ORIGINAL ARTICLE

PREVALENCE OF FEMALE GENITAL MUTILATION AND ATTITUDE OF MOTHERS TOWARDS IT IN SERBO TOWN

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ABSTRACT

Background: *Female genital mutilation (FGM) is one of the most harmful traditions still practiced in many parts of the developing world, including Ethiopia. Information on the attitude of women towards this harmful practice is, however, scarce. Therefore, the objective of this study was to assess the attitude of mothers towards female genital mutilation (FGM) and its prevalence among both mothers and their daughters in Serbo Town, Jimma Zone, South west Ethiopia.*

Methods: *A community based cross sectional study was conducted on mothers in Serbo Town, in January 2001. A sample of 138 mothers with at least one daughter was included in the study. Data on socio-demographic characteristics, knowledge of mothers about the ill effects of FGM, their attitude towards FGM as well as reasons for the practice were collected using a pre-tested structured questionnaire. A systematic sampling technique was employed to identify the study subjects. Data was sorted manually and analysis was done using a scientific calculator and X^2 and p-values were determined using EPI-INFO version 6.*

Results: *A total of 138 mothers were involved making the response rate 100%. The majority were in the age range of 25–34 years 39(28.3%), Oromo by ethnicity 86(62.3%) and Muslim 71(51.4%). Most mothers were housewives 104(75.4%) and illiterate 65(47.1%). Fifty-three (38.4%) had monthly income of less or equal to 100 Birr. One hundred eighteen (85.5%) of the mothers were married.*

One hundred thirty three (96.4%) mothers and 86(62.3%) of their daughters had undergone FGM. FGM in daughters is significantly associated with their maternal age, income of the family and educational level ($P < 0.05$). But there is no significant association between FGM in daughters and mother's ethnicity, religion, occupation and marital status ($P > 0.05$). One hundred twelve (81.2%) had positive attitude towards FGM, i.e. they want to continue the practice in future, although 72(52.2%) of the mothers reported to know the ill effects of FGM. Mothers' attitude is significantly associated with their age, religion, income and education ($P < 0.05$). The main reasons for FGM practice were hygienic and aesthetic, religion and adherence to culture and tradition.

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Conclusion: ***Although the study showed that the prevalence of FGM among daughters is significantly lower than among mothers it is still widely practiced and majority of the study population favors its continuation. Hence it is recommended that collaborative effort should be made to strengthen Information, Education and Communication (IEC) to build the awareness of the community on the practice and its ill effects on the health of women.***

Key words: *Female Genital Mutilation, Prevalence, Attitude, Mothers, Daughters.*

INTRODUCTION

Female genital mutilation (FGM) is one of the most harmful traditions still practiced in many parts of the developing world. Today the practice survives primarily in large areas of Africa among a variety of tribes. The custom involves removing some or most part of the female external genitalia (1). It is because of the severity, and irreversibility of the damage inflicted on the girls body that the procedure has been termed as 'female genital mutilation, often abbreviated as FGM (1,2). The origin of FGM stretches far back in history, and it has been practiced in many parts of the world (1).

FGM is generally differentiated into four types by WHO/UNICEF/UNFPA jointly in 1997. Type I- Excision of prepuce with or without part or all of clitoris, Type II- Excision of clitoris with or without partial or total excision of labia, Type III (Infibulation) – Excision of part or all of the external genitalia and stitching or narrowing of the vagina and Type IV- Unclassified. E.g. Angura cuts (scraping of tissue surrounding the vaginal orifice) and Gishiri cuts (cutting of the vagina) (2 - 4).

It is estimated that more than one hundred thirty two million girls and women through out twenty-eight countries of

Africa have their genitals mutilated. Furthermore, 2 million women and girls are at risk of undergoing some forms of the procedure every year (2,5).

FGM is the most dangerous and humiliating traditional practice that violates the right of women. Moreover, it is proved that all forms of FGM entail an immediate and long-term life threatening damage to physical and mental health of women and children (1,2,4).

Different studies had shown that FGM is sustained by beliefs, traditions, and superstitions, all of which are deeply rooted and not easy to change (3,6,7). Furthermore, deeper analysis has showed that illiteracy, poverty and poor health services contribute to the perpetuation of the practice (6). Data from the 1989 – 1990 Sudan Demographic and Health Survey (DHS) brought to picture that 90% of women surveyed had their daughters mutilated or planned to do so and religion, education and age influence the practice. Uneducated, aged Muslim favors the practice or had positive attitude to wards the practice of FGM (8).

The age at which FGM is carried out varies from area to area. Reports indicate that some African countries or tribes perform it on infants a few days old, on children between 6 –10 years of age, in adolescence and occasionally in adulthood (5). Elderly women, traditional birth attendants (TBAs) and midwives usually perform it (1,3,7,9). The reasons for the practice are reported to be psychosexual, sociological, hygiene and aesthetic, myths and religion. Some Muslim communities have frequently carried out FGM in the genuine belief that it is demanded by the Islamic faith. However the practice of

FGM predates Islam and there is no substantial evidence that it is a religious requirement of Islam (3,5,7,10).

In Ethiopia, FGM is widely practiced (11-14). The National Committee on Traditional Practices in Ethiopia (NCTPE) reported that more than 90% of women and girls had undergone FGM (11). This source reported that infibulation is common among women in Harerghie and Somali Region, excision among Guragie, Tigre, Oromo and Shankila while clitoridectomy is common among the Amharas and Tigrigna speaking Muslims – called Jeberti. The Demographic and Health Survey (DHS) [12] reported that the practice is lower among younger women and urban rural residence, education, and work status do not make any notable difference in the practice of female circumcision. Fear that external genitalia will grow to the size of a male penis is said to be one of the reasons that drive Ethiopian women to FGM. It is also believed that a female external genitalia is dirty and some associate it with religion and social norm (3, 13). However, there is no any study that documented the magnitude of the problem in Serbo. Moreover, information on the attitude of women / mothers who are the targets of this humiliating practice does not seem to be given due attention. Such information is needed to promote behavioral change towards the practice and facilitate its abolition.

Thus, the objective of this study was to determine the attitude of mothers aged 15 years and above on FGM and its prevalence among mothers and their daughters in Serbo town. Furthermore it described some socio-demographic factors influencing the practice, the reason why it is being practiced and who the decision-makers are.

METHODS AND MATERIALS

A community based cross sectional study was conducted to assess the attitude of mothers towards female genital mutilation (FGM) and its prevalence among both mothers and their daughters in Serbo Town, Jimma Zone in January 2001.

Serbo town is located 22 kms to the east of Jimma town on the main road to Addis Ababa. During the study period, it had a population of 4, 173 of which 1999 were males and 2164 females. In this rural town, there is one health station staffed by 3 health assistants. The main ethnic groups dwelling in the town are Oromo and Amhara. The staple food of Serbo town is teff and maize. It has one elementary and one junior secondary school. It has protected water supply.

The study population constituted of mothers aged 15 years and above who had at least one daughter and who were residing in Serbo town during the study. Using the prevalence of FGM 90% from previous study (11), with 95% confidence interval and a margin of error of 5% the sample size was calculated to be 138. Systematic sampling technique was employed to identify the study subjects. Mothers from every 6^{th} house were interviewed after identifying the first house by lottery method. Substitution was used where necessary. Data on Socio-demographic characteristics, knowledge of mothers about the ill-effects of FGM, attitude of mothers towards FGM as well as reasons for the practice were collected using a pretested structured questionnaire. Five senior health officer students were recruited and trained for two days. Permission from the responsible organ was obtained prior to the initiation of the study. The purpose of the study was explained and informed consent secured from each study subject before conducting interviews. They were not required to give names in

order to ensure confidentiality. The principal investigator closely supervised data collection. And a sample of completed questionnaire was rechecked on daily basis for completeness and consistency. Incomplete and inconsistent questionnaires were given back to the responsible data collectors for rectification. Then the data was edited, cleaned, compiled manually and frequency, percentage and rates were calculated using scientific calculator. Statistical test was applied where necessary. Likert scaling was used to measure the responses to each attitude statement (15). The score of 60.0% or below was graded as unfavorable attitude and above this cut-off point as favorable attitude.

RESULTS

A total of 138 mothers who had at least one daughter was involved in the study and interviewed. The majority of the respondents were in the age range of 25 – 34 years, 39 (28.3%), Oromo by ethnicity, 86 (62.3%) and Muslim, 71(51.5%). Most mothers were housewives, 104 (75.4%) and illiterate, 65 (47.1%). Only 5 (3.6%) attended tertiary level (12+ grade) education. Fifty-three (38.4%) had monthly income of less or equal to 100 Birr. One hundred eighteen (85.5%) mothers were married and 4 (2.9%) were never married.

Among the 138 mothers of the studied population 133 (96.4%) had undergone FGM. The five who were not subjected to the practice were from the Yem ethnic group and were orthodox by religion. Eighty-six out of 138 mothers (62.3%) had their daughters circumcised.

Reasons for the practice of FGM were also addressed in this study. These were maintenance of hygiene and aesthetic of female genitalia, 113 (85.0%), culture and tradition, 101(75.9%), religious command, 103 (77.4%), myths (fear that clitoris can grow to the size of penis), 93 (69.9%) and attenuation of female sexuality and preservation of virginity, 85 (63.9%).

The majority, 112 (81.2%) of the respondents had positive attitude towards FGM, i.e., they favor and want to continue the practice in future. One hundred nine (79.0%) mothers preferred circumcising their daughters than being condemned by the society, 105(76.1 %) believed failure to circumcise is violating religious rule, culture and tradition and 103 (74.6 %) believe that uncircumcised female is unclean. The ill effect of FGM is known by 72 (52.2%) of the mothers (Table1). Among seventy-two mothers who reported to know the ill effects, 57 (79.2%), 51 (70.8%), 42 (58.3%) and 29 (40.3%) identified bleeding, difficult labor, infection and sexual problem respectively.

Table 1: Mothers Attitude and Awareness towards FGM Practice, Serbo Town Jimma Zone, Jan. 2001.

		Number	%
Mothers attitude			
	Positive*	112	81.2
	Negative **	26	18.8
	Total	138	100.0
Mothers awareness			
	Know ill effect FGM	72	52.2
	Do not know ill effect of FGM	66	47.8
Total		138	100.0

* Favor the continuation of FGM
** Do not favor the continuation of FGM

The commonest age interval during which the mothers and their daughters were mutilated is in between 5–9 years that accounts for 84 63.2%) and 47 54.7%) respectively. Village women, TBAs, local healers and health workers were the practitioners in this order of importance. The decision-makers for the genital mutilation were mothers and fathers in 103 (77.4%) and 102 (76.7%), respectively. Grand mothers, 83 (62.4%), grand fathers, 80 (60.2%), intimate relatives, 79 (59.4%), tribe leaders, 78 (58.6%), neighbors, 77 (57.9%) and religious leaders, 72 (54.1%) were also reported to be decision makers.

Maternal age, income of the family and educational status were found to be significantly associated with FGM in daughters ($P < 0.05$). The rate of FGM among daughters significantly increases as the age of mothers increases above 25 years, family income decreases from 350 birr, and lower educational level (below junior secondary). But there is no significant association between daughters genital mutilation and mothers ethnicity, religion, occupation and marital status ($P > 0.05$) (Table 2).

The study also revealed that mothers' attitude towards FGM is significantly associated with their age, religion, income and education ($p < 0.05$). Mothers above 35 years of age, Muslim by religion, with monthly income of 350 and below and elementary and lower educational status favor the continuation of FGM (Table 3).

Table 2: Maternal Characteristics Versus FGM in Daughters, Serbo town, Jimma Zone, Jan. 2001 (n=138)

Maternal characteristics		Daughters genital mutilation		
		Yes	No	X^2 P-value
		Number (%)	Number (%)	
Age				
	15-24	8(24.2)	25(75.8)	39.77
	25-34	21(53.8)	18(46.2)	df=4
	35-44	28(80.0)	7(20.0)	p=0.000
	45-54	17(100.0)	0(0.0)	
	≥55	12(85.7)	2(14.3)	
Ethnicity				
	Oromo	55(64.0)	31(36.0)	2.65
	Amhara	17)70.8)	7(29.2)	df=2
	Others	14(50.0)	14(50.0)	p=0.266
Religion				
	Muslim	43(60.6)	28(39.4)	1.92
	Orthodox	39(67.2)	19(32.8)	df=2
	Protestant	4(44.4)	5(55.6)	p=0.383
Occupation				
	Housewife	63(60.6)	41(39.4)	1.67
	Merchant	10(58.8)	7(41.2)	df=2
	Others	13(76.5)	4(23.5)	0.433
Income				
	≤100	40(75.5)	13(24.5)	11.75
	101-200	23(65.7)	12(34.3)	df=3
	201-350	13(56.5)	10(43.5)	p=0.008
	≥351	10(37.0)	17(63.0)	
Literacy status				
	Illiterate	50(76.9)	15(23.1)	28.45
	Read and write	13(81.3)	3(18.7)	df=3
	1-6	17(58.6)	12(41.4)	p=0.000
	7 and above	6(21.4)	22(78.6)	
Marital status				
	Married	71(60.2)	47(39.8)	1.60
	Others	15(75.0)	5(25.0)	p=0.205

Table 3: Mothers Attitude Towards FGM Versus their Socio-demographic Characteristics, Serbo town, Jimma Zone, Jan. 2001. (n= 138)

Maternal characteristics		Daughters genital mutilation		
		Yes	No	X^2 P-value
		Number (%)	Number (%)	
Age				
	15-24	22(66.7)	11(33.3)	14.13
	25-34	28(71.8)	11(28.2)	df=3
	35-44	32(91.4)	3(8.6)	p=0.003
	≥45	30(96.8)	1(3.2)	
Ethnicity				
	Oromo	72(83.7)	14(16.3)	1.13
	Amhara	19(79.2)	5(20.8)	df=2
	Others	21(75.0)	7(25.0)	p=0.569
Religion				
	Muslim	63(88.7)	8(11.3)	5.48
	Orthodox	49(73.1)	18(26.9)	p=0.017
Occupation				
	Housewife	88(84.6)	16(15.4)	3.30
	Others	24(70.6)	10(29.4)	p=0.069
Income				
	≤100	50(94.3)	3(5.7)	23.11
	101-200	27(77.1)	8(22.9)	df=3
	201-350	21(91.3)	2(8.7)	p=0.000
	≥351	14(51.9)	13(48.1)	
Literacy status				
	Illiterate	61(93.8)	4(6.2)	42.71
	Read and write	16(100.0)	0(0.0)	df=3
	1-6	24(82.8)	5(17.2)	p=0.000
	7 and above	11(39.3)	17(60.7)	
Marital status				
	Married	95(80.5)	23(19.5)	0.23
	Others	17(85.0)	3(15.0)	p=0.634

Positive= Favor the continuation of FGM
Negative= Do not support FGM

DISCUSSION

Female genital mutilation (FGM) is a harmful traditional practice that violates the right of women and girls, and has serious consequences upon their health. According to this study it is widely practiced in the study area and the prevalence among mothers and their daughters is higher than that reported in the Ethiopian Demographic and Health Survey (DHS) (12). The study also revealed that the prevalence in daughters is significantly lower than in mothers. However, it is beyond the scope of this study to show whether this finding is heralding an intergenerational change in its practice or simply indicating that girls are waiting for an appropriate induction time to undergo the fate their mothers had experienced.

The practice is prevalent among all ethnic groups identified in the study. Nevertheless it is less frequent among the Yem. Although small in number, five mothers from this group were not circumcised, nor did their daughters. The remaining three who had been circumcised had their daughters circumcised as well. This however indicates the need for further large-scale study to reach at a conclusion.

Different studies had documented that FGM is sustained by the decision of family and community for different beliefs, traditions, and superstitions that are deeply rooted and not easy to change (3,7,10). Consistent with this, maintenance of hygiene and beauty of the genitalia, religion, fear that clitoris can grow to the size of penis, preserving virginity and preventing promiscuity were reported to be the reasons for the continuation of this harmful practice in this community. Nevertheless the position of religion needs further explanation as FGM predates both Islam and Christianity and moreover, the 'Koran' is reported to state that the women's body must be undefiled (3) and the Bible recommends circumcision only for males.

Fifty two percent of the mothers were aware of some ill effects (bleeding, infection, difficult labor and delivery). And yet 81.2% of the mothers favor the continuation of this harmful traditional practice and this is higher than the 60% reported in the DHS study (12). The study clearly showed a gap between knowledge and attitude. The traditional value (fear of condemnation by society, belief that it is violating religious rule and culture) attached to FGM might be one of the possible explanations for the existing gap.

Parents, grand parents, relatives and religious leaders are involved in the process of decision-making. The practitioners, as documented in different similar studies (1,3,7,9), are also identified to be untrained village women, traditional birth attendants, local healers and health workers. The multiplicity of decision-makers and practitioners clearly indicates the complex nature of the problem and hence the need for collaborative efforts in the realization of its abolition. It is also reported that the majority of these operations are conducted using unsterile materials in unsterile environment without anesthesia. Moreover, similar to other reports (14), it is also reported that raw eggs and butter mixed with some herbs are used postoperatively to allegedly prevent bleeding and avoid infection. However the unhygienic conduct of the operation and the application of unsterile materials can result in a detrimental effect particularly in this era of HIV/AIDS pandemic.

The induction age of FGM in both mothers and daughters in this study is mainly before early adolescence, 5-9 years, in accordance with reports from different studies (14, 16, 17). Some mothers commented the importance of the above timing claiming that uncircumcised (unmutilated) girls are considered "sinful"

and are not allowed to pray, cook food, take part in coffee ceremony and any form of social affairs. It is clear that such discriminatory act might nurture the continuation of the practice despite its ill effects.

Maternal age is one of the factors that were found to influence the prevalence of FGM on daughters. The prevalence of FGM among daughters significantly ($P<0.05$) increases as the age of mothers increases above 25 years and this is consistent with other reports (8,12). Family income and maternal literacy status were other factors that were found to be associated with the practice of FGM among daughters. The prevalence was higher among daughters from low-income family and mothers with low educational status (read and write followed by illiterate) and this fact had been documented in other studies (6, 8, 10, 12). This finding might indicate the role of socioeconomic growth in the process of eradication of this harmful traditional practice.

Similarly, mother's attitude towards FGM is also found to be influenced by their age, religion, income and literacy status, i.e., mothers above thirty-five years of age, Muslims, those with lower monthly income and lower literacy status (illiterate and read and write category) favor the continuation of the practice. This observation is in conformity with reports from elsewhere (8).

In conclusion FGM is widely prevalent in the study area and the majority of the study population favors its continuation. However the prevalence among daughters is significantly lower than that among mothers. The induction age is commonly before early adolescence and the decision-makers are mainly parents and other family members. The operation is mainly performed by untrained persons under unhygienic conditions with unsterile instruments. Maternal age, family income and maternal literacy were found to influence practice and attitude towards FGM.

Based on the above finding, continuous, comprehensive and community based awareness raising activity aimed at abolition of this harmful traditional practice is recommended. Further research on the subject with emphasis on factors influencing the practice also highly recommended.

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