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CLINICAL ARTICLE

Female genital mutilation among mothers and daughters in Harar, eastern Ethiopia

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ABSTRACT

Objective: To assess the practice of female genital mutilation (FGM) among mothers and daughters, and to investigate sociodemographic factors influencing the practice of FGM in Harar, Ethiopia. *Methods:* A community-based cross-sectional study was conducted among women aged 15 years or older who had at least one living daughter younger than 12 years via the Harar Health and Demographic Surveillance System 2013. Data were collected through face-to-face interviews. The practice of FGM was compared between mothers and their daughters. Whether the daughter had undergone FGM was included as an outcome variable in bivariate and multivariate analyses. *Results:* Among 842 mothers, 669 (79.5%) reported that they had undergone FGM themselves, and 160 (19.0%) that their daughter had undergone FGM. Traditional practitioners were said to be the major performers of FGM by 151 (94.4%) mothers. Mothers whose daughter was mutilated mentioned social acceptance (144 [90.0%] women) and better marriage prospects (96 [60.0%]) as the major benefits. Genital mutilation of daughters was significantly associated with maternal age, education to grade 1–4, and FGM experience. Amhara ethnic origin was significantly associated with a reduced likelihood of FGM among daughters. *Conclusion:* Over one generation, the incidence of FGM has reduced. Increasing advocacy against FGM and enforcement of law should be emphasized.

1. Introduction

Female genital mutilation (FGM) is the practice of removing part or all of the external female genitals. WHO has classified FGM into four categories. Type I (clitoridectomy) involves removal of the clitoral hood, almost invariably accompanied by removal of the clitoris itself. Type II involves removal of the clitoris and inner labia. Type III (infibulation) involves removal of all or part of the inner and outer labia, and usually the clitoris, coupled with fusion of the wound, leaving a small hole for the passage of urine and menstrual blood; the fused wound is opened for intercourse and childbirth. Type IV involves several miscellaneous acts [1,2].

FGM is recognized as a violation of human rights and constitutes a severe form of discrimination against women. It is nearly always performed on girls, so is a violation of the rights of children. The practice also violates an individual's rights to health, to security and physical integrity, and to be free from torture and degrading treatment. The health consequences of FGM include urinary retention and exposure to urinary system, wound, and general systemic infections. FGM also exposes the women to tetanus, hepatitis, and HIV infection. Some of the late complications of FGM include damage to the urethra and bladder with infection and incontinence [3,4].

Nevertheless, WHO estimates that approximately 100–140 million women and girls around the world have experienced FGM. The practice is performed in some communities because of a belief that it reduces a woman's libido and makes her attractive to her husband [5–7]. In societies where FGM is a valued practice, daughters undergo the practice to adhere to the culture and norms of the community. In these communities, FGM is valued for benefits to the prospects of marriage and a decent life.

The prevalence of FGM in Central and West African countries varies from 69% in Mali to 1% in Cameroon, Ghana, and Niger. The frequency of FGM is higher in East African countries: in Somalia, Sudan, Kenya, and Ethiopia, its prevalence can be as high as 95% [8–10]. According to reports from the United Nations Children's Fund (UNICEF) and others [11–13], Ethiopia has the tenth highest prevalence of FGM in the world (74.3%), and is one of the countries with the highest number of infant girls undergoing some form of FGM [11]. In 2009, 38% of mothers reported that at least one of their daughters had been mutilated [14]. In other studies [15–17], 64% and 88.1% of mothers in the Amhara and Oromia regions of Ethiopia, respectively, reported that their daughters had undergone the practice; older age, Christian religion, and illiteracy were strong predictors of genital mutilation of daughters.

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In Ethiopia—aside from government efforts to educate the public about the problem and to enforce the law criminalizing the practice—there are several organizations working to reduce FGM in high prevalence areas. As a result, several studies have indicated that public awareness has increased; however, the practice of FGM is not abating [2,17].

Most studies on FGM in Ethiopia have focused on existing knowledge, attitude, and practice, and do not provide information on current practice relative to efforts made to reduce it. Therefore, the aim of the present study was to assess the practice of FGM over a generation by comparing information from mothers and daughters, and to investigate sociodemographic factors that influence the practice among the parents of young girls living in Harar in Ethiopia.

2. Materials and methods

The present community-based quantitative cross-sectional study of FGM was conducted among women with at least one daughter living in Harar, eastern Ethiopia, between February 1 and 28, 2013. The study protocol was approved by the institutional review board of the College of Health and Medical Sciences, Haramaya University, and written consent was obtained from all participants.

The source population for the present study was women aged 15 years and older living in the Harar site of the Health and Demographic Surveillance System (HDSS). The Harar HDSS is an urban HDSS located in Harar, a city approximately 510 km from the capital, Addis Ababa. At its creation in 2010, the Harar HDSS included six of the 19 *Kebeles* (the smallest administrative unit in Ethiopia with an average population of 5000) of Harar, which were selected by considering the socioeconomic composition of the population and corresponded to approximately 9000 households and 32 000 individuals. In 2012, the site had a total population of 32 437, with a male-to-female ratio of 0.92 [18]. In 2015, an additional six *Kebeles* were included in the HDSS to make the total *Kebeles* under surveillance 12 out of 19, increasing the total number of households to 19 000 with a population of 62 000.

Women with at least one daughter younger than 12 years were the sample population. A computer-assisted lottery method was used to select households containing eligible study participants from each *Kebele* on the basis of the registries of Harar HDSS database. Eligible women were randomly selected from these households using a computer-assisted lottery method. Women without at least one female child and those who were unable to communicate during data collection owing to factors such as severe illness were excluded from the study. If more than one woman with a daughter was living in the selected house, a lottery method was used to select a particular woman for interview. The presence of girls aged 12 years or younger in the selected households was verified using the Harar HDSS database.

Data were collected through a face-to-face interview by female fieldworkers using a structured questionnaire adopted from UNICEF [12]. The study participants were informed of the objective, benefits, and risks of the study, in addition to their rights, by the data collectors before the start of data collection. The questionnaire was translated into local languages (Afan Oromo, Hareri, and Amharic languages) and piloted in a nearby locality. Two field supervisors checked the consistency and completeness of the responses.

Via a single-population proportion formula and a design effect of two, the necessary sample size was determined to be 842. Data from the interviews were double-entered into worksheets by two data entry clerks using EpiData version 3.0 (EpiData Association, Odense, Denmark) and were analyzed via SPSS version 16.0 (SPSS Inc, Chicago, IL, USA). The data were described using tables, frequencies, and proportions generated for each of the independent factors. The prevalence of FGM among mothers and daughters was compared by proportion.

In multivariate analysis, the outcome variable was genital mutilation of daughters, defined as the practice of FGM to a daughter by traditional practitioners, neighbours, relatives, or health professionals as a rite of passage from childhood to adulthood. The independent factors were sociodemographic characteristics and women's perceptions of FGM. Both crude and adjusted analyses were done to identify the factors influencing the practice of genital mutilation of daughters. The effect of independent variables on the outcome variable (genital mutilation of daughters) was assessed via the odds ratio with 95% confidence interval.

3. Results

Among 842 study women, most were aged 25–39 years (Table 1). Oromo and Amhara were the most common ethnic groups (Table 1). Among the total respondents, approximately three-quarters were married, and almost all were Orthodox Christian or Muslim (Table 1). Those who could not read or write, and those who had attended school until grades 1–8 accounted for more than half of the participants (Table 1). The mean monthly family income was 1313 ± 1119 Ethiopian Birr (ETB; US$1 was equivalent to 19 ETB at the time of the study).

All mothers had heard about FGM at the time of the interview, and 669 (79.5%) were themselves mutilated. Regarding genital mutilation of daughters, 160 (19.0%) mothers reported that their daughters had undergone the practice. Among these women, almost all reported that their daughters had undergone removal of flesh from their genitalia; few reported that the genital area had been stitched or cut without

Table 1
Sociodemographic characteristics of study mothers (n = 842).

Variable	No. (%)
Age, y	
15–19	2 (0.2)
20–24	70 (8.3)
25–29	261 (31.0)
30–34	241 (28.6)
35–39	165 (19.6)
40–44	61 (7.2)
45–49	24 (2.9)
≥50	18 (2.1)
Ethnic origin	
Oromo	330 (39.2)
Harari	42 (5.0)
Amhara	318 (37.8)
Tigre	39 (4.6)
Gurage	75 (8.9)
Other	38 (4.5)
Marital status	
Single	20 (2.4)
Married	623 (74.0)
Living in union	90 (10.7)
Separated	34 (4.0)
Divorced	31 (3.7)
Widowed	44 (5.2)
Religion	
Muslim	372 (44.2)
Orthodox	387 (46.0)
Catholic	15 (1.8)
Protestant	68 (8.1)
Education	
Unable to read/write	186 (22.1)
Grade 1–4	165 (19.6)
Grade 5–8	196 (23.3)
Grade 9–10	96 (11.4)
Grade 10–12	120 (14.3)
University/college	79 (9.4)
Income, ETB	
≤600	222 (26.4)
601–1000	286 (34.0)
1001–1600	125 (14.8)
>1600	209 (24.8)
FGM status	
Mutilated	669 (79.5)
Not mutilated	173 (20.5)

Abbreviations: ETB, Ethiopian Birr; FGM, female genital mutilation.

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