

Tribal Perspectives on Female Genital Mutilation (FGM) and HIV and AIDS Risks among Married Women in Nigeria

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ABSTRACT This paper analyzed risk of contracting HIV that is associated with Female Genital Mutilation (FGM) due to the involvement of traditional circumcisers. The demographic and health survey for 2008 were used. The data were analyzed with Ordered Probit regression. The results indicated that majority of the circumcised women (89.18 percent) would not want their daughters to be circumcised. A Yoruba woman was 25.67 points more likely to be at high HIV risk from FGM than women from other tribes. Those that indicated cleanliness, social acceptance, better marriage prospects, sexual pleasure and religious approval as reasons for female circumcision were 8.85 percent, 3.53 percent, 7.51 percent, 23.45 percent and 6.68 percent points more likely to be at high HIV risk from FGM than other women. Those women that were resident in North-Central, North-East and North-West were 6.53 percent points, 15.06 percent points and 7.98 percent points respectively less likely to be at high HIV risk from female circumcision than those from South South zone, while those from South-East and South-West were 16.56 percent points and 8.51 percent points respectively more. There is need for efforts to provide proper education to dissuade traditional teachings on the benefits of FGM.

INTRODUCTION

Nigeria is the most populous country in Sub-Saharan Africa (SSA). The 2006 National Population Census put the population at about 140 million {National Bureau of Statistics (NBS) 2009}. Annual population growth rate between 1991 and 2006 was 3.85 percent. The male population was slightly higher than female, accounting for 50.80 percent of the total population in 2006. The blend of cultural splendors from the northern part, which predominantly inhabits the Hausa and Fulani, to the southern part that predominantly inhabits the Yoruba and Igbo portray the country as a crystallized gallery of ceaseless perfection. Nigeria consists of more than 250 ethnic groups and 500 local languages {National Agency for the Control of AIDS (NACA) 2012; Ojua et al. 2013}, Nigeria is a quintessence of perfectly mixed cultural diversity. Civilization resulting from attainment of western education makes some of the cultural heritages to be contended with. This became more tenacious in the wake of emerging health challenges like Acquired Immune Deficiency Syndrome (AIDS) which is caused by Human Immunodeficiency Virus (HIV).

HIV is a virus that weakens the immune system thereby subjecting infected individuals to morbidity from several opportunistic diseases. It had been emphasized that there had never

been any disease like AIDS, which cuts across different regions of the world and possesses such unique capability to tear apart fabrics of socio-cultural prowess with some catastrophic consequences. There have been perpetual increases in the number of HIV infected people despite several interventions to curtail its transmission. In Nigeria, by the end of 2011, about 3,459,363 people were living with HIV virus and estimated 1,449,166 people required Anti-Retroviral Drug (ARV). In conformation with World Health Organization (WHO) guidelines, HIV prevalence rates in Nigeria had been monitored through Anti-Natal Clinic (ANC) Surveillances with results showing a decline in prevalence rates from 4.6 percent to 4.1 percent between 2008 and 2010, respectively (NACA 2012).

Although efforts to reduce its human immune distorting impacts through anti-retroviral drugs have proved successful, policy makers are strongly of opinion that there is the need for drastic reduction in exposure of people to the risk of viral transmission. It is therefore widely advocated that human sex-related behaviors and cultural practices that can subject people to HIV vulnerability should be carefully revised in line with and internationally acceptable standards and fundamental rights of people (Eze 2009; NACA 2012). Culture acts as a dynamic liberation force through various actively engaged and respected institutions in the society. There have

been several conflicts between households' integration into the larger economy via civilization and the desire to get them separated from unwholesome practices that had been handed over through some cultural practices.

In Nigeria, there are many tribes with different cultural practices, many of which provide direct avenues for HIV transmission. Specifically, some people hold the belief that HIV results from witchcraft attacks (Secker 2012). Misconceptions about sources of infection connote outright inability to seek protection. Other critical issues are wife hospitality which may still be practiced in some cultures (Makurdi 2006), spouse sharing (Osagbemi et al. 2004; Osagbemi and Jegede 2001), polygamy, wife inheritance, keeping of concubines (Eze 2009), tribal marks and body incisions that are sometimes required for traditional healing and spiritual protection (Peters et al. 2004). In places like Benue, Kogi, and Nsukka where some of these practices are common, it had been shown that HIV prevalence rates are quite high (Eze 2009).

Female genital mutilation (FGM) is another cultural practice that may promote HIV transmission (Etokidem 2007). This is a circumcision performed on a woman by cutting part of her reproductive organ. A global estimate in 1999 indicated that women and girls totaling about 130 million had been subjected to severe pains of FGM, while 2 million are at risk every year (World Health Organization [WHO] 1999). Another estimate had noted that every year, 3 million girls and women are subjected to FGM which sometimes threatens life depending on deepness of the cut (UNICEF 2005). Specifically, FGM is rooted in some people's cultural norms as a process for preparing women for marriage. In some instances, however, FGM is culturally viewed as a way of reducing sexual drives of women in order to ensure that virginity is preserved and for curtailing future extramarital tendencies. In the cultures of the Igbo, though lacking scientific basis, FGM is believed to make women become more attractive to men (Egwatu and Agusa 1981; Abiodun et al. 2011).

Globally, however, FGM is generally perceived as a violation of women's fundamental human right (UNICEF 2005). Involvement of several traditionalists in the act subjects women to a very high risk of HIV transmission or any other infection like hepatitis B. This is due to the likelihood of unhygienic conducts and lack of sterilization of their equipment (Ojua et al. 2013).

The practice had also been traced to complications at childbirth, which is often resolved with caesarean operations (Abiodun et al. 2011). There have been legislative pronouncements forbidding FGM in some Nigerian states, although the extent of their enforcement is not certain. However, International and national legislative actions are required to complement activities of civil organizations in the efforts to get it eradicated (Population Reference Bureau 2001).

Although in some cultures, civilization and western religious practices seem to have reduced the practice of FGM, the degree of compliance to pressures from international bodies is still not well understood. In rural areas, some cultural norms may still be well upheld due to ignorance and gender inequality in marital issues. FGM is a violent act against women and efforts to eradicate it have been spearheaded in some African countries. In Kenya, it was noted that expansion of evangelical churches is making parents ignore the culture of female circumcision. One important aspect of the problem is that in some places, uncircumcised girls are often ostracized. This often makes the girls to request for circumcision as a mark of readiness to be given out in marriage (The National Board of Health Welfare 2006).

The issue of HIV risk that may be associated with FGM is paramount because of several gender disparities in HIV infection and bearing of associated stigma and discrimination. Policy makers are interested in understanding the different socio-cultural mechanisms that predispose women to HIV vulnerability. In Nigeria, the tribal perspectives which had been explored in this paper are vital because of some cultural issues that explain HIV transmission and prevalent rates. Therefore, I used the 2008 Demographic and Health Survey (DHS) data to analyze exposure of married women to FGM and the extent of associated HIV risks due to involvement of traditional circumcisers and birth attendants. In the remaining parts of the paper, materials and methods, results and discussions and conclusion were presented.

MATERIAL AND METHODS

The Data

The 2008 DHS data were collected by following the 2006 enumeration areas. The objective of the survey was collection and analysis of

comprehensive data on households' health and demographic issues. Child immunization, HIV knowledge and FGM were among the issues covered extensively in the survey. Samples were selected with two stage stratified cluster design. In all, 888 clusters were selected with 286 from urban areas and 602 from rural areas. A total 36800 representative households were selected, although 34070 completed the survey. The women and men of reproductive ages were also selected for interview. In this study, data in the couple recode file were used. Extensive description of data collection methods had been provided by National Population Commission (NPC) [Nigeria] and ICF Macro (2009).

Analytical Model

The Ordered Probit regression was used to analyze the data because the respondents were grouped into four categories which are; those that were circumcised by traditional health practitioners (high risk), those that had no knowledge of who circumcised them (medium risk), those that were circumcised by medical practitioners (low risk) and those that were not circumcised (no risk). The division of risk level was based on the understanding that traditional practitioners may not sterilize their equipment, thereby subjecting women to high risk of HIV infection, among others. Following Greene (2003), the model can be specified by assuming a function Y_i^* which is of observed and unobserved variables.

$$Y_i^* = \beta_0 + x_{1i}\beta_1 + x_{2i}\beta_2 + \dots + x_{ki}\beta_k + \beta_i \quad 1$$

Y_i^* is the latent index of risk levels from female genital mutilation, β are the parameters to be estimated and x is are Ekoi tribe (yes =1, 0 otherwise), Fulani tribe (yes =1, 0 otherwise), Hausa tribe (yes =1, 0 otherwise), Ibibio tribe (yes =1, 0 otherwise), Igala tribe (yes =1, 0 otherwise), Igbo tribe (yes =1, 0 otherwise), Ijaw tribe (yes =1, 0 otherwise), Kanuri tribe (yes =1, 0 otherwise), Tiv tribe (yes =1, 0 otherwise), Yoruba tribe (yes =1, 0 otherwise), number of unions, number of other wives, Ignorant of HIV (yes =1, 0 otherwise), woman said FGM is for cleanliness (yes =1, 0 otherwise), woman said FGM is for social acceptance (yes =1, 0 otherwise), woman said FGM is for better marriage prospects (yes =1, 0 otherwise), woman said FGM is for preservation of virginity (yes =1, 0 otherwise), woman said FGM is for better sexual pleasure (yes =1, 0

otherwise), woman said FGM is for religious approval (yes =1, 0 otherwise), woman said circumcision is by religious demand (yes =1, 0 otherwise), woman said FGM should continue (yes =1, 0 otherwise), Men's awareness of FGM (yes =1, 0 otherwise), FGM for cleanliness (men) (yes =1, 0 otherwise), FGM for social acceptance (men) (yes =1, 0 otherwise), FGM - marriage prospects (men) (yes =1, 0 otherwise), FGM- virginity (men) (yes =1, 0 otherwise), FGM- more sexual pleasure (men) (yes =1, 0 otherwise), FGM - religious approval (men) (yes =1, 0 otherwise), circumcision is by religion (men) (yes =1, 0 otherwise), circumcision should continue (men) (yes =1, 0 otherwise), age, smokes cigarette (yes =1, 0 otherwise) (yes =1, 0 otherwise), North Central (yes =1, 0 otherwise), North East (yes =1, 0 otherwise), North West (yes =1, 0 otherwise), South East (yes =1, 0 otherwise), South West (yes =1, 0 otherwise), urban (yes =1, 0 otherwise), education (years), Islam religion (yes =1, 0 otherwise), Wealth index, husband's years of education, household head age, husband reads newspaper (yes =1, 0 otherwise), husband listens to radio (yes =1, 0 otherwise) and husband watches TV (yes =1, 0 otherwise).

Actually, if the latent index is above a certain value, high or low risk level would be reported. The interval decision rule can be expressed as:

$$\begin{aligned} Y_i=1 & \quad \text{if } Y_i^* \leq u_1 & 2 \\ Y_i=2 & \quad \text{if } u_1 < Y_i^* \leq u_2 & 3 \\ Y_i=3 & \quad \text{if } u_2 < Y_i^* \leq u_3 & 4 \\ Y_i=4 & \quad \text{if } Y_i^* > u_3 & 5 \end{aligned}$$

The probabilities of each of the risk levels can be expressed as:

$$\begin{aligned} \Pr(Y_i=1) &= 1 - \phi[x_i\beta - u_1] & 6 \\ \Pr(Y_i=2) &= \phi[x_i\beta - u_1] - \phi[x_i\beta - u_2] & 7 \\ \Pr(Y_i=3) &= \phi[x_i\beta - u_2] - \phi[x_i\beta - u_3] & 8 \\ \Pr(Y_i=4) &= \phi[x_i\beta - u_3] & 9 \end{aligned}$$

The marginal effect is a function of point of expansion (X 's) and frame of reference for outcome (Y). This can be expressed as:

$$d \Pr(Y_i=5)/dx_i = d \phi[x_i\beta - u_3]/dx_i = \beta \phi[x_i\beta - u_3] \quad 10$$

In STATA software, `mfx compute, predict t(outcome(1, 2, 3 or 4))` command was used to compute the marginal effects with respect to different levels of Y after estimating equation 1.

RESULTS AND DISCUSSION

Women's FGM Involvements and Attitudes

Table 1 shows the awareness of the married women on FGM across the ethnic groups. It re-

veals that among Yoruba tribe, 92.51 percent was aware of FGM, while 90.37 percent of the Igbo was aware. Awareness is directly related to long time practice of FGM in the southern part of Nigeria. In a survey conducted by UNICEF (2001), it was found that FGM was highly practiced in South-South, South East and South-West Nigeria. The lowest awareness level was among Igala (20.16 percent), Fulani (22.61 percent), Tiv (31.19 percent) and Hausa (33.27 percent). Using data collected by National HIV/AIDS and Reproductive Health Survey (NARHS) survey in 2005, Abiodun et al. (2011) also found that awareness about FGM was highest among women from South West and South East with each having 78.3 percent.

Table 1: Awareness and circumcision of women across major ethnic groups in Nigeria

<i>Ethnic group</i>	<i>Aware (%)</i>	<i>Circum-cised</i>	<i>Frequ-ency</i>
Ekoi	86.96	38.04	92
Fulani	22.61	4.67	920
Hausa	33.27	12.65	2 483
Ibibio	77.31	17.65	119
Igala	20.16	0.78	129
Igbo	90.37	56.95	748
Ijaw/ Izon	88.89	32.00	225
Kanuri/ Beriberi	60.82	0.94	319
Tiv	31.19	1.49	202
Yoruba	92.51	69.94	1 081
Others	40.53	12.60	2 413
Total	49.74	22.65	8 731

Source: Author's computations from Nigeria 2008 DHS data (file NGCR51FL.SPSS)

Also, awareness levels and involvement in female circumcision were highly correlated ($\tau = 0.8163$). This implies that there is very high association between awareness and involvement. Specifically, 69.94 percent of the Yoruba women were circumcised. This was the highest percentage which was followed by 56.95 percent for Igbos. Also, lowest reported circumcision rates were among the Igala (0.78 percent), Kanuri (0.94 percent) and Tiv (1.49 percent). Mandara (2004) similarly found that in among women that were subjected to medical examination in northern Nigeria, 29 percent of the Hausas were circumcised while Yoruba was 73 percent. Although female circumcision is often low among Hausa people, it had been reported that the type performed on women could be for religious reason and it is often more painful with very high ten-

dencies of complications (Mandara, 2004; Okeke et al. 2012).

Table 2 shows the distribution according to where FGM was done. It shows that all the women that were circumcised in the Ekoi tribe were at risk of HIV because it was conducted by traditional circumciser. Also, 100 percent, 100 percent and 93.10 percent of the women that were circumcised from the Hausa, Ibibio and Fulani were at risk of HIV because the method that was used was traditional. Among the Yoruba and Igbo, where most of the women reported to have been circumcised, trained nurses were involved with 24.30 percent and 34.27 percent respectively. Although female circumcision is seen as violation of the fundamental right of women, traditional circumcisers' and traditional birth attendants' involvements also subject the women to higher health risks (Abiodun et al. 2011). These include HIV transmission since equipment may not be sterilized. Others are infection with hepatitis, excessive bleeding and permanent damage to the genital organ. Several studies have identified traditional birth attendants and local circumcisers as the people that perform circumcision with local equipment (Mandara 2004; Okeke et al. 2012).

It should be emphasized that some women were circumcised by trained nurses and doctors. Involvement of medical practitioners was informed by attempt to introduce FGM into the forefront of medical and health service delivery. However, WHO (1982) sternly issued a statement that forbids any hospital or nurse to be engaged in such harmful activity. Shell-Duncan (2001) also noted that in 1994, a resolution against FGM was passed by the International Federation of Gynecology and Obstetrics, which warned any medical practitioner from involvement. It emphasized that ever since then, other international bodies like UNICEF had made similar declarations.

Table 3 shows the distribution women based on intention to circumcise their daughters. It shows that majority of the respondents (89.18 percent) would not want their daughters to be circumcised. Across the tribes, no woman from the Tiv was willing to circumcise her daughter, while 96.30 percent, 96.03 percent, 95.07 percent and 95 percent of the Kanuri, Fulani, Hausa and Igala would not circumcise their daughters. These findings are direct reflections on willingness of people to discontinue with the practice.

Table 2: Distribution of respondents based on who performed the circumcision

	<i>Doctor</i>	<i>Trained nurse / midwife</i>	<i>Other health professional</i>	<i>Traditional "circumciser"</i>	<i>Traditional birth attendant</i>	<i>Other traditional</i>	<i>Don't know</i>
Ekoi	0.00	0.00	0.00	100.00	0.00	0.00	0.00
Fulani	0.00	3.45	0.00	93.10	0.00	0.00	3.45
Hausa	0.00	0.00	0.00	95.69	3.02	1.29	0.00
Ibibio	0.00	0.00	0.00	80.00	20.00	0.00	0.00
Igala	0.00	100.00	0.00	0.00	0.00	0.00	0.00
Igbo	2.10	34.27	2.10	40.56	20.28	0.70	0.00
Ijaw/ Izon	0.00	26.67	0.00	60.00	13.33	0.00	0.00
Kanuri/ Beriberi	0.00	25.00	0.00	75.00	0.00	0.00	0.00
Tiv	0.00	100.00	0.00	0.00	0.00	0.00	0.00
Yoruba	4.19	24.30	0.56	67.88	2.23	0.28	0.56
Others	1.83	13.76	0.00	78.90	5.50	0.00	0.00
Total	2.22	17.63	0.55	72.84	5.88	0.55	0.33

Source: Author's computations from Nigeria 2008 DHS data (file NGCR51FL.SPSS)

It also reflects the fact that the popularity of female circumcision is declining and reflects great hope that it would soon be eradicated. However, in a study by Mandara (2004), 21 percent of the women that were interviewed indicated that they would circumcise their daughters. Odoi (2005) and Okeke et al. (2012) noted that women attain formal education and high social status, they are able to disapprove of FGM and would not want their daughters to face such cultural victimization.

Table 3: Distribution of respondents based on intention to have female child circumcised

<i>Ethnic group</i>	<i>No</i>	<i>Yes</i>	<i>Don't know</i>	<i>Frequency</i>
Ekoi	86.44	13.46	1.92	59
Fulani	96.03	1.59	2.38	126
Hausa	95.07	1.97	2.96	406
Ibibio	91.55	5.63	2.82	71
Igala	95.00	0.00	5.00	20
Igbo	87.16	10.37	2.47	405
Ijaw/ Izon	82.07	11.72	6.21	145
Kanuri/ Beriberi	96.30	0.00	3.70	135
Tiv	100.00	0.00	0.00	50
Yoruba	85.47	9.98	4.56	461
Others	87.20	9.67	3.13	672
Total	89.18	7.49	3.33	2,550

Source: Author's computations from Nigeria 2008 DHS data (file NGCR51FL.SPSS)

Factors Explaining HIV Risk Levels Due to Female Circumcision

Table 4 shows the results of Ordered Probit regression. It shows that the model produced a

good fit for the data as shown by the statistical significance ($p < 0.01$) of the Likelihood Ratio Chi Square. Out of the tribe dummy variables, Hausa (+), Ibibio (-), Igala (-), Kanuri (+), Tiv (-), and Yoruba (+) were statistically significant ($p < 0.10$). Also, out of the variables that captured benefits of FGM as highlighted by women, cleanliness, social acceptance, sexual pleasure and religious approval were statistically significant ($p < 0.05$) and with positive coefficients. However, out of the variables included to capture the benefits of FGM as reported by men, only cleanliness and religious approval were statistically significant ($p < 0.01$) with negative and positive parameters, respectively. The zonal variables all have parameters that were statistically significant ($p < 0.01$) although all the northern zone dummies were with negative sign while southern were with positive sign. Also, parameters of the variables for women wanted circumcision to continue and husband awareness of FGM were statistically significant ($p < 0.01$) with positive sign.

Table 5 shows the marginal coefficients across different HIV risk levels. The results show that a Hausa woman is 3.05 percent points more likely to be at high HIV risk from FGM than women from other tribes. An Ibibio woman is 3.58 percent points less likely to be at high HIV risk from FGM than women from other tribes. Also, an Igala woman is 3.84 percent points less likely to be at high HIV risk from FGM than women from other tribes. A Kanuri woman is 16.19 percent points more likely to be at high HIV risk from FGM than women from other tribes, while a Tiv woman is 9.10 percent points less likely.

Table 4: Estimated parameters for the determinants of HIV risk from FGM based on Ordered Probit Model

<i>Variables</i>	<i>Parameters</i>	<i>Std error</i>	<i>t-statistics</i>	<i>Mean</i>	<i>Std Dev</i>
Ekoi	-0.1884	0.1507	-1.25	0.0105	0.1021
Fulani	-0.0382	0.1013	-0.38	0.1054	0.3070
Hausa	0.1762	0.0802	2.20	0.2844	0.4511
Ibibio	-0.2586	0.1361	-1.90	0.0136	0.1160
Igala	-0.2814	0.1678	-1.68	0.0148	0.1207
Igbo	0.0432	0.0895	0.48	0.0857	0.2799
Ijaw	-0.1310	0.1058	-1.24	0.0258	0.1585
Kanuri	0.6793	0.1369	4.96	0.0365	0.1876
Tiv	-1.2187	0.3275	-3.72	0.0231	0.1503
Yoruba	1.0131	0.0647	15.65	0.1238	0.3294
Number of union	0.0772	0.0584	1.32	1.1198	0.3247
Number of other wives	-0.0173	0.0311	-0.56	0.4022	0.6700
Ignorant of HIV	0.0433	0.0582	0.74	0.1687	0.3745
FGM - cleanliness (women)	0.4198	0.0836	5.02	0.0337	0.1804
FGM social acceptance (women)	0.1904	0.0728	2.61	0.0467	0.2111
FGM- better marriage prospects	0.3677	0.0748	4.91	0.0435	0.2040
FGM - virginity (women)	-0.0502	0.0684	-0.73	0.0513	0.2206
FGM - sexual pleasure (women)	0.8925	0.0924	9.66	0.0257	0.1581
FGM - religious approval (women)	0.3295	0.1306	2.52	0.0150	0.1216
Circumcision is by religion (women)	0.0885	0.0624	1.42	0.0833	0.2763
FGM for cleanliness (men)	-0.1399	0.0439	-3.19	0.0320	0.1759
FGM for social acceptance (men)	-0.1114	0.0931	-1.20	0.0276	0.1638
FGM - marriage prospects (men)	0.0429	0.0771	0.56	0.0442	0.2056
FGM- virginity (men)	0.0961	0.0731	1.32	0.0517	0.2213
FGM- more sexual pleasure (men)	0.0094	0.0524	0.18	0.1175	0.3220
FGM - religious approval (men)	0.3385	0.0680	4.98	0.0651	0.2466
Circumcision is by religion (men)	0.1479	0.1156	1.28	0.0182	0.1337
Circumcision should continue (men)	-0.0037	0.0578	-0.06	0.1343	0.3410
Continue circumcision (women)	0.4393	0.0598	7.34	0.1086	0.3111
Men's awareness of FGM	0.2179	0.0399	5.47	0.7115	0.4531
Age	0.0031	0.0576	0.05	0.1490	0.3561
Smokes cigarette	-0.0051	0.0031	-1.61	30.374	8.2431
North Central	-0.4817	0.0727	-6.62	0.1859	0.3890
North East	-1.4183	0.1117	-12.70	0.2293	0.4204
North West	-0.5564	0.0998	-5.58	0.2933	0.4553
South East	0.6997	0.1123	6.23	0.0639	0.2446
South West	0.4166	0.0841	4.95	0.0974	0.2965
Urban	-0.0086	0.0475	-0.18	0.2689	0.4434
Education (years)	0.0114	0.0088	1.29	2.2519	2.6060
Islam religion	0.0054	0.0058	1.07	0.5889	0.4921
Wealth index	0.0000	0.0000	1.08	-16210	99057.96
Husband's yrs of education	-0.0056	0.0086	-0.66	2.9742	2.6626
Head age	0.0014	0.0024	0.56	39.8048	10.1029
Husband reads newspaper	0.0596	0.0437	1.36	0.3518	0.4776
Husband listens to radio	0.0464	0.0661	0.70	0.8591	0.3479
Husband watches TV	0.0363	0.0504	0.72	0.4775	0.4995
cut1	1.1321	0.1426			
cut2	1.2819	0.1427			
cut3	1.3624	0.1428			
LR chi ² (49)	= 4690.07***	Log likelihood = -3518.0685	Pseudo R2	= 0.4000	

Source: Author's computations from Nigeria 2008 DHS data (file NGCR51FL.SPSS)

However, a Yoruba woman is 25.67 points more likely to be at high HIV risk from FGM than women from other tribes. These results are pointing to tribal differences in HIV risk that is associated with female circumcision. The Yoruba women are at the highest risk although the trends should

have declined. The Yoruba people's inclination towards female circumcision can also be emphasized from the culture of inscribing tribal marks on the faces of their children. It should be noted that with recent modernization and education, that practice is being gradually phased out.

Table 5: Marginal coefficients of parameter estimated for different HIV risks variables (dy/dx)

Variables	High HIV Risk		Medium HIV risk		Low HIV risk		No HIV risk	
	Para-meter	t-value	Para-meter	t-value	Para-meter	t-value	Para-meter	t-value
Ekoi	-0.0273	-1.42	-0.0032	-1.31	-0.0063	-1.29	0.0368	1.39
Fulani	-0.0063	-0.39	-0.0007	-0.38	-0.0014	-0.38	0.0083	0.39
Hausa	0.0305	2.08	0.0032	2.12	0.0062	2.15	-0.0399	-2.10
Ibibio	-0.0358	-2.28	-0.0043	-2.05	-0.0085	-2.02	0.0486	2.21
Igala	-0.0384	-2.06	-0.0046	-1.84	-0.0092	-1.80	0.0523	1.99
Igbo	0.0075	0.48	0.0008	0.49	0.0016	0.49	-0.0099	-0.49
Ijaw	-0.0199	-1.35	-0.0023	-1.28	-0.0045	-1.27	0.0266	1.33
Kanuri	0.1619	3.86	0.0127	5.00	0.0230	5.67	-0.1976	-4.12
Tiv	-0.0910	-13.33	-0.0130	-7.73	-0.0274	-8.09	0.1314	12.13
Yoruba	0.2567	11.64	0.0178	10.21	0.0316	13.26	-0.3060	-12.78
Number of union	0.0126	1.31	0.0014	1.30	0.0027	1.30	-0.0167	-1.31
Number of other wives	-0.0028	-0.55	-0.0003	-0.55	-0.0006	-0.55	0.0038	0.55
Ignorant of HIV	0.0073	0.73	0.0008	0.74	0.0015	0.74	-0.0096	-0.73
FGM-cleanliness (women)	0.0885	4.09	0.0080	4.59	0.0150	4.98	-0.1114	-4.27
FGM social acceptance (women)	0.0353	2.36	0.0036	2.49	0.0068	2.56	-0.0457	-2.41
FGM-better marriage prospects	0.0751	4.1	0.0070	4.47	0.0132	4.80	-0.0953	-4.26
FGM-virginity (women)	-0.0081	-0.76	-0.0009	-0.75	-0.0018	-0.75	0.0108	0.76
FGM-sexual pleasure (women)	0.2345	7.17	0.0158	8.78	0.0277	11.24	-0.2780	-7.84
FGM-religious approval (women)	0.0668	2.13	0.0063	2.42	0.0118	2.54	-0.0849	-2.20
Circumcision is by religion (women)	0.0153	1.34	0.0016	1.38	0.0031	1.39	-0.0200	-1.36
Continue circumcision (women)	0.0901	6.05	0.0083	6.18	0.0156	6.86	-0.1141	-6.31
Men's awareness of FGM	0.0361	5.48	0.0039	4.98	0.0077	5.20	-0.0477	-5.49
FGM for cleanliness (men)	-0.0231	-3.19	-0.0025	-3.08	-0.0049	-3.13	0.0306	3.19
FGM for social acceptance (men)	-0.0171	-1.28	-0.0019	-1.22	-0.0038	-1.22	0.0229	1.27
FGM - marriage prospects (men)	0.0073	0.55	0.0008	0.56	0.0015	0.56	-0.0097	-0.55
FGM- virginity (men)	0.0168	1.25	0.0018	1.28	0.0034	1.30	-0.0220	-1.26
FGM- more sexual pleasure (men)	0.0016	0.18	0.0002	0.19	0.0003	0.19	-0.0021	-0.18
FGM - religious approval (men)	0.0675	4.23	0.0064	4.51	0.0121	4.81	-0.0861	-4.38
Circumcision is by religion (men)	0.0263	1.15	0.0027	1.22	0.0052	1.24	-0.0342	-1.17
Circumcision should continue (men)	-0.0008	-0.08	-0.0001	-0.08	-0.0002	-0.08	0.0010	0.08
Age	0.0007	0.08	0.0001	0.08	0.0002	0.08	-0.0010	-0.08
Smokes cigarette	-0.0008	-1.63	-0.0001	-1.62	-0.0002	-1.63	0.0011	1.63
North Central	-0.0653	-8.06	-0.0079	-6.40	-0.0157	-6.76	0.0889	7.94
North East	-0.1506	-19.34	-0.0184	-10.50	-0.0372	-13.24	0.2061	20.54
North West	-0.0798	-6.4	-0.0093	-5.53	-0.0184	-5.76	0.1076	6.37
South East	0.1656	4.77	0.0131	5.97	0.0237	6.89	-0.2024	-5.11
South West	0.0851	4.12	0.0079	4.52	0.0149	4.85	-0.1078	-4.29
Urban	-0.0015	-0.19	-0.0002	-0.19	-0.0003	-0.19	0.0019	0.19
Education (years)	0.0019	1.29	0.0002	1.28	0.0004	1.29	-0.0025	-1.29
Islam religion	0.0009	1.07	0.0001	1.06	0.0002	1.07	-0.0011	-1.07
Wealth index	0.0000	1.08	0.0000	1.08	0.0000	1.08	0.0000	-1.08
Husband's yrs of education	-0.0009	-0.66	-0.0001	-0.66	-0.0002	-0.66	0.0012	0.66
Head age	0.0002	0.57	0.0000	0.57	0.0000	0.57	-0.0003	-0.57
Husband reads newspaper	0.0099	1.34	0.0011	1.34	0.0021	1.35	-0.0131	-1.35
Husband listens to radio	0.0074	0.71	0.0008	0.70	0.0016	0.70	-0.0099	-0.71
Husband watches TV	0.0061	0.73	0.0007	0.73	0.0013	0.73	-0.0080	-0.73

Source: Author's computations from Nigeria 2008 DHS data (file NGCR51FL.SPSS)

The parameters of the benefits that were indicated by the women for circumcision revealed that those that indicated cleanliness, social acceptance, better marriage prospects, sexual pleasure and religious approval as reasons for female circumcision respectively were 8.85 percent, 3.53 percent, 7.51 percent, 23.45 percent and 6.68

percent points likely to be at high HIV risk from FGM than other women. The results have pointed at perception of more sexual pleasure as the primary driving force promoting HIV risks that are associated with female circumcision.

Furthermore, the women that indicated that female circumcision should continue were 9.01

percent points more likely to be at high HIV risk from FGM than other women. Similarly, men that were aware of female circumcision had wives that were 3.61 percent points more likely to be at high HIV risk from female circumcision than other women. The men that indicated that female circumcision brings about cleanliness for women had wives that were 2.31 percent points less likely to be at high HIV risk from female circumcision than other women. Also, the women that indicated that female circumcision bring religious approval had wives that were 6.75 percent points more likely to be at high HIV risk from female circumcision than other women.

All the zonal parameters for northern part of the country were with negative sign. Precisely,

Those women that were resident in North-Central were 6.53 percent points less likely to be at high HIV risk from female circumcision than those from South South zone. Also, women that were resident in North-East and North-West were 15.06 percent points and 7.98 percent points respectively less likely to be at high HIV risk from female circumcision than those from South South zone. However, women that were resident in South-East and South-West were 16.56 percent points and 8.51 percent points respectively more likely to be at high HIV risk from female circumcision than those from South South zone.

CONCLUSION

Female circumcision is a cultural practice which has been described as perfect violation of women's fundamental human rights. In this paper, efforts had been made to analyze the HIV risks associated with FGM due to involvement of traditional circumcisers. The findings show that FGM awareness was highly correlated with involvement. It is therefore important that efforts to eradicate the practice should be concentrated among those that are aware of it with special reference to Yoruba women. It is important to also note that perceived benefits of female circumcision represent the primary driver of their involvement, and with higher risky consequences. This implies that those efforts to address the problem should itemize the fallacies in those benefits that traditions have taught people as benefit from circumcision. It should be emphasized that majority of those women that were circumcised had no intention of circumcising their daughters. This presupposes that when

with more efforts by stakeholders, the practice of FGM would be completely eradicated.

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