6.16	0.000	1.555257	2.351213
Traditional	3.208474	3.80	0.000	1.758349	5.854532

Christianity (R)	1.000				
Middle	0.7990112	-2.31	0.021	0.6602349	0.9669573
Rich	0.7045161	-2.31	-3.01	0.56053	0.8854886
Poor (R)	1.000				
_cons	0.2617957	-8.04	0.000	1.887736	0.3630646

Table 5

Attitude 2	Odds Ratio	t	p>/t/	[95% conf. Interval]	
Igbo	2.266224	4.28	0.000	1.556843	3.298836
Yoruba	2.683964	5.43	0.000	1.87845	3.834896
Hausa (R)	1.000				
Rural	1.279271	2.15	0.032	1.021847	1.601545
Urban (R)	1.000				
24-34	1.279271	-1.89	0.060	0.7989048	1.004501
35+	0.801399	-3.20	0.001	0.6994758	0.9181739
15-24 (R)	1.000				
Currently Married	1.03849	0.41	0.679	0.8681193	1.242296
Formally Married	1.045459	0.33	0.741	0.8032206	1.360754
Never Married (R)	1.000				
No Education	0.9259873	-0.72	0.470	0.7515882	1.140854
Primary	0.7893395	-1.97	0.049	0.6234582	0.9993562
Secondary +(R)	1.000				

Islam	2.124058	6.04	0.000	1.663025	2.7129
Traditional	4.059738	4.16	0.000	2.094137	7.870294
Christianity(R)	1.000				
Middle	0.8495363	-1.64	0.102	0.6986096	1.033069
Rich	0.625396	-3.83	0.000	0.4915398	0.7957038
Poor (R)	1.000				
-cons	0.2051663	-8.50	0.000	0.1422987	0.2958089
*p< 0.05, R-Reference Category					