

An exploration of attitudes toward female genital cutting in Nigeria

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Abstract Female genital cutting (FGC) continues to be widespread particularly in sub-Saharan African countries. We use data from the 1999 Nigeria Demographic and Health Survey to consider factors that influence attitudes toward this procedure held by Nigerian women aged 15–49. We test four models: model 1 explores whether attitudes are consistent with a view of FGC as a social convention associated with marriageability of women. Model 2 examines the impact of modernization factors such as education and urbanization. In model 3, the influence of media and community activities are considered. Model 4 includes all of the factors in the three previous models. We find strong support for considering FGC a social convention. Modernization has minimal impact on attitudes about FGC mainly through its influence on the social convention.

Keywords Female genital cutting · Health · Modernization · Women

Introduction

Female genital cutting (FGC)¹ affects nearly 130 million women alive today (Mackie, 1996; PRB, 2002; Rice, 2001). FGC primarily occurs in 28

¹ Female genital cutting is also referred to as female genital mutilation (FGM) and female circumcision. We use FGC in the literature review as the terminology female circumcision minimizes the severity of the surgery in some cases and female genital mutilation is viewed as judgmental and pejorative. Female genital cutting is a more neutral term describing what takes place.

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Sub-Saharan African countries (Kassindja & Bashir, 1999; Kouba & Muasher, 1985), but is becoming an issue in Western countries particularly among immigrant populations (Retlaff, 1999). FGC includes “Procedures involving partial or total removal of external female genitalia or other injury to female genital organs whether for cultural or non-therapeutic reasons” (Toubia & Izett, 1998, p. 5). Because of widespread geographical dispersion, the high number of women involved, and health complications related to cutting, the World Health Organization, the United Nations Commission on Human Rights, and Amnesty International all define FGC as a health, political, and human rights issue (Nussbaum, 1999; Rice, 2001; Toubia & Izett, 1998). Worldwide opposition exists to FGC, but the practice continues. This paper examines attitudes toward continuing the practice of FGC and attempts to determine factors influencing these attitudes in Nigeria.

Literature review

Female genital cutting as a social convention

The practice of FGC probably originated in the Imperial Courts near the Red Sea in what is now Egypt and Sudan. Initially the ruling class used FGC to control women; however, over time, the practice spread to lower classes and throughout the geographical region. As the practice became more widespread, the severity of the cutting also increased (Mackie, 2000).

Today, FGC varies widely by culture, and diverse customs and traditions surrounding the practice support FGC's continuation. Women and men in many regions readily acknowledge they engage in FGC because their elders and village leaders did so (Carr, 1997); thus, the most significant predictor of whether a daughter will be cut is whether her mother was cut (Foster, 1992; Mackie, 1996; Yoder & Henry, 2002). Additionally, Horowitz and Jackson (1995) argue that in cultures where FGC is practiced it is a “necessary condition of life” (p. 4). For example, in a study of Nigerians, almost one-half of respondents reported they practiced FGC because it is their people's way of life (Toubia & Izett, 1998). In specific cultures, FGC also gives women a sense of self by helping identify their social roles and securing societal privileges and obligations otherwise denied to them (van der Kwaak, 1992; Yoder & Henry, 2002). These forces can be seen in places where FGC, when done at puberty, serves as a rite of passage marking a girl's transition into adulthood (Browne, 1991).

Social beliefs and practices also contribute to FGC's continuation by failing to specify accurately FGC's negative impacts on a woman's health and childbearing (Retlaff, 1999). Members of some cultures believe that FGC actually enhances health and sexual pleasure for both men and women (van der Kwaak, 1992), and others believe FGC increases fertility and improves the health of an unborn child (Rice, 2001). In Nigeria, for instance, a study of the Yoruba found 77% of rural women thought their circumcision lowered the

potential dangers to an unborn child. Only 8% of rural women recognized the increased risks of childbearing after having been cut (Orubuloye, Caldwell, & Caldwell, 2000). Lack of health education and more general cultural norms regarding health both contribute to these beliefs.

While many customs, traditions, and beliefs perpetuate FGC, marriageability of women is the primary factor influencing the practice's continuation. Mackie (2000) describes FGC as a *social convention*, because of its relationship to marriageability. Women come to believe men will not marry an uncut woman, and men believe uncut women are promiscuous. A woman thus is considered a good potential wife or mother only if she has been cut (US Department of State, 2001), because FGC often helps protect her virtue and promote her fidelity, modesty, and chastity (Kouba & Muasher, 1985; Lightfoot-Klein, 1989; Mackie, 2000; Retlaff, 1999). Since women desire and benefit from marriage and men do not want an unfaithful partner, the social convention becomes unbreakable, and FGC continues.

Oppressive patriarchal gender roles help maintain the practice of female genital cutting and reinforce ideas behind the convention hypothesis (Daly, 2000; Mackie, 1996; Mousette, 1996). FGC is especially prevalent where polygyny exists (Browne, 1991). Both polygyny and FGC can serve to control women's chastity, help establish paternity of children (Mackie, 2000), and perpetuate marriage and family norms—reinforcing the FGC social convention associated with marriageability.

Peer pressure based on tradition also encourages women to accept being cut or having their daughters cut (Althaus, 1997; Lightfoot-Klein, 1989; Mackie, 2000; Orubuloye et al., 2000). Over time, this pressure helps FGC become a deeply embedded cultural practice that is almost universal in groups where it is found (Mackie, 2000). Individuals and communities are reluctant to give up what is perceived as important even when they recognize a practice as potentially harmful (RHO, 2003).

To eliminate FGC, Mackie (2000) suggests using a participatory education program to explain factually, with tact and respect, that most of the world does not cut women's genitals and to describe accurately the benefits of women being left intact. An informed understanding of the issues encourages individuals to pledge not to cut their daughters. When a critical mass of community group members agree to refrain from cutting, the social convention for marriage quickly shifts to uncut women with FGC no longer being viewed as a desirable or necessary custom. Using this strategy, Mackie (2000) argues, FGC could be abandoned in a matter of years, regardless of economic development or cultural diffusion, much as foot-binding was eliminated in China.

Social factors influencing attitudes toward female genital cutting

Orubuloye et al. (2000) maintain that in the twentieth century, economic growth and the development of nation-states overwhelmed traditional life in many African countries. Increased levels of education, urbanization, and mass

communication often contributed to abandoning traditional practices (Mackie, 2000). Social and economic development, however, have not had the same effect on FGC as they have had on mortality and morbidity patterns (van der Kwaak, 1992). Widespread formal education programs, for example, have not reduced FGC as effectively as a modernization approach would propose. Education and improved socioeconomic status typically have more immediate impacts on men than women; thus, women, given a modernization approach, should report less willingness to abandon the practice and should more actively perpetuate FGC (Mackie, 2000; PRB, 2002). Furthermore, in parts of Africa, Lightfoot-Klein (1989) reports female genital cutting actually has been reintroduced as an alleged return to African ideals, in spite of modernization.

Despite skepticism over the value of the modernization perspective in explaining FGC reduction, Shell-Duncan, Obiero, and Muruli (2000) argue that attitudes and values about abandoning FGC will eventually change as part of broader social and economic evolution, and attitude change may affect the marriage convention. Furthermore, Obi (2004) contends that FGC persists because women lack education and allow community leaders to make decisions for them. With economic empowerment, women can work more freely to abandon the practice.

As education of women and awareness of health consequences of FGC rise, more women work to eliminate the practice (Nussbaum, 1999). However, in many areas, girls experience FGC before their own education can affect their personal likelihood of circumcision (PRB, 2002). Still, mothers with at least a secondary education cut their daughters significantly less than women with a primary education (Toubia & Izett, 1998). So too, in areas where more women occupy professional positions requiring higher levels of education, lower levels of FGC exist (Johnson & Wernet-Beyer, 2001). In fact, Mandara (2003) reports tertiary education is the strongest predictor of whether a woman wants FGC performed on her daughter. Educated women also prefer less severe forms of cutting for their daughters (Horowitz & Jackson, 1995). In spite of literature suggesting that education deters cutting, some studies (e.g., Carr 1997; Mackie, 2000) indicate that more highly educated women actually favor continuation of the practice because it is associated with higher socioeconomic classes.

Age also might influence the acceptance of modern ideas and play a role in breaking the social convention. Younger women approve of FGC less than older women (Yoder & Henry, 2002). In a study of pregnant women in Nigeria, prevalence of FGC declined with age (Obi, 2004); however, in seven out of nine countries included in a report prepared by the Population Reference Bureau (2002), actual FGC levels are similar between older and younger women.

The amount and severity of female genital cutting is greater in rural areas where cultural traditions and the marriage convention regarding FGC may be stronger and residents have less exposure to modernizing ideas (Horowitz & Jackson, 1995; Rice, 2001). In these areas, nonmedical, traditional practitioners usually perform the surgery with any available sharp implement. Urban

women, in contrast, undergo surgery in hospitals and clinics (Retlaff, 1999). Furthermore, women in urban areas demonstrate more accurate knowledge of FGC's consequences than their rural counterparts (Orubuloye et al., 2000). Young, urban woman also criticize the procedure more than those living in rural areas (PRB, 2002; Yoder & Henry, 2002). The practice seems to be declining in urban areas of many African countries as social norms have changed (Toubia & Izett, 1998). Urban areas receive modern ideas and health care more quickly than rural ones accounting for the decline in the practice of FGC.

Female genital cutting in Nigeria

Country-specific research is necessary to understand attitudes about FGC, the complexity of the practice among ethnic groups within a given country, and the role of cultural and demographic factors relevant to abandoning the practice (Yoder & Henry, 2002). This paper examines Nigeria, the most populated African nation and the country home to the largest number of cut women in the world (Johns Hopkins University, 2003).

In Nigeria, with approximately 120 million people and over 250 ethnic groups, considerable diversity exists regarding the practice of FGC (US Department of State, 2001). Type I (clitoridectomy), Type II (excision), and Type III (infibulation) of FGC are all practiced in Nigeria by different ethnic groups in different geographical locations. In general, Type III, the most severe form, is practiced more extensively in the northern regions, while Types I and II predominate in the south (US Department of State, 2001).

A reliable estimate of FGC in Nigeria is difficult to obtain due to secrecy often surrounding the topic. However, of the six major ethnic groups only one, the Fulani, does not routinely cut women. The largest ethnic group, the Yoruba, primarily perform Type I and Type II cutting, while the Hausa and Kanuri engage in Type III. The Ibo and Ijaw practice all types depending on local community norms (US Department of State, 2001). Thirteen out of 21 states in Nigeria report ethnic populations practicing FGC (Toubia & Izett, 1998). A 1985 national, but not representative, survey conducted by the National Association of Nurses and Nurse Midwives in Nigeria estimates the prevalence of FGC at about 40%. The Demographic and Health Survey (1999) puts the figure at 25.2% (National Population Commission [Nigeria] 2000). A Nigerian Non-Governmental Organization Coalition reported that one-third of Nigerian households practice some type of cutting (US Department of State, 2001). Many Nigerian health experts, however, consider these estimates low given that all three major ethnic groups cut women (Toubia & Izett, 1998; US Department of State, 2001).

Although no federal law prohibits FGC in Nigeria, the Nigerian government lists FGC as a "harmful traditional practice" and several states have passed laws banning the practice (US Department of State, 2001). Formal campaigns against FGC have existed in Nigeria since the 1980s. Media have

been integral to many campaigns. In fact, more than 60% of groups working on abandonment of FGC cite media as an important program outlet (PRB, 2002). For example, the Nigerian Council of Women broadcasts regular radio programs encouraging abandoning FGC. The Inter-African Committee of Nigeria uses community meetings and local media in urban and rural areas to convey negative consequences of FGC especially to schoolchildren. Nurses, midwives, and pediatricians in Nigeria also have long campaigned against the practice. A series of workshops in Lagos trains health professionals to educate others at the local and state level. In addition to personal community outreach, medical professionals have used television talk shows, plays, newspapers, booklets, and radio broadcasts to convey the negative effects of cutting girls to the public (Orubuloye et al. 2000).

About one-half of rural women and a slightly higher percentage of urban women in Nigeria have heard or read information against FGC (Orubuloye et al. 2000). Furthermore, more educated women are over twice as likely as less educated ones to report reading or hearing about FGC abandonment campaigns. Orubuloye et al. (2000) indicate both women and men are influenced by these efforts. Over 30% of respondents in their study stated the reason for not circumcising their daughter was campaigns against it. They also found evidence of success in that some families have circumcised only the oldest daughter after learning about negative outcomes from public health programs.

The Women's Centre for Peace and Development concluded that Nigerians practice FGC due to a cultural dictate (US Department of State, 2001). Uncircumcised women are seen by Nigerians as unclean, promiscuous, physically undesirable, and unmarriageable (Johns Hopkins University, 2003). Nigerians believe lack of cutting poses health risks to women and their children. One traditional Nigerian belief is that a child will die if its head touches the clitoris during childbirth. All of these beliefs suggest FGC continues in Nigeria because it has become a social convention.

We continue the study of FGC in Nigeria by focusing on factors that influence attitudes toward the practice. Nigeria has a strong social convention supporting FGC. Additionally Nigeria has experienced some elements of modernization and has made efforts to reduce FGC. Nigeria thus provides an ideal situation to compare the social convention model with the modernization one. We investigate how this social convention relates to attitudes about FGC and the role that modernizing factors play in influencing this relationship.

Methods

Data for this study come from the 1999 Nigeria Demographic and Health Survey (DHS) undertaken by the National Population Commission with the support of the United Nations Population Fund and the US Agency for International Development (National Population Commission, 2000).

The 1999 Nigeria DHS includes a module of questions about female circumcision² asked only to women. The sample was designed to be representative of women, both married and unmarried, aged 10–49 living in households.³ The National Population Commission restricts its analysis to women 15–49, arguing that most of their variables are not relevant to younger women. We also restrict our analysis to these women ($N = 8,199$).⁴

We would like to be able to consider men's attitudes toward FGC in addition to our consideration of women's. While the Nigerian DHS included a module of questions for men, this module did not include specific questions about FGC. Women were asked whether they thought their husband/partner thought female circumcision should be continued. Almost 40% of women responded that they did not know. For the other women, over 95% said their husband would have the same view as they had. Given this perceived consistency between partners, we do not feel this measure would add substantially to our analysis.

Our concern is with understanding the factors that influence women's attitudes toward continuing female genital cutting. To determine these attitudes, we use the DHS question that asks, "Do you think female circumcision should be continued, or should it be discontinued?" A substantial percentage (26%) of respondents answered they did not know. While we drop these respondents from analysis to focus on the comparison between those clearly favoring or opposing circumcision, this percentage suggests that attitudes about circumcision might be changing in Nigeria.

We begin our analysis with an examination of the social convention perspective (Model I). Model I includes measures of respondent's circumcision status and the amount of circumcision found within the respondent's ethnic group. This model suggests that circumcision continues because of the social convention concerning the necessity of FGC for marriage of women (e.g., societal norms and values supporting it). Mackie (2000) argues that circumcision continues until there is a critical mass of women who are unwilling to be circumcised. Thus, we expect women who have been circumcised, consistent with the social convention, to have more favorable attitudes toward continuing the practice. We also expect women in ethnic groups with a lower percentage of women circumcised to show less support for FGC. For this investigation, we classify respondents as to whether they had (32%) or had not been circumcised (68%)⁵ We also distinguish between women who belong to ethnic groups with less than 50% of women circumcised (55%) and those who

² We use the term "circumcision" in the methods and analysis because that is how the questions were asked to respondents in the DHS.

³ The survey also collected information from men ($N = 2,680$), although these data are not used in our analysis.

⁴ Of the 8,918 eligible women identified in sample households, 8,199 responded, yielding a 92% response rate.

⁵ About 15% (1,257) of woman did not report an answer to this question. We omit these women from the analysis.

belong to ethnic groups with more than 50% of the women circumcised (45%).

Since past studies have correlated education, age, and place of residence with prevalence of FGC, Model II explores the impact of these modernization variables on circumcision attitudes. We expect that more “modernized” women will show less support for FGC. As indicators of modernization, we use a woman’s educational level in years (mean = 4.70 grades; sd = 5.10) and her age (mean = 29.7 years; sd = 8.82). Additionally, we create a dummy variable for urban residence (32.0% urban).

Our third model considers the impact of specific efforts that might change the social convention concerning circumcision. These actions may also reflect contact with modern ideas. We expect women with more exposure to specific programs against FGC and to modern ideas, in general, to have less support for the practice. To measure exposure to programs against FGC, we use a question asking about activities against female circumcision taking place in their community. About 10.5% reported knowing about such activities. Included in the no activities group are 26% who answered that they don’t know and 64% who reported no activities. Many programs encouraging abandonment of FGC report media use when disseminating information (Orubuloye et al. 2000). We examine three measures of media use: read newspaper once a week (20.9%), watched television every week (33.3%), and listened to the radio every day (50.8%).

Our final model includes the variables in the previous three models. It allows us to ascertain the relative impact of social convention and modernization factors as well as the interactions between the factors. We hypothesize that social convention has the most impact on attitudes about FGC.

Analysis and discussion

Our analysis begins by considering FGC from the social convention approach. Mackie (1996) contends FGC is expected for marriageability of woman and the practice continues until a critical mass of individuals and families rejects the practice (Mackie, 2000). Results of logit analysis suggest a strong relationship between a woman’s circumcision status and her attitude about continuing circumcision. Having been circumcised greatly increases the odds of favoring continuation of circumcision (odds ratio = 29.56), supporting the social convention approach. Whether the majority of a woman’s ethnic group has been circumcised also influences her view on circumcision. Women who belong to ethnic groups with over 50% of women circumcised are 32% more likely to favor continuing circumcision than women whose ethnic groups have less than 50% of women circumcised. This analysis shows strong support for the social convention of FGC for the marriageability of women as an explanation for continued support for the practice of FGC (Table 1).

Model 2 investigates the impacts of education, age, and place of residence (urban versus rural), allowing us to compare the role of modernization

Table 1 Odds ratios from logit analysis of woman's characteristics on favoring circumcision

	Model 1	Model 2	Model 3	Model 4
Mother circumcised	29.56**			39.75**
Group circumcised (1 = >50% yes)	1.32*			1.70**
Mother's education		1.02*		0.92**
Mother's age		1.03**		0.98**
Urban residence (1 = yes)		1.01		0.94
Read newspaper once a week			0.84	1.06
Watched television every week			1.11	0.85
Listened to radio every day			1.30**	1.06
Community activity $N = 4,224$			1.04	0.42**

* $P < .05$; ** $P < .001$

variables with that of social convention regarding attitudes toward continuing FGC. Education and age have small statistically significant influences on a woman's attitudes toward circumcision. Each additional year of education increases the odds of favoring FGC by about 2%, contrary to our expectation. General schooling is limited in the sample (mean = 4.9 years), and may not be sufficient for women to recognize potential health risks and to forego the practice. Specific health education about the risks may be more relevant to changing attitudes and breaking the FGC social convention. As expected, older women are slightly more likely to favor continuing circumcision: a one-year increase in age increases the probability of wanting circumcision continued by about 3%. Older women, perhaps, are more tied to the convention because they are more traditional in marriage, family, and gender role expectations. Whether one lives in an urban or rural place does not influence attitudes about circumcision. Taken together, education, residence, and age exert little influence on circumcision attitudes (pseudo $R^2 = .01$). Social convention plays a much more significant role (pseudo $R^2 = .36$) in explaining continued support for FGC.

Model 3 considers efforts to change attitudes directly through community activities about eliminating FGC and indirectly through exposure to the media. Surprisingly, a community activity advocating abandonment of female circumcision has no impact on support for circumcision in this equation; however, media's role varies by type of media. Only listening to the radio has a significant relationship with FGC attitudes. Radio may be more widely available and less expensive than other media. Radio also does not require literacy as print media do. These factors help to account for radio's relationship with FGC attitudes, and the lack of relationships for other media. Yet contrary to expectations, respondents who listened to the radio every day are 30% more likely to favor continuing circumcision than those who listened to the radio less than once a day. This finding is particularly surprising given the positive correlations between radio use and education ($r = .389$) and between radio use and urban residence ($r = .282$) in our sample. Nigerian radio broadcasts programs against FGC (Orubuloye et al., 2000), but these programs have not changed attitudes. Social reaction theory suggests people

sometimes rebel when told to do something, especially when they view the action as threatening. Broadcasting opposition to FGC may create a backlash among those who want to honor or revive traditional African culture. Neither increased education nor simply hearing information on the radio is sufficient to convince a critical mass to break the social convention concerning FGC.

The final model includes all of the variables. In this model, a woman's circumcision status continues to have the strongest impact on her views about circumcision: women who have not been circumcised are less supportive of continuing the practice. In fact, adding the modernization and media variables increases the impact of woman's circumcision status from a factor of about 29 to a factor of about 40. The impact of ethnicity doubles between Model 1 and Model 4. When all of the variables are included, being from an ethnic group with over 50% of the women circumcised increases the odds of favoring circumcision's continuation by 70%.

Several other changes are noted between Model 4 and the previous ones. With a woman's circumcision status in the equation, the relationships between education and circumcision attitudes and age and circumcision attitudes both reverse direction. In equation 4, increased education decreases the odds of favoring continuing circumcision; for each additional year of education, women are about 8% less likely to want to continue FGC (odds ratio = .92). Older women too have less support for continuing circumcision; for every additional year of age, women are about 2% less like to favor continuing circumcision (odds ratio = .98). Perhaps older women have seen the harmful effects of FGC on themselves. Furthermore, if their older daughters' circumcisions had complications, they may not want their younger daughters circumcised.

None of the media variables make a significant contribution in this model, but an awareness of community activities against FGC does shape attitudes. Those who know about activities in their community are about 58% more likely to oppose continuing circumcision than those unaware of these activities. Direct activities to change the social convention surrounding FGC have some success in changing attitudes about the practice, but their impact is secondary to and partially dependent upon whether a woman has been circumcised. The modernization variables also have little impact on attitudes toward abandoning FGC, especially as compared to the role of woman's circumcision status, offering additional support for the social convention hypothesis.

We further clarify the relationship between woman's circumcision status and attitudes about circumcision by calculating predicted probabilities of favoring circumcision under different conditions. First, we want to see how the predicted probabilities of favoring circumcision vary among those women who are not circumcised (Table 2). For uncircumcised women, we calculate probabilities for those with more "traditional" outlooks (i.e., rural, women from ethnic groups with over 50% of women circumcised, who do not read the newspaper, do not watch television, and do not listen to the radio, and who had no awareness of community activity against circumcision) and those in less traditional situations (i.e., urban women whose ethnic groups have less than 50% of their women circumcised, who do read the newspaper, watch

Table 2 Predicted probabilities of favoring circumcision under different conditions when woman not circumcised

	Min → Max	0 → 1
<i>“Traditional” conditions</i>		
Circumcised—no	.644	.644
>50% ethnic group circumcised	.022	.022
Education—mean	-.062	-.006
Age—mean	-.037	-.002
Urban residence—no	-.003	-.003
Read newspaper once a week—no	.003	.003
Watched television every week—no	-.008	-.008
Listened to radio every day—no	.003	.003
Community activity	-.031	-.031
Predicted probability of favoring circumcision given specified conditions	Discontinue = .945	Continue = .055
<i>“Nontraditional” conditions</i>		
Circumcised—yes	.325	.325
<50% ethnic group circumcised	.009	.009
Education—mean	-.015	-.002
Age—mean	-.009	-.000
Urban residence—yes	-.001	-.001
Read newspaper once a week—yes	.001	.001
Watched television every week—yes	-.002	-.002
Listened to radio every day—yes	.001	.001
Community activity	-.017	-.017
Predicted probability of favoring circumcision given specified conditions	Discontinue = .987	Continue = .013

television, listen to the radio, and who identified a community activity against circumcision). For all groups, we use the mean value for education and age to calculate predicted probabilities.

Table 2 presents the predicted probabilities of a woman favoring circumcision given that she is not circumcised. For both traditional and less traditional women, the predicted probability of favoring continuing circumcision is less than .06. Neither variations in sociodemographic conditions nor variations in media/activity shape attitudes toward circumcision for these uncircumcised women. These women want the practice abandoned. Once a woman has personally discontinued the practice of circumcision, other factors have little impact on her views of circumcision.

We also calculate predicted probabilities for women who have been circumcised. Table 3 presents the predicted probabilities of favoring the continuation of circumcision given that the woman is circumcised. With the woman circumcised, sociodemographic conditions affect the probabilities of circumcision attitudes. The predicted probability of favoring continuing circumcision with a rural woman of average education and age, whose ethnic group is mostly circumcised, and who has no media/activity exposure is .66. In contrast, a woman with average education and age living in an urban area, who reads newspapers, watches television, and listens to the radio, has

Table 3 Predicted probabilities of favoring circumcision under different conditions when woman is circumcised

	Min → Max	0 → 1
<i>“Traditional” conditions</i>		
Circumcised—no	.644	.644
>50% ethnic group circumcised	.122	.122
Education—mean	-.323	-.014
Age—mean	-.154	-.003
Urban residence—no	-.014	-.014
Read newspaper once a week—no	.011	.011
Watched television every week—no	-.036	-.036
Listened to radio every day—no	.011	.011
Community activity	-.204	-.204
Predicted probability of favoring circumcision given specified conditions	Discontinue = .301	Continue = .699
<i>“Nontraditional” conditions</i>		
Circumcised—yes	.325	.325
<50% ethnic group circumcised	.127	.127
Education—mean	-.283	-.020
Age—mean	-.159	-.005
Urban residence—yes	-.015	-.015
Read newspaper once a week—yes	.012	.012
Watched television every week—yes	-.038	-.038
Listened to radio every day—yes	.012	.012
Community activity	-.209	-.209
Predicted probability of favoring circumcision given specified conditions	Discontinue = .662	Continue = .338

community activity against circumcision, and belongs to an ethnic group who is mostly uncircumcised has a predicted probability of favoring continuing circumcision of .34.⁶ Modernization factors may play some role in helping to break the social convention about FGC. But, the impact is clearly secondary to social convention's impact, and only after the initial breaking of the social convention by a critical mass of people will FGC become completely unacceptable.

Conclusions

Much research on FGC has been ethnographic, small-scale, community-based, or medical in nature. Use of a large-scale national survey to study attitudes toward FGC helps to understand the prevalence and pervasiveness of a cultural practice that has extensive demographic, health, and human rights

⁶ For circumcised women, varying the educational level does have some influence on the predicted probability of favoring continuing circumcision. Setting education at zero years increases the probability of favoring continuing by about 10% for both traditional and nontraditional women; conversely, setting education at twelve years decreases the probability by about 10% from the predicted probability with mean education.

ramifications. Research with a country-specific data set such as that used in this study offers a method to study a sensitive cultural issue with less bias than other research approaches and may be able to guide nationwide government programming decisions.

A strong relationship exists between women's circumcision status and attitude toward abandoning the practice. A woman who has not been circumcised favors discontinuing the practice, and this relationship only increases in strength when other conditions are added to the equation. Uncircumcised women, particularly those belonging to ethnic groups that have a majority of woman uncircumcised, have rejected FGC—a rejection evident across sociodemographic statuses.

Education and age both have small statistically significant relationships with attitudes toward FGC; however, these relationships are influenced by a woman's circumcision status. When a woman's circumcision status is taken into account, increased education increases opposition to the practice. Increased age also increases opposition, after controlling for circumcision status. Nevertheless, education and age have substantially less impact on attitudes toward FGC than a woman's circumcision status has, suggesting modernization has a minimal influence on FGC and much of this influence may be indirect by changing views about the social convention of FGC and marriageability.

Our findings offer strong support for the social convention hypothesis. If a woman is not circumcised, she favors abandoning the practice regardless of her personal sociodemographic characteristics and her exposure to general media sources. Furthermore, belonging to an ethnic group where most women are not circumcised reduces support for circumcision, consistent with Mackie's (1996) view that FGC will be abandoned when a critical mass of group members no longer support the social convention.

Mackie (2000) further argues that education about FGC, public discussion, and public declaration of intent not to cut daughters all contribute to developing this critical mass of individuals willing to break the convention surrounding cutting. Additionally, the Population Reference Bureau (2002) suggests active social marketing in targeted areas to reduce the incidence of FGC. This marketing would involve an outreach program convincing local leaders to decry the practice. Our findings show woman who are aware of community activities against FGC are more in favor of abandoning the practice, particularly women who have not been circumcised and are part of ethnic groups where the majority of women have not been circumcised. Community-based efforts to empower women and break the convention appear likely to change practices regarding FGC and to reinforce changes that have already occurred.

Instead of outright condemnation, perhaps careful reflection about what circumcision means in cultures and why it is perpetuated would be a more effective influence on abandoning the practice (Horowitz & Jackson, 1995; Nussbaum, 1999). The Tostan project in Senegal, for example, encourages informed dialogue between women, men, community members, and religious

leaders about the rights of women and FGC. It has led to abandoning the practice in over 1,000 villages in Senegal and has served as a model for programs in other African countries as well (Tostan, 2005).

Female genital cutting is a powerful part of social life in areas where it is practiced. Our study demonstrates strong support for the social convention hypothesis. It is necessary for people in these cultures to realize they can give up harmful practices without giving up their culture in order to abandon FGC. Efforts to eliminate FGC must influence everyone involved in the practice if they are to be successful.

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