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FEMALE GENITAL CIRCUMCISION:

SOCIAL INDICATORS THAT INFLUENCE
ATTITUDES ON ABANDONMENT OF FGC IN
NIGERIA

by

JOANNA EISELE

B.S. University of California at Davis, 1998

A thesis submitted in partial fulfillment of the requirements
for the degree of Master of Arts
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ABSTRACT

More than “100 million girls and women worldwide have undergone female genital mutilation/cutting (FGM/C) and more than three million girls are at risk for cutting each year on the African continent alone” (Population Reference Bureau 2009). The practice is recognized internationally as a violation of the human rights of girls and women, and constitutes an extreme form of discrimination against women. Research has shown that reasons given for continuing the practice of FGC vary widely across cultural and social contexts. Little research has been conducted towards understanding and predicting attitudes toward FGC, which in turn can help inform program policy in the hopes of better understanding the socio-cultural complexities inherent in the practice of FGC. This study suggests that with increased levels of education support for FGC decreases. Additionally, access to media was shown to have a significant impact on support for the practice. This study found that men and women experience and are influenced by media in different ways. Media based abandonment programs must acknowledge the gender gap in media access and direct their programs towards the most appropriate outlet for the target group. This study’s most significant finding is that the strongest predictor of a woman’s attitude towards FGC is whether she herself has undergone the procedure. Women who have undergone FGC will likely support the continuation of the practice. Encouraging these women to forgo the practice and let their daughters experience their bodies differently from their mothers is the greatest challenge abandonment programs face.

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ACRONYMS

Behavior change communication	BCC
Constructive Men's Engagement	CME
Demographic and Health Surveys	DHS
Female Circumcision	FC
Female Genital Cutting	FGC
Female Genital Mutilation	FGM
Gender Focus Program	GFP
Generation dialogue	GD
Information, Education and Communication	IEC
Multiple Indicator Cluster Survey	MICS
National Council for Childhood and Motherhood	NCCM
Nigeria Demographic Health Survey	NDHS
Positive Deviant	PD
The Interagency Gender Working Group	IGWG
United Nations	UN
United Nations Children's Emergency Fund	UNICEF
United Nations Development Program	UNDP
United States Agency for International Development	USAID
World Bank	WB
World Health Organization	WHO

INTRODUCTION

According to the Population Reference Bureau, “An estimated 100 million to 140 million girls and women worldwide have undergone female genital mutilation/cutting (FGM/C) and more than three million girls are at risk for cutting each year on the African continent alone. The cutting varies from a symbolic nicking of the clitoris, to the excision of tissue and partial closure of the vaginal area, called infibulation” (PRB 2009).

Appendix A provides a detailed explanation of the procedure. The ritual aspects vary from the straightforward cutting of an infant in the household context, to complex rituals involving the cutting of groups of adolescent girls held in seclusion for weeks or months. In some societies, the procedure is “routinely carried out when a girl is a few weeks or a few months old; in most, it occurs later in childhood or in adolescence” (Yoder et al. 2004: ix). FGC poses serious physical and mental health risks for women and young girls. The practice is recognized internationally as a violation of the human rights of girls and women, and constitutes an extreme form of discrimination against women. The practice is nearly always performed on minors, and is therefore a violation of the rights of children (WHO 2010). FGC is illegal in most practicing countries, yet legislation and education aimed at eliminating the practice have resulted in only limited abandonment of the practice.

Effecting change is difficult, as reasons given for continuing the practice of FGC vary widely across cultural and social contexts (Dræge 2007; Gruenbaum 2005; and Kabeer 2001). Although levels of support for the practice have fallen across the board (see table 1), FGC still continues to be performed regularly across Africa. Support for the

practice varies within and across communities, influenced by many factors including: age, gender, access to media, personal background, and education. This paper will provide an analysis of social indicators that may help predict attitudes toward FGC in Nigeria, which in turn can help inform program policy in the hopes of better understanding the socio-cultural complexities inherent in the practice of FGC.

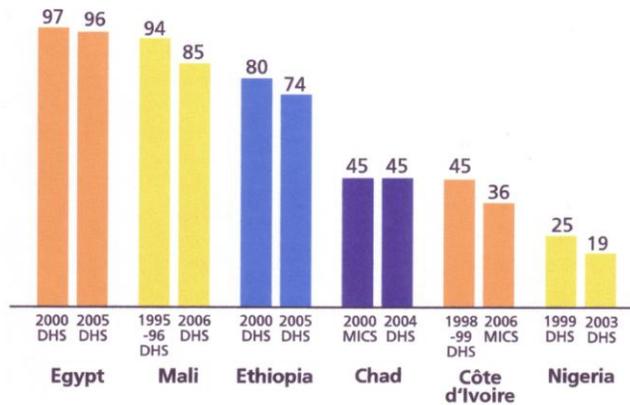
Table 1 FGC Prevalence across Africa

Source for table on this page: Population Reference Bureau, *Female Genital Mutilation/Cutting: Data and Trends* (2008).

Trends in FGM/C Prevalence

Over the last decade, a downward trend in percent of women cut in some countries indicates that abandonment of FGM/C seems to be taking hold, although in others there still is little or no apparent change.

Percent of women ages 15–49, by survey year



LITERATURE REVIEW

Female genital cutting is practiced to various degree in 28 countries in Africa and the Middle East¹. This paper will look at one of these countries: Nigeria. In many ways Nigeria is representative of much of Africa. A former British colony that gained independence in 1960, today there are about 374 identifiable ethnic groups, with the Igbo, Hausa, and Yoruba as major groups. Nigeria is bordered by Niger in the north, Chad in the northeast, Cameroon in the east, and Benin in the west. To the south, Nigeria is bordered by approximately 850 kilometers of the Atlantic Ocean (See Appendix B). According to the Demographic and Health Survey (DHS 2008), since 1980 oil production has accounted for more than two-thirds of the GDP and more than 80 percent of the total government revenues. Nigeria's individual characteristics are also in line with the rest of the continent. According to the DHS 2008, the average marrying age is 18.3 years and birthrates are at 5.7 births per woman. Additionally, more females than males have never attended school (40 percent compared with 28 percent). The proportion of women who have never attended any formal schooling increases from 26 percent, among those aged 10-14, to 78 percent for those aged 65 and above. For men, the proportion increases from 20 percent of those 10-14, to 62 percent of those aged 65 and older.

¹ The term *female genital mutilation* (FGM) “stigmatizes the practice to the detriment of the programs trying to change it” (USAID 2000). The more neutral term *female genital cutting or female genital circumcision* (FGC), preferred by an increasing number of researchers, is the term recommended by the United States Agency for International Development (USAID), and is used in this document to refer to the practice. Female genital cutting (FGC) is the more “technical” of the two terms and FGM the more powerful and denunciatory. This paper will use FGC throughout the text, without wishing in any way to minimize the damage done by the practice.

Thirty percent of Nigerian women are circumcised. However, prevalence of FGC among the Yoruba (58%) and Igbo (51%) is higher than in other ethnic groups. In Nigeria, female circumcision occurs mostly during infancy; four in five women (82%) who have been circumcised had their circumcision before their first birthday. According to the DHS (2008), three major forms of FGC are practiced in Nigeria: female circumcision (*Angurya* and *Gishiri* cuts) and hymenectomy. *Angurya* involves the scraping of the vaginal orifice and is usually performed on infants within seven days of delivery. *Gishiri* cuts involve the cutting of the vaginal wall.

Efforts to understand the practice of FGC are extensive. Research has attempted to explain the “who, what, when, where and why” of FGC. The practice varies widely within and between countries, yet in every society in which it is practiced, FGC is “a manifestation of gender inequality that is deeply entrenched in social, economic and political structures. Like the now-abandoned foot-binding in China and the practice of dowry and child marriage, female genital mutilation represents society’s control over women” (WHO 2008: 5).

Most families carry out FGC in order to ensure the marriageability and status of their daughters within the intra-marrying group and/or to preserve virginity. Family decisions about whether or not to have their daughters undergo FGC are based on game theory, wherein “what one family chooses to do depends upon what other families in that community choose to do. No one family has an incentive to deviate; if they do, their daughter is destined to not be married or to have a poor marriage” (Mackie and LeJeune 2009). Ideally, if everyone gives up FGC no one would suffer the consequences associated with noncompliance, but for that to be effective it is necessary for everyone in

the intra-marrying community to give up the practice together (Innocenti Digest 2005; Mackie and LeJeune 2009; PRB 2006). According to the World Bank (2004), “The decision by anyone to reject FGM/FGC encompasses changes at different levels. It involves recognizing its harmfulness, the power of refusing or making desirable choices and being able to act. Others eventually emulate them. However, the risk of failure is fuelled by community repercussions.”

Making abandonment of FGC more complicated is the fact that there is a large gap between believing that FGC should be abandoned and the actual choice to abandon it. Campaigns that effectively increase the knowledge of their target groups on the dangers of FGC do not always result in the desired and predicted behavior changes (Eschborn 2005; Hornik et al. 2002). It is often the case that many people opposed to the continuation of FGC still have their daughters cut. Some explain this discrepancy in attitude and behavior as one part of diffusion theory, where change in behavior occurs in stages and such stated support for abandonment can be a precursor to actual and substantial changes in behavior (Hornik et al. 2002; Shell-Duncan and Herniund 2006).

The groups that abandonment programs must focus on, then, are the people who say they want the practice abolished; those are the people most likely to eventually stop practicing FGC (Yoder et al. 2004). Programs must be able to identify which community members make up this key group, and direct their efforts toward strengthening the resolve of these people. Little work has been done to this end. There is a wealth of survey data now available, but ethnographic studies are few (Yoder et al. 2004). This type of work must be done in the social context that FGC exists in, and must be culturally

sensitive. This paper will piece together existing data and examine individual indicators that can help predict attitudes toward FGC in Nigeria.

Factors influencing attitudes toward FGC

The goal of this study is to look at the relationships between age, education levels, gender, exposure to mass media, and a woman's cut status to predict which type of people are the most inclined to eliminate FGC. Figure 1 illustrates how complicated the reasons for continuing the practice are. These relationships are not linear, however, and existing research has shown that correlations between these indicators are not always consistent (Diop et al. 2008; Gruenbaum 2005). In other words, it is not always the case that younger women who have high levels of education and high exposure to media will always oppose FGC. The strength between these five selected indicators and predicted attitudes may also be influenced by many other indicators including, but not limited to FGC prevalence rates, religion, wealth, literacy, and location (urban vs. rural). In Nigeria however there is no significant difference in FGC rates by wealth index, religion, or location. So although much data have been collected about these additional indicators, the five indicators selected for this study are thought to be the most influential, and appear as key factors in anti- FGC campaign strategies (Barker et al. 2007; Gruenbaum 2005; Jaldesa et al. 2005; PRB 2006; Pulerwitz et al. 2000; Shell-Duncan 2001).

These indicators have been studied extensively by a variety of international organizations, however the interaction between these indicators and their combined effects are not well understood. This study will therefore only consider these five indicators: age, education, gender, access to media, and cut status.

Figure 1

Why the Practice of FGC Continues: A Mental Map

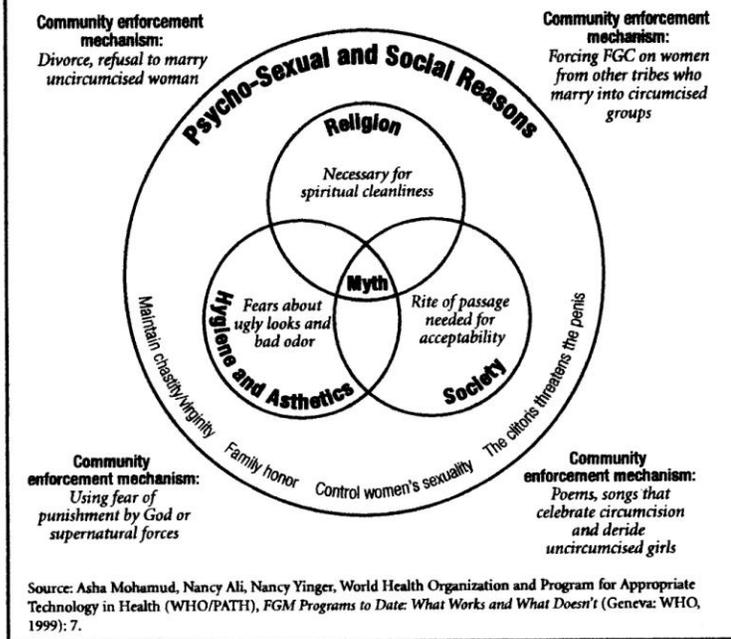


Figure 1: A Mental Map of FGC

Age

It is generally accepted that younger cohorts are more likely to support abandonment of FGC (Gruenbaum 2005). This may be because younger cohorts are more likely to have been exposed to formal schooling, which is often a vehicle for transferring information about values. Education may be important to determining relative power within a social group, and may also be associated with the continuity or discontinuity of traditional practices (Williams and Sobieszcyk 1997). El Dareer (1982) has found that younger women are generally much more likely to oppose all forms of the practice, or to favor the less severe types than are older women.

Many organizations have recognized a gap in support for FGC by age. Tostan in Senegal and IntraHealth in Ethiopia focus on bringing older and younger groups together for intergenerational dialogue (PRB 2006) in an attempt to have the young convince the old to abandon the practice. IntraHealth programs specifically aim to bridge information and communication gaps among, and between, fathers, mothers, young women, and young men.

A variety of non-governmental organizations (NGOs) in Guinea have focused on the great potential age may have on FGC. They have aimed to mobilize the youth and create a space for dialogue between generations. These dialogue sessions are meant to enable young and old to reflect on their own traditions and values, and allow participants to consider under what conditions change should come about. Presentations use traditional proverbs and sayings to encourage each group to ask the other generation questions about themselves they would not normally have the chance to ask. The Guinea program encourages the use of music, role-playing, and songs to get participants to share

information and ideas. It has also found that young, uncircumcised girls can be trained to educate their peers and become role models for their communities (Eschborn 2005).

Some research has been written regarding the effect older cohorts may have on support for the abandonment of FGC. This approach emphasizes the power of the old to create change as opposed to emphasizing the power of youth as seen in most anti-FGC campaigns. Older religious leaders and influential families may hold sway over both young and old, and may also play a large role in educating their peers (Population Council 2008). This use of role models is called the Positive Deviance Approach (PDA). It was created in the 1990s by Save the Children in Vietnam to work against malnutrition. The program aimed to identify children who were healthy, amongst the majority of their malnourished peers, to better understand how their parents were able to find better solutions to the pervasive problem of malnutrition than their neighbors within the same resource base. Positive Deviants (PDs) were used to teach others how to effect positive change in children's nutrition.

In Egypt, where FGC levels are over 90 percent (DHS 2008), the FGM/C Abandonment Program (FGMAP) has adapted the PDA model, looking to involve all age groups. PDA is also the approach used by the FGM-Free Village Model project in Egypt led by the United Nations Development Program (UNDP). It has relied largely on mobilizing community leaders, including doctors and legal personnel as well as youth volunteers, as main advocates for the cause (PRB 2006). Both programs have seen support for FGC decrease in communities exposed to the programs. This may prove key as gerontocracy is standard in Nigeria, in which case, the elder community members may be the most appropriate to focus on.

Education

Education is a very powerful factor in predicting attitudes and behaviors regarding health and human rights issues (PRB 2006). Some research suggests that increased levels of education have not prompted a decline in adherence to the practice (Mackie 1996) and that in some countries, like Uganda, FGC is being introduced in parts of the country that have never practiced it as an imagined return to African traditions (Lightfoot-Klein 1989). In Nigeria, many women who had undergone FGC and who were more educated had a doctor perform the cutting. In other words education may not lead to abandonment but to “harm reduction practices,” where women understand that there are physical ramifications to FGC so they seek to have it done in a “clean” setting (Jaldesa et al. 2005; Shell-Duncan 2001).

Other research suggests a strong correlation between educational attainment and FGC. However, establishing a relationship between a woman’s FGC status and her educational level can often be misleading because FGC usually takes place before education is completed and often before it commences. A mother’s level of education, however, appears to be a significant determinant of FGC status of daughters (Innocenti Digest 2005). In Egypt “the percentage of girls circumcised is higher among daughters of non-educated mothers (64.7%) as opposed to daughters of women who attended university (23.4%)” (Population Council 2008: 9). In Iraq, among Kurds overall FGC rates are high at 74 percent, yet rates among university graduates are much lower at 30 percent (fgmnetwork.org). As implied above, this may have more to do with the parents’ educational achievement than the students. Though very little is known about FGC in

Iraq, it follows that more educated parents would chose not to cut their university-bound daughters.

High levels of educational attainment are also associated with increased exposure to mass media (Williams and Sobieszczyk 1997). This, in turn, implies that media campaigns are more successfully reaching educated people. It is for this reason that a large part of Tostan's program is dedicated to increasing school enrollment and literacy rates so that messages about FGC can be better spread and received (Diop et al. 2008; PRB 2006).

Gender

A general assumption is that men force women to undergo FGC, and that those women are the victims of a barbaric patriarchy. Much research has shown this to be false. Studies on gender and FGC are anything but straightforward. Interestingly, men are actually more likely to support the abandonment of the practice than women, while women insist on maintaining the practice by not involving men in the decision of whether or not to cut their daughters (DHS 2008; Shell-Duncan 2006). Yet men have historically been seen as obstacles to women's control over their health and welfare (Cornwall 2003; Kabeer 2001). Many NGOs have created programs that recognize and attempt to address this problem. The Interagency Gender Working Group (IGWG) focuses on constructive men's engagement (CME), which "aims to involve men in women's health as supportive partners to women, and as agents of change in the family and community" (<http://www.igwg.org/Articles/missionpossible.aspx>).

Very little research, however, has been done to explore men's views on FGC and the effect men's attitudes have on women's opinions on FGC. A deeper understanding of men's attitudes on FGC may help illuminate men's role in shifting the "social norm so that going uncut becomes positively sanctioned and being cut becomes negatively sanctioned" (Mackie and LeJeune 2009). Some studies suggest men could be important partners in the abandonment of FGC (Barker et al. 2007; Pulerwitz et al. 2000). Engender Health realized how important men are in changing how women live and experience their lives, and created Men as Partners (MAP) and Men Engage in 1996. The Sonke Gender Justice Network, with support from UNICEF, created the One Man Can campaign to enlist men for women's equality. A growing body of evidence suggests that "programs that work with men and boys can have a significant impact on increasing men's support for gender equality, and in reducing a range of health problems including FGC" (Barker, Nascimento, Segundo, and Pulerwitz 2004).

Additionally, very little research has focused on health problems men face because their partners have been circumcised. Almroth et al. (2001) suggest that many men experience problems including difficulty in penetration, wounds/infections on the penis, and psychological problems. This study found that the majority of young married men would have preferred marrying a woman who had not undergone FGC.

R.W. Connell (1995) suggests that hegemonic masculinity reproduces gender hierarchies and inequalities, of which FGC is a part. Robert Wyrod's (2008) research in Uganda also focuses on men and masculinity. He concluded that we must address "how men understand women's rights, and how their attitudes are tied to local conceptions of masculinity" in order to make changes to social conventions like FGC. He suggests that

there are “connections between masculinity and gender politics” that are neglected by FGC abandonment efforts.

Wyrod and Connell’s emphasis on the importance of changing ideas of masculinity is negated, to some degree, by much other research. Mackie and LeJeune (2009) state that “in fact, in the majority of cases it is mothers or grandmothers who organize and support the cutting of their daughters, and in many places the practice is considered ‘women’s business’” (p. 5). Dræge (2007) suggests that, while women may not have decision-making power anywhere else in their lives, they control the cutting, especially grandmothers and mothers-in-law. Shell-Duncan (2006) suggests that grandmothers and paternal aunts, in particular, often exert considerable influence. And that generally it is the women, not the men, who demand FGC, as it is “one of the few socially-defined areas over which women have any control” (PRB 2006).

Access to media

The Population Reference Bureau states that “FGC abandonment initiatives are increasingly incorporating media campaigns into their strategies as the power of radio, television, and film, in particular, is harnessed to disseminate information, increase awareness, and promote advocacy around FGC abandonment.” They suggest that media messages can be particularly effective in helping to create a social environment conducive to change (PRB 2006).

Most programs use *organized diffusion* to get their message across. Organized diffusion strategy refers to a process through which the knowledge and actions of one family or community can spread to other families, or communities, through social

networks (Innocenti Digest 2005). A secondary focus of organized diffusion is the development of mass-media programs that support dialogue, rather than transmit messages (Mackie and LeJeune 2009; PRB 2006). In *Diffusion of Innovations*, Everett Rogers (2005) suggests the use of mass media to achieve rapid and effective influence towards behavior change. Through media, he argues, audiences can accept new ideas and communication can improve. Communication that effectively merges media and community interventions will result in changing behavior or attitudes towards FGC. Programs using elements and principles of social networks, and media campaigns have demonstrated a significant reduction in the prevalence of FGC years after the original programmatic intervention (Ndiaye et al., in press).

Organized diffusion campaigns are based on two strategies: Information, Education and Communication (IEC), and Behavior Change Communication (BCC). IEC techniques are designed to raise awareness, promote dialogue, support women's empowerment, develop community based solutions, and encourage community declarations (Rahman and Toubia 2000). BCC includes focus discussion groups and media campaigns using radio, television, and print (PRB 2006; World Bank 2004).

While many programs have sung the praises of media campaigns, there is little literature assessing the effectiveness of these campaigns in regions where access to media is low. The fact that media campaigns can only be successful if there is access to that media is obvious. Across Africa, the proportion of people with no weekly exposure to media is very high (Afrobarometer 2003). More importantly, exposure to media is lowest in rural areas where the prevalence of FGC is highest. Additionally, the rate of non-exposure to any media at least once a week increases with age for both women and men.

Lower levels of educational attainment are also associated with decreased exposure to mass media (DHS 2008; PRB 2006). Literacy rates follow these same patterns as well, rendering printed rural media campaigns against FGC ineffectual.

This is not to say that, through organized diffusion, media messages can't trickle down from those with media access to those without. Tostan's work in Senegal, where literacy is between 25-50 percent, includes weekly children's radio programs in native languages that reach thousands. Additionally, Tostan uses drawings and illustrations that do not require literacy in order to be understood. IntraHealth in Ethiopia has focused on media exposure as well. In Ethiopia this is a questionable approach as 60 percent of people have no access to media and literacy is low at 25 percent (DHS 2005).

The Zero Tolerance for FGM project in Mali uses television and radio spots to promote the abandonment of female genital circumcision. In Mali, prevalence rates are high; 85 percent of women have undergone FGC. While literacy rates are very low, ranging from 10-30 percent, regular access to media is relatively high. In 2006, 70 percent of people listened to the radio once a week and 40 percent viewed television weekly (DHS 2006). Literacy rates are higher in Nigeria, at about 50 percent, while media usage is lower. Radio usage is at about 50 percent and television is at 40 percent (DHS 2008).

Research by Meekers and Suzuki (2008) suggests that media messages that focus on the health risks FGC poses to women are most effective in lowering support, suggesting that future FGC media campaigns should aim to highlight the health risks long associated with the practice. Additionally, their research also suggests that women are concerned about what men think about FGC; therefore campaigns should also target men.

Media campaigns alone would not be enough to change attitudes on FGC in most communities. However, as part of a multi-dimensional approach that combines media elements with community interventions, media campaigns could be a very important factor toward predicting support for the abandonment of the practice.

Cut

The current literature in the field of FGC contains very little information specifically related to the role women who have undergone FGC play or could potentially play in FGC abandonment programs. There is little research regarding how this group of women feel about the practice, or about why they support or do not support the practice. Meekers and Suzuki (2008) found in their research in Egypt (where FGC rates are 97%) that high exposure to FGC-related messages, and a woman's belief that men want the practice discontinued, resulted in lower levels of support from women.

Support for the abandonment of FGC varies widely among women and girls. However, it is important to note that many women who are circumcised state that they want the practice to stop. In many cases these women's attitudes have changed, but their behaviors have not, as many of these women still cut their daughters. Research suggests that these circumcised women who do not support FGC may be the most important group of women, that it is the circumcised mothers who do not intend to cut their daughters who can have the biggest impact on abandonment (Shell-Duncan and Herniund 2006; WHO 2008; World Bank 2004).

The FGM/C Abandonment Program (FGMAP) in Egypt has attempted to identify and mobilize women who have undergone FGC but whom are against the practice and

encourage them to promote anti-FGC campaigns. Research has yet to address the following questions: Are these the women who have the most potential power to get their peers to give up the practice? Will these women forever support the practice because they need to feel that they were not harmed or mutilated by their mothers who had them cut? Will they cut their daughters for the same reason? What factors could influence these women to speak out against FGC?

In Nigeria, prevalence rates of FGC are relatively low. Only 30 percent of women have undergone FGC, yet stated support for the practice for men and women is roughly 20 percent. Creel (2001) suggests that there are “striking contrasts in some countries between prevalence rates of FGC and low approval rates for the practice.” For example, in Burkina Faso, 72 percent of women ages 15 to 49 have undergone FGC, while only 18 percent state they approve of the practice. In Eritrea, 95 percent of women have been cut, yet only 57 percent approve of the practice (Creel 2001). Creel suggests that this contrast may in part be due to the fact that many people will claim to not support the practice due to its illegality.

The discrepancy between belief and practice has been widely studied. Shell-Duncan and Herniund (2006) attribute this discrepancy to “stages of change” theory wherein change “operates along a continuum, and where broad stages of change characterize segments of this continuum.” Mackie and LeJeune (2009) attribute the gap to “social convention theory” wherein the continuation or the abandonment of any social norm involves a set of social rewards and punishments. Both theories suggest that where social pressure to comply with FGC is high, any changes in attitudes will occur before changes in behavior.

Summary

In sum, many studies have tried to understand why FGC persists and to find a way to get people to give up the practice. Some studies have suggested that without educational advancements, younger women will continue to hold favorable attitudes toward female circumcision (Feldman-Jacobs and Ryniak 2006; Williams and Sobieszczyk 1997). These studies suggest that FGC continues in part because so many women are unable to get an education. Additional data suggest that women also have lower access rates to media, which many organizations use as an informal educational tool to discuss women's health issues including FGC. A large amount of time and money have been invested in an attempt to better understand FGC and the factors that ensure the practice continues, and so much data have been collected and analyzed. This study is designed to help explore how these factors operate, in hopes of providing additional insight to how to eliminate support for the practice. Specifically, this study tests the following hypotheses:

1. Men will have lower levels of support for FGC than women
2. Increases in education levels will reduce support for FGC for women and men.
3. Younger individuals will be less likely to support FGC than older persons
4. Increased exposure to media (radio, television, newspaper) will reduce support for FGC for women and men.
5. Women who have undergone FGC will be more likely to support FGC than women who have not undergone FGC.

DATA AND METHODS

Data

All data used in this paper comes from the Demographic Health Survey (DHS). The DHS is funded by the U.S. Agency for International Development (USAID) and regularly collects a wealth of information on widely different topics in over 80 countries. The information is processed and presented in the final survey reports and contain a variety of recommendations regarding policy choices and challenges. The purpose of the DHS is to provide quality information to plan, monitor, and improve population, health and nutrition programs. To assist with data collection, DHS uses a survey research tool called CS Pro to perform hierarchical data entry, complex consistency checking, tabulation of survey data, and computation of sampling errors.

Sample

The survey used in this research is from the Nigeria Demographic Health Survey (NDHS) of 2008. The NDHS was a nationally representative survey of 33,385 women age 15-49 and 15,486 men age 15-59. The survey includes a sample of more than 36,000 households. All women age 15-49 in these households and all men age 15-59 in a sub-sample of half of the households were individually interviewed. The 2008 NDHS sample was selected using a stratified two-stage cluster design consisting of 888 clusters, 286 in the urban and 602 in the rural areas. The survey design determined that a minimum of 950 interviews would be completed per state. In each state, the number of households was distributed proportionately among its urban and rural areas.

In this survey participants who had never heard of FGC were not asked any further questions on the subject. This resulted in 31 percent of men surveyed and 45 percent of women being omitted from questions regarding their attitudes towards FGC. The final sample included 18,286 women age 15-49 and 10,607 men age 15-59.

Dependent Variable

The dependent variable for this study is “Circumcision should continue or be stopped.” It is measured “continue,” “stop,” “depends,” or “don’t know.” Very few people responded “depends” or “don’t know.” To create a dichotomous variable, “stop, depends and don’t know” were re-coded and compressed into one measure. This recoding could be a potential limit to this analysis. For female respondents 14,536 (79.5%) thought FGC should stop and 3,750 (20.5%) thought the practice should continue. Of the 79.5 percent of respondents who answered “stop,” 13 percent would have fallen into the original categories of “don’t know” or “depends.” For male respondents 8,180 (77.1%) thought FGC should stop and 2,427 (22.9%) thought the practice should continue. Of the 77.1 percent of respondents who answered “stop,” nine percent would have fallen into the original categories of “don’t know” or “depends.” Only one question regarding personal attitudes regarding the practice of FGC was asked of participants. All other questions regarding FGC were concerned with why it may be done, and how and by whom it is done.

Independent Variables

The four independent variables used in this analysis include gender, age, educational achievement, and exposure to media. For women, an additional independent variable is whether or not they have undergone FGC, labeled “cut.” Like the dependent variable regarding attitude towards FGC, this question was also only asked of women who had heard of FGC. Cut is measured as yes (1) or no (0). Percentages below therefore represent only those women who had heard of FGC.

Age is measured in nine categories by five year increments starting at 15 years of age and ending at 59 for men and 49 for women. There is no explanation given for the difference in age categories between genders. Excluding women over 49 from giving their attitudes on FGC may be an important limitation of these data as decisions regarding FGC are often made and/or influenced by elder female family members.

Educational achievement is measured as “no education,” “primary,” “secondary,” or “higher.” The differences between men and women suggest that a significant discrepancy exists between the sexes and their opportunities for education.

All three variables related to media exposure are measured identically. Respondents were asked how often they were exposed to newspapers, radio, and television. Responses include “not at all,” “less than once a week,” “at least once a week,” or “almost every day.” An additional variable was created that combines media exposure to newspaper, radio and television after finding that the alpha coefficient for the combined media variable for women is .693 and for men .677. This variable, called

“media,” was used in the binary regressions. Frequencies and percentages for all variables are listed in Table 2 below.

Table 2 Descriptive Statistics for Independent Variables

Independent Variables (Women)	Mean/Percent	Standard Deviation	Minimum	Maximum
Age	28.65	9.493	15	49
Education		1.016	0	3
None	(39.7%)			
Primary	(19.7%)			
Secondary	(32.7%)			
Higher	(7.9%)			
Media				
Radio	1.45	1.224	0	3
Television	1.04	1.241	0	3
Newspaper/Magazine	.34	.732	0	3
Cut	.4578	.49823	0	1
Yes	(45.8%)			
No	(54.2%)			

Independent Variables (Men)	Mean/Percent	Standard Deviation	Minimum	Maximum
Age	31.69	11.69	15	59
Education		1.725	0	3
None	(23.6%)			
Primary	(21.0%)			
Secondary	(41.9%)			
Higher	(13.5%)			
Media				
Radio	2.24	1.043	0	3
Television	1.36	1.243	0	3
Newspaper/Magazine	.81	1.025	0	3

Analysis

I ran separate analyses for the male and female data sets. Analysis of Variance (ANOVA) was run in order to establish any significant relationship between the selected indicators and attitudes regarding FGC. A more detailed analysis was then run to better understand the statistically significant relationships found between my dependent and independent variables. Binary logistic regressions were conducted to see if any of the independent variables could predict attitudes towards FGC. A binary logistic regression was run for women that included four independent variables: age, education, media, and cut status. Similar analysis was completed for men, excluding cut status. A second regression was run for women that included: age, education, newspaper, radio, television, and cut status. Similar analysis was completed for men, excluding cut status.

Limitations of data

These data have some limitations. The surveys are very long and touch on a variety of topics that are unrelated to female genital circumcision (FGC). The FGC component is asked at the end of the survey and respondents may not respond thoughtfully or take their time considering the questions after such a long survey. Additionally, all respondents to the survey who had not heard of FGC were not asked any further questions about the procedure and so nearly 45 percent of the original sample size did not give their opinions on whether FGC should stop or continue (my dependent variable). It is also unclear in the data set if any persons had heard of FGC but refused to, or were uncomfortable giving an opinion on FGC.

Another limitation is that women over 49 were not included in the survey. This is problematic, as older women in households hold much sway over the continuation and support of FGC.

It is also difficult to know if some significance found in this study is due to this data set's very large sample size, which may not reflect realistic and important relationships.

Despite the limitations, these data can provide a solid base from which we can begin to understand which indicators will be most useful in predicting attitudes towards FGC.

Demographics

The women surveyed have an average of three children and 70 percent are married. Men surveyed have an average of three children, 54.5 percent are married, and 41.5 percent have never been married. Of both men and women surveyed 46 percent are Islamic and 40 percent Christian. Of women surveyed 54 percent have no electricity in their home. Interviewers read the questions to participants and recorded all answers as 50 percent of women and 27 percent of men surveyed cannot read at all, while 43 percent of women and 61 percent of men surveyed can read whole sentences.

FINDINGS

Support for FGC in Nigeria is generally low, with only 20 percent of women and 22 percent of men who responded stating the practice should continue. This lack of support may reflect the fact that prevalence of FGC is relatively low at 30 percent. This study suggests that men's and women's attitudes about FGC are influenced to varying degrees by different factors. Separate data analyses were conducted for men and women, and findings suggest significant differences in indicators that influence men and women.

Using the statistical package, SPSS, chi-square tests were employed to assess the bivariate relationships and logistic regression models for the multivariate analyses. Results of bivariate analyses are shown in Table 3. Results of the logistic regression analyses are shown in Tables 4, 5, and 6.

Bivariate Analysis

Initially Analysis of Variance (ANOVA) was run in order to establish any significant relationship between the selected indicators and attitudes regarding FGC. For women, all indicators appeared to be significant; a relationship was found between age, education, newspaper, radio, television, and cut status.

For men, the results suggest that a significant relationship exists between attitudes on FGC and education and exposure to television. Age and exposure to radio and newspaper did not appear significant.

Table 3 Relationships between attitudes towards FGC and independent variables

	Women	Men
Age	15.66*	14.24
Education	103.68****	78.74****
Newspaper	64.63****	5.69
Radio	15.94****	5.60
Television	61.10****	67.75****
Cut	78.84****	-----

Source of data: the Nigeria Demographic Health Survey (NDHS) of 2008.
 ****p<.001; ** p<.01; * p<.05 (two-sided tests)

Multivariate Analysis

Multivariate analysis was conducted in order to better determine the relative effect of various factors. By controlling for certain variables, it is possible to determine whether others become significant or lose significance. In addition, logistic regressions were run in order to understand the directionality of these relationships. In this study the dependent variable is influenced by multiple factors. Multivariate analysis was used in order to test multiple predictor variables.

A binary logistic regression was run for women that included four independent variables: age, education, media, and cut status. Similar analysis was completed for men, excluding cut status (see table 4).

The initial regressions used a condensed media variable and suggested that media

had a significant effect on men’s attitudes regarding FGC, but no significant effect on women. This suggests that although many anti-FGC campaigns include media components in their programs, their messages are not affecting women’s attitudes towards FGC.

Table 4 Logistic Regression Results using Media Variable

Women	B	S.E	Exp(B)
Age	-.087***	.011	.917
Education	-.313***	.027	.731
Media	-.001	.010	.999
Cut	2.773***	.056	16.014
Constant	-2.431***	.072	.088

Men	B	S.E.	Exp(B)
Age	-.011	.010	.989
Education	-.097**	.031	.907
Media	.055***	.012	1.056
Constant	-1.284***	.074	.277

Source of data: the Nigeria Demographic Health Survey (NDHS) of 2008.

***p<.001; ** p<.01; * p<.05 (two-sided tests)

For women, age was a significant indicator of attitude regarding FGC. For every one-unit increase in age, we expect a 0.09 increase in the log-odds of FGC, holding all other independent variables constant. Thus, each additional year increase of age

decreases support in the continuation of FGC by .92 times. This suggests that as age increases, support for FGC decreases. The older women support FGC less.

Education was also found to be a significant predictor of FGC attitudes for women. For every one-unit increase in education, we expect a 0.30 increase in the log-odds of FGC, holding all other independent variables constant. Thus, each additional year increase in education decreases the belief that FGC should continue by .74 times. This suggests that as education increases, support for FGC decreases. More educated women support FGC less.

The strongest predictor of attitude however is the cut status of women. Findings suggest that women who have been cut support the continuation of FGC by a log odds of 2.771 ($p < .001$). Thus, being cut increases support in the continuation of FGC by 15.98 times. This suggests that women who are not cut support FGC less and that women who have been cut will support the continuation of the practice.

A more detailed analysis of the media variable was conducted to ascertain which, if any, media outlets had an impact on FGC attitudes. The media variable was therefore further broken down providing a more detailed understanding of how, independently, the three media components affect attitudes. I wanted to see whether different types of media might be more significant than others. A second regression was run for women and included: age, education, newspaper, radio, television, and cut status (see table 5). Similar analysis was completed for men, excluding cut status (see table 6).

Analysis of the second set of regressions using the deconstructed media variables suggests a significant difference between the effect of media on men and women. Here I found that while the combined media variable suggested that media had no effect for

women, when broken down, significant relationships appear.

For women, radio ($p < .05$) and television ($p < .05$) were significant predictors of attitudes. For every one-unit increase in the variable “radio,” we expect a 0.42 increase in the log-odds of FGC, holding all other independent variables constant. This suggests that as radio exposure increases, the support for FGC increases by 1.04 times. Women who listen more to the radio are more supportive of FGC.

For every one-unit increase in the variable “television,” we expect a 0.05 increase in the log-odds of FGC, holding all other independent variables constant. This suggests that as television viewing increases, support for stopping FGC increases by .95 times. Women who watch more television support FGC less. Newspaper lost its significance in this analysis. This may be due to the fact that so few women read the newspaper regularly.

Table 5 Logistic Regression Results for Women with Expanded Media Variable

Women	B	S.E	Exp(B)
Age	-.087***	.011	.917
Education	-.300***	.028	.741
Newspaper	.011	.031	1.011
Radio	.042*	.020	1.043
Television	-.050*	.021	.951
Cut	2.771***	.056	15.975
Constant	-2.457***	.073	.086

Source of data: the Nigeria Demographic Health Survey (NDHS) of 2008.
 *** $p < .001$; ** $p < .01$; * $p < .05$ (two-sided tests)

No relationship was established between men's attitudes on FGC and their age. However, education was found to be a significant predictor of FGC attitudes for men. For every one-unit increase in education, we expect a 0.08 increase in the log-odds of FGC, holding all other independent variables constant. Thus, each additional year increase in education decreases the belief that FGC should continue by .93 times for men. This suggests that as education increases, support for FGC decreases. More educated men support FGC less.

For men newspaper ($p < .001$), which was not found to be significant in the bivariate analysis and television ($p < .001$) were significant. For every one-unit increase in the variable "newspaper," we expect a 0.11 increase in the log-odds of FGC, holding all other independent variables constant. This suggests that as newspaper reading increases, support for stopping FGC also increases by .90 times. Men who read the newspaper more often support FGC less.

For every one-unit increase in the variable "television," we expect a 0.22 increase in the log-odds of FGC, holding all other independent variables constant. This suggests that as television viewing increases, the support for FGC increases by 1.25 times. Men who watch television more often have higher levels of support for FGC.

Table 6 Logistic Regression Results for Men with Expanded Media Variable

Men	B	S.E.	Exp(B)
Age	.002	.010	1.002
Education	-.075*	.032	.928
Newspaper	-.110***	.029	.896
Radio	-.021	.028	.979
Television	.221***	.024	1.248
Constant	-1.293***	.086	.274

Source of data: the Nigeria Demographic Health Survey (NDHS) of 2008.
***p<.001; ** p<.01; * p<.05 (two-sided tests)

DISCUSSION

There is conflicting research regarding FGC and which gender supports the practice more. It is widely thought that men force women to undergo FGC. Research suggests this is not the case (Dræge 2007; Gruenbaum 2005; Shell-Duncan and Herniund 2006). In Nigeria, a male dominated country, women hold little power politically and socially. However, FGC is one arena that women seem to control. It is a practice that men have historically had little to do with, and until recently has been a subject considered quite taboo for men to discuss.

This paper thus hypothesized that men would demonstrate lower levels of support for FGC than women. The findings of this study suggest that, counter to expectations; men did not report lower levels of support for FGC than women. However, the differences between the sexes were not very large.

The Population Reference Bureau (2006) suggests that there is currently little opportunity for men's involvement in anti-FGC campaigns. If men consider FGC a 'woman's issue,' they will resist getting involved and fail to relate and identify with the issues women face. However, since men and women seem to demonstrate similar levels of support for FGC it appears that organizations should encourage men to get involved in the eradication of the practice.

A new approach to understanding gender that moves beyond stereotypes and generalizations, and works with men on a personal level to open up lines of communication and space for dialogue is needed (Cornwall 1997; Middlestadt et al. 2007).

The second hypothesis tested in this paper states that increases in education for both men and women will result in decreases in support for FGC. The findings suggest that, consistent with the hypotheses, as educational levels increase levels of support for FGC dramatically decrease. There was little difference found between the sexes, as increases in education significantly reduced support for FGC for both women and men.

A majority of abandonment programs include general education aspects. They include human rights seminars with the intent of teaching women that they have a right and responsibility to control their bodies. They also include health education programs that aim to help men and women understand the dangers and health risks associated with FGC. Additionally, many human rights organizations with an interest in FGC abandonment include literacy components in their programs. As suggested previously, those with access to education also tend to have greater access to media.

Many anti-FGC programs focus on increasing the number of young girls attending school. Tostan's program also includes informal education for those girls and women who do not attend school. These programs focus on problem solving, human rights, and health and hygiene. The goal of these programs is that increases in education will empower women to make changes in their communities (including abandoning FGC).

Findings suggest mixed support for this study's hypothesis regarding age. While age of women appears to be a significant predictor of attitudes towards FGC, no such relationship appears with men. This may be because access to education is higher overall for all age groups of men. My findings for women, however, were unexpected and are not in line with current research. This study found that older women have lower levels of

support for FGC than younger women. This may not be a very meaningful finding as there is not a large variation in support across the age groups.

Current research suggests that younger women are significantly less likely to support FGC than older women (El Dareer 1982; Gruenbaum 2005; Shell-Duncan and Herniund. 2006). It is generally accepted that younger individuals will be less likely to support FGC than older persons. This may be due to the preconceived notion that young people are more likely to try new things and older people are more likely to cling to tradition. Additionally, since FGC is usually performed before age one, young women who oppose the practice may prove key to future abandonment programs. As these women begin to become mothers they may choose not to cut their daughters.

However, recent research suggests that older people can often help encourage change (Population Council 2008). A variety of anti-FGC programs have focused on intergenerational dialogue, bringing together young and old to encourage the sharing of fears and ideas about FGC (PRB 2006). The FGM-Free Village Model project in Egypt relies heavily on the input of older women. Intergenerational dialogue may prove significant where gerontocracy is standard, as elder women hold much influence in individual families' decision making regarding FGC.

The relationship between age and attitudes towards FGC clearly warrant further research. It may be that other factors have a more meaningful impact on attitudes and that age is not a very important indicator in and of itself.

The fourth hypothesis states that increased exposure to media (newspaper, radio, and television) will reduce support for FGC for women and men. The findings suggest that the effect of media on attitudes was not clear cut. The concept of mass media

exposure alone can tell us little about significance. Exposure to media did appear in part to reduce support for FGC to some degree for both men and women.

However, not all three types of media analyzed had equal impact on men and women, and it is the directionality of these relationships that is interesting. For men there appears to be an inverse relationship between support for FGC and exposure to newspaper. However, increased exposure to television resulted in increased support for FGC. Further research on this phenomenon is warranted. An analysis of the male television viewer may reveal much about reinforcing masculinities and male dominance.

Additionally, listening to the radio has no significant effect on men's attitudes towards FGC and was found to increase women's support for the practice. This is a finding worth further analysis as over 57 percent of men and 28 percent of women listen to the radio almost every day. Future research to better understand why radio has no significant effect on the attitudes of male listeners and a negative effect on women's attitudes would help inform current abandonment programs. An analysis that considers the content of radio messages regarding FGC, the frequency and the time of day the messages are given, as well as men's and women's opinions regarding abandonment messages would contribute much towards improving the effectiveness of abandonment plans that focus their efforts and funds on media campaigns.

For women, radio and television were significant indicators of attitude. Newspapers had no significant effect on women's attitudes. This may be due in part to the fact that over 78 percent of women surveyed do not read a newspaper at all and over 50 percent are illiterate. This may also indicate that women have less free time to spend on activities (like reading) that cannot be done in conjunction with other tasks (listening

to the radio while cooking). Other media outlets like listening to the radio or watching television do not require women to stop other work in order to hear or see messages. Analysis of media campaigns within abandonment programs must evaluate the effectiveness of any written messages used. Shifting the focus of these campaigns to media outlets that are more successfully received and understood by women is crucial. There is no current research addressing media campaigns' effectiveness. Nor have studies attempted to understand why men and women respond differently to media outlets.

Women who have no family tradition of practicing FGC are unlikely to adopt or support the practice. Hence, the final hypothesis states that women who have undergone FGC will be more likely to support FGC than women who have not undergone FGC. Findings suggest that there is a significant relationship between women who have undergone FGC and their attitudes toward the continuation of FGC ($\chi^2 (1, n=18260) = 3411.33, p=.000$). In other words those women who had undergone FGC were statistically more likely to support the continuation of FGC. However, there were some women surveyed who were cut and did *not* support the continuation of the practice. It is this segment of the population that may be crucial towards abandonment of the practice. Additional research aimed at understanding why these women do not support FGC could greatly inform current programs and policies.

In Nigeria, the majority of women who have undergone FGC did so before their first birthdays. This is of critical importance, since these women have no memory of being cut, they will also have no knowledge of the pain involved in the practice. These women never knew what it was like to be uncut and so cannot readily wish differently for their own daughters.

Implications for policy

A data set that included information on the elder women of these communities may provide additional insight to how to eliminate support for the practice. Additionally, because FGC rates in Nigeria are fairly low (30%), generalizing the findings of this research to countries with much higher rates may not be possible.

The results of this study suggests that increasing media, education, and literacy rates amongst women may be a crucial step to increasing support for the abandonment of FGC. However, not all media campaigns are created equal. This study suggests that gender specific media messages must be created and disseminated in the appropriate media outlets. Funding agencies should consider which type of media is used, to whom it's directed, at what time of the day it will be better received and how do those the media is directed at feel about the content of the various messages.

The majority of current anti-FGC campaigns contain some media component. Across Africa, messages to end the practice are delivered via newspaper, radio broadcast, and television. However, access to these media formats is limited in a largely impoverished continent. Women have especially low literacy and media access rates, further limiting the effectiveness of media campaigns. Additionally, only half of those surveyed in this study have electricity in their homes, effectively eliminating television messages.

An evaluation of existing abandonment campaigns with special attention paid to the various indicators and how they influence men and women in very distinct ways has not been conducted. Campaigns must not only consider the socio-cultural complexities of

FGC across Africa, but also the idea that it is experienced very differently by men and women.

The most significant finding of this study however is the strong relationship between women's cut status and their support for FGC. Considering all other influential and predictive factors discussed in this study, cut status is the ultimate determinate. Any anti-FGC campaign that does not specifically address this relationship will fail to change ideas about the practice. The reality is that women who have been cut are the driving force behind the continuation of the practice.

CONCLUSIONS

In recent years female genital cutting has received much attention and funding from the international community. What has been missing to date, however, has been a large-scale study focused on understanding factors that influence attitudes and behavior change regarding FGC. Despite the popularity and growing interest in certain programs, a comprehensive evaluation of eradication programs has not been completed.

The most effective approach to eradicating female genital mutilation seems to be multifaceted. However, each community presents different challenges and ideas regarding the practice; the results of this research suggest that approaches must vary according to gender. Change has begun, but must occur at many strategic points throughout society and promote a different norm publicly (Shaaban and Harbison 2005).

Programs that use a non-coercive, non-judgmental approach, where the focus is on fulfilling human rights and empowering girls and women are key. Community awareness of the harm caused by the practice must also increase in a way that will not lead to medicalization of the practice. The ultimate goal is to ensure that the process of organized diffusion ensures that the decision to abandon the practice spreads rapidly from one community to another and is sustained. Creating and mobilizing a critical mass of community members willing to deviate from the practice, ensuring a change in norms, is crucial.

A primary focus should include facilitating interpersonal communication within and between social networks, so private issues like FGC can become a topic to be openly discussed. A secondary focus should be on the development of mass-media programs that

consider gender differences as well as the differences in access to mass media that exist between genders.

Additionally, because the extent of formal education remains one of the strongest predictors of attitudes toward daughters' exposure to circumcision, continuation of the practice, and public support for the practice, adherence to the custom may change as formal schooling becomes increasingly available to more children (Williams and Sobieszczyk 1997).

Little funding and research have been directed at understanding the role women who have undergone FGC play, or could potentially play, in FGC abandonment programs. Circumcised women who do not support FGC may be the most important group of women and must be targeted by abandonment programs. Mothers who have been circumcised and do not intend to cut their daughters can have the biggest impact on abandonment, and can be mobilized to educate their peers and to reduce the social pressure to comply with FGC.

APPENDIX A: CLASSIFICATION OF FGC

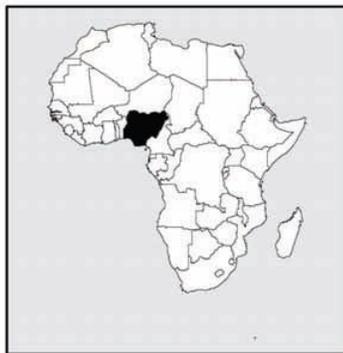
Female genital mutilation is classified into four major types.

1. Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
2. Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
3. Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
4. Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Source: WHO, 1996: 9.

APPENDIX B: MAP OF NIGERIA

NIGERIA



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