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Female genital cutting starts to decline among women in Oromia, Ethiopia

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Abstract The study explored factors influencing attitudes towards the practice of female genital cutting (FGC) among women in Oromia region, Ethiopia. Representative data from 2221 women aged 15–49 years from the Ethiopia Demographic and Health Survey in 2005 were evaluated. Overall, 88.4% of women had undergone FGC. Prevalence significantly decreased with birth date, ranging from 95.1% in women aged 45–49 years to 75.8% in those aged 15–19 years. Overall, 63.7% of women favoured the discontinuation of FGC, while 29.7% favoured its continuation. Education was strongly correlated with a stance against the practice: while only 54.6% of illiterate women were against it, this figure was 95.5% among women who had completed secondary school. While the reported prevalence was similar among Christian (87.8%) and Islamic women (89.1%), 56.3% of Islamic women favoured discontinuation compared with 70.5% of Christian women. The higher that women scored on empowerment indices, the more they opposed the practice. In logistic regression models, educational level ($P = 0.001$), personal FGC experience ($P = 0.001$), religious affiliation ($P = 0.02$) and self-empowerment were factors ($P = 0.01$ and $P = 0.004$) significantly associated with favouring discontinuation. Future efforts encouraging an end to FGC must include the illiterate population in the Oromia region and focus on improving the status of women.

KEYWORDS: female circumcision, female genital cutting, female genital mutilation

Introduction

Female genital cutting (FGC), also known as female circumcision and female genital mutilation, is a traditional practice common to most societies in north-eastern Africa, where it was almost universally conducted until some decades ago (Baron and Denmark, 2006; Klouman et al., 2005; Missailidis and Gebre-Medhin, 2000; Msuya et al., 2002; Tag Eldin et al., 2008; UNICEF, 2005). The World Health Organization (WHO) estimated that more than 130 million

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women are affected by FGC worldwide (WHO, 2008). FGC has been subject to considerable debate for about half a century and 30 years ago the WHO launched a programme to support governments in an attempt to combat FGC (WHO, 2008). In line with this, the Ethiopian Ministry of Health subsequently began educational programmes to eradicate the practice 20 years ago (Ethiopia Demographic and Health Survey, 2006).

Ethiopia belongs to one of the least developed countries worldwide with a fertility rate of 5.4%, a crude birth rate of 39 per 100,000 and a life expectancy at birth of 53 years as of 2007 (UNICEF, 2007). It is home to some 80 ethnic groups, of which the Oromo group constitutes the largest one, comprising about 30% of the country's population of some 80 million people. While the ethnic group of Oromo is spread throughout the entire country, the Oromia region is an administrative unit situated around the capital Addis Ababa, stretching from the border of the Sudan in the east to the Kenyan and Somalian borders in the south-west. In this region, 85% of the population identifies themselves as belonging to the Oromo.

The practice of FGC is widespread throughout the country, with 74% of women of reproductive age having undergone the procedure as of 2005 (Ethiopia Demographic and Health Survey, 2006). Prevalence and type of FGC varies among ethnic and regional groups, with the practice being most common in the eastern parts of the country (**Table 1**), home to the Afar and Somali groups. Religion is used by many as the basis for their justification in performing these procedures, despite the fact that there is no doctrinal basis for this practice in Islam, Christianity or Judaism. FGC is a deeply rooted tradition reinforced by customary beliefs that it ensures hygiene and preserves a girl's chastity and fertility, thus making her a more valuable potential wife as well as securing family honour. In most communities, women who have not undergone FGC are considered likely to be promiscuous and, therefore, unworthy of marriage. Hence, the practice is regarded not only as a positive experience that is beneficial to girls but also as a prerequisite for an honourable marriage. Among communities performing FGC in girls at older ages, it is usually seen as a rite of passage and, therefore, is thought of positively, granting a girl respect within a village by making her a woman.

In order to gather information as to what extent FGC is practised in Ethiopia, questions related to the practice were included in the 2005 Ethiopia Demographic and Health Survey (2006). The current report analyses data gathered in the women residing in the Oromia region. The analysis presents the reported prevalence of FGC in women of reproductive age and examines socio-economic factors and personal characteristics that may have an influence on the attitudes of women towards FGC. Specifically, the objective of the study was to elucidate which factors are associated with support for the discontinuation of FGC in women and to explore preventative factors that could be useful in future educational programmes in Oromia communities. As rapid abandonment of FGC is unrealistic, while understanding and development of sensitive approaches will help managers addressing future goals. Along these lines, the following hypothesis was tested: a women's feeling of self-empowerment is proportional to the degree to which she takes a stance against the practice.

Materials and methods

The Ethiopia Demographic and Health Survey (2006) sample is a stratified, two-stage clustered sample of some 14,000 Ethiopian households. It includes a representative survey of women of reproductive age (15—49 years). The current paper investigates interview data gathered from women residing in Oromia region (n = 2230). Data used here include socio-economic information such as age, residence, educational status (years of schooling, educational level achieved), religion (Christian, Islamic), ethnic group, economic status (a wealth index derived from household assets, in quintiles), current working status, three indicators of women's empowerment and information related to FGC (Ethiopia Demographic and Health Survey, 2006) The latter included questions as to whether the respondent and her daughter(s) had undergone FGC, and, if so, at which age and whether type III (infibulation) was conducted or not and, finally, whether the respondent supported the continuation of FGC or not.

Empowerment refers to a positive capacity and strength of an individual. It was defined here by responses to several questions. First, sexual empowerment was elucidated by

Table 1 Classification of female genital cutting methods according to the World Health Organization.

Type	*Extension of female genital cutting*	*Other names*	*Ethnic groups practising this type in Ethiopia*
Type I	Excision (removal) of the clitoral hood with or without removal of all or part of the clitoris	Clidoridectomy, sunna circumcision	Amhara, Tigray
Type II	Excision (removal) of the clitoris and the labia minora with or without excision of the labia majora	Excision	Oromo, Gurage, Tigray
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and repositioning the labia minora and/or the labia majora, with or without excision of the clitoris	Infibulation, pharaonic circumcision	Afar, Somali
Type IV	Pricking, piercing or incision of the clitoris and/or labia	*Mariam Girz*	Amhara (Gojam)

counting the number of reasons (out of three offered) considered legitimate for a women to refuse sex with her husband (husband has a sexually transmitted infection, husband is unfaithful, wife is not in the mood). Second, the approval of intimate partner violence (domestic violence) by questioning what reasons (out of five offered) considered to be justified for a husband to beat his wife (burning the food, going out without telling him, neglecting the children, refusing sex, arguing with her husband). Relevant responses were used to determine the status of a respondent in relation to society and partner as well as her approval of a subordinate position. Since there is no accepted definition of adequate and/or high self-empowerment, the scale was arbitrarily divided according to the distribution of answers. Third, a subsample of 1465 married women was asked who in the household had the final say on their health care. Relevant answers were also evaluated in relation to attitudes towards FGC.

Data analysis was conducted using Statistical Package for Social Sciences version 12.0 (SPSS, Chicago, IL, USA). Logistic regression models were used to estimate factors influencing attitudes towards FGC. The outcome variable was dichotomous (favouring the discontinuation of FGC versus not doing so). Covariates considered in the model were variables significantly related to the outcome variable in univariate analysis and included age, education, wealth index (1–5), residence (urban versus rural), self-empowerment (three indicators) and religious affiliation. The empowerment indices were dichotomized into tertiles (I: 0–2 reasons justified to refuse sex with husband versus all three reasons justified; II: 0–2 reasons justified to beat a wife versus 3–5 reasons). Nagelkerke's pseudo-R^2 and the Hosmer–Lemeshow goodness-of-fit test were used to assess model performance.

Results

The original sample contained 2230 women, of whom nine did not know their status; their data were deleted. The data set thus included 2221 women of reproductive age (15–49 years), with a median age of 25 years. Overall, 84% (1853) identified themselves as belonging to the ethnic group of Oromo, while 10.3% (228) were Amhara, 1.3% (28) Gurarge or Gedeo, and 99 women belonged to one of the other ethnic groups. Fourteen percent of the respondents lived in an urban environment, while 86% resided in rural areas. Characteristics of the study population are displayed in **Table 2**. Reportedly, 88.4% (1964) of the women had experienced FGC, while 11.6% (257) reported not having undergone the procedure. According to WHO, 2.7% (51/1910) reported type III (Table 1), while no relevant information was available for 99 women (4.5%). Prevalence decreased over time in the birth cohorts and was 95.9% (351/366) in women above 40 years, significantly higher than the prevalence in women below 20 years (75.8%, 402/530; chi-squared = 5.30, $P = 0.02$), indicating a change over time. Prevalence of FGC did not differ among religions, with 87.8% (1036/1180) of Christian women having undergone FGC compared with 89.1% (871/978) of Islamic women. While 30.0% of all women (644/2221) mentioned being in favour of the practice's continuation, 62.4% (1385/2221) favoured its discontinuation.

Table 2 Descriptive characteristics from the sample of 2221 women (aged 15–49 years) in Oromyia region, Ethiopia 2005 (Ethiopian Demographic and Health Survey, 2006).

Variable	*All (n = 2221)*	*Favouring continuation (n = 644)*	*Favouring discontinuation (n = 1385)*
Median age (years)	25.5	28.1	24.6
Experience of FGC	1964 (88.4)	613 (95.2)	1220 (88.1)
Urban residency	318 (14.3)	38 (5.9)	273 (19.7)
School attendance	633 (35.1)	130 (20.2)	619 (44.7)
Currently working (n = 1930)	848 (38.2)	263 (40.8)	526 (38.0)
Income falling within the three poorest quintiles	1282 (57.7)	448 (69.6)	704 (50.8)
Religious affiliation			
Christian faith	1153 (51.9)	273 (42.4)	809 (58.4)
Self-empowerment indicator I (%)[a]			
0–1 reasons acceptable	16.1	20.8	13.3
2 reasons acceptable	16.8	17.4	16.1
3 reasons acceptable	67.2	61.8	70.6
Self-empowerment indicator II (%)[b]			
No reason acceptable	19.2	12.6	22.5
1–3 reasons acceptable	30.1	32.1	31.3
4–5 reasons acceptable	50.1	66.3	46.2

Values are number (percentage) unless otherwise stated; FGC = female genital cutting.
[a]Number of reasons (out of three offered) considered legitimate for a woman to refuse sex with her husband.
[b]Number of reasons (out of five offered) considered legitimate for a husband to beat his wife.

A subsample of mothers with daughters ($n = 1244$) were asked if their daughter(s) had undergone FGC; 37.4% (465) mothers reported positively. If mothers aged below 30 years were excluded from analysis ($n = 674$), 41.4% (279) had no daughter circumcised, while 58.6% (395) had one. The median circumcision age, when 50% of the daughters were circumcised, was 6.2 years, and 25% and 75% were circumcised at the ages of 3.5 and 9 years, respectively. Median age at date of FGC was younger in Christian girls (5.9 years) than in those belonging to the Islamic faith (7.7 years).

While the lowest FGC prevalence was observed among the highest income category, there was no trend seen across the four lower income groups. However, the percentage of women in favour of the discontinuation of the practice increases as the income category rises from a 48.5% (179/369) in the lowest category to 80.6% (411/510) in the wealthiest one. Prevalence was similar in urban (264/317) and rural women (1700/1904). However, more urban women favoured the discontinuation of FGC (86.3%, 272/315) than those in rural areas (59.8%; 1107/1851; chi-squared 16.0, $P < 0.001$). Education was significantly associated with disapproval of the practice, with results from multiple regression models showing that with each year of additional schooling, the odds of disapproving the practice increased by 20% (OR 1.19, **Table 3**, **Figure 1**). A woman's own FGC experience shaped her attitude towards the disapproval of the practice. Only 61.9% (1215/1964) of women who had been cut were in favour of the practice, as opposed to 81.2% (164/202) of women who had not undergone the procedure (chi-squared 5.72, $P = 0.0168$, **Figure 1**). Of working women, 64% (453/708) were not in favour of FGC, while 57.5% (532/926) of non-working women were. Neither this nor the age at first marriage was significant.

Two-thirds of respondents (67.2%, 1470/2189) considered all three reasons offered acceptable reasons to refuse sex with the husband, while 8.2% (179/2189) considered no reason was acceptable to refuse sex with the husband. Only one-fifth (434/2204; 19.7%) of respondents rejected all forms of intimate partner violence, while half of the respondents accepted four or all five reasons for a husband to beat his wife. Support for the continuation of FGC rose significantly with the acceptance of domestic violence (Pearson chi-squared = 50.58, df = 5, $P = 0.001$). Twice as many women who agreed with domestic violence favoured the continuation of FGC than women who considered domestic violence illegitimate in all cases (chi-squared 6.71, $P = 0.001$). Likewise, support for the discontinuation increased significantly the less the women accepted violence. Only one in seven women (112, 14.6%) who rejected all reasons for a husband to beat his wife favoured the continuation of FGC, whereas one in three women (323, 36.7%) who agreed with all five reasons did so. Likewise, four out of five (80.7%) women disagreeing with a husband beating his wife favoured discontinuation as opposed to only 57% (504) of women who agreed with all five reasons (**Figure 2**).

Discussion

As a result of its representative design, the Ethiopia Demographic and Health Survey provides an authoritative picture of the population in Oromia region, Ethiopia. It therefore offers an extremely useful tool that allows the characterization of the population and examination of the factors that are associated with a variety of outcomes; it can also be used to understand women's perceptions and how certain factors might affect their behaviour. However, there are some methodological limitations: as data was taken by interview, no clinical verification of a woman's status was sought, which was a potential source of misclassification. Some authors have found complete agreement between reporting and clinically verified FGC (Elmusharaf et al., 2006), while others report differences of up to 20% (Klouman et al., 2005). In addition, only self-reported information on behaviours and attitudes was used here, and it is not clear to what extent these will translate into actual

Table 3 Logistic regression model of the attitude towards the discontinuation of female genital cutting in women of reproductive age, Oromyia region, Ethiopia 2005 ($n = 2071$; Nagelkerke's pseudo-$R^2 = 15$).

Independent variable	β	*SE*	*Wald chi-squared*	*P-value*	*exp(β) OR*	*95% CI*
Education (years of schooling)	0.17	0.03	38.24	0.001	1.19	1.13—1.25
Own FGC experience	−0.73	0.21	12.60	0.001	0.48	0.07—0.89
Income (in quintiles)	0.14	0.04	10.90	0.001	1.15	1.07—1.23
Empowerment indicator I[a]	0.13	0.05	6.40	0.01	1.14	1.04—1.24
Empowerment indicator II[b]	−0.08	0.03	8.09	0.004	0.93	0.87—0.99
Religious affiliation (Christian = 0, Islamic = 1)	−0.24	0.10	5.66	0.02	0.79	0.59—0.97
Age (5-year groups)	−0.04	0.03	1.98	NS	0.96	0.90—1.02
Residence (urban = 0, rural = 1)	−1.57	0.21	0.54	NS	0.86	0.45—1.27
Constant	1.09	0.54	4.15	0.04	2.98	

CI = confidence interval; NS = not statistically significant; OR = odds ratio.
Model chi-squared = 353, Hosmer—Lemeshow chi-squared = 5.75, df 8; 59% correct predictions.
[a]Number of reasons (out of three offered) considered legitimate for a woman to refuse sex with her husband.
[b]Number of reasons (out of five offered) considered legitimate for a husband to beat his wife.

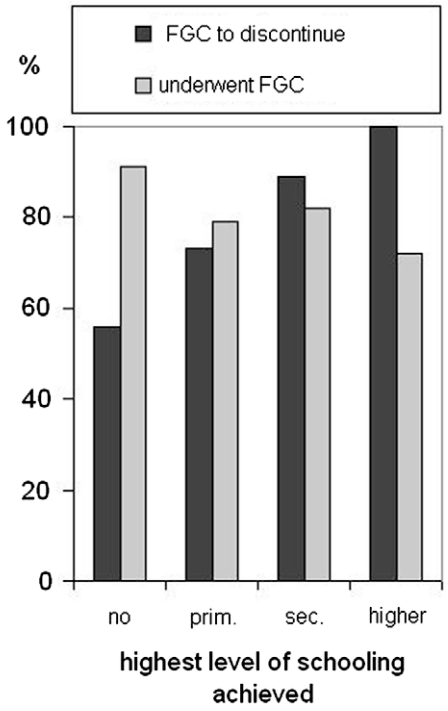

Figure 1 Prevalence of and opposition to female genital cutting (FGC) in in women of reproductive age in Oromia, Ethiopia, 2005, in relation to level of high school education. No = none; prim. = primary; sec. = secondary.

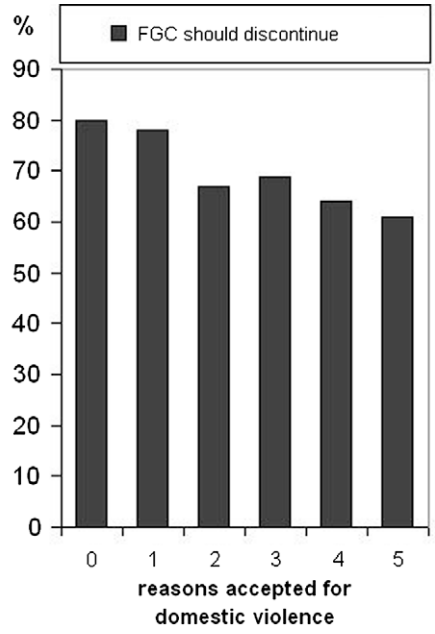

Figure 2 Opposition to female genital cutting (FGC) in women of reproductive age in Oromia, Ethiopia, 2005, in relation to acceptance of intimate partner violence (0—5 different reasons considered legitimate for a man to beat his wife).

behavioural changes. However, four important findings emerge from the data.

First, FGC has slowly started to dwindle in women in the Oromia region over the course of the last three decades as demonstrated in a declining prevalence across birth cohorts. While the prevalence is still high, this fact is promising.

Second, the data confirm the findings of surveys made in other African countries (Jones et al., 1999; Klouman et al., 2005; Msuya et al., 2002; Tag Eldin et al., 2008) that education is the single most important factor in women's attitudes towards the abolishment of FGC. Over 90% of women with secondary education in Oromo region oppose the practice. By contrast, only half of women who never attended school do so. Raising the educational level is thus a corner stone in the abolishment of FGC in the Oromia region.

Third, approval of intimate partner violence by women is widespread in Oromia region. Sadly, it is a common phenomenon in many African societies (Anderson et al., 2007) including Ethiopia, where domestic violence is a long-established tradition. Women have a low status in most Ethiopian communities, often being subject to physical and psychological abuse (Gossaye et al., 2003; Mulugeta et al., 1998). Hence, the fact that the majority of women in Oromia region approved of domestic violence is not surprising in this context.

Fourth, two-thirds of the women were reportedly favouring the discontinuation of FGC. A similar finding has been reported from Nigeria (Osinowo and Taiwo, 2001). Again, this is promising. The more likely a woman is to reject domestic violence, the more she disagrees with the continuation of FGC. A clear relationship is seen between women's empowerment and a positive attitude towards the elimination of FGC. Regardless of the surface motivation for FGC to be conducted, ultimately the practice maintains a relative inferior status of women within the society, as the practice supposes that women lack the right of self-determination, i.e. to decide on their own when and with whom they would like to engage in sexual activity. Supporting women's self-esteem will therefore be a crucial factor in all future attempts to eradicate the practice.

The practice of FGC is a complex tradition that cannot be addressed in isolation from its cultural environments. As the practice is limited to societies with pronouncedly patriarchal organization, its origins may be perceived as a means of enforcing the male's superior role over his wife, ensuring her chastity. It is important, though, to consider FGC without criticisms and find ways to transform the harmful physical act of cutting into another symbolic act of initiation, should elimination efforts be successfully adopted by communities. Providing women with alternative ways of defining their social identities and positions, proposing alternative rites of passage that retain the cultural aspects, for example conducting ceremonies at which it is announced that a girl has become a woman, will be beneficial. Creating a positive culture with festivals has been found to be a particularly rewarding approach in other countries (Chelala, 1998; Chege et al., 2001). Enlisting the constant support of health professionals, educators, religious leaders, traditional birth attendants and circumcisers and supplying the latter with alternative livelihoods is also critical. Empowering women economically and providing them with health and human rights information will additionally contribute to altering

their perspectives in ways that will contribute to and help sustain attitudinal and behavioural change.

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