FEMALE GENITAL MUTILATION PRACTICE IN NIGERIA: PATTERNS, PREVALENCE AND REMEDIES. ***By Chinyere C. P. Nnorom; Department of Sociology, University of Lagos; Lagos, Nigeria.***

Abstract

The paper analyzed the data collected during the NDHS 1999 survey on FGM with a view of ascertaining the type and extent of prevalence. The study revealed that FGM is widespread in all the regions with clitoridectomy accounting for about 80 percent of the cases. Infibulation and excision were also found to be in practice though on a smaller scale. When compared with NDHS 2003, there were considerable similarities in the two surveys. Other studies conducted by some individuals and organisations by state, type and prevalence rates were also reviewed and it was discovered that types II and IV were the more common. Prevalence rate ranged from 1 percent to a nearly 100 percent in some states. Durkheim's functionalist theory was used to support the continued existence despite the outlined implications. The paper suggests ways the practice could be curtailed so as to ensure better health for women.

Key Concepts: **female genital mutilation, prevalence, patterns, practice**.

INTRODUCTION/BRIEF LITERATURE REVIEW.

Female Genital Mutilation (FGM) practice is as old as history itself. Although the history of its origin is not clear, it seems to be traced back to Ancient Egypt some 2000 years ago (Kiragu, 1995). In addition, some authors associate the practice as a component of the African Culture (Gibbs, 1965) in the same way as it is in other groups of the world (Hosken, 1993). The practice entails cutting parts of the female external genitalia or other injury to the female genitals either for cultural or any other non-therapeutic reasons (World Health Organisation (WHO) [1995].

Traditionally, FGM is called 'Female Circumcision' (FC) but the realisation of its harmful physical, psychological and human rights consequences has led to the use of the terms, 'Female Genital Mutilation' or 'Female Genital Cutting' (FGC) to describe more accurately the consequences of the procedure and distinguishes it from the much milder 'male circumcision' (Kiragu, 1995). The practice, which exists in many forms, is found in almost all parts of the world. It is in practice in one form or the other in 28 countries in the African continent, in a few countries on the Arab Peninsula, among some minority communities in Asia, and among migrants from Africa, Arab and Asia who have settled in Europe, Australia and North America (Dorkenoo and Elworthy, 1992; Hosken 1993; Toubia, 1993). It is also believed to have been practised at one time or other in many Western countries (Hosken, 1993; Lightfoot-Klein, 1989; WHO, 1986).

Between 100 million and 132 million women worldwide are estimated to have undergone the operation while another 2 million face the torture on a yearly basis (Hosken 1993; Toubia, 1993; United Nations Children's Emergency Fund [UNICEF], 1994). In addition, the operation is forced on approximately 6000 girls worldwide daily – about 1 every 15 seconds (fgmnetwork.org). In Africa alone over 50 million women had been circumcised and female circumcision is practised less often in parts of Near East, Asia, South America and Australia (Rushwan, 1984). The operation is performed on girls whose ages range from 3 days to puberty as a rite of passage to true femininity and sometimes is justified as an embellishment required for securing a husband (Assad, 1980; Ogunmode, 1979; Ragheb *et al*. 1978; WHO, 1979). In some parts of Africa, FGM is delayed until during pregnancy or until two months before a woman is due for delivery (Owunmi, 1993; Akpabio, 1995). This is based on the assumption that the baby may die if he/she comes into contact with the mother's clitoris during birth although there is no medical evidence to support this. Some cultures also perform circumcision after death (Penawou, 1980), where the woman was not circumcised when she was alive.

Some studies conducted in the past in Nigeria had shown that FGM is widespread in the country. It is estimated that more than 50 percent of Nigerian girls/women had been circumcised while a substantial number face the torture yearly (Inter–African Committee [IAC] {Nigeria} 1997). Some of these studies include those of Owunmi (1993) and Myers *et al*. (1985) among the Urhobos of Delta State; Myers *et al.* (1985) among Ishan and Bini of Edo State; Adeneye (1995) in Abeokuta of Ogun State; Olafimihan (1993) in Ibadan of Oyo State and Ilorin of Kwara State; Akpabio (1995) in Oyi in Anambra State and Ibibio in Akwa Ibom State; Ofikwu-Abba (1993) among the Idoma speaking people of Benue State and various studies by IAC (Nigeria) at different times in Adamawa, Borno, Jigawa, Kaduna, Lagos, Plateau and Rivers states among others.

Findings of these varied studies had continued to expose the unflinching attitude of the practitioners. While many reasons are advanced for this deeply entrenched cultural practice, the basic intention is to diminish female sexual pleasure in order to achieve virginity before marriage and fidelity after marriage. There is no proof to show that circumcised women are less promiscuous. In as much as promiscuity should not be encouraged, FGM practice has been found to have physical, psychological, psychosexual and health implications on the victims. In addition, the practice is sustained because of the supposed pleasure that the husband will derive at the expense of the woman. Despite these implications and the efforts being made by the world body, to eradicate this health threatening practice, many countries in

Africa (Nigeria inclusive) and elsewhere have continued to subject their womenfolk to the practice. Most girls/women in Nigeria still face the ritual annually irrespective of their religious inclinations.

This paper critically reviews the patterns and prevalence of FGM as documented by the Nigeria Demographic and Health Survey (NDHS) reports of 1999 and 2003, the first of its kind to have a national coverage. Other studies conducted in the country are also reviewed and suggestions for its prevention and eradication to ensure a better health for women for more equitable society are recommended. To achieve this, the paper is divided into seven sections. This introductory/brief literature review aspect forms the first section. Section two looks at the definitions and types of FGM as classified by individuals, groups and organisations; section three discusses the patterns of FGM found in different regions (and states) in Nigeria and the extent of their prevalence; section four enumerates the reasons behind the practice. The health implications of the practice are discussed in section five. Section six examines the justification for the continued existence of the practice through a theoretical backing while section seven outlines suggestions and recommendations for the prevention and, possibly, total eradication of the practice in the country.

DEFINITIONS AND TYPES OF FGM

FGM, FC or FGC as it is variously called refer to the cutting or alteration of the female genitalia for social rather than medical reasons (Rahman and Toubia, 2000:4). It has also been referred to as any practice which includes the removal or the alteration of the female genitalia (Sarkis, 2003). It also comprises all methods involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons (WHO, 2001:1). IAC [Nigeria] 1997:4 defined it as 'any interference with the natural appearance of the female external genitalia using a blade, knife or any sharp instrument in order to bring about either a reduction in size of the clitoris or a complete removal of the vulva'. From the foregoing definitions, FGM can be defined as any act (deliberate or not) to partially or wholly tamper with the female external reproductive organ under the guise of culture, religion or any other belief.

Several forms of FGM thrive in the world today and they vary from culture to culture and from place to place. Okonofua identified four types performed in Nigeria. These include *Type I* (also known as *Sunna*) – excision of the hooded clitoris with or without excision of the tip of the clitoris. *Type II* – removal of the hooded clitoris together with partial or total removal of the labia minora (inner lip). *Type III* (also called *infibulation*) – excision of part or all of the external genitalia with or without the stitching of the

raw edges together/narrowing of the vaginal opening. *Type IV – Angurya* or *Gishiri* cuts incision extending from the vaginal opening anteriorly or posteriorly into surrounding tissue with damage to the urinary bladder/urethral opening or rectum and anus (listed in IAC [Nigeria] 1997).

Fgmnetwork.org identified three main types that are practised worldwide. These are: the *Sunna* circumcision or type I; *Clitoridectomy* or type II and *Infibulation* or type III, which is regarded as the most extreme form. These types conform to the types I – III identified by Okonofua. The above identifications also correspond to the one made by Modupe-Thomas (1995) but added the fourth type which she termed *De-infibulation* and *Re-infibulation*. The former refers to a situation where the infibulated victim is provided an appropriate setting during labour and delivery to avoid further complications like *Vesico-Vaginal Fistula* (VVF) among others. The latter refers to the restoration of the woman to the *original state* after delivery. WHO (1995) also identified four types. Types I – III corresponds to Type I – III identified above. Their type IV is what they termed 'a new category that encompasses a group of other operations on the external genitalia including introcision (e.g. gishiri cuts), piercing or incising the clitoris and/or labia, stretching the clitoris and/or labia, cauterization, scraping and or cutting off the vagina, introduction of corrosive substances and herbs into the vagina, and similar practices' (p.1).

Having identified the types of FGM in practice worldwide, the patterns and prevalence of FGM as found in different regions by National Population Commission (NPC) [Nigeria] (2000 and 2003) and states by some individuals and organisations are discussed in the next section.

PATTERNS AND PREVALENCE OF FGM IN NIGERIA

Prevalence and patterns of FGM in Nigeria were recorded by the NPC (Nigeria) [2000, 2003] as well as other studies conducted by some individuals and organisations in the country. This section reviews the data with a view of making a critical assessment of the situation. For NPC (Nigeria) [2000], which is the main focus of this paper, a total of 8, 206 women aged between 10 – 49 years were interviewed from different regions in the country. Women aged 10-14 years were included in the survey because the pretest conducted before the survey revealed teenage pregnancy, motherhood and early age at commencement of sexual activities (p. 7). However, analysis was restricted to women aged 15-49 because most of the variables were not relevant to women of younger ages. Table 1 (see Appendix) presents the percent distribution of women aged 15 – 49 by whether they have been circumcised, and if so by type of circumcision according to background characteristics. The table shows that 25 percent of

the total respondents were circumcised compared with 60 percent who were not circumcised. When broken down by age groups, the rate of circumcision increased with increase in age. This could be understood to mean that most women within 30 – 49 age category may have been circumcised before the awareness campaign on its harmful effects became apparent. The table also reveals that more urban than rural dwellers were circumcised and circumcision is more prevalent in the southwest, southeast and central region than in the northwest and northeast. This goes to explain that the practice is more of a cultural than religious phenomenon. Surprisingly, respondents with no education were the least circumcised followed by those with secondary education. Primary educated respondents had the highest percentage of circumcised respondents followed closely by those with higher education. This may mean that educated respondents may have been circumcised at a very tender age when they had no say in the matter.

On the type of circumcision performed, 82 percent of the total respondents claimed to have undergone clitoridectomy, 7 percent mentioned excision while 4 percent indicated infibulation. When analyzed by background characteristics the table revealed that older females aged 45 – 49 years performed more infibulation (87 percent) than any other age group and infibulation is more prevalent in the Northeast (50 percent) than excision (21 percent) and clitoridectomy (14 percent). In the other regions, clitoridectomy is more prevalent although excision and infibulation were slightly high in the Northwest. Central region recorded the least in both excision and infibulation with less than 1 percent prevalence rate. Those without education recorded the highest percent in clitoridectomy (85 percent) and infibulation (5 percent) but had the least in excision but primary educated respondents had the highest in excision. The result shows that the higher the education of respondents the less likely she is to be infibulated though primary educated respondents were excised more than infibulated.

Table 2 describes the percent distribution of circumcised women by age at circumcision according to background characteristics. From the table, it was discovered that most respondents (42 percent) were circumcised at birth and 23 percent were circumcised after attaining age 5 and above. Only very few (8 percent) had their circumcision performed between 1 – 4 years. When diagnosed by regions, most southeasterners (49 percent) and South westerners (41 percent) performed circumcision at birth-contrary to their northern counterparts who performed it mostly at age 5 and above. The higher the education, the higher the tendency for circumcision to be performed at birth and the lower the education the higher the possibility of performing infibulation after 5 years. Most excision and clitoridectomy are performed at birth and while more urban than rural dwellers perform circumcision at birth the reverse is the case at age

5 and above. In addition, the rural-urban differential may not give the true picture because most urban dwellers may have performed the rite in the rural area before moving to the urban centres.

Table 3 relates the opinion of all respondents (whether circumcised or not) on whether FGM should be continued by their characteristics and circumcision status. The table shows that most urban and rural dwellers are of the opinion that the practice should be discontinued although 17 percent and 15 percent respectively want the practice to continue. However, respondents from the Southwest top the list of those who want the practice to continue followed by the southeast. Most respondents from all the regions approve of its discontinuation with Northeast having the greatest share (63 percent) and Southwest with the least percentage (39 percent). What informed this response from the Northern region might not be unconnected with infibulation, which is a more severe form, and which is found to be more prevalent in those regions than in the southern part. On the other hand, more of those with primary education want the practice to continue while the highest percentage that feels the practice should be discontinued came from those with higher education. This response by the higher educated respondents shows that the higher the education the more likely one is aware of the health implications of the practice. Circumcised respondents are most likely to want the practice continued. The *Don't know* response exhibited by both circumcised and uncircumcised respondents may be as a result of fear of the outcome of their responses or better still, their having a genuine undivided opinion of the issue.

Table 4 illustrates responses of women with daughters on whether their eldest daughters were circumcised or they plan to circumcise them in future. The table shows that 20 percent of the women had already circumcised their eldest daughters, 4 percent still plan to circumcise those uncircumcised and 74 percent had no plan to do such. When broken down by regions, more respondents from the southwest had circumcised their eldest daughter but more southeasterners (8 percent) plan to circumcise theirs and more northerners had no plans to circumcise their daughters. For education, more of those with primary and secondary education had circumcised their daughters and many more still plan to circumcise but most of those without education have no plans to circumcise their daughters. This may mean that more educated respondents are more difficult to convince in what they have internalized than their non-educated counterparts. On circumcision status, those who are circumcised are more likely to circumcise their daughters and plan to circumcise those not yet circumcised than their non-circumcised counterparts. This may mean that those circumcised are more likely to believe in the reasons for circumcision than those not circumcised.

Table 5 seeks to know the reasons of women (who feel FGM should continue) for supporting FGM and 50 percent of them attribute their reason to *custom* and *tradition*, another 35 percent attribute it to what they term *Good tradition*. Another significant reason given was *preservation of virginity/prevention of immorality* (14 percent). For those who don't support the continuation of the practice (Table 6) reasons given in order of significance are: *bad tradition, against religion, medical complications, painful personal experiences, against dignity of women and prevents sexual satisfaction.* From table 5 and 6 it is of importance to mention here that tradition rather than any other reasons enumerated above is responsible for the continuing existence of FGM. So, for any meaningful headway to be made in its eradication, custodians of customs and traditions must be carried along. Circumcision practitioners were the main providers of circumcision (37 percent) followed closely by traditional birth attendants (TBAs) [36 percent] and Nurse/Midwife (11 percent) and least of them all, doctors with 2 percent.

The result of the NDHS 2003 did not differ so much from the above analysis except that some variables used in the 1999 survey were not included in the 2003 survey, which may make comparison difficult. For instance, attitude towards female circumcision was disaggregated by sex in 2003 but 1999 survey had information on women respondents only. Ethnic affiliation and South South region featured in the 2003 survey, which was conspicuously omitted in the 1999 survey. So, while the North Central was the third most prevalence region in 1999, the South South occupied the third position in 2003 (Table 8). Twenty five percent of women in 1999 were circumcised as against 19 percent in 2003 but 42 percent and 75 percent respectively were circumcised at age zero and below one and more respondents were circumcised after five years in 1999 survey (23 percent) than in 2003 (21 percent)[See Table 9].

Nevertheless, 66 percent of women and 63 percent of men in 2003 (Tables 13 & 14) wish the practice discontinued as against 47 percent of women in 1999 indicating that more people may have realised the dangers inherent in the practice. Three most important reasons given by women in 2003 for the continuation of the practice are: preserve virginity/prevent premarital sex (36 percent), better marriage prospects (35 percent) and social acceptance (28 percent). For the men, preservation of virginity/prevention of premarital sex, better marriage prospects and more pleasure for the man (23 percent) were their three most important reasons (See Table 12). Those not in support of the practice, their single most important reason (for the women) is more sexual pleasure for the woman (35 percent) and more sexual pleasure for the man (45 percent)[for the men] (Table 15). In sum, the differences in the responses in the two surveys are similar in many respects indicating that the two surveys can be used without any significant change in meaning or interpretation.

As the data from NDHS 1999 and 2003 were not broken down by states, some studies conducted by individuals and organisations by states were used to supplement the NDHS 1999 and 2003 data. Table 7 shows the data by state, type, prevalence and source. From the table, types II and IV are the more common forms of circumcision in Nigeria but while type II is common in the southeastern and southwestern states, type IV is found mostly among the Northern states. Benue and Ondo states have a nearly 100 percent prevalence rate of type II, while type IV and type I are more prevalent in Kebbi and Osun states respectively. Except in Rivers and Plateau states, practitioners of type I reside in the western states of the country. It is only Borno state where type III is practised. The state with the least prevalence is Kogi State with 1 percent prevalence rate. Altogether, the prevalence rate of FGM in Nigeria varies from 1 percent to a nearly 100 percent indicating that the practice is still deeply rooted in the country. For a better understanding of its continued practice, some reasons given for its retention worldwide, and Nigeria in particular, is reviewed in the next section.

REASONS FOR CONTINUED PRACTICE OF FGM

The continued practice of FGM appears to be largely grounded in a desire to terminate or reduce feelings of sexual arousal in women so as not to engage in pre-marital sex or adultery. As the clitoris holds a massive number of nerve endings, and generates feelings of sexual arousal when stimulated, leaving it untouched will lead to promiscuity. Secondly, uncircumcised women in countries where it is largely practised may have difficulty getting a marriage partner as most men in such countries prefer circumcised women since they are considered more likely to be faithful than non-circumcised women. Other claims in support of FGM include:

- The clitoris is dangerous and must be removed for health reasons. While some believe it could make a man sick or die, others think it could make him impotent. Others still believe it will affect a child if its head touches it and others feel the milk of the mother will become poisonous if her clitoris touches the baby.
- The presence of the clitoris and labia minora emits bad genital odour and so cutting it off is healthy and necessary.
- FGM prevents vaginal cancer
- An unmodified clitoris can lead to masturbation or lesbianism.
- FGM prevents nervousness from developing in girls and women.
- FGM prevents the face from turning yellow.

- FGM makes a woman's face more beautiful
- If FGM is not done, older men may not be able to match their wives' sex drive and may have to resort to illegal stimulating drugs.
- An intact clitoris generates sexual arousal in women, which can cause neuroses if repressed (religioustolerance.org). And the list is endless.

Other reasons identified by Modupe-Thomas (1995:7) in her discussions with those determined to continue the practice are: aesthetic reasons, to curb promiscuity, as a rite of passage and to prevent infertility and as a cure for infertility.

The reasons enumerated above, we know, are unfounded but they seem to be quite convincing to most practitioners. Or better still, they feel that tradition and custom must be preserved for continuity sake. This position is buttressed by the NDHS (1999) data. As many as 85 percent support the continuation of the practice on grounds of custom and tradition which by implication need not be challenged whether good or bad. This could be the only reason that can lay credence to its continued existence. To this end, the next section looks at the health implications facing women as this practice continues unabated.

THE HEALTH IMPLICATIONS OF FGM PRACTICE

Several health implications have been advanced for victims of FGM. These implications had been found to be similar in almost all societies where it is practised. However, the immediate and long-term health consequences of FGM vary according to the type and severity of the procedure performed. The immediate health consequences as identified by WHO (2000) include: *severe pain, shock, hemorrhage, urine retention, ulceration of the genital region and injury to adjacent tissue.* Hemorrhage and infection can also cause death. More recently, concern has also arisen about possible transmission of the Human Immuno-deficiency Virus (HIV) – the virus that causes Acquired Immune Deficiency Syndrome (AIDS) – due to the use of the same instrument in multiple operations – though this has not been subjected to further research.

The long-term consequences include *cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia (painful sexual intercourse) and sexual dysfunction and difficulties with childbirth.* On psychosexual and psychological health, FGM may leave a lasting mark on the life and mind of the women that has gone through it. On the long run, women may suffer feelings of incompleteness, anxiety and depression (pp. 1-2).

Modupe-Thomas (1995:6-7) identified *urinary tract infection, Haematocoipos, obstructed labour, dermoid cyst and inability to consummate the marriage* as some of the complications faced by infibulated victims.

With these health implications made known to both practitioners and custodians of culture and tradition, the practice goes on unabated. Even the supposedly victims are willing to face the excruciating pains rather than face shame, humiliation and antagonism in their various societies. Also where the victims do not believe in the reasons enunciated for the practice they still find themselves complying with the customs and traditions. What could be responsible for this unquestionable compromise? This is what the next section hopes to unfold as it looks at the theoretical justification for its practice.

THEORETICAL CONSIDERATIONS/ISSUES.

Most Radical Feminists, though differ in their interpretation of the root of patriarchy, agree that it entails the misuse of women's bodies and sexuality in some form. Firestone (1971) argues that men direct women's roles in reproduction and child rearing. Because women are biologically capable to bear children, they become reliant materially on men for protection and livelihood. This 'biological inequality' is socially organized in the nuclear family. For her, women can be liberated only through the obliteration of the family and the power relations that exemplify it. For the Radical Feminists, all existing societies are laden with subjugation and every institution in place in society has a structure that promotes domination and subjugation between classes be it castes, races, tribes, religions, age groups or gender. However, of all these system of domination and oppression, the most prominent form of oppression is to be found in gender. Through participation in Patriarchy, men learn how to hold others in contempt, see them as non-human and control them as a result. Central to this argument is the picture of patriarchy as violence practised by men and male dominated organizations against women. Violence may not always take the form of evident physical brutality but can be concealed in more intricate practices of exploitation and control: in standards of fashion and beauty; in dictatorial principles of motherhood, monogamy, chastity, and heterosexuality; in sexual harassment in the workplace; in the practices of gynaecology, obstetrics, and physiotherapy; in unpaid household drudgery and underpaid wage work. Violence exists whenever one-group controls in its own interest the life chances, environments, actions, and perceptions of another group, as men do women. Men create and maintain patriarchy not only because they have the resources to do so but also because they have real interests in making women serve as submissive apparatus. Women are for one thing, a uniquely effective means of satisfying male sexual desires. Their

bodies are, further, essential to the production of children. As men are to derive sexual satisfaction from women's bodies, FGM is seen as one way of achieving that hence, the continued practice.

In as much as Patriarchy entrenches male domination and subjugation of the female gender, it is worthy of note that women in almost all known societies mostly sustain the practice of FGM. This raises the question as to who should have the greater blame in its continued practice. If women who go through physical, psychological, psychosexual and health implications are willing to subject fellow women to such practice, then there is more to it than Patriarchy. However, that is not to say that their subordinate position in power relations should be ignored in trying to explain the observed inclination.

Durkheim's (1938) functionalist theory lays credence to the continued existence of FGM in various societies where it is practised. For Durkheim, society has a reality of its own over and above the individuals who comprise it. Members of society are constrained by what he termed *social facts*, which, external to the individual, direct his ways of action, thinking and feeling and are endowed with a power of coercion by which they enforce control. Beliefs and moral codes are handed down from one generation to another and shared by individuals who constitute a society. So, it is not the consciousness of the individuals, which directs his behaviour but common beliefs and sentiments, which transcend the individual and shape his consciousness. He explains that the continuing existence of a social fact lies in its function, that is, in its usefulness for society. They continue in existence, therefore, because they contribute in some way to the maintenance of society in that they serve some social end.

The most important of the functional prerequisite, to him, is *social order*. He sees consensus as a way a collection of individuals can be integrated to form an ordered society. So, without consensus or agreement on fundamental moral issues, social solidarity becomes impossible and individuals will not be bound together to form an integrated social unit. Without social obligations backed by moral force, the cooperation and reciprocity which social life requires would be absent. These social obligations are what he termed a *collective conscience* which consists of common beliefs and sentiments.

Durkheim's analysis helps one to understand the reason behind the persistence of FGM in spite of its well-known health implications. The practice is embedded in the customs and traditions of societies where it operates and interpreted as a social fact which must persist because of the supposed usefulness it serves the society: that of attenuating sexual desire in the female, maintaining chastity and virginity before marriage and fidelity during marriage as well as increasing male sexual pleasures, among others. This degradation of the female gender to the status of a *sexual tool* of the partner is not unconnected with the position the female gender occupies in the contraction of marriage – that of a property for the husband

to be used as he likes. This is so because he who pays the piper dictates the tune. Women, most often, are in the receiving end in the contraction of marriage. The men do all the giving and in some societies the bride price and the bride wealth demanded are so outrageous that the men see their partner as properties purchased that could be used as desired. So, the women's opinions are not sought in family matters even when her opinion might lend a great weight. In that regard their opposition to the practice of FGM may not be given due consideration if the men see the practice as worthwhile. For the wide gaps existing between the sexes to be closed up or narrowed, marriage contraction which gives the male gender an upper hand in a supposedly equal relationship should be revisited.

The next and final section suggest tactics, strategies and remedies that can be adopted to make the practice of FGM a thing of the past in this country.

STRATEGIES FOR PREVENTION AND ERADICATION

First and foremost, Nigerian government should recognise this problem and identify with it. It is one thing to recognise FGM as violating the rights of women and another to enforce laws that bring to justice those who perpetrate this act. If government of Nigeria is committed to its eradication, laws prohibiting the act should be made known and available at the local and state levels where most of these acts are perpetrated. This will require translating such laws into local languages for local inhabitants to internalise. Also media houses should be co-opted in the sensitisation programme so that the dangers of FGM are incorporated into news and other interesting programmes the public patronise.

The use of drama to drive home the point should also be tried and real life situations used to make the dangers a reality to victims and practitioners alike. Here the non-governmental organisations, ministries of Health at both the federal and state levels and other stakeholders should go into these villages and areas and educate practitioners on the dangers of FGM.

In many areas where FGM is practised it serves as an initiation rite and that is why many practitioners see its eradication as an encroachment on their custom. To avoid such antagonism, such initiation rites should be encouraged to go on without mutilation. In other words, other rituals associated with the practice can still be allowed to go on without necessarily mutilating the victim. This will bring a sense of fulfillment on the part of societal members and participants.

Abolishing FGM practice means creating unemployment for the practitioners and this could be one of the reasons for the reluctance to abolish the practice. Alternative jobs must be provided for these practitioners to discourage them from being tempted to continue the practice. Effort should be made to

retrain the practitioners to adapt into other areas of endeavour easily. The effort being made by Women's Health and Action Research Centre (WHARC) in Benin, Edo state is commendable and the practitioners having been provided with alternative and more rewarding jobs are now openly condemning the practice and advising couples to desist from mutilating their daughters. Messages of this kind passed from former practitioners to their community members are sure to lend weight to its eradication.

Male involvement in the entire exercise should not be swept under the carpet. Most societies where the practice persists are patriarchal in nature. In such societies, women have little or no say and as such cannot effect any change. Sensitisation of the male gender becomes imperative since most reasons given for its persistence are for their pleasure. If they oppose these reasons by campaigning openly against FGM then, one may be convinced to believe that the practice is not instituted in the first place for their pleasure.

Finally, education of the girl child will go a long way in the achievement of FGM eradication. In the first place, education will equip her with the knowledge of knowing the health implications of FGM. When confronted with such problem, as many women face, she will be in a better position to argue her case convincingly. Secondly, it will empower her in knowing when to seek redress when her right is infringed upon or threatened.

The issue of HIV/AIDS should not be ignored when discussing FGM. Most of these mutilations are done under unhygienic conditions coupled with using the same instrument for multiple operations. The implications cannot be ignored in this era of HIV/AIDS pandemic, a disease that is still incurable and have devastating consequences on the population.

CONCLUSION

The paper looked at FGM in Nigeria as documented by the NDHS 1999 report with a view to identifying the patterns, prevalence and practice. It also compared the findings with the NDHS 2003 report and found many similarities in the two surveys. The paper revealed that FGM is widespread in the country and the rate of prevalence range from 1 percent in a place like Kogi state and to a nearly 100 percent in places like Benue and Ondo States. While type II was prevalent in the southern regions, type IV was found to be more common in the North but type I was concentrated in the southwest except Rivers and Plateau states where it was also found to be in practice. Most women in the NDHS 1999 report had clitoridectomy operation (82 percent) but infibulation, though small, was mostly practised in the northern

regions. Customs and traditions were the most significant reasons mentioned for the support of the practice and circumcised women are more likely to have their female daughters circumcised.

For the practice to be eradicated, governments – both at the federal, state and local levels – should be more responsive to the situation and enforce workable laws to deter practitioners from continuing the practice. Alternative employment should be created for these practitioners and enlightenment campaigns should be designed with various cultures in mind to suit different purposes. Such campaigns could be turned to drama to make the message more meaningful.

The inclusion of the male folk in the whole exercise is also recommended as one of the viable strategies to be explored.

Finally, educating the girl child is also considered very important as this will help to eradicate the practice in the long run. In addition, educating a woman entails educating a nation. For development and progress attained in other parts of the world to reach this nation, inequality in the provision of education for the sexes must be revisited.

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APPENDIX

Table 1: **Percent distribution of women aged 15-49 years by whether they have been circumcised and among those circumcised, percent distribution by type of circumcision according to background characteristics.**

Background Characteristics Age	Circumcised	Not circumcised	No of Women	Type of Circumcision Clitoridectomy	Excision	Infibulation	No. of women
15-19	8.8	38.6	1775	82.0	5.1	7.8	157
20-24	19.6	65.2	1521	81.4	7.8	3.4	298
25-29	26.4	69.0	1516	81.2	8.3	2.9	400
30-34	31.3	67.4	1137	82.1	6.5	3.2	356
35-39	31.0	67.9	992	81.0	6.7	5.7	307
40-44	37.9	60.9	696	81.3	6.6	4.7	264
45-49	48.3	51.3	568	86.9	4.7	0.8	274
Residence							
Urban	30.0	51.5	2540	77.8	6.9	4.1	761
Rural	22.9	63.0	5666	84.8	6.6	3.6	1295
Region							
Northeast	1.9	91.1	1292	(13.7)	(20.6)	(49.9)	25
Northwest	2.6	92.4	1087	(69.1)	(14.7)	(13.3)	28
Southeast	36.5	39.1	1886	75.0	11.7	3.7	689
Southwest	48.4	32.5	2080	84.2	4.6	3.3	1008
Central	16.4	69.1	1861	98.6	0.7	0.7	306
Education							
No Education	15.6	81.1	3324	85.1	5.2	5.2	518
Primary	36.1	48.0	1868	83.0	8.0	1.9	674
Secondary	27.6	40.3	2506	79.9	6.7	4.6	692
Higher	33.8	54.7	508	79.6	6.5	3.6	172
Total (Nigeria)	25.1	59.5	8206	82.2	6.7	3.8	2056

(Culled from NPC (Nigeria) 2000 p.135)

- (Note: The percentage of missing variables was omitted in all the tables. Subtracting 100% from the sum of the percent in each category will give the percentage of missing variables).
- All figures in bracket are based on 25-49 unweighted cases.

Table 2: Percent distribution of circumcised women by age at circumcision according to background characteristics.

Background Characteristics	*Age at Circumcision* 0	1-4	5+	Number of Women
Residence				
Urban	43.1	7.9	17.6	761
Rural	40.7	7.8	26.6	1295
Region				
Northeast	(7.8)	(20.9)	(51.1)	25
Northwest	(16.2)	(12.6)	(39.6)	28
Southeast	49.1	2.7	28.4	689
Southwest	40.6	10.7	16.2	1008
Central	33.1	8.6	31.7	306
Education				
No Education	34.5	10.7	26.8	518
Primary	44.1	6.4	22.7	674
Secondary	42.4	6.4	22.5	692
Higher	50.1	10.5	18.8	172
Type of circumcision				
Clitoridectomy	41.4	8.7	23.3	1690
Excision	44.0	2.9	37.0	139
Infibulation	20.4	9.5	37.3	77
Other/missing/DK	52.5	2.1	4.1	150
Total (Nigeria)	41.6	7.8	23.3	2056

(Ibid. p.137) DK = Don't Know

Table 3: Percent distribution of all women by opinion on whether female Genital cutting should be continued according to background characteristics and circumcision status.

Attitudes toward FSC

Background Characteristic	Should be continued	Should be discontinued	Don't know	Number of Women
Residence				
Urban	16.7	48.7	16.6	2540
Rural	14.8	46.2	24.9	5666
Region				
Northeast	1.8	63.2	27.9	1292
Northwest	3.6	48.3	43.5	1087
Southeast	19.4	43.7	12.8	1886
Southwest	31.4	38.6	11.4	2080
Central	9.8	47.7	28.0	1861
Education:				
No Education	11.8	49.3	35.6	3324
Primary	23.1	44.8	16.4	1868
Secondary	15.3	40.7	12.3	2506
Higher	10.7	71.3	7.1	508
Circumcision Status:				
Circumcised	54.4	37.0	8.6	2056
Not Circumcised	2.8	63.2	33.8	4879
Total (Nigeria)	15.4	47.0	22.3	8206

Ibid. p. 139

Table 4: Percent distribution with daughters by whether the oldest daughter is circumcised or circumcision is planned according to background characteristics and circumcision status.

Status of Eldest Daughter

Background Characteristics	Daughter Circumcised	Plan to Circumcise	No Plan to Circumcise	Number of Women
Age				
15-19	3.9	3.8	89.1	157
20-24	8.2	6.4	82.5	546
25-29	13.7	4.5	79.4	951
30-34	19.4	3.9	74.4	895
35-39	21.0	3.3	74.7	858
40-44	28.3	3.2	67.2	614
45-49	41.9	2.6	54.8	482
Residence:				
Urban	24.5	3.7	70.5	1316
Rural	18.4	4.1	75.4	3187
Region:				
Northeast	1.6	0.6	95.3	785
Northwest	2.2	0.3	93.3	681
Southeast	30.6	8.1	60.6	861
Southwest	43.9	5.5	49.7	1126
Central	11.9	3.8	82.4	1050
Education:				
No Education	14.6	2.0	81.0	2352
Primary	29.2	6.3	63.0	1111
Secondary	24.4	6.9	67.4	815
Higher	19.4	2.3	77.9	225
Circumcision Status:				
Circumcised	59.9	10.9	28.3	1416
Not Circumcised	1.9	0.7	95.4	3064
Total (Nigeria):	20.2	4.0	73.9	4503

(Ibid. p.140)

Table 5*: **Percent distribution of women by reasons for supporting FGM**

Reason	% Of Women
Good Tradition	35.4
Custom and Tradition	50.2
Religious demand	2.0
Cleanliness	5.3
Better Marriage Prospects	6.7
Greater Pleasure of husband	2.6
Preserve Virginity / Prevent Immorality	14.3
Other	5.6
D/ K	1.9
No. of Women	1263

(Ibid. p.139)

Table 6*: Percent distribution of women by reasons for not supporting FGM

Reason:	% Of Women
Bad tradition	60.6
Against religion	22.4
Medical complications	22.3
Painful personal experience	10.4
Against dignity of women	10.1
Prevents sexual satisfaction	6.5
Other	3.2
D/K	2.8
No. of Women	3857

(Ibid.p.140)

*In tables 5 & 6, multiple responses were accepted.

Table 7*: **Percent of FGM by states and type in Nigeria**

State	Type	% of Prevalence	Source
Adamawa	IV	60-70%	IAC* (1991)
Akwa Ibom	II	65-75%	IAC (1992)
Anambra	II	40-60%	Ezumezu (1993)
Bauchi	IV	50-60%	IAC (19991)
Benue	II	90-100%	(l bi d)
Borno	II, III, IV	10-90%	IAC (1992) El-Yakub (19994)
Delta	II	80-90%	IAC (1994) owunmi (1993)
Edo	II	30-40%	IAC (1992)
Imo	II	40-50%	IAC (1995)
Jigawa	IV	60-70%	IAC (1990)
Kadunna	IV	50-70%	Ibid
Kebbi	IV	90-100%	Ibid
Kogi	IV	0-1%	IAC (1996)
Kwara	I, II	60-70%	Olafimihan (1993)
Lagos	I	20-30%	IAC (1992)
Ogun	I, II	35-45%	Adeneye (1995)
Ondo	II	90-98%	IAC (1995)
Osun	I	80-90%	IAC (1989)
Oyo	I	60-70%	Onadeko and Adekunle (1985)
Plateau	I, IV	30-90%	IAC (1989)
Rivers	I, II	60-70%	IAC (1993)

*(Source: IAC (Nigeria) 1997 :12-13).

*Inter-African Committee

● Table 8: Knowledge and Prevalence of Female Circumcision

Percentage of women who have heard of female circumcision, percentage of women circumcised, and the percent distribution of circumcised women by type of circumcision, according to background characteristics, Nigeria 2003.

Background characteristic	Percentage of women who heard of female circumcision	Percentage of women circumcised	Number of women	Type of circumcision				Total	Number of women
				Cut no flesh removed	Cut, flesh removed	Sewn closed	Not determined		
Age									
15-19	43.1	12.9	1,716	2.2	37.8	5.1	55.0	100.0	221
20-24	52.8	17.0	1,494	1.8	43.1	2.9	52.2	100.0	253
25-29	57.5	20.8	1,382	1.8	40.2	2.2	55.8	100.0	288
30-34	55.0	19.4	941	1.1	43.6	7.6	47.7	100.0	183
35-39	60.8	22.2	816	2.4	44.3	4.9	48.4	100.0	181
40-44	53.6	22.2	688	1.2	49.0	1.9	47.9	100.0	153
45-49	59.6	28.4	583	3.9	51.0	3.6	41.6	100.0	165
Residence									
Urban	68.7	28.3	2,629	1.5	37.6	4.0	56.9	100.0	744
Rural	45.0	14.0	4,991	2.5	49.6	3.9	44.0	100.0	701
Region									
North Central	36.0	9.6	1,121	1.2	64.6	2.5	31.7	100.0	107
North East	40.1	1.3	1,368	*	*	*	*	*	18
North West	25.1	0.4	2,095	*	*	*	*	*	9
South East	87.7	40.8	737	0.3	12.2	2.7	84.8	100.0	300
South South	82.5	34.7	1,342	3.0	66.0	7.5	23.5	100.0	466
South West	85.7	56.9	958	2.2	36.3	1.3	60.3	100.0	545
Ethnic Group									
Fulani	19.4	0.6	463	*	*	*	*	*	3
Hausa	28.5	0.4	2,055	*	*	*	*	*	8
Igbo	86.5	45.1	1,037	1.3	28.3	3.1	67.3	100.0	467
Kanuri	58.5	0.5	232	*	*	*	*	*	1
Tiv	27.9	0.9	170	*	*	*	*	*	1
Yoruba	88.2	60.7	865	2.1	38.3	0.9	58.7	100.0	525
Other	54.8	15.7	2,797	2.5	66.1	7.8	23.6	100.0	439
Total	53.2	19.0	7,620	2.0	43.5	3.9	50.6	100.0	1,445

Note: Total includes 1 case with data missing on circumcision. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

● Source: NPC (Nigeria) and ORC Macro, 2004: 202.

Table 9: Age at Circumcision

Percent distribution of circumcised women by age at circumcision, according to background characteristics, Nigeria 2003

Background characteristic	Age at circumcision in years				Total	Number of women
	<1	1-4	5+	Don't know/ missing		
Age						
15-19	78.4	1.7	14.2	5.7	100.0	221
20-24	77.2	1.1	18.7	3.1	100.0	253
25-29	79.5	0.2	17.7	2.5	100.0	288
30-34	64.3	0.3	27.4	8.1	100.0	183
35-39	71.6	3.3	24.4	0.7	100.0	181
40-44	72.4	1.5	24.3	1.8	100.0	153
45-49	73.5	0.6	21.1	4.8	100.0	165
Residence						
Urban	79.2	0.9	16.8	3.1	100.0	744
Rural	69.6	1.5	24.4	4.5	100.0	701
Region						
North Central	51.6	1.7	42.1	4.6	100.0	107
North East	*	*	*	*	*	18
North West	*	*	*	*	*	9
South East	94.1	0.1	4.9	0.9	100.00	300
South South	55.2	2.1	38.0	4.7	100.0	466
South West	86.4	0.7	9.1	3.8	100.0	545
Ethnic Group						
Igbo	88.9	0.3	9.4	1.4	100.0	467
Yoruba	87.4	1.2	7.1	4.4	100.0	525
Other	45.0	2.0	47.4	5.5	100.0	453
Type of circumcision						
Cut, no flesh removed	(69.7)	(0.0)	(30.3)	(0.0)	(100.0)	29
Cut, flesh removed	60.6	1.9	35.2	2.3	100.0	628
Sewn closed	37.4	5.0	49.2	8.4	100.0	57
Not determined	89.6	0.3	5.2	4.8	100.0	732
Total	74.6	1.2	20.5	3.8	100.0	1,445

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure Is based on fewer that 25 unweighted cases and has been suppressed.

[8] Ibid. p.203

Table 10: Daughter's circumcision experience and type of circumcision

Among women with at least one living daughter, percentage with at least one circumcised daughter, percentage who intend to have their daughter circumcised, and percent distribution by type of circumcision among most recently circumcised daughters, according to the background characteristics, Nigeria 2003.

Background characteristic	Percentage of women with at least one daughter circumcised	Percentage of women who intend to have daughter circumcised	Number of women with at least one daughter	Among circumcised daughters, type of circumcision				Total	Number of women
				Cut, no flesh removed	Cut, flesh removed	Sewn closed	Not determined		
Age									
15-19	0.5	5.0	183	*	*	*	*	*	1
20-24	4.4	3.9	538	(1.5)	(63.7)	(2.5)	(32.3)	(100.0)	23
25-29	6.9	2.3	898	12.6	54.1	5.4	27.9	100.0	62
30-34	6.4	4.4	715	4.1	71.5	2.0	22.5	100.0	45
35-39	11.3	3.5	707	3.7	69.1	4.0	23.2	100.0	80
40-44	12.9	2.7	582	2.4	77.0	3.7	16.9	100.0	75
45-49	23.8	1.4	506	4.3	64.6	3.1	28.0	100.0	120
Residence									
Urban	15.0	3.1	1,294	2.9	68.0	3.4	25.7	100.0	194
Rural	7.5	3.2	2,834	6.7	65.9	3.7	23.7	100.0	213
Region									
North Central	6.6	3.3	606	1.1	59.8	0.0	39.1	100.0	40
North East	0.2	0.4	856	*	*	*	*	*	2
North West	0.9	0.9	1,320	*	*	*	*	*	12
South East	25.7	4.9	324	7.3	42.1	9.5	41.1	100.00	83
South South	17.2	10.6	621	1.7	81.0	6.1	11.2	100.0	107
South West	40.8	3.0	401	5.2	73.0	0.0	21.9	100.0	164
Education									
No education	5.6	1.6	2,158	7.4	58.1	3.9	30.6	100.0	121
Primary	14.8	4.2	1,000	0.6	73.7	3.2	22.6	100.0	148
Secondary	14.9	5.7	786	8.6	65.1	4.3	22.0	100.0	117
Higher	11.8	4.4	185	(0.0)	(79.8)	(0.0)	(20.2)	(100.0)	22
Ethnic Group									
Igbo	25.8	4.5	447	5.3	52.5	9.5	32.7	100.0	115
Yoruba	46.3	2.6	371	4.9	70.6	0.0	24.5	100.0	172
Other	3.6	3.0	3,311	4.5	75.5	2.9	17.1	100.0	120
Wealth quintile									
Lowest	6.8	3.1	903	6.7	71.5	3.1	18.7	100.0	61
Second	6.2	2.6	874	1.9	72.0	3.4	22.7	100.0	54
Middle	8.2	1.9	822	5.1	64.9	7.7	22.2	100.0	67
Fourth	11.1	4.0	770	6.1	68.9	3.0	22.0	100.0	85
Highest	18.4	4.2	759	4.4	62.7	2.1	30.8	100.0	140
Total	9.9	3.1	4,129	4.9	66.9	3.6	24.6	100.0	407

Note: Figures in parentheses are based on 26-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

[e] Ibid. p.204

Table 11: Aspects of Daughter's Circumcision

Percent distribution of most recently circumcised daughter by the age of the daughter at the time she was circumcised, and the person performing the circumcision, Nigeria 2003.

Aspects	Percent
Age of daughter when she was circumcised (in years)	
0	85.0
1-4	4.1
5-6	1.8
7-8	2.0
9-10	0.5
11-12	0.9
13+	3.9
Don't know/missing	1.8
Person who performed the circumcision	
Traditional circumciser	60.6
Traditional birth attendant	10.0
Other traditional	1.0
Doctor	2.0
Nurse/midwife	24.3
Other health professional	0.4
Don't know/missing	1.8
Total	100.0
Number	407

[•] Ibid. p.205

Table 12: Perceived benefits of undergoing female circumcision

Among women and men who say they think female circumcision should be continued, percentage who cite specific reasons, according to urban-rural residence, Nigeria 2003

	Women			Men		
	Residence			Residence		
Reason	Urban	Rural	Total	Urban	Rural	Total
Reason for supporting female circumcision						
cleanliness/hygiene	5.1	8.4	6.8	5.5	14.4	10.0
Social acceptance	34.0	21.9	27.7	9.1	22.7	16.0
Better marriage prospects	26.8	42.0	34.6	28.3	31.9	30.1
Preserve virginity/prevent premarital sex	49.0	23.4	35.8	48.3	41.8	45.0
More sexual pleasure for the man	7.1	3.5	5.3	24.7	21.7	23.2
Religious approval	10.4	12.2	11.3	11.2	6.2	8.7
Helps delivery	24.6	25.8	25.2	20.2	20.9	20.5
Other	9.6	21.3	15.7	15.7	5.9	10.7
Number	**407**	**436**	**843**	**135**	**141**	**276**

[•] Ibid. p.208

Table 13: Attitudes toward female circumcision: women

Percent distribution of all women who have heard of female circumcision by opinion on whether female circumcision should be continued and by opinion on whether men think female circumcision should be continued, according to background characteristics, Nigeria 2003.

	Attitude toward female circumcision					Believes men think that female circumcision should be:					
Background characteristic	Should be continued	Should be discontinued	Depends/ don't know	Missing	Total	Continued	Discontinued	Depends/ don't know	Missing	Total	Number of women
Age											
15-19	23.4	60.0	15.2	1.4	100.0	20.8	42.7	35.5	1.0	100.0	739
20-24	21.3	66.2	10.6	1.9	100.0	19.9	49.1	29.0	2.0	100.0	789
25-29	17.0	70.1	12.2	0.7	100.0	14.9	51.5	32.8	0.7	100.0	794
30-34	15.8	73.7	9.9	0.5	100.0	15.8	53.1	30.6	0.5	100.0	518
35-39	24.9	66.7	8.4	0.0	100.0	21.1	51.2	27.7	0.0	100.0	496
40-44	20.0	64.9	14.8	0.4	100.0	18.6	51.5	29.6	0.3	100.0	369
45-49	24.9	62.9	11.2	1.0	100.0	19.5	49.4	30.1	1.0	100.0	347
Residence											
Urban	22.5	64.7	11.9	0.9	100.0	18.7	49.4	31.0	0.9	100.0	1,805
Rural	19.4	67.9	11.8	1.0	100.0	18.5	49.4	31.2	0.9	100.0	2,248
Region											
North Central	13,2	64.2	19.1	3.6	100.0	12.1	42.0	42.3	3.6	100.0	403
North East	7.3	78.6	13.5	0.6	100.0	5.9	55.5	37.9	0.7	100.0	548
North West	13.5	70.5	13.1	2.9	100.0	11.5	55.7	30.7	2.1	100.0	527
South East	23.9	67.4	8.6	0.0	100.0	20.4	56.8	22.8	0.0	100.0	646
South South	18.9	73.7	7.2	0.2	100.0	20.0	52.6	26.9	0.5	100.0	1,107
South West	38.3	46.3	15.1	0.3	100.0	31.3	34.9	33.6	0.3	100.0	821
Education											
No education	19.1	64.7	14.7	1.6	100.0	15.5	47.8	35.2	1.5	100.0	1,023
Primary	23.1	64.5	11.6	0.9	100.0	18.9	47.8	32.2	1.0	100.0	949
Secondary	23.2	65.4	10.9	0.6	100.0	22.6	48.9	28.1	0.5	100.0	1,666
Higher	10.4	79.7	9.1	0.8	100.0	9.2	59.3	30.6	0.9	100.0	415
Circumcision status											
Not circumcised	9.3	76.3	12.9	1.4	100.0	8.3	57.1	33.3	1.3	100.0	2,607
Circumcised	41.5	48.6	9.8	0.1	100.0	37.0	35.7	27.1	0.2	100.0	1,445
Total	20.8	66.4	11.8	0.9	100.0	18.6	49.4	31.1	0.9	100.0	4,052

[8] Ibid. p.206

Table 14: Attitudes toward female circumcision: men

Percent distribution of all men who have heard of female circumcision by opinion on whether female circumcision should be continued and by opinion on whether women think female circumcision should be continued, according to background characteristics, Nigeria 2003.

	Attitude toward female circumcision					Believes men think that female circumcision should be:					
Background characteristic	Should be continued	Should be discontinued	Depends/ don't know	Missing	Total	Continued	Discontinued	Depends / don't know	Missing	Total	Number of women
Age											
15-19	20.2	54.0	25.0	0.8	100.0	17.1	40.2	42.0	0.8	100.0	127
20-24	19.0	62.1	18.4	0.5	100.0	15.8	50.1	33.0	1.0	100.0	223
25-29	22.6	59.9	17.6	0.0	100.0	16.1	46.5	37.4	0.0	100.0	211
30-34	17.0	67.4	15.6	0.0	100.0	8.9	58.9	32.1	0.0	100.0	229
35-39	22.1	61.3	16.6	0.0	100.0	15.4	54.9	29.7	0.0	100.0	163
40-44	10.2	75.8	14.0	0.0	100.0	8.0	55.9	36.1	0.0	100.0	166
45-49	24.8	62.6	12.6	0.0	100.0	15.2	49.2	35.6	0.0	100.0	117
50-54	19.8	57.7	22.5	0.0	100.0	16.7	53.5	29.9	0.0	100.0	103
55-59	21.4	66.3	12.3	0.0	100.0	15.3	45.8	38.9	0.0	100.0	89
Residence											
Urban	23.1	59.8	17.0	0.2	100.0	13.0	49.9	37.0	0.2	100.0	586
Rural	16.7	65.9	17.3	0.1	100.0	14.5	52.2	33.0	0.3	100.0	840
Region											
North Central	17.4	75.6	6.9	0.0	100.0	12.6	68.1	19.3	0.0	100.0	154
North East	8.7	73.7	17.3	0.3	100.0	9.4	50.8	39.1	0.7	100.0	307
North West	14.5	64.3	21.2	0.0	100.0	11.7	53.6	34.7	0.0	100.0	276
South East	28.4	45.5	26.2	0.0	100.0	12.2	42.4	45.4	0.0	100.0	156
South South	24.1	64.1	11.4	0.4	100.0	20.4	51.6	27.6	0.4	100.0	279
South West	27.8	52.7	19.5	0.0	100.0	16.4	44.0	39.6	0.0	100.0	254
Education											
No education	15.2	63.7	21.0	0.0	100.0	15.2	46.5	38.3	0.0	100.0	280
Primary	24.6	57.6	17.8	0.0	100.0	17.4	44.8	37.8	0.0	100.0	362
Secondary	20.1	61.2	18.4	0.4	100.0	12.8	51.4	35.2	0.6	100.0	549
Higher	14.4	77.0	8.6	0.0	100.0	9.7	66.3	24.0	0.0	100.0	235
Total	19.3	63.4	17.3	0.1	100.0	13.9	51.2	34.6	0.2	100.0	1,426

[8] Ibid. p.207

Table 15: Reasons for not Supporting Female Circumcision

Among women and men who say they think female circumcision should be discontinued, percentage who cite specific reasons, according to urban-rural residence, Nigeria 2003

	Women			Men		
	Residence			Residence		
Reason	Urban	Rural	Total	Urban	Rural	Total
Reason for not supporting female circumcision						
Fewer medical problems	33.0	34.2	33.7	25.8	35.6	31.8
Avoid pain	18.8	21.7	20.5	27.2	22.3	24.2
More sexual pleasure for her	38.9	32.5	35.3	41.9	28.8	33.9
More sexual pleasure for the man	25.1	24.0	24.5	53.0	45.0	48.1
Follows religious	2.3	3.1	2.8	3.6	5.1	4.5
Number	1,168	1,525	2,693	350	554	904

[8] Ibid. p.208