Article

Prevalence of Female Genital Mutilation (FGM): The Prospective Form Angacha District Kembata Community; SNNPRS, Ethiopia

Asebe Awol Amado[1]

Abstract:

Female genital mutilation (FGM) is recognized internationally as a violation of the human rights of girls and women, constituting an extreme form of gender discrimination with documented health consequences. The study assessed the prevalence of FGM practice in the study area. The study was both quantitative and qualitative, and to this end, a cross-sectional prospective descriptive study in the Kembata Community district was conducted. Participants were chosen from six randomly selected kebeles in Angacha Woreda. The variables studied were epidemiological. Data were entered and analyzed using SPSS version 20 software. The quantitative data were presented as mean, percentage, and frequency while the qualitative data were analyzed and interpreted thematically and the results were presented in narrative form. Of the 278 participants (women of childbearing age "15-49"), 92.4% practiced FGM, and 77.7% without the help of a medical professional. Moreover, traditions, reproductive and community roles, norms, and values regarding gender equality are the major push factors for the continuation of the FGM. Based on the findings, it was concluded that the prevalence of FGM is high in the study area. Attitudinal transformation is needed through a cooperative and collaborative campaign of all stakeholders in the entire community to minimize the prevalence of FGM.

Keywords: Female genital mutilation, Kembata Community, and Ethiopia.

INTRODUCTION

Female genital mutilation (FGM) is recognized internationally as a violation of the human rights of girls and women, constituting an extreme form of gender discrimination with documented health consequences. About 140 million girls and women are living with the consequences of FGM, globally. The reasons for the practice vary across cultural groups (WHO, 2010).

A global review of FGM shows that the custom of FGM is known to be practiced in one form or another in more than 28 countries in Africa, including Ethiopia. The practice of FGM is most prevalent in African countries, such as Ethiopia, Nigeria, Sudan, and Egypt (Allen *et al.,* 2013; WHO, 2011). Ethiopia has also been one of the countries with the highest rates of Female genital cutting in Africa, according to the UN Secretary General's report on violence against children (UN, 2012).

The term *prevalence* is used to express a country with a proportion of women and girls who underwent FGM at some stage in their lives. According to the Demographic Health Survey (DHS) (2011), the estimated prevalence of FGM in girls and women (15-49 years) is 74.3% in Ethiopia. The prevalence of FGM in Ethiopia varies depending on ethnic origin and region. Ethiopia is home to 25 million girls and women who have experienced FGM. More than half are in the regions of Oromia and Amhara. Overall, 65% of girls and women, aged 15 to 49, have undergone FGM. The highest prevalence is in Somali (99%) and Afar (91%) regions (DHS, 2011).

[1]Lecturer and Researcher, Dilla University, Ethiopia

Correspondence may be sent to Asebe Awol Amado via email at asebeawol@gmail.com

Every girl and woman has the right to be protected from FGM, which is a manifestation of entrenched gender inequality with devastating consequences. Female genital mutilation is a violation of human rights, and has been included in Ethiopia's criminal code since 2004 (UNICEF, 2020). In communities where FGM is practiced, it is not considered as a dangerous act and a violation of the rights of women and girls, but as a necessary step to raise a girl 'properly' in order to make her 'eligible for marriage' (Amnesty International, 2010).

Southern Nation's Nationalities and Peoples Region (SNNPR) Ethiopia is the home of many nations, nationalities, and people with different cultures and languages. Most of the people (over 85%) live in rural areas with low access to health, education, and other social services. Culture and traditional ideology has highly constrained women's empowerment, which inordinately affected their economic, social, and political participation and constrains, as well as their reproductive and sexual decision-making power. It can be argued that providing women access to resources is important in order to ensure their empowerment, but it is not the only measure to be done to reach that end. In addition to providing access to resources, it is necessary to reverse the discourse that marginalizes women and to transform the existing cultural ideology that resonates with proper womanhood in terms of domesticity (Sintayehu, 2012).

In Ethiopia, FGM practices have attracted little attention from researchers. This has contributed to the paucity of literature on the issue. The few publications that these studies yielded have, nonetheless, contributed towards narrowing the noticeably wide gap in the research literature. Mihiret (2016) examined FGM and its impact on women in Bona Zuria Woreda (Sidama Zone), focusing on the legal perspective. She concluded that FGM is a criminal offense according to the legislation.

The study conducted by FDRE (Federal Democratic Republic of Ethiopia) and the Ministry of Women, Children and Youth Affairs (MoWCYA) (2013) delved on harmful traditional practices (HTPs) that have an effect on the lives and livelihoods of women and children in the country. It was also based on secondary data and specifically focused on the three most common forms of HTPs, namely FGM, child marriage, and abdication. Similarly, based on a qualitative research by Young Lives (2013), the contested understanding and practices of female early marriage and circumcision in Ethiopia was underscored. These studies are all significant because they provide valuable insights regarding FGM.

In terms of education, many young girls are dropped out of school, and score low results because of absenteeism linked to serious health problems caused by FGM practice. It is against the human and reproductive health rights of women and girls because it causes serious consequences for their physical, mental, social, and psychological state. The Southern region of Ethiopia is the only region in which there is some involvement of medical personnel who administer FGM.

Studying the prevalence of FGM practice on a different spatial and cultural context is important, as it may help get a complete picture of the phenomenon. Female genital mutilation is a deeply rooted tradition in many communities in Ethiopia, including Kembata. It is a problem that matters a lot, which needs to be studied and understood. The findings of this study, therefore, may be vital for the victims of the FGM practice, especially girls and women who are considered at most risk of FGM as well as other community members who are prone to the complications of FGM, either directly or indirectly. In the study there are many girls who lose their life due to excessive bleeding in performing the practice. The problem is deep-rooted in the study, and it needs every stakeholder's effort to minimize its severity toward women and girls who have been victims of FGM. Hence, this study is designed to study the prevalence of FGM that affects the lives and livelihoods of women and girls within the cultural milieu of the Kembata community. It is also important to promote awareness regarding FGM, which has long been ignored in the community, by suggesting intervention mechanisms that may eradicate the practice and, ultimately, empower the victims of this harmful cultural practice. Additionally, it paves the way for further academic and applied studies.

OBJECTIVE

The study aimed to assess the prevalence of the FGM practice in the Kembata community of Southern Ethiopia

METHODOLOGY

Research design and approaches

This is a cross-sectional prospective descriptive study conducted in the Kembata Tembaro Zone, Angacha District, from 1 September 1, 2019 to May 30, 2020. Both quantitative and qualitative research approaches were employed.

Sampling techniques, sample size determination, and study population

Probability (simple random) and non-probability (purposive) sampling strategies were utilized in this research. The target population of the study was women, aged 15 to 49, who live in Kembata Zone, Angacha District. Study subjects were recruited based on their age category from the source population. Research was conducted in 6 out of 18 randomly selected rural kebeles proportionate to the size of the existing number of householders in each kebele. The selected kebeles are considered to be highly FGM practicing areas. A total of 6000 households with women at reproductive age level (15 to 49 years old) were gathered. The sample size was calculated from the source population. It was also determined by using a single population proportion formula (Cochran, 1977, as cited in Bartlet & Higgins, 2001). A total of 278 women at the reproductive age level (15 to 49 years old) were sampled. From each kebeles, households were chosen using a systematic sampling technique until the allocated sample size was achieved. One woman of reproductive age per household was selected for the interview. If more than one eligible female was found in a household, a woman who has a husband was interviewed.

Sources of data

Both primary and secondary sources of data were examined. Creswell (2003) explained that variation in data collection yields greater validity and provides a detailed information that one methodology cannot solely produce for the information required. Alternatively, researchers may first survey a large number of individuals, and then follow up with a few of them to obtain specific language and voices regarding a particular topic.

Data collection tools and procedures

Detailed structured questionnaires were designed to collect both quantitative and qualitative data. The questions consisted of both close and open-ended questions to generate both types of data according to the attributes of the variables. After the development of all questions for the household survey, a pilot survey was carried out before the actual survey to refine the questions both in terms of language usage, to find alternatives to close-ended questions, and to reduce miscommunication between the interviewer and interviewee. Interviews involved research participants who are experts from different concerned governmental organizations, such as Women and Children Affairs, Religious Institutions Leaders, Culture and Tourism Bureau, in order to fully understand the prevalence of FGM. The participants were selected purposively for qualitative data to triangulate the findings obtained by quantitative methods. Interviews were used as one of the methods of generating data for understanding HTPs in study communities. These interviews were also managed under multiple visits. Key informant interviews from Women and Children Affairs Office experts, kebele administrative, and women who suffer FGM were also interviewed. The key informants interviewer (KII) was selected based on expertise, information, and experience regarding FGM with their community. Those sources of information add more explanation and promote awareness on the forgotten facts about the harmful cultural practice of FGM. Apart from interviews and KII, Focus Group Discussions (FGDs) were held in the course of the fieldwork. Four FGDs, an hour each, were held in four kebeles of the study area. Each FGD consists of six to ten participants

who have experience and knowledge about the issue. The FGDs focused on the themes of prevalence and push factors of the FGM practice in the community. Through a focus-group, discussions were raised to learn about the socio-cultural and situation-induced processes underlying the life of women. Ennew (l994) stated that the advantage of focus group discussions is that they can give an idea about what the general opinion is among a wide group of people at any time.

Ethical consideration

All of the study participants were informed about the purpose of the study before the actual data collection. Since the study was conducted to assess the prevalence of FGM and to alleviate its harmful effects that influence the lives and livelihood of women as well as their personal dignity, the privacy of the informants and respondents and the confidential nature of the study were prioritized and respected.

Inclusion and exclusion criteria

Women who were at childbearing age (15 to 49 years old), and at the same time lives in Angacha District were considered; however, women with severe sickness, mental health problems, and above 49 years were excluded from the study.

Method of data analysis

Quantitative data was entered and analyzed using SPSS version 20 software and presented as mean percentage and frequency. The qualitative data are analyzed and interpreted thematically and the results are presented in narrative form.

RESULTS AND DISCUSSION

Socio-demographic characteristics of the study participants

From the total respondents of study, 210 (75.5%) are 15 to 25 years old, 39 (14%) are 26 to 36 years old, and the remaining 29 (10.5%) are 37 to 49 years old. When it comes to their religion, 229 (82.4%) are Protestants, 39 (14%) are Orthodox, and only 10 (3.6%) are Muslims. Educational status shows that 136 (48.9%) completed grades 7 to 12, 90 (32.4%) cannot read and write, 23 (8.3%) are in elementary school education (grades 1 to 6), and 29 (10.4%) are diploma graduates and above. A total of 113 (40%) are students while 54 (19/4%) are housewives (see Table 1).

Table 1. Socio-demographic characteristics of women interviewed in Angacha District

Variable		Frequency (n=278)	Percentage (%)
Age	15-25	210	75.5
	26-36	39	14
	37-49	29	10.5

Religion	Protestant	229	75.4
	Orthodox	39	14
	Muslim	5	1.3
	Others	5	1.3
Marital status	Single	167	60.1
	Married	106	38.1
	Divorced	5	1.8
Education level	Cannot read and write	90	32.4
	Grades 1-6	23	8.3
	Grades 7-12	136	48.9
	Diploma and above	29	10.4
Occupation	Farmer	31	11.2
	Housewife	54	19.4
	Civil servant	28	10.1
	Daily laborer	15	5.4
	Merchant	37	13.3
	Student	113	40.6

The prevalence of FGM

Currently, FGM is widely practiced in both literate and illiterate groups of the community. Of the 278 participants (women of childbearing, aged 15 to 49 years old), 257 (92.4%) of confirmed that FGM is still practiced in the community while the remaining 21 (7.6%) responded that FGM is not being practiced in the community. The latter response may be due to misunderstandings and lack of awareness regarding the issue. When it comes to who administers the procedure, 216 (77.7%) underwent FGM on their own at different age levels while 130 (46.8%) are health professionals. Most of the respondents (227, 81.7%) revealed that the is major instrument used for FGM practice are scissors. Finally, findings showed that Protestants are dominant FGM victims in the study area, and students, aged 15 to 25 years old, are mostly the victims of the practice. They decided to undergo FGM due to the fear of peer discrimination in their social circles in school. The practice is conducted twice a year when schools are closed and students are on break, and the season when the availability of food is abundant. Particularly, FGM is carried out in September and January of each year.

Table 2. Prevalence of FGM in the study area

Variable	Frequency (n=278)	Percent (%)
Is FGM practice in your community?		
Yes	257	92.4
No	21	7.6
Had you undergone FGM?		
Yes	216	77.7
No	62	22.3
At what age you are exposed to FGM?		
1-5	9	3.2
6-10	22	7.9
11-15	145	52.2
16-20	45	16.2
Who performs FGM?		
Traditional birth attendant	91	32.7
Village women	57	20.5
Health professional	130	46.8
What Type of instruments is used to perform FGM?		
Razor	51	18.3
Scissor	227	81.7

The FGD participants disclosed that, currently, the prevalence of FGM has an increasingly alarming rate in the community. They reported that the circumcision (FGM) is performed by health professionals at nighttime in rural villages. The villagers gather in groups of five up to ten girls at one specific home as they wait for the health professionals to arrive. The majority of the FGD participants added that the maximum service payment for a single female circumcision (FGM) done by a professional ranges from 300 to 500 birr.

Key informants interviewer (KII) from the Women's Affairs Office said that the declaration has brought some changes but still fails to eradicate FGM because the practice is still evident at present. The KII also confirmed that some health practitioners are pursuing alternative sources of income through FGM.

"In the past, village women were [the ones who] circumcised our daughter [in an] unhygienic [environment] in our home, and this increases the risk of infection and other severe diseases but now these are carried out with civilized tools and skilled professionals" (KKI, 40-year-old married woman).

Future Plan towards FGM practice

Table 3 shows that 61.9% of the respondents have a plan to circumcise (FGM) their daughters while 38.1% do not have a plan to let their daughters experience the procedure. Conversely, in a study conducted in Somali, 62.7% of women had no future plans to mutilate their daughter (Mohammed, 2015). This might be due to the difference in the level of current anti-FGM interventions. The area of Amhara regional state has a stronger intervention program carried out by all stake holders with high commitment to eradicate FGM than the study area of this research.

Table 3: The future plan of respondents towards FGM

Variable		Frequency (n=278)	Percent (%)
Do you have a plan to circumcise your daughter in the future?	YES	106	38.1
	NO	172	61.9

The result of this paper shows that both fathers and mothers are the primary supporters of FGM in the family (44.6%), next only to mothers (37.1%), fathers (15.5%), and others (brothers, sisters, relatives) (2.9%). Previous studies had consistent results with this research. According to a survey conducted in the Iraqi Kurdistan Region, 75% of mothers support FGM in the family (UNICEF, 20014). A similar study done in Amhara Region also showed that 77.4% of mothers support FGM (Nega, 2012; Nurilign et al., 2014).

Table 4. The highest supporter of FGM at the family level

Variable	**Frequency (n=278)**	**Percentage (%)**
The main decision maker of FGM in family?		
Father	43	15.5
Mother	103	37.1
Both father and mother	124	44.6
Others (brothers, sisters, relatives)	8	2.9

"I finished seventh grade and was forced to FGM by my family and left school because of marriage during the time I haven't [had] any thought to [get] married, but my mother forced me to do it. She told me that education is no more necessary for girls, and the only thing that women do is childbearing and caring. At the time, I didn't know who want to marry me and to become my husband. Everything [was] decided by my mother. She told me that I [had] to agree to get married. I had no choice." (30-year-old woman, FGD participant).

The push factors of FGM practice in Kembata Community

The qualitative data yielded from FGDs showed that the most influential and determinant push factor of the FGM practice in the study community is marriage. Men are allowed to visit the families of the girls who have undergone mutilation while those who are not mutilated are not accepted to marry in the society. Until now, young girls decide to be mutilated just to avoid social discrimination from their peers and community. Hygiene is another factor influences the decision to undergo FGM to the point that it is called *cutting off the dirt*. According to the FGD participants, the followers of this tradition in the community believe that if a girl were not mutilated, she would become poor in her husband's care and treatment, such as a household profession like cooking, domestic work, and childcare. As such, it can be concluded that community, domestic, and reproductive roles are the significant push factors of FGM in the Kembata community. The quantitative result shows that

the main push factors to perform FGM in the study area are to: respect norms and traditions of society (34.5%); increase the chance of marriage (19.4%); admit a girl into womanhood (13.7%); and minimize her speech and speed at home and outside of the home (10.8%) (see Table 5). The finding of the study shows that both productive, reproductive, and community roles push the young girls to FGM in the study area. Similarly, 50% of Egyptian and Nigerian women believed that FGM would prevent adultery, improves marriage prospects for unmarried girls, and proofs a girl's virginity (Turillazzi *et al.*, 2007; Wondimu and Nega, 2012). This shows that tradition and the opportunity of marriage for practicing FGM are also widely accepted by females in societies in different regions of Africa. It is reasonably obvious that the perception and acceptance of FGM are widespread across all regions in Africa.

Table 5. The push factors of the FGM practice

Variable	Frequency (n=278)	Percentage (%)
What are the determinant pushing factors for the FGM practice in your community?		
To keep respect the norms and Traditions of society	96	34.5
To increase the chance of marriage	54	19.4
To reserve virginity	11	4.0
To reserve sanitation	5	1.8
To keep the dignity of the family	30	10.8
To indicator for womanhood	38	13.7
To minimize her talk and speed	30	10.8
To make childbirth easier and prevent infant death	14	5.0

CONCLUSION

Female Genital Mutilation (FGM) is a serious issue in the Kembata community that restricts gender equality, socio-economic rights, and freedoms of girls and women. The Southern regional state in Ethiopia is the only region in which there is some involvement of medical personnel conducting FGM. The prevalence of FGM in the Kembata community is also high. The practice is increasing at an alarming rate in both literate and illiterate groups of the community. Women and young girls who are at the reproductive age level (15 to 49 years old) are the main victims of FGM. It is one of the major causes of the high rates of reproductive health and maternal mortality cases in the community.

When it comes to who conducts FGM, the main practitioners are health professionals. Traditions, reproductive, productive, and community roles, norms, and values regarding gender equality are the major push factors of continuing of FGM. Mothers are also the main supporters of the FGM practice at the family level. In the study area, monitoring and controlling the girls or daughters in a family is the responsibility of the mother; as such, gender identity is one factors involved in the FGM practice in the Kembata community.

The government of Ethiopia should play an important role in the intervention of FGM by promoting awareness and developing and applying strong practical laws and policies regarding gender equality. On a good note, the government and NGOs working in the study areas have been making efforts to intervene in the traditional practice of FGM that harms the lives and livelihoods of girls and women. However, these efforts and services remain limited. A combined effort is needed from all stakeholders eradicate the FGM practice that affects the lives of girls in Southern Ethiopia, particularly, in the Kembata community.

SUGGESTIONS

The following suggestions are drawn from the findings of the study:

- Anti- FGM interventions should be directed by governmental and non-governmental organizations toward the alleviation of stigma and FGM encouragements at the community level;
- The government should strengthen the legal measurement of the FGM practice involved in the study area.
- Federal and regional women affairs offices should look for a way to provide information regarding FGM and gender equality, incorporating a strong level of FGM awareness in their designed strategies in order to minimize the prevalence of the practice; and

Further research is also recommended to unearth other possible factors contributing to FGM in the community and at the same time, conceptualize and implement appropriate intervention strategies to eventually eradicate FGM in the community.

ACKNOWLEDGMENT

During my fieldwork, many people have generously helped me, and to list them all here would cover too many pages. However, for the countless acts of kindness, hospitality, and support, I am profoundly grateful. I greatly acknowledge the households, religious leaders, elders, and kebele administrative organs of the study area who shared their knowledge and experiences with me. I appreciate the support of experts and administrators at the *district* and zone levels.

REFERENCES

Allen, K., Marshall, D., Waritay J. and Wilson A. (2013). Country Profile: FGM in Ethiopia. 28.

TOO MANY. Amnesty International. 2010. Report on Human Rights.

Amnesty International. (2013). *End FGM. A European campaign.* Retrieved from http://www.endfgm.eu/en/female-genital-mutilation/what-is-fgm/effects-of-fgm.

Central Statistical Authority. (CSA) (2011). *Ethiopian demographic and health survey study, Addis Ababa, Ethiopia.*

Cherinet H. (2003). *A profile on gender relations: Towards gender equality in Ethiopia.*

Cochran G. (1963). *Sampling techniques*: 2nd Ed. New York: John Wiley and Sons,Inc.

Ethiopia Demographic Health Survey. (2011). *Central Statistical Agency: Addis Ababa, Ethiopia.*

Getnet M., & Wakgari D. (2009). *Prevalence and associated factors of female genital mutilation among Somali refugees in Eastern Ethiopia: A cross sectional study, School of Public Health, Addis Ababa University.*

Kembatti Mentti Gezma (KMG). (2014). *Annual report of Female Genital Mutilation, Kembata Tembaro Zone, Durame.*

Mihiret. (2016). *Female Genital Mutilation and its impact on women in Bona Zuria Woreda (Sidama Zone), Southern, Ethiopia.*

Ministry of Women's Affairs (MOWA). (2015). *National action plan for gender equality 2005-2015. Addis Ababa, Ethiopia.*

Mohamed M. (2015). *Assessment of barriers of behavioral change to stop FGM practice among women of kebribeyah district, Somali regional state, eastern Ethiopia. Addis Ababa University, Ethiopia.*

Nega A. (2012). *Female genital mutilation: prevalence, perceptions and effect on Women's health in Kersa district of Ethiopia; International Journal of Women's Health 2012:4 45–54.*

Nurilign A., Getechew, *et al.* (2015). Knowledge, attitude, and practice of women towards female genital mutilation in Lejet Kebele, Dembecha Woreda, Amhara Regional State. *Journal of Gynecology and Obstetrics* , *3*(2), 21-25.

Sintayehu P. (2012). *The fight against female genital mutilation in Kembata Tembaro Zone, Durame, Hawassa University, Ethiopia.*

Turillazzi E. (2007). Female genital mutilation: The ethical impact of the new Italian law. *Journal of Medical Ethics, 33,* 98–101.

UNICEF. (.2012). *Joint programme on female genital mutilation/cutting, annual report*

UNICEF. (2014). *The dynamics of social change towards the abandonment of female genital mutilation/cutting in five African countries.*

UNICEF. (2020). A *profile of female genital mutilation in Ethiopia.* UNICEF, New York.

World Health Organization. (2011). *Global health observatory database.* Retrieved from http://www.unfpa.org/public/home/news/pid/14400

Young Lives. (2013). *Harmful traditional practices and child protection: Contested understanding and practices of female early marriage and circumcision in Ethiopia.* Oxford Department of International Development: UK.