



# Key Factors, Drivers and Gatekeepers of Female Genital Mutilation in Ethiopia: A Meta-synthesis of National and Regional Studies

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## Authors' contributions

*This work was carried out in collaboration among all authors. Author OO conceived the manuscript documentation, drafted and finalized the manuscript. All the authors read, reviewed and approved the final draft of the manuscript.*

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## ABSTRACT

Female Genital Mutilation (FGM) is a harmful practice that consists of all procedures involving partial or total removal of the female external genitalia or other injuries to the female genital organs for non-medical reasons. This meta-synthesis aimed to identify and describe key factors, drivers, and gatekeepers of FGM practices in Ethiopia and was conducted using systematic searches in electronic databases (PubMed, PsycINFO, and Google Scholar) and grey literature published from 2012 to 2021. The main factors and drivers of FGM practices were cultural and traditional practices including marriageability and religious obligations. Other drivers were poor enforcement of laws against the practice including medicalization of FGM practice. The key gatekeepers included traditional birth attendants who were also mostly female circumcisers; mothers, grandmothers, and older women who were reported as major promoters, circumcisers, and key decision makers on the practice. Religious leaders and health workers also played pivotal role in the prevention of FGM as trusted source of information dissemination. It is therefore important that Programme and policy strategies to eliminate the practice are tailored to the local context, not only addressing these factors and drivers but involving the gatekeepers.

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## 1. INTRODUCTION

Female Genital Mutilation (FGM) is a harmful practice that consists of all procedures involving partial or total removal of the female external genitalia or other injuries to the female genital organs for non-medical reasons. All forms of FGM can cause immediate and long-term health risks including physical, psychological, emotional, and social health problems; the risk increases with the extent of the cutting [1,2]. FGM is recognized as a pervasive violation of human rights, and other international conventions [3].

FGM is a global challenge with an estimated two hundred million girls and women worldwide having undergone the procedure [1]. It is estimated that the prevalence may increase to sixty-eight million by the year 2030 with a projection of nearly five million girls undergoing the procedure yearly if more actions are not taken toward eradicating the practice [4]. The practice of FGM is concentrated mostly in Africa, Asia, and the Middle East and it is characterized by the partial or total excision of the female external genitalia and is associated with entrenched cultural practices in most communities in Sub-Saharan African countries [1,2,5].

In Ethiopia, the average national prevalence of FGM among women and girls aged 15-49 years was reported to be 65 percent though with notable disparities across regions and settings. Three regions in the country have the highest prevalence, Somali 99 percent, Afar 91 percent, and Harar 82 percent [6,7]. The aforementioned three regions are predominately Muslim with Somali and Afar also being pastoralist. The age of cutting varies substantially by region and religion with nearly half of cut women undergoing FGM when they were younger than 5 years old, whereas nearly 3 in 10 were cut after age 10 [7].

Given the unacceptably high prevalence of FGM in the country, Ethiopia has been striving to address the issue through the implementation of several strategic and program measures. This included an appropriate legal framework and policy provisions that promote the rights of women and girls and criminalizes FGM as a violation of human rights. FGM has been

prohibited in Ethiopia's criminal code since 2004 and the Ministry of Health banned the medicalization of FGM in all public and private medical facilities in the country in 2017 [8].

In addition, the government of Ethiopia developed the National Costed Roadmap to End Child Marriage and Female Genital Mutilation-2020-2024 which aims to bring about the complete abandonment of child marriage and FGM in Ethiopia by 2025 [9].

The purpose of the meta-synthesis was for scoping review of evidence on the key factors, drivers, and gate keepers of FGM practices in Ethiopia to help improve programs aimed to end FGM in regions with high prevalence with a particular focus on pastoralist communities.

## 2. METHODOLOGY

A systematic search of published articles was conducted from main electronic databases (PubMed, PsycINFO, and direct search from Google Scholar) with no language restrictions. In addition, searches of the grey literature were also conducted including theses, policy briefs, and program evaluation reports of organizations. In addition to the above, specific keywords, such as "pastoralist communities", 'factors' "drivers", and "gatekeepers" of FGM in Ethiopia", were used to retrieve studies for the meta-synthesis.

### 2.1 Inclusion and Exclusion Criteria

Studies were included if focused on factors, drivers, and gatekeepers of FGM; conducted in Ethiopia or referenced Ethiopia and used all study designs with clear methodologies for enabling an assessment of quality, studies not exceeding the past 10 years (2012-2021) published as research studies, evaluation reports, policy briefs, and theses. Studies conducted before 2012 and outside the scope of the research were excluded.

### 2.2 Data Quality Control

After the first selection of studies was completed, methodological quality control measures using a designed critical appraisal

checklist to minimize the inclusion of irrelevant documents into the synthesis were undertaken by two reviewers. Studies by authors without some institutional affiliation, questionable reputability of the journal/publisher, the inadequacy of the methodology of the study, the inappropriateness of the sampling method used, lack of objectivity in the analysis, and questionable ethicality were used as quality assurance techniques to eliminate the irrelevant studies.

### 2.3 Data Abstraction, Coding, and Synthesis

A qualitative analysis software (ATLAS.ti) was used to extract the key codes, themes, and findings from the selected qualitative studies. Meta-syntheses were done by combining or summarizing the interpretation of the text, particularly from the findings of included studies into one or more related thematic areas. This was followed by groupings of codes into one or

more descriptive themes and subthemes. Finally, the coded qualitative data were synthesized according to the flow of themes and sub-themes.

### 3. RESULTS

Fig. 1 shows the analysis of the articles included in the study. A total of 133 articles were included in the initial search. After removing duplicate articles and excluding other articles based on the inclusion criteria, 43 full texts were assessed for eligibility. Twenty-six articles were finally included in the study following the quality control exercise conducted. The final articles used mainly qualitative methods (21), while 2 used quantitative methods and 3 used mixed methods. Most of the studies were published articles (13) and others were project evaluations (5) and policy briefs or reports (6) and theses (2). Twenty-two of the studies were conducted in Ethiopia and four referenced Ethiopia.

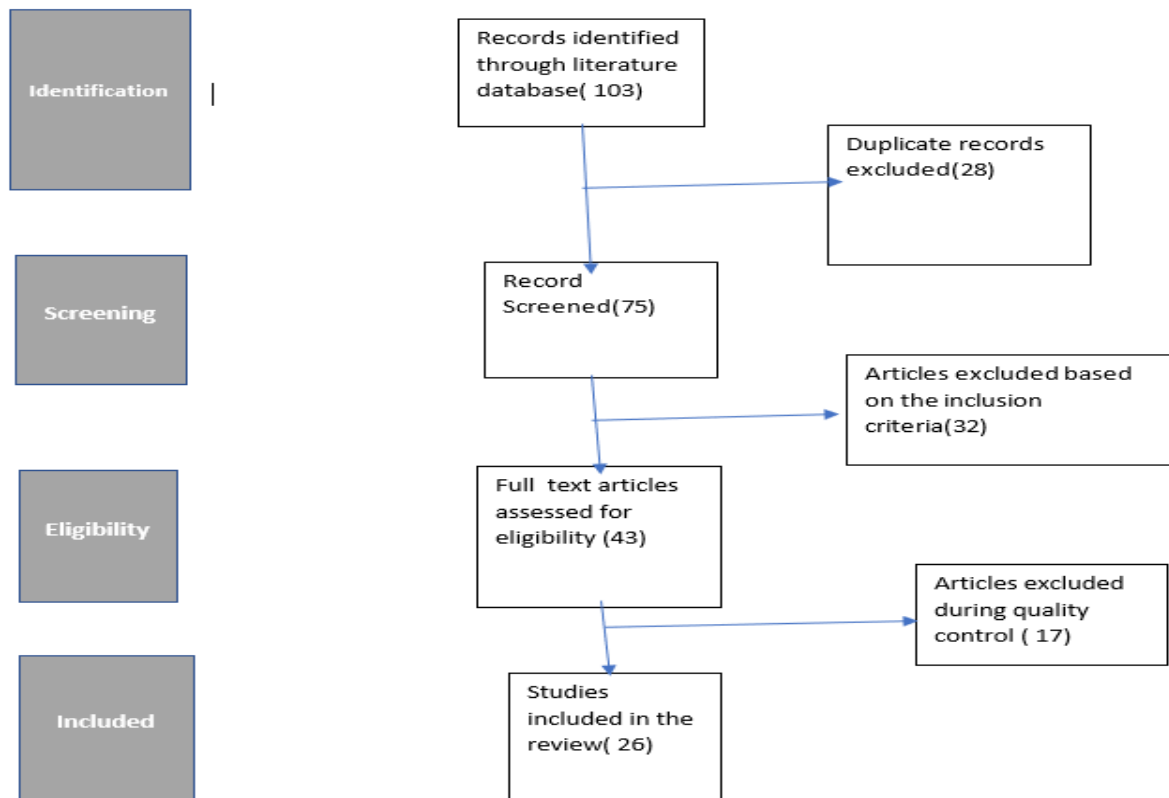


Fig. 1. Number of articles eligible for the study

## 4. DISCUSSION

### 4.1 Factors and Drivers of Female Genital Mutilation (FGM) in Ethiopia

The main factors and drivers of FGM as reported in the studies are:

#### 4.1.1 Cultural and social expectations

FGM has been considered a traditional practice to fulfill social expectations and reinforce gender norms, including marriageability. The practice is considered a means for the preservation of cultural values and norms in traditional societies of Ethiopia [10-15]. Women from Somali tribes practice infibulation (Type III FGM) on their daughters considering it as part of the existing culture of their tribal group [10]. The practice is considered an intervention to narrow the women's genital organs, control women's and girls' sexual desires; secure the cleanness of women's genital organs; increase the sexual pleasure of men, and ensure abstinence from premarital sex [11-17].

The ability of a girl to get married is influenced by being circumcised which makes her 'clean and pure' and maintain her virginity before marriage because of harmful gender norms, including the belief of boys/men that only circumcised girls are good for marriage and able to maintain family/relationship [13,14,18].

#### 4.1.2 Religious obligations

Type 1 FGM also known as 'Sunnah cut'(consisting of the partial or total removal of clitoris), is believed to be a religious obligation for the Muslim population [10-15,17]. However, the religious requirements of FGM are debatable and remain controversial [10]. A study conducted in the Harar and Somali regions of Ethiopia indicated that religion is the major reason for the perpetuation of the practice [10]. This evidence is collaborated by the Ethiopian Demographic Health Survey of 2016 which indicated that 41 percent of Muslim women believed that FGM is a religious requirement [6].

#### 4.1.3 Community's attitude

Parents are concerned about discrimination faced by uncircumcised girls in the communities and the inability to get married and rejection by the community [10]. A study in Fafan and Arsi, predominantly Muslim communities reported that

abandoning the practice involved high social risk, such as sanctions against uncut girls and social exclusion [13]. Uncircumcised girls are considered unclean and face stigma and discrimination [14]. Likewise, a study conducted in Jijjiga (Somali Region) revealed that an uncircumcised woman was considered as hypersexual, infidel/unfaithful, non-Muslim, and impure [19]. A study by Gebremariam et al. in Jijjiga, Somali Region found that traditional community norms and values were the main predictors of whether the practice of FGM is right or wrong [20].

#### 4.1.4 Level of education of women

The educational status of women was found to have a well-recognized impact on interventions to combat FGM. The practice was reported higher among mothers with less education and suggested to be due to their poor exposure to information about FGM and its consequences [3, 21,22]. A study by Andarge reported poor awareness of existing laws and regulations as one of the major challenges in fighting against FGM in Ethiopia [11]. Studies reported higher rate of circumcision in girls who have older parents than girls from young parents, this was attributed to poor knowledge/awareness among older parents about the anti-FGM declaration, associated complications, and issues related to gender equality [16,23]. Similarly, in three of the studies reviewed, women's education was identified as an independent predictor/risk factor for FGM in Somali Jijjiga, Amhara, and Afar regions of Ethiopia [18,20,23]. Women in a rural communities who are mostly uneducated were found to have quite higher acceptance and continuation of the practice of FGM [23].

#### 4.1.5 Poor law enforcement against the Practice of FGM

Ethiopia has a full-fledged policy on FGM and an act of the parliament which criminalizes FGM as a violation of human rights and prohibited in Ethiopia's criminal code since 2004 [8]. However, studies on the enforcement/implementation of the legal framework to combat FGM practice are very limited. Weak government engagement and enforcement of legislation were identified as one of the major reasons for the perpetuation of the practice [19]. The fear of violating the community's cultural norms and values was said to be a possible reason for weak enforcement by government agencies [19]. Another study reported that laws enforcement implemented as

a single intervention can be counterproductive" since these tend to "alienate beneficiaries from health services, reduction in the age of cutting and secrecy in performing FGM [24].

#### 4.1.6 Medicalization of FGM

This practice even though illegal in the country is being done by health workers. A previous study by UNICEF reported that nearly all FGM in Ethiopia was performed by traditional practitioners (89 percent), while medical personnel rarely performed the practice (2 percent) [7]. The study reported that Southern Nations, Nationalities, and People's Region (SNNPR) region was the only region in which there was some involvement of medical personnel with 1 in 10 women who underwent FGM done by doctors, nurses, midwives, or other health professionals. However recent studies done in Afar and Somali regions indicated that some health workers even though they believe it's against human rights, supported and practiced medicalization of 'Sunnah cut' type 1 of circumcision because of their religious belief, and also because of their perception that it makes FGM safer compared to the traditional method by reducing the risk of infibulation and medical complications [25,26]. The studies reported that 20 per cent (Afar) and 55.5 per cent (Somali) healthcare providers from hospitals; 30 per cent (Afar), and 36 percent (Somali) of health care providers from health centres, admitted to having practiced FGM [25,26]. These findings indicate that medicalizing the practice of the 'sunah' type is becoming increasingly common and a way of encouraging the practice of FGM to continue in most part of Ethiopia like Afar and Somali regions of Ethiopia.

## 4.2 Gatekeepers of FGM

The review identified the following key gatekeepers:

### 4.2.1 Traditional Birth Attendants (TBAs)

Most of the traditional female circumcisers are traditional birth attendants (TBAs) in Ethiopia. A study conducted in Harari and Somali Regions shows that most FGM were performed by traditional female circumcisers who considered the practice as their job or source of income which sustains the FGM practice [15]. Providing other means of livelihood for them has been identified as a strategy to reduce the practice of FGM in the country [10]. A study in the Afar

Region reported that TBAs who have no training in the prevention and care of FGM tend to circumcise without any hesitation while the trained TBAs were hesitant to do the same [11].

### 4.2.2 Mothers and grandmother or older women

Available evidence have shown that mothers, grandmothers, and older women are major FGM promoters, circumcisers, and key decision makers on the practice in the communities [10,13,15,27]. The poor literacy rate of grandmothers and old women was found to contribute to the perpetuation of the practice of FGM. Most of them have no awareness of the criminalization and medical complications associated with the FGM practice nor do the human rights issue [23]. These women were reported to perceive the advocacy for an ending of the practice of FGM as an attack on their tradition and dignity [15]. Mothers and women thus hold the key to curbing FGM in Ethiopia, but they must be empowered through education and behavioral change interventions to dampen any fears about violating their traditions.

### 4.2.3 Fathers/men

Fathers, followed by mothers and religious leaders, usually hold a central place in promoting and arranging the practice of circumcision of their female children [10,17]. Seventy percent of decisions to circumcise their daughters were reported to be made by both parents while only one-in-five FGM practice is decided by mothers only [10]. In addition, there were also male circumcisers reported in some communities [27].

### 4.2.4 Health Care Providers

Healthcare workers are regarded as one of the most reliable sources of information to improve positive health-seeking behavior by community members. They have been engaged in providing appropriate information and community awareness about the impacts of FGM which brought about tangible change in the community. However, some of them still have attitudes and practices that positively promote and could encourage Female Genital Mutilation (FGM) practices, including the medicalization of FGM despite their knowledge of the health consequences and their acceptance as a violation of the rights of women and girls [14,25,26]. This has resulted in a wrong message to the communities that FGM practice is

acceptable if done by a health professional and in the hospital facility. This has high tendency of depriving the community members of access to accurate information that will enable them to make informed decisions about FGM and efforts to eradicate the practice [25,26].

#### 4.2.5 Religious leaders

Religious leaders play a pivotal role in the prevention of FGM as communities and women trust information disseminated in mosques and churches by them [10,13,16]. This is done by minimizing the misinterpretation of FGM as one component of religious obligation. However, from the various studies, their role in stopping the practice has been mixed. In Afar and Somali Region, some religious leaders still promoted 'Sunnah cutting' as a religious obligation and secretly advised the believers not to abandon the practice entirely and rather only reduce the severity of the practice, since it is the true meaning of Islam [27,28]. However, some religious leaders objected to the practice [27,28]. Among the Christian communities, FGM practice was reported denounced as a religious obligation and the declaration made against it by the religious leaders from the Evangelical Churches Fellowship of Ethiopia (ECFE), the Ethiopian Orthodox Tewahedo Church (EOTC), and the Ethiopian Catholic Church Mehari [13,14].

### 5. CONCLUSION

The study identified key drivers and gatekeepers for FGM practice in Ethiopia, especially in the region with high prevalence. Program and policy strategies must be tailored to the local context, not only addressing these drivers but involving the gatekeepers in developing the appropriate solutions to eliminate the practice.

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### DISCLAIMER

The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of any affiliated agency of the authors.

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### COMPETING INTERESTS

Authors have declared that no competing interests exist.

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