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Original Research Article

A Multi-Country Study On Female Genital Mutilation and Inter-Generational Practices

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ABSTRACT

Objective: The focus of this study to examine the female genital mutilation practices in women and her daughter and their future prospective by selected characteristics in all selected African countries.
Methods: In this study Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) data (2009-11) are used to examine the female genital mutilation in women and her daughter. Twelve African countries were chosen for the analysis based on the various type of socio-economic and demographic profile along with FGM prevalence.
Results: Consideration prevalence of FGM has been found in Somalia, Guinea and Mali about 98 % than their counterpart. Result shows that the education has played a significant role to control FGM practices. The negative association has been found between women's education and FGM likewise in daughter FGM also. Results also illustrate the practice of flesh removed from genital area remarkable higher among all countries as compared to other genital excision practices. Burkina Faso have two major genital excision practice i.e. flesh removed from genital area and genital area just nicked without removing any flash followed by Chad. Significant result has been found in many of countries, women genital mutilation, women want to genital mutilation practices continue ever they had FGM along with daughter.
Conclusion: This study depicts the strength and the weakness point where FGM practices are considerable higher. It is required to take immediate action with the help of local organizations. Religious institutions and community leaders should work together to engage in a process of change. The community based awareness programme should implement as soon as possible to control harmful practices. Free education and health care facility provide at grassroots level, especially in rural areas.

Key words: Female genital mutilation; Tradition; Muslim; Education; African countries.

INTRODUCTION

World Health Organization (WHO) has defined Female Genital Mutilation (FGM) also known as Female Genital Cutting (FGC) is as all processes which involve partial or complete removal of the external female genitalia or injury to the female genital organs/part, whether for cultural or any other non-therapeutic reasons. FGM is an unhealthy and unhygienic traditional practice inflicted on girls and women worldwide. [(1)] FGM is widely recognized as a violation of human rights especially for women/girls. It's not only a rigorous form of inequity against women, but also one kind of violation against the rights of girls, on whom it is most commonly performed. [(2)] This practice

is deeply rooted in social norms, cultural beliefs, tradition and strongly associated with ethnicity and perceptions over decades and generations to generation. The change of people mind about cultural beliefs of FGM practices is not easy task to change this practice. FGM is a culturally rooted practice; efforts to end it require understanding and changing the beliefs and perceptions that have sustained the practice generation to generation. [(2)]

Globally, FGM is practiced in more than 28 countries in Africa and a few scattered communities another part of the world. According to Frost et. al. estimation about 100 million to 140 million girl's and women's are worldwide have undergone Female Genital Mutilation/Cutting (FGM/C) and more than three million girls are at risk for cutting each year in the African continent alone. [(3)] If current trends continue, as many as 30 million girls are at risk of being cut before their 15th birthday. The upholders of FGM argue that the removal of the female genitalia contributes to the cleanliness and purity of girls/women's. In some societies popular terms for genital mutilation are synonymous with purification. However, many studies also show that the majority of the girl child and women in most practicing countries think FGM/C should be end. The practice is more widespread among teenagers than among their middle-aged counterparts in most of the African countries.

Among the communities that practice of FGM, the procedure is a highly valued ritual, whose purpose is to mark the transition from generation to generation or childhood to womanhood. The age and time at which FGM is practiced differ from community to community, and can be carried out from as early as a few days after birth or immediately after the birth of a woman's first child. In these societies people are habitual with FGM, it correspond to part of the rites of passage or initiation ceremonies intended to impart the skills and information a woman will need to fulfill her duties as a wife and mother. In particular communities, they are bringing out FGM practices due to religious, believing that their faith requires.

This practice strongly carries through one generation to another generation among the Muslim community; particularly true of Muslims, who adhere to the practice. Other communities also consider female genitalia to be ugly, offensive or dirty, and thus the removal of the external genitalia makes a woman more hygienic and appealingly pleasing. Some subscribe to the Notion that FGM boosts a woman's fertility, and the chances of her children's survival. [(5-7)] Those women/girl who has undergone female genital cutting can suffer immediate and long-term complications. Bleeding, haemorrhage, infections, tetanus, oliguria, sepsis, and death are some of the immediate complications that have been documented. [(4,5)] The most common problems i.e. severe pain and bleeding and Infection also poses an immediate risk are happening among genital cutting women. [(7)] Women also can suffer from long-term health effects include psychological and psychosexual trauma, infertility, susceptibility to bacterial vaginosis and genital herpes and obstetric complications, including prenatal death. [(7-10)]

In some communities in African countries, all members of communities practicing FGM have a role in perpetuating it. In the families of girls or women who undergo FGM support it because it makes their daughters marriageable. The family believed that the genital cutting ensures that the girls are ready to have suitors and a satisfactory bride price. In these communities, no eligible man would consider marrying a girl who has not had genital cutting, these practice makes woman or girl culturally and socially acceptable. [(4)]

It is in this important way that female genital mutilation is supported and encouraged by men. The communities were practicing FGM there is truly no place for the woman who does not have undergone the procedure. The women/girl is called derogatory names, and it is often unused to the status and accesses to positions and roles those 'adult' women in that community can occupy. Another thing is that for FGM is its assumed ability to diminish women's desire for sex. After cutting away of the sensitive part of the genitalia kills the emotion associated with the organ of girl/ women. [8] The creation of the nation, which brought together many communities within common borders, as well as the forces of globalization, has contributed to the blurring of boundaries in all societies.

Type of Female Genital Mutilation/ Cutting Practices

There are many difficulties associated with classification of FGM. Girls or women may not always remember of which procedure was performed on them because they are not able to recall FGM age or time. In case if they were cut from an early age group, girls may not even recall, she has undergone through FGM/C or not. Furthermore, there may be significant variation in the magnitude of FGM while the procedure is commonly carried out without anesthetic in terribly conditions, and girls often struggle to resist. [11,12] The Female Genital Mutilation/Cutting has been classified into four broad categories. Type I involves the excision of the prepuce with or without partial or total clitoridectomy. Type II includes Excision (removal) of the clitoris, together with part or all of the labia minora (the inner vaginal lips). These are the most widespread practice form. Type III entails removing part or all of the external genitalia (clitoris, labia minora and labia majora). This is also known as Pharaonic circumcision, is extremely severe and involves binding a woman's leg for around1.5 month to allow for the formation of scar tissue. [11]

The remnant edges are sewn together, infibulated, leaving only a small opening for menstruation, urination and potential coitus; it's also known as Pharaonic circumcision. Type IV includes other forms of genital manipulation such as burning, pricking, or scraping. [11-14] Women often use for adhesive substances such as eggs, sugar and even animal dissipate on the wound to enable it to heal. One study have addressed Mali country genital mutilation condition that the genital cutting often has to re-open the vagina to allow for making convenient childbirth, and then re-stitch vagina after the childbirth, leaving it as small as before, or a little larger to reduce painful intercourse. Frequently the genital cutting is called on the girl's wedding night to open her up so she can accomplish her marriage. [11,12]

MATERIALS AND METHODS

The Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) are most significant source of demographic data at globally. It's gives information on a variety of socio-economic and demographic characteristics. Present study based on data from Demographic Health Survey (DHS) and Multiple Indicator Cluster Surveys (MICS) 2009-2013 from twelve African countries namely, Benin Standard (11212) 2010-12, Burkina Faso (17087) 2010, Chad (13541) 2010, Cote D'Ivoire Standard (9411) 2011-12, Ghana (7666) 2011, Guinea Standard (9142) 2012, Kenya (758) 2009, Mali (10240) 2012-13, Nigeria (16381) 2011, Senegal Standard (14228) 2010-11, Sierra Leone (13339) 2010 and Somalia (5460) 2011 were chosen and analyzed based on the various types of socio-economic and demographic profile along with FGM

prevalence. Both the data (DHS&MICS) set provided profound information about female and her daughter Genital Mutilation (FGM/C) and their future prospective.

The assumption is that women respondent straightforwardly when the interviewer asked about their genital mutilation status and that they knew the type and extent of FGM that was performed on their genitalia. [(15)] FGM practices are carried out at a very young age; many cultures believe a taboo about such kind of discussions. [(16)] Doctors also help the respondent to identified genital mutilation type at the time of the survey. Those Doctors was engaged in survey, and they are specialized, in general comprehensive medicine and Gynecologists' and working in the various types of hospitals and medical colleges across the world. These doctors were previously trained in order to be able clearly to identify the different types of FGM/C performed. [(17)]

Description of Variables:

The variables used for this study are categorized into two categories like, response and predictor variables.

***Response variables*:**

Female Genital Mutilation: The both data (DHS and MICS) set have provided information about FGM. The data provided direct information about female or girls undergone through female genital practices or not. For this study FMG categorized into two categories (Dichotomous) i.e. 'Yes' and 'No'.

The following questions used to address the women and girls Genital Mutilation/Cutting practices and their future prospective:

- Respondent circumcised? (Yes, No)
- Number of daughters circumcised? (No daughter circumcised, 1, 2, 3, 4, etc.) and
- Should practice be continued or discontinued.

All the daughters' response was coded into dummy variables. For example, those had genital mutilation recorded 'Yes' as '1'and those do not had genital mutilation were coded 'No' as '0'.

Predictor Variables:

Place of Residence: The DHS and MICS data sets incorporated sample from both rural and urban areas. Thus, the information on FGM is available for both rural and urban areas and used in this study to examine the rural-urban differentials in the prevalence of FGM.

Age group: The women and her daughter aged group 15 years and above have chosen for the study. This study used four categorical age variable i.e. '15-24 years', '25-34 years', '35-44 years' and '45-49 years'.

Level of Education: Information on education of the respondents has collected in both the data set. Present study used education variable categorized into four categories i.e. 'No Education', 'Primary', 'Secondary' and 'Higher'.

Wealth Index: Wealth index direct have been taken from the data set. In the both data set, Wealth index have been categorized into five category i.e. 'Poorest', 'Poorer', 'Middle', 'Richer' and 'Richest'.

Statistical Analysis: Bivariate and multivariate analysis has been carried out for the analysis. In this study, twelve countries have been chosen for the analysis. The logistic regression model was undertaken for the all selected countries. The data has been analyzed using SPSS-20 and STATA -12 software. The analysis also carried out for selected background characteristics such as the place of residence, age group, level of education, wealth index etc.

RESULTS

Figure1 shows the composition of Female Genital Mutilation (FGM) practices in all selected African countries 2009-13. Out of total selected countries like Somalia Northeast Zone and Guinea Standard contributed of FGM much higher (15 percent) than other countries whereas Mali Standard 14 percent and Sierra Leone 13 percent are adding. However, FGM practices in Benin Standard, Ghana and Kenya have very less contributed only 2 percent as compared to their counterpart.

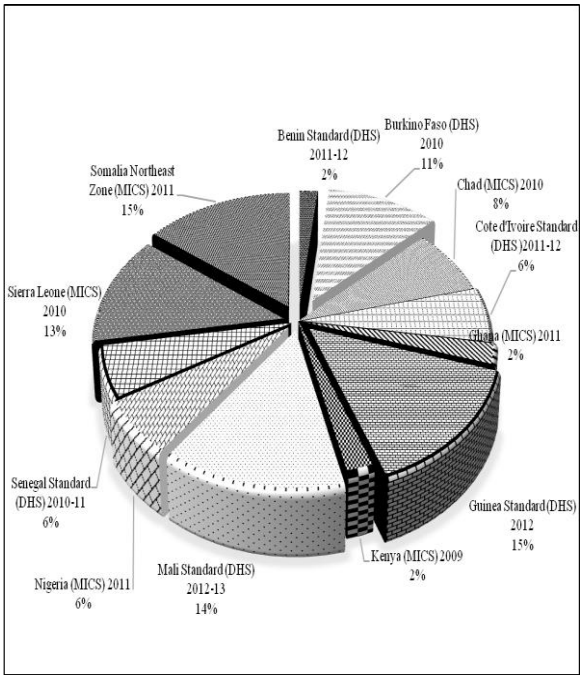

Figure 1. Distribution of Female Genital Mutilation (FGM) in all selected African countries, 2009-13.

The Figure2 depicts Levels of Intergenerational practices of Female Genital Mutilation (FGM) of Mother and her Daughter and their future prospective in selected African countries. This Figure reveals that the level of FGM practices is significantly higher in Somalia Northeast Zone, Guinea Standard, Mali Standard, Sierra Leone and Burkina Faso as compare to all selected countries. The result also shows Daughter's FGM practices are much higher in Kenya, Nigeria, Sierra Leone and Ghana than their counterpart. Those women had FGM and her daughter also had and they also want to continue genital mutilation practices. In Chad country mother and her daughter had less contributed to FGM practices, but they significantly want to continue genital mutilation practices. In Some countries, i.e. Sierra Leone, Somalia Northeast Zone and Mali have higher levels of FGM practices, but still women want to genital practices continue. Results highlighted particularly in Chad, Guinea standard and Mali countries mothers have high prevalence of FGM respectively 53.5%, 97.9% & 92.6% compared to their daughters (22.6%, 32.3%& 47.6%) but prevalence of continuing about FGM is highly reported (89.3%, 75.2% & 72.0%).

Types of Female Genital Mutilation practices among all selected countries have shown in figure 3. In this study, three major practices are considered in the analysis for each country. The result shows that, Flesh removed from genital area practice remarkable higher than other practices across all selected countries. Likewise, the practices of Genital area just nicked without removing any flash is considerable higher in Burkina Faso (77.5%) and Chad (74.0%) as compare to other countries. However, majority women have fallen in the practices of Genital area sewn closed in Somalia Northeast Zone (88.3%) than other selected countries. Likewise, Genital area sewn closed practices is ignorable in Burkina Faso (1.1) and Cote D'lvore (6.6%) than other countries.

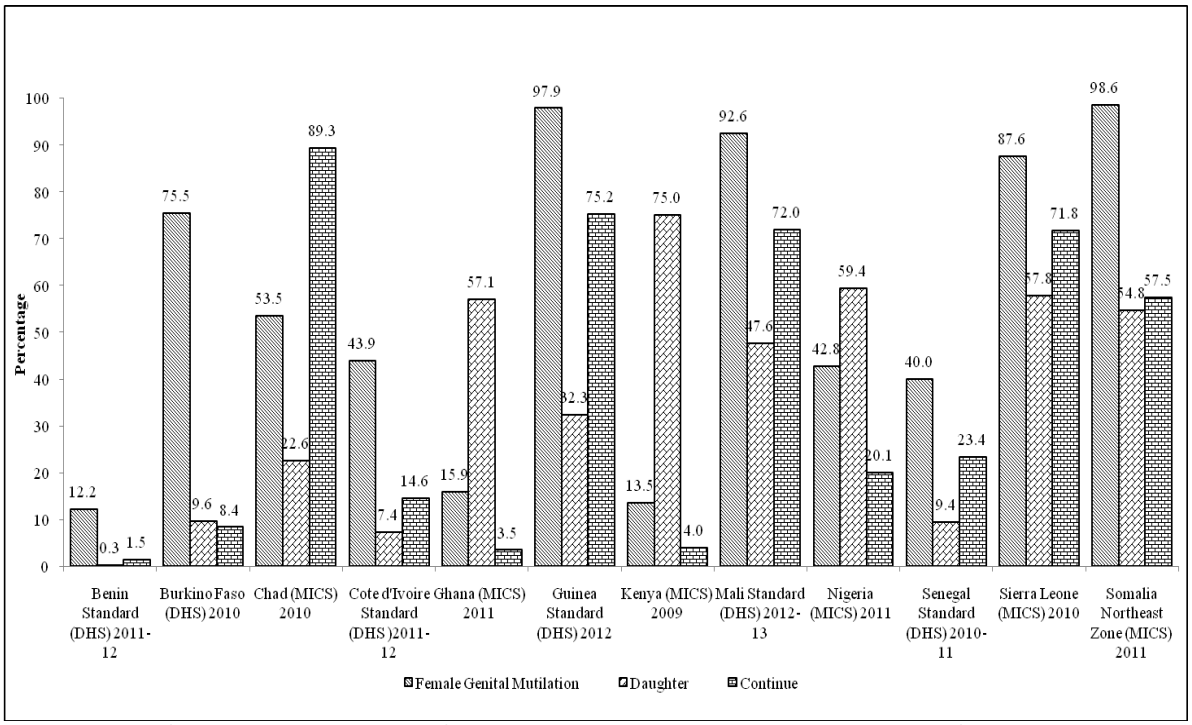

Figure 2. Levels of Intergenerational practices of Female Genital Mutilation (FGM) among all selected African countries, 2009-13.

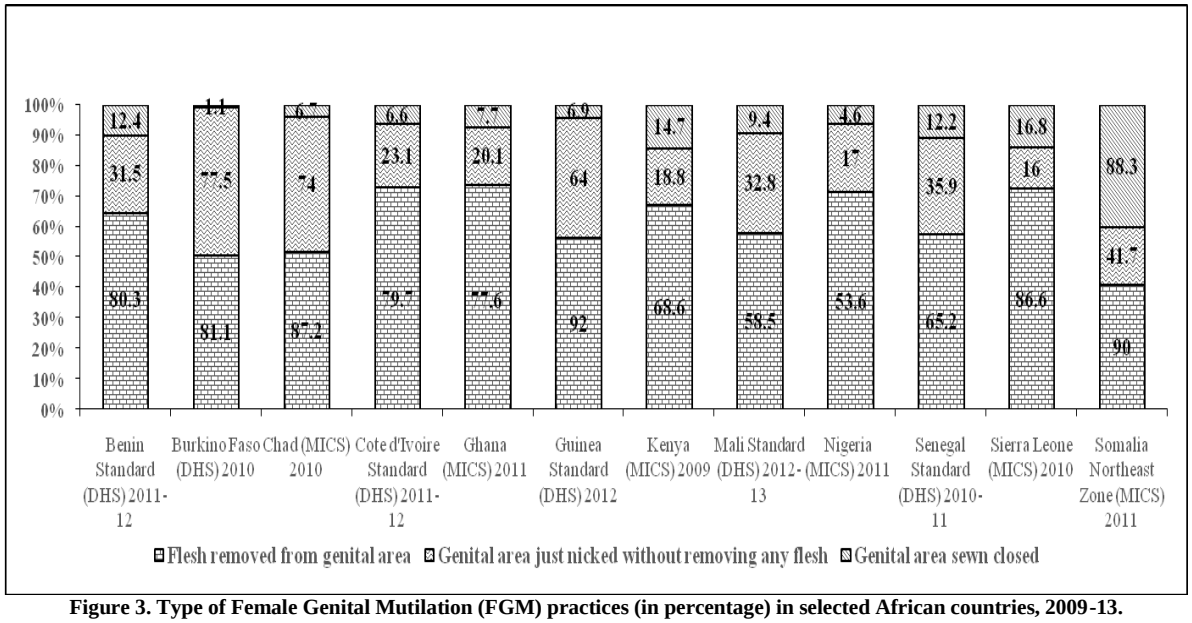

Figure 3. Type of Female Genital Mutilation (FGM) practices (in percentage) in selected African countries, 2009-13.

Table 1 illustrates that Odd ratio from binary logistic regression of Female Genital Mutilation (FGM) for all selected African countries by background characteristics, 2009-12. A number of explanatory variables such as women's age, marital status, religion, education, place of residence, and wealth index have been found to be statistically significant determinants of Female Genital Mutilation (FGM) practices among all selected countries. Start from women age group 25-34, increasing age is associated with progressively increased by FGM practices in all countries.

Table 1. Result from Binary Logistic Regression (Odd Ratio) of FGM and 95 % CI by selected background characteristics in selected African countries, 2009-13.

Background Characteristics	Benin (DHS) 2011-12	Burkino Faso (DHS) 2010	Chad (MICS) 2010	Cote D'IVOIRE (DHS) 2011-12	Ghana (MICS) 2011	Guinea (DHS) 2012	Kenya (MICS) 2009	Mali (DHS) 2012-13	Nigeria (MICS) 2011	Senegal (DHS) 2010-11	Sierra Leone (MICS) 2010	Somalia (MICS) 2011
	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI
Age Group												
15-24®	1	1	1	1	1	1	1	1	1	1	1	1
25-34	1.66 (1.35,2.04)	1.85 (1.67,2.03)	0.75 (0.63,0.98)	1.87 (0.77,2.99)	1.77 (1.51,3.15)	2.24 (1.35,3.15)	1.65 (1.21,2.36)	1.29 (1.15,3.44)	1.21 (1.11,2.24)	2.36 (1.55,2.75)	1.32 (0.41,2.12)	1.54 (1.12,3.24)
35-49	2.71 (2.19,3.39)	3.13 (2.80,3.50)	1.68 (1.05,2.83)	1.19 (1.06,1.14)	1.53 (1.07,1.80)	2.11 (1.11,2.51)	1.98 (1.02,2.66)	2.11 (1.59,2.74)	2.11 (1.01,2.87)	2.23 (1.21,1.88)	1.11 (1.02,2.18)	2.01 (1.40,2.24)
Marital status												
Never Married®	1	1	1	1	1	1	1	1	1	1	1	1
Married	2.97 (2.16,4.10)	1.74 (1.56,1.94)	1.04 (0.83,1.31)	2.31 (2.00,2.67)	1.56 (1.03,2.84)	1.97 (0.46,4.05)	2.32 (0.84,3.65)	3.21 (2.21,6.17)	2.17 (1.16,2.10)	2.10 (1.01,3.40)	1.25 1.01,2.45)	1.24 (0.96,2.66)
Widows/ Div/Sep	1.42 (1.21,2.36)	2.13 (1.17,3.33)	1.28 (1.08,1.53)	1.89 (1.28,1.72)	1.64 (1.36,2.15)	1.22 (0.91,2.56)	3.21 (1.21,4.87)	2.53 (1.12,2.76)	1.62 (1.11,2.51)	1.22 0.81,2.68)	1.21 (0.82,2.11)	1.71 (1.12,1.75)
Religion												
Muslim®	1	1	1	1	1	1	1	1	1	1	NA	NA
Catholic©	0.24 (0.12,0.87)	0.77 (0.69,0.86)	0.45 (0.38,0.52)	0.18 (0.15,0.21)	0.88 (0.34,0.98)	0.44 (0.32,0.87)	0.58 (0.12,0.92)	0.21 (0.20,0.87)	0.55 (0.22,0.77)	0.72 (0.26,0.85)	NA	NA
Others	0.56 (0.36,0.68)	0.44 (0.39,0.49)	2.35 (1.99,2.79)	0.20 (0.18,0.22)	0.98 (0.45,1.87)	0.66 (0.34,0.98)	0.87 (0.45,0.88)	0.86 (0.44,0.88)	0.36 (0.22,0.64)	0.46 (0.21,0.73)	NA	NA
Education												
No Education®	1	1	No cases	1	1	1	1	1	1	1	No cases	1
Primary	0.47 (0.36,0.60)	0.77 (0.49,0.86)	1	0.54 (0.48,0.61)	0.87 (0.68,2.32)	0.88 (0.46,1.60)	0.98 (0.54,1.98)	0.95 (0.16,1.60)	0.57 (0.26,1.70)	0.87 (0.56,2.40)	1	1.81 (1.22,4.02)
Secondary	0.57 (0.34,0.63)	0.55 (0.49,0.62)	0.74 (0.45,1.56)	0.41 (0.35,0.48)	0.78 0.55,1.23)	0.67 (0.24,1.63)	0.65 (0.55,1.56)	0.57 (0.32,1.53)	0.87 (0.84,1.63)	0.44 (0.24,1.21)	1.75 (1.41,3.05)	1.31 (1.20,1.37)
Higher	0.22 (0.12,0.63)	0.34 (0.23,0.71)	0.51 (0.30,0.98)	0.19 0.12,0.80)	0.63 (0.28,0.81)	0.32 (0.25,0.63)	0.34 (0.12,0.63)	0.42 (0.23,0.93)	0.52 (0.32,0.73)	0.40 (0.12,0.93)	1.31 0.91,2.66)	1.21 (1.00,2.15)
Place of Residence												
Urban®	1	1	1	1	1	1	NA	1	1	1	1	1
Rural	1.97 (1.33,2.13)	1.24 (1.12,2.17)	1.77 (1.14,2.91)	1.95 (1.82,2.11)	1.54 (1.11,4.54)	1.45 (1.23,3.73)	NA	1.37 (1.03,2.21)	1.24 (1.00,2.53)	1.51 (1.41,3.12)	1.21 (1.01,2.38)	1.41 (1.20,3.05)
Media Exposure												
Yes®	1	1	NA	1	1	1	NA	1	1	NA	1	1
No	1.06 (0.92,1.22)	1.10 (1.00,1.21)	NA	1.68 (1.61,1.77)	1.24 (0.84,2.35)	2.16 (1.22,5.02)	NA	1.61 (1.14,2.20)	1.26 (0.45,2.32)	NA	1.24 (0.51,2.13)	1.57 (1.11,3.24)
Wealth Index												
Poorest®	1	1	1	1	1	1	1	1	1	1	1	1
Poorer	1.15 (1.05,1.89)	1.01 (1.00,2.15)	1.44 (1.05,1.97)	0.88 (0.75,1.03)	1.11 (0.45,2.15)	1.01 (0.55,1.72)	1.11 (0.66,2.12)	1.22 (1.01,1.58)	1.22 (1.15,2.01)	1.14 (1.00,2.58)	1.32 (1.12,2.88)	1.74 (1.22,2.78)
Middle	0.98 (0.41,1.19)	0.92 (0.21,2.05)	0.65 (0.38,0.94)	0.40 0.39,1.65)	0.88 (0.71,0.95)	0.74 (0.44,2.09)	0.98 (0.54,2.33)	0.71 (0.41,0.88)	0.93 (0.41,0.99)	0.56 (0.44,2.01)	0.87 (0.45,2.52)	0.81 (0.35,0.99)
Richer	0.62 (0.44,0.78)	1.10 (1.06,2.26)	0.57 (0.31,2.08)	0.11 (0.09,1.35)	0.92 (0.71,2.33)	0.62 (0.29,0.99)	0.75 (0.22,0.84)	0.42 (0.29,2.08)	0.51 (0.38,0.78)	0.40 (0.34,0.67	0.54 (0.33,2.11)	0.62 (0.41,0.97)
Richest	0.26 (0.19,0.67)	0.97 (0.82,1.13)	0.74 (0.29,0.94)	0.14 (0.08,0.59)	0.58 (0.22,0.82)	0.27 (0.17,0.77)	0.39 (0.11,0.81)	0.36 (0.12,0.54)	0.44 (0.41,0.73)	0.36 (0.32,0.85)	0.46 (0.30,0.92)	0.47 (0.32,1.41)

Note- ®reference category, Div/Sep, Divorce, Separate, ©any type of Christian.

Table 2. Result from Binary Logistic Regression (Odd Ratio) of daughter's FGM and 95 % CI by selected background characteristics in selected African countries, 2009-13.

Background Characteristics	Benin (DHS) 2011-12	Burkino Faso (DHS) 2010	Chad (MICS) 2010	Cote D'IVOIRE (DHS) 2011-12	Ghana (MICS) 2011	Guinea (DHS) 2012	Kenya (MICS) 2009	Mali (DHS) 2012-13	Nigeria (MICS) 2011	Senegal (DHS) 2010-11	Sierra Leone (MICS) 2010	Somalia (MICS) 2011
	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI	OR & 95% CI
Age Group												
15-24®	1	1	1	1	1	1	1	1	1	1	1	1
25-34	1.12 (1.05,2.04)	1.13 (1.07,2.13)	1.23 (1.00,2.56)	1.87 (1.11,2.10)	1.21 (1.08,2.55)	2.03 (1.11,2.85)	1.12 (1.11,2.42)	1.23 (1.01,2.38)	1.71 (1.08,2.68)	2.01 (1.41,2.05)	1.29 (0.61,2.72)	1.08 (0.88,2.14)
35-49	1.21 (1.09,2.39)	1.15 (1.00,2.50)	1.88 (1.15,2.53)	0.99 (0.36,1.34)	1.21 (1.07,2.20)	1.11 (1.00,2.24)	1.37 (1.22,2.53)	1.18 (1.10,2.37)	1.53 (1.21,3.81)	1.20 (1.01,2.07)	1.11 (0.82,3.58)	1.11 (0.44,2.34)
Marital status												
Never Married®	1	1	1	1	1	1	1	1	1	1	1	1
Married	1.97 (1.36,2.13)	1.74 (1.56,1.94)	1.12 (0.63,2.31)	1.21 (1.00,2.54)	1.16 (1.00,2.14)	1.19 (1.11,3.25)	1.42 (0.84,2.15)	1.23 (1.11,2.10)	1.07 (0.60,2.24)	1.10 (1.01,2.31)	1.25 (1.11,2.75)	1.24 (0.96,2.66)
Widows/ Div/Sep	1.22 (1.01,2.16)	2.13 (1.17,2.63)	1.48 (1.00,2.13)	1.31 (1.00,2.10)	1.12 (1.01,2.25)	1.20 (1.07,2.16)	1.21 (1.14,3.81)	1.53 (1.00,3.24)	1.62 (1.11,2.51)	1.22 (0.81,1.68)	1.21 (1.12,2.71)	1.21 (1.02,1.91)
Religion												
Muslim®	1	1	1	1	1	1	1	1	1	1	NA	NA
Catholic©	0.44 (0.32,0.87)	0.57 (0.20,0.86)	0.45 (0.22,1.22)	0.65 (0.45,1.57)	0.88 (0.44,1.84)	0.81 (0.42,0.97)	0.61 (0.21,1.22)	0.51 (0.42,0.97)	0.56 (0.40,1.31)	0.72 (0.46,1.25)	NA	NA
Others	0.46 (0.36,0.68)	0.68 (0.39,0.99)	0.45 (0.29,0.69)	0.40 (0.30,0.92)	0.48 (0.36,0.53)	0.66 (0.40,0.81)	0.71 (0.44,0.88)	0.86 (0.54,1.38)	0.85 (0.52,1.94)	0.56 (0.31,0.73)	NA	NA
Education												
No Education®	1	1	No cases	1	1	1	1	1	1	1	No cases	1
Primary	1.23 (1.11,1.60)	0.77 (0.34,2.66)	1	1.04 (0.48,2.45)	0.87 (0.48,0.92)	0.78 (0.44,1.24)	0.98 (0.62,1.78)	0.91 (0.46,1.91)	0.57 (0.26,0.90)	0.87 (0.46,1.41)	1	0.88 (0.30,1.32)
Secondary	1.27 (1.14,2.63)	0.65 (0.45,0.92)	0.57 (0.31,0.86)	0.46 (0.25,0.72)	0.98 0.59,2.91)	0.81 (0.44,1.92)	0.85 (0.45,1.79)	0.75 (0.61,1.73)	0.87 (0.54,1.63)	0.70 (0.34,1.71)	1.05 (1.00,3.05)	0.72 (0.58,1.85)
Higher	0.42 (0.22,0.93)	0.57 (0.33,0.84)	0.42 (0.31,1.28)	0.27 0.22,0.81)	0.68 (0.21,0.77)	0.42 (0.24,0.93)	0.76 (0.34,0.96)	0.42 (0.12,0.53)	0.62 (0.22,0.88)	0.50 (0.33,0.73)	0.51 0.41,0.96)	0.51 (0.20,1.10)
Place of Residence												
Urban®	1	1	1	1	1	1	NA	1	1	1	1	1
Rural	1.23 (1.03,1.62)	1.24 (1.02,2.19)	1.38 (1.14,3.91)	1.65 (1.02,2.41)	1.84 (1.20,2.65)	1.61 (1.37,3.11)	NA	1.91 (1.15,2.81)	1.90 (1.13,3.09)	1.52 (1.11,2.22)	1.57 (1.04,2.04)	1.71 (1.10,3.48)
Media Exposure												
Yes®	1	1	NA	1	1	1	NA	1	1	NA	1	1
No	1.12 (0.52,1.82)	1.14 (1.11,2.11)	NA	1.74 (0.60,2.02)	1.44 (1.31,2.15)	1.54 (1.00,2.22)	NA	1.12 (1.05,2.33)	1.22 (1.12,2.63)	NA	1.57 (1.37,2.85)	1.30 (1.11,3.85)
Wealth Index												
Poorest®	1	1	1	1	1	1	1	1	1	1	1	1
Poorer	0.95 (0.45,1.51)	1.10 (1.08,2.17)	1.21 (1.05,2.07)	0.97 (0.75,2.13)	1.03 (0.35,2.21)	1.06 (1.00,2.12)	0.85 (0.16,1.82)	0.91 (0.31,0.92)	1.22 (1.15,2.51)	0.87 (0.20,1.21)	0.83 (0.31,2.72)	1.12 (1.00,2.38)
Middle	0.90 (0.41,0.99)	0.93 (0.50,0.99)	0.85 (0.34,1.14)	0.75 (0.54,1.55)	0.88 (0.57,0.99	0.79 (0.54,2.12)	0.98 (0.34,2.01)	0.81 (0.44,0.89)	0.98 (0.58,2.87)	0.75 (0.24,0.81)	0.85 (0.55,2.13)	0.81 (0.65,1.82)
Richer	0.71 (0.40,0.92)	0.91 (0.38,1.42)	0.57 (0.11,0.84)	0.57 (0.28,0.85)	0.92 (0.71,2.53)	0.62 (0.20,0.97)	0.75 (0.32,0.84)	0.49 (0.32,0.78)	0.61 (0.48,0.91)	0.47 (0.30,0.95)	0.52 (0.37,0.61)	0.61 (0.34,0.94)
Richest	0.42 (0.32,0.80)	0.78 (0.42,0.85)	0.74 (0.22,0.89)	0.63 (0.26,1.21)	0.78 (0.22,0.93)	0.45 (0.20,0.94)	0.89 (0.44,1.93)	0.46 (0.22,0.85)	0.35 (0.11,0.60)	0.57 (0.22,0.97)	0.50 (0.31,0.92)	0.47 (0.22,0.96)
Note- ®reference category, Div/Sep, Divorce, Separate,© any type of Christian,												

For all age groups; FGM practices are higher likelihood across country as compared to a reference group. Likewise, those women belong to married category; they are significantly associated with FGM as compared to never married group. The significant association with FGM has been found in all countries. Those women belong to non-Muslim category i.e. Catholic and Other religion categories; they have associated with significantly decreased of FGM practices. The FGM practices less likely to be found among women belong to primary, secondary and higher educated group as compared to the reference group. [14] Furthermore, Place of residence and Media exposure directly associated with FGM practices across the nation. Those women have belonged to the rural area they have significantly associated with FGM as compared to the urban area. Likewise, those women have touched from the media they have less significant associated with FGM practices as compared to the reference category. Poorer category women significantly associated with FGM practices as compared to the poorest group. From Middle to richest group women are less likely to have FGM practices than the reference group. These results have been found among all selected countries.

Table 2 explains daughter FGM odd ratio for each selected African countries by selected background characteristics. Those women's are belonging to age group 25-34 have significant associated with daughter FGM than the reference category. Likewise, the daughter age group 35-49 was also higher than the age group 15-24 years. These situations have been found among all selected countries. The daughter's FGM practices are more likely to be found in married group as compared to the reference group. The same result has found in widows/separate/divorce category across all selected countries. However, the Muslim category is having more FGM practices than their counterpart. Likewise, other religion group women have been found less significant of daughter FGM as compared to the reference group. As education increased FGM practices decreased in all countries. Furthermore, primary educated category have a significantly less FGM practice followed by Secondary and higher educated group. wealth index is negatively associated with daughter FGM practices; as wealth index increasing from poorer to richest, FGM practice is decreasing (less likely as compared to reference category) to be found in Table 2.

DISCUSSION

The overall results show all selected background characteristics i.e. age of the women, education, residence, media exposure and religion were the most significant socio and demographic variables associated with the risk of FGM in all African countries. [17] As an age increased, the proportion of respondents and their daughters who had undergone FGM increased. The more education, media exposure and more economically active women's and her daughter are more able to understand the hazards of FGM harmful practices. [18] They want to refuse unnecessary procedure and accept to FGM dangerous practice, also declined to continue her daughter such kind of things among all countries. Among all selected African countries; those women's and girl's had undergone FGM are vulnerable group for affecting many gynecology morbidities like Sexually Transmitted Infections (STI) etc.The FGM may have led to physical complication i.e. Urinary Tract Infection (UTI), Pelvic infections, Infertility, Keloid scar, Sexual dysfunction and problem in childbirth. Women and daughter have significant morbidities as compared to those

do not have FGM practice among African countries. [18,19]

The FGM practices continue due to tradition; Custom and beliefs of the person or community that is lead to FGM practices are passed from generation to generation. People have strongly felt their traditions, customs which are often guided by taboos. The FGM practices are rooted in traditions; it is not easy to change. People adhere to these patterns of behavior and they believe that they are the right things to do. Likewise, The Society strongly believed that female genital mutilation (FGM) practices are ensure to girls virginity because girl's virginity is a requirement for marriage, which is very necessary for the family to maintain a family's honors and to secure the family line. In some society; these practices are required for religion. [22,23] FGM practices are subject to powerful social pressure from their community, family members and peer group to undergone through FGM among many African countries. If women's or girls are not undergone through genital mutilation; they are threatened with rejection by society and family members. [19-21] For controlling FGM, the global efforts to bring an end to the tradition of female genital mutilation are increasing, with many African countries putting in place legislation into the practice, and a number of international organizations making the elimination of FGM a priority. [21-25]

CONCLUSION

The study reveals that Female genital mutilation /cutting (FGM/C) is a deeply rooted and extensively supported by social, economical, lack of educational levels and cultural factors in all African study countries and these factors guiding to continue for FGM practice to next generation. This study also supported to Heli. B, WHO member (2011), stated that 'FGM is sensitive topic and dealing with sexuality, traditions, cultural and religious values'25. Perform of the Female genital mutilation /cutting (FGM/C) is involve, partial or total removal of the external genitals of girls and women for spiritual, social, or other non-medical reasons, has leading to immediate and long-term health and social effects, specially related to Obstetrics complications/Birth complications, other reproductive morbidities, sexually transmitted infections, due to removal of or damage to highly sensitive genital tissue, may affect sexual sensitivity and lead to sexual problems, decreasing sexual pleasure, pain during sex, pelvic infections, physical & mental pain, due to removal of highly sensitive genital tissue of early age girls may lead to severe bleeding and infections, or it leads to shock and die.

Therefore It is clear that harmful, abolished and unhealthy deep rooted renowned Female genital mutilation /cutting (FGM/C) is to be eliminate from the human society, for that this study recommends some policy markers, where there is need a multidisciplinary approach by involving NGO's legislation body's, community leaders, professional health organizations, women empowerment bodies by conducting some catchy program mes, like awareness about harmful effects of FGM/C, Improving women empowerment in the society, Improving educational levels in the general public, Local health facility teams should be educating to women to liberate from FGM complications by visiting monthly basis in the study area, Engaging all groups, like traditional or religious leaders, social activists, politicians, celebrities, young girls, women and men's need to make discussion with in the community and ensuring the harms of FGM practices and disclose to general people it is not a good tradition.

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Institutional Ethical Committee Clearance Statement

Measure DHS produces a wide variety of publications that provide country-specific and comparative data on population, health, and nutrition in developing countries. Based on the results of the Demographic and Health Surveys, the publications provide timely baseline data for use by policymakers and program managers in survey countries, as well as population and health organizations and researchers throughout the world (for detail see-https://dhsprogram.com/publications/instructions.cfm). Over two decades, close to 300 Multiple Indicator Cluster Surveys have been carried out in more than 100 countries, generating data on key indicators on the well-being of children and women, and helping shape policies for the improvement of their lives. Download reports of MICS surveys and request access to available datasets. Archives can also be downloaded for select surveys (for detail see-http://mics.unicef.org/about).

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