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SOCIO-DEMOGRAPHIC AND ECONOMIC CORRELATES OF FEMALE GENITAL MUTILATION IN ADAMA TOWN, OROMIYA REGION OF ETHIOPIA.

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A Thesis Submitted to the School of Graduate Studies of Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Master of Science in Demography.

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Dedicated

With loving pleasure of her

unfailing love and patience

to

my Mom

ETALEMAHU TACHIBELE

who has shared my problems and encourage my aspiration for success.

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ABSTRACT

Female genital mutilation has been common in Ethiopia for several generations. Both Muslim and Christian population practice genital mutilation.

In this study an attempt was made to explore socio-demographic and economic correlates of female genital mutilation, the prevalence of female genital mutilation, women and men's attitudes toward the practice in Adama town among women of reproductive age.

In the survey 709 women and 71 men were selected from the study area randomly through retrospective survey conducted in March 2002. It was observed that the prevalence of female genital mutilation is widely practiced in Adama. Among 709 women participated in the study 557 of them were mutilated and only 104 had given approval for the continuation of the practice. Similarly, among 71 men respondents 18 gave support for the continuation.

Bivariate analysis towards the prevalence and approval of FGM revealed significant differences in most of the socio-demographic and economic variables between mutilated and non-mutilated women and between supporters and non supporters of FGM respectively. The significant factors that have valid relationship with the prevalence and approval of FGM were again taken to multivariate analyses.

The out come of the logistic regression model indicate that women who were in the age group 30 - 49 years, women who stayed in Adama town 0 to 4 years, women born in the countryside, ever married

women and Muslim women were appeared with high prevalence of FGM. Similarly women who stayed in Adama town 0-4 years, women who have never been in school, women who have never been at work, women with total house hold income Birr 0 to 120 and ever married women were identified as highly supporters of FGM.

To abandon female genital mutilation it is good to give focus on the improvement of the status of women through education and economic empowerment. A mass media campaign also plays a major role in getting rid off FGM.

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CHAPTER ONE

INTRODUCTION

1. 1. Background of the Study

All Societies have certain socially accepted norms of behavior that are based on age, gender, social distinction, culture and religion. Such norms are often referred to as traditional practice, which include those relating to children, relations between women and men and marriage and sexuality (WHO, 1997). One deeply rooted traditional practice that can have serious health consequences for girls and women in Africa is Female Genital Mutilation (FGM).

The term Female Circumcision is often used in the literatures; however, it contains a semantic error. For this reason instead of the term "Circumcision" [i.e., the circular cutting clitoral prepuce] which does not constitute a complete cutting off or excision of a bodily part, the term mutilation is used. USAID prefers the neutral term female genital cutting (PRB, 2001)

In order to ensure standardization and consistency, the WHO recommends four-type of classification. In Type I [Clitoridectomy] the clitoris is held between the thumb and index finger, pulled out and amputated. In addition to the amputation of the clitoris, Type II [Excision], the clitoris is removed as described above and the labia minora are partially or totally excised or shaved. In Type III [Infibulation] the amount of tissue removed is extensive. The raw edges of the labia majora are then stitched together using thorns, poultices and the legs are tied together for 2-6 weeks. A small opening is left at back to allow for the passage of

urine and menstrual blood. It is the severest form of FGM and also causes the most damage to reproductive health. Type IV includes practices ranging from the stretching of the clitoris and/or labia and the introduction of herbs and other substances into the vagina to different type of cuts (WHO, 1998).

No one knows exactly how FGM was started, but both male and female versions are among the most ancient of human surgical interventions. The earliest known writings on the subject suggest that it has been practiced in Egypt for at least 2,000 years and also archaeological findings have turned up 2,000 years old Egyptian mummies of mutilated women. Ethnologists believe that such manipulations served as psychological cohesive forces gluing together the members of a society and fostering a sense of belonging (Emily and D'Aulaire, 1981, 82).

Though many conflicting theories have been put forward, most theories about the origins of genital mutilation suggest that these procedures provided a means for families to safe guard the 'value' of women, guaranteeing virginity before marriage and the creation of legitimate heirs during marriage (Cloudsley, 1983).

Supporting this fact COFAP, 1997 suggest that: Ethiopian people also justify that female genital mutilation provided either on the basis of religious or socio - cultural grounds. The most frequent mentioned reasons include make women un-promiscuous and faithful to her husband, not to break utensils, weak, obey and to get married.

The control of women bodies and the domination of their sexuality that exists in every society of the world have been given a better attention since the last two decades. More researchers

devoted much of their time on the fact that policy makers and opinion leaders have rarely acknowledged it and come up with a strong global consensus against this practice and consolidate the will and resources of regional, national and international institutions to stop it (Abdella, 1982).

WHO has been the leading United Nations specialized agency to take a position against FGM, starting in the 1960s. It is coordinating action in this area with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA). In April 1997, WHO, UNICEF and UNFPA issued a joint statement expressing their common purpose in supporting the efforts of governments and communities to promote and strengthen action for the elimination of FGM. In recent years, increasing recognition of the human rights of women and children has brought additional calls for the practice to be stopped (WHO, 1998).

Estimate put the number of women, who have undergone through the rite from 100 million to 132 million. The exact figure is unknown since the practice is not discussed openly and resulting deaths are usually simply ascribed to 'Fate' (Kiragu, 1995: 1).

Most ethnic cultures in Ethiopia are interwoven with myths, superstition and a false conception of man with his psychic and sexual life, which contradict the basic findings of sciences. The role of men's psychic and sexual life in FGM can be observed through the control of their bodies and the oppression of women's sexuality in one form or the other that ranges from the subtle to the overt: economic, intellectual and physical. As a result there are traditional practices in almost all ethnic cultures that adversely affect the health of people, goals of equality, political and social rights and hinder economic development (NCTPE, 1998: 4).

It is recognized that women from infancy to adulthood suffer the most effects of the traditional practices. Among these practices FGM can be pointed out, by many literatures, as the most harmful. In Ethiopia, the practice of genital mutilation has persisted for centuries and is still prevalent to a varying degree among all regions except Tigrai, Gambella and a number of ethnic groups in Southern Nations, Nationalities and Peoples Region (SNNPR). Various religious groups practice it in both rural and urban areas (NCTPE, 1998: 52).

International standards applicable to the issue of FGM are already in place. In addition to various pertinent international and regional human rights conventions and declarations, most affected countries have ratified the United Nations' Convention to Eliminate All Forms of Discrimination Against Woman as well as Children's Rights Convention (Toubia, 1995: 45). The practice, however, in many parts of Ethiopia contradicts these laws. In spite of the prohibiting rules and regulations, a substantial number of women in Ethiopia still support FGM. More than 80 percent of them have already undergone the procedure (CSA and ORC Macro, 2001:33).

1. 2. Statement of the Problem

FGM is deeply embedded in a way of life. It is often regarded as a basic part of growing up and is viewed by many adult Ethiopian women as a unique proof of their woman-hood. Different literatures revealed that an estimated 85-114 million women in over 30 countries have undergone some form of genital mutilation. As many as 100 million African women have been mutilated and at least 1 million African girls are undergone through the practice every year (Kiragu, 1995; Toubia, 1995).

FGM is nearly universal among women in the horn of Africa. For example, the 1995 Eritrea Demographic and Health Survey (DHS), 1995 Egypt DHS, 1983 Somalia National Survey on Fertility and Family planning, 1989/90 Sudan DHS and 1998 Kenya DHS have reported that 95%, 97%, 96%, 89% and 38% of females have been circumcised respectively. There is also a wide spread support and practice for genital mutilation in Ethiopia with four out of five women aged 15-49 [or 80 percent of all women aged 15-49] having been mutilated (CSA and ORC Macro, 2001: 33).

In some cultures, FGM is believed to keep sexual desire in check, reduce neonatal mortality and represents an important part of girls' initiation into women-hood (IAC, 1998). It is extremely difficult to convince many Ethiopian women and men that this maiming, life-threatening practice ought to stop. When asked whether the practice should continue, in the 2000 Ethiopia DHS, 60 percent of all women stated that they supported FGM. However, it can have severe physical, sexual and psychological consequences (CSA and ORC Macro, 2001: 33). According to World Health Organization there are physical, sexual and psychological consequences of FGM (WHO, 1994).

1. 2. 1. Physical Consequences

Lay practitioner with little or no formal knowledge of human anatomy or medicine often performs FGM. In most cases, the operation takes place under unhygienic conditions and with out anesthesia or sterile instruments (Dareer, 1982). Genital mutilation can have many immediate and long-term health consequences. These consequences vary considerably by the type and severity of cutting, with the most serious complications associated with infibulation. The immediate consequence includes difficulty in passing urine, urine retention, hemorrhage, infection, fever, stress, shock and damage of the genital organs (WHO, 1994).

Overtime, mutilated woman may also develop menstrual complications, vulvar abscesses, obstetric complication, urinary tract infections, chronic pelvic infection and low fertility or sterility (Shandal, 1967). In addition to these, genital mutilation, especially infibulation may make sexual intercourse painful (WHO, 1994).

1. 2. 2. Sexual Consequences

Genital mutilations that involve injury to or removal of the clitoris, particularly the clitoral tip and the labia minora result in damage to the concentrated nerve complex responsible for releases of chemicals in the brain that reduce pain and stress, for pelvic muscular and secretory activities and for the transmission of sensory information to the central nervous system. Erection of a partially mutilated clitoris stretches scarred erectile tissue and stimulates damaged clitoral nerve tissues, which can be a painful and mentally inhibiting ordeal and orgasm is also difficult (WHO, 1998).

1. 2. 3. Psychological Consequences

The experience of genital mutilation is commonly associated with psychosomatic and mental problems, symptoms and disorders that affect a wide range of brain functions. Girls have reported disturbances in eating, sleep, mood and cognition. These were manifested in sleeplessness, nightmares, appetite or weight loss or excessive gain, post-traumatic stress, panic attacks, mood instability and difficulties in concentration and learning. As they grow older, women may develop feelings of incompleteness, loss of self-esteem, depression, chronic anxiety, phobia, panic or even psychotic disorders (WHO, 1998).

Thus, it is seen that the ritual practice of FGM is not only painful but also has direct consequences on health and social conditions of the woman as a whole. Further, it is realized that there is a great need to convince the woman and the people in general. Hence, in order to

over come the stated problems caused by female genital mutilation and achieve the country's goals for population and reproductive health, it is required to take some steps. The limitation of the existing methods of controlling genital mutilation in the country [Ethiopia] may be ascribed to socio-demographic and economic factors.

1. 3. Rationale of the Study

It is no longer considered a taboo discussing on the practice and harm of FGM. African Heads of State and international organizations have forwarded statements, and programs have been developed against this and other harmful traditional practices affecting the health of women and children. Most important of all, these efforts are being initiated by Africa and Arab women who are mobilizing to end the practice (IAC, 1998).

Although FGM has attracted international attention as mentioned earlier, the scientific research that documented the extent of its practice and support among women in Africa and elsewhere is still in its infancy. In most countries of Africa, including Ethiopia, the few available research documents are mostly designed to show the health consequences rather than the causes of FGM.

This research may highlight the prevalence of the ritual practice of female genital mutilation among women in reproductive age group residing in Adama town (i.e., 78.6 percent). Since information was needed on social context of FGM in Adama on events associated with the age of women, and on the practice of FGM itself, it was sought to find out how FGM is situated in the social context of young girls, to what extent women are able to recall and how women and men perceive FGM.

In this context, the socio-demographic and economic determinants of genital mutilation in relation to reproductive health concern will have been considered. Having this into consideration, this study can be highly significant in many respects:

- It will introduce the socio-demographic and economic determinants of FGM and suggest valuable information on the causes to help efforts among governmental, non-governmental and community based organizations and religious institutions to eliminate such ritual practices.
- It will contribute to the existing publications on traditional and cultural practices harmful to the girl by giving further insights to researchers and students, specially on issues related to genital mutilation and also open doors for further studies in this area.
- It will provide information on FGM of the community involved in this practice, its socio-cultural foundation and the level of awareness of the population with regard to its harmful effects.

1. 4. Objectives of the Study

1. 4. 1. General Objective

The overall objective of the present study is to understand about the prevalence of the continuing practice of FGM and identify the factors responsible for its prevalence and continuation in the study area of Adama town, Oromiya region of Ethiopia by conducting a special survey on female respondents in the reproductive ages.

1. 4. 2. Specific Objectives

Specifically this study is aimed at:

- Examining the influence of selected socio-demographic and economic factors for the prevalence of FGM in the study area;

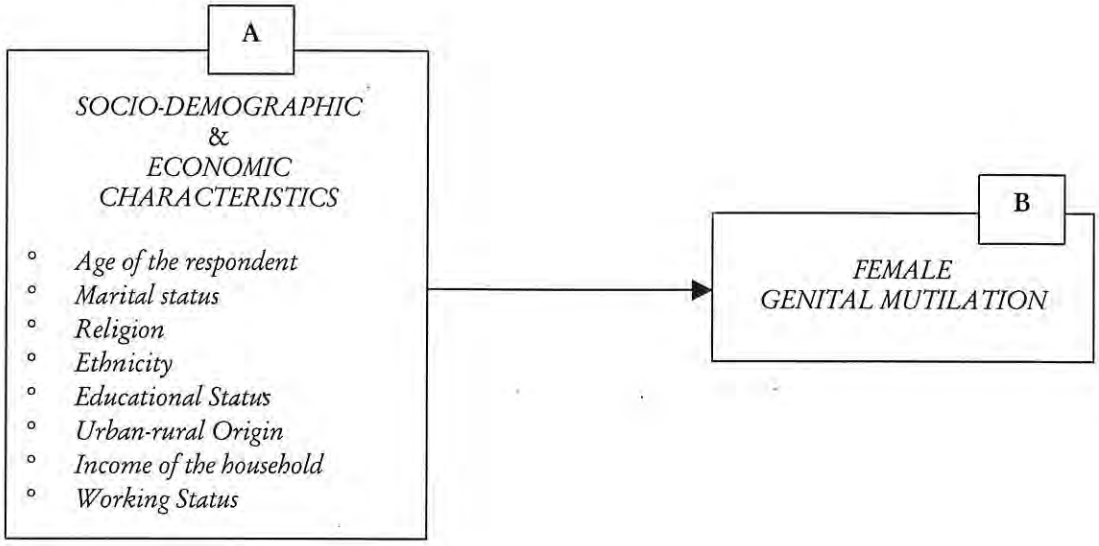
- Examining the selected socio-demographic and economic factors for women's approval or non-approval of the continuation of FGM in the study area;
- Examining men's and women's attitude towards FGM;

1. 5. Conceptual Framework of the Study

As it is stated clearly in the coming literature section and seen in the following figure 1, we find that there are multitudnal factors that determine the ritual practice of FGM. Many of the literatures (Islam and Uddin, 2001; Mbacke, et al., 1998; Jones, et al., 1999; Carr, 1997; Khalif, 1994; Leonard, 1996; Yoder, et al., 2001; Toubia, 1995) assert that social factors such as misinterpreted religious doctrine, ethnicity and education are the most common determinants.

Theoretically, the study is based on the belief that, it is possible to intervene effectively in the practice of FGM to eliminate or substantially reduce the tendency by identifying the major causes. In this simple conceptual framework it is clearly seen that socio-demographic and the economic factors [A] affect the ritual practice and approval of the continuation of genital mutilation [B] (see Fig. 1. 1). A central theoretical assumption here is that FGM is, by and large, socially constructed with the important 'players' or the above stated factors.

Figure 1. 1: Proposed conceptual framework that shows the interrelationship between the factors that affect FGM.



Source: The author

1. 6. Research Hypotheses

The study has the following hypotheses:

- Lower the economic status of the women higher the support for the practice of FGM.
- Higher the education of the women lower the support for the practice of FGM.
- Muslim women are significantly more likely than other religious women to undergo mutilation.
- Ever married women are more likely to undergo FGM than those who are single.

1. 7. Organization of the Study

The thesis is organized with six chapters. The first chapter, which is titled as an introduction, constitutes statement of the problem, background, significant, objectives and hypotheses of the study. Under review of related literature, Chapter Two, studies of genital mutilation, the practice of genital mutilation in Africa and the context of female genital mutilation in Ethiopia are considered in detail. Chapter Three presents the data and methods of the study. Source of

data, research design, method of data collection, processing and analysis are discussed thoroughly. The background characteristics of the study population are presented in Chapter Four. Chapter Five focuses correlates of female genital mutilation, specifically the socio-economic and demographic factors on the prevalence and the approval of female genital mutilation are identified with the help of bivariate and multivariate method of analysis. The final chapter, Chapter Six, deals with the summary, conclusions and recommendations of the present thesis.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2. 1. The Practice of Genital Mutilation in Africa

In this section the practice of genital mutilation in Africa is going to be reviewed so that one can easily compare the Ethiopian situation with the others and observe the existing similarities and differences toward the practice among the countries. Moreover, it has provided support for variation in prevalence and approval with in ethnic groups, religious groups, etc.

Globally, at least 2 million girls a year are at risk of genital mutilation - approximately 6000 per day (Toubia, 1995: 5). FGM was known to be practiced in one form or another in 28 nations of the African continent, in few countries of the Arab Peninsula, among some minorities in Asia, and among migrants from these areas who have settled in Europe, Australia and North America (Kiragu, 1995: 1).

Although FGM has been Practiced on almost every continent in the past and today, the last great hold of the ritual is Africa with cases reported from 32 countries stretching in a broad band from Sub-Saharan West-Africa to Egypt and down through Ethiopia, Kenya, Tanzania and Probably into Mozambique (Abdella, 1982).

The most common type of FGM practiced in Africa today is Type II [Excision], which was reported to be used in more than 20 countries and the most damaging form of mutilation [Infibulation] is mainly practiced in the horn of Africa and the Sudan, but has also been

reported from Kenya, Mali and Nigeria (Abdella, 1982). Excision mainly practiced from East Coast of Africa to the West, from Ethiopia to Senegal and from South Egypt to Tanzania (Hirut, 2000: 8).

Table 2. 1 presents percentage of the prevalence of female genital mutilation in selected countries of Africa where a DHS survey was conducted during 1989 to 2000.

Table 2. 1: National level prevalence of FGM in national surveys of countries, 1989 – 2000

Country	Prevalence of FGM (%)	Year of Survey
Burkina Faso	72	1998/99
Central African Republic	43	1994/95
Cote d'Ivoire	43	1994
Egypt	97	1995
Eritrea	95	1995
Guinea	99	1999
Kenya	38	1998
Mali	94	1995/96
Niger	5	1998
Nigeria	25	1999
Somalia	96 – 100	1982 – 93
Sudan	89	1989/90
Tanzania	18	1996
Togo	12	1996
Yemen	23	1997
Ethiopia	80	2000

Source: Http:// www. measuredhs. int.

Note: Prevalence of FGM (percent) given in the above table may not coincide with those given in the next paragraphs due to different reasons.

In the following paragraphs a brief review of the literatures on the prevalence and type of female genital mutilation by the major regions of Africa, like North East Africa, Central Africa, The Horn of Africa, East Africa, West Africa and South East Africa, has been made.

North East Africa

Egypt

In Egypt most women are excised or mutilated, a practice that can be traced back to the pre-Islamic era. Marie Bassili Assaad, Egyptian social scientist, also has written in detail on the origins, meaning and traditional values associated with the custom and reviewed current research in Egypt. She has undertaken a pilot study to investigate the present extent of the practice, which is still there but is deeply embedded in custom and tradition and shrouded in secrecy (Assaad, 1980: 3 -16).

The prevalence of cutting exceeds 92 percent among women in nearly all regions of Egypt. Women from the sparsely populated Frontier Governorates are least likely to have undergone genital mutilation. Even among these women, however, 75 percent of the women have been mutilated (Carr, 1997: 16).

Central Africa

Central Africa Republic (CAR)

The largest differences in prevalence based on ethnic and regional residence exist in CAR. Prevalence of the practice ranges from 3 percent among the Yakoma-Sango and Mboom to 84 percent among the Banda, one of the country's largest ethnic groups. The prevalence of cutting among CAR's largest ethnic group, the Gabaya, is 32 percent. Nearly one in four

women belong to an ethnic group with a prevalence level under 10 percent. Similarly striking differences in prevalence probably rooted in ethnicity exist by region. Nine out of ten women underwent mutilation in region RS IV, with major borders facing Chad and Sudan. In contrast, fewer than 30 percent experienced these procedures in the western regions RS II [14 percent] as RS [28 percent] bordering Cameroon and Chad respectively (Carr, 1997: 15).

The Horn of Africa

Ethiopia

The history of Ethiopia has combined to create a complex mosaic of diverse ethnic groups. The recent archeological discoveries in Afar and Oromiya regions indicate Ethiopia as a home to one of the most ancient settlement of the human race, dating back to over 3 million years. As of mid 1999 the country had a total population of 61.7 million, about 1 percent of the world's total population and 8 percent of Africa's total. Growing by 2.92 percent or by 1.8 million persons, between mid 1999 and mid 2000, the population of Ethiopia was estimated to be 63.5 million in year 2000 (NOP, 2000).

FGM has been common in the country for several generations at least and perhaps much longer. Both Muslims and Christian populations practice genital mutilation in Ethiopia. Twenty-eight ethnic groups (mostly in SNNPR) do not practice FGM while infibulation is practiced, to a varying degree, in five ethnic groups (Somali 90%, Afar 63%, Berta 10%, Harari 5% and Oromo 1%). According to the baseline survey on harmful traditional practice conducted by NCTPE (1998) the type of genital mutilation which was predominantly practiced in each ethnic group was Sunna (or Clitoridectomy). Over 50 percent of circumcision which was carried out among the Agew/Kamyr, Argoba, Fadashi, Goffa, Harari, Kebena, Oromeo, Silitie and Werji ethinic groups were Sunna and followed by excision (NCTPE, 1998).

As it was sighted from different documents by Dr. Hirut Terefe Gemeda in her Dissertation for Doctoral Grade in Ethnology 'A Study of FGM and Reproductive Health: The Case of Arsi Oromo, Ethiopia', genital mutilation is practiced in Ethiopia in many different forms, depending on the ethnic group. In the highland of Ethiopia, in the areas of Addis Ababa, all baby girls are excised, usually before they are 40 days old. Infibulation is most commonly practiced in the areas adjacent to Somalia and in the Harrar region where as many of the populations in the Ethiopian highlands, the Amhara, the Beta Israel or the Ethiopian Jews [felashas] and some of the Oromo as well as the monotheistic groups and Cushetic population in south, practice excision (Hirut, 2000: 10).

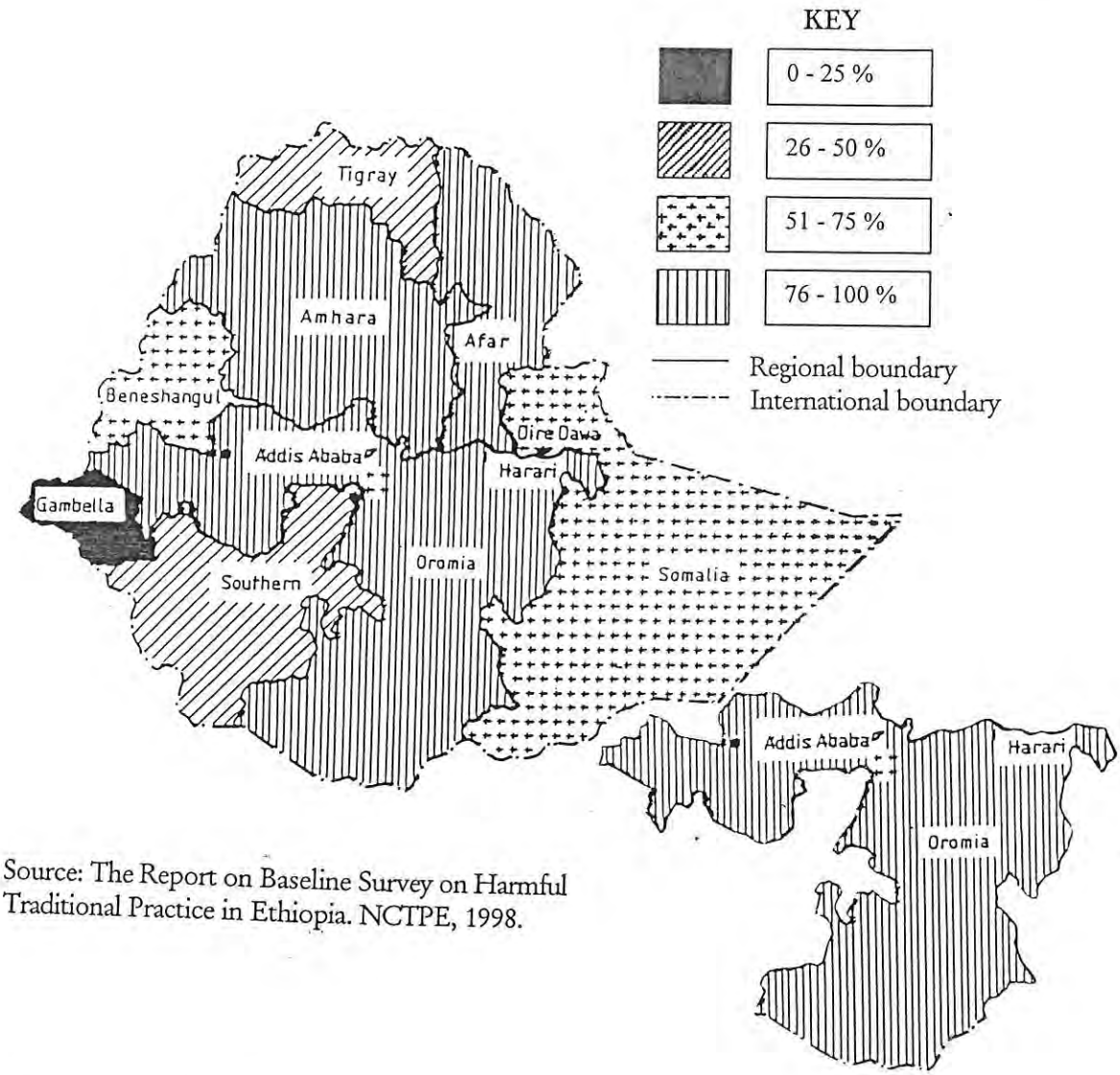
Depending on the region, girls usually undergo genital mutilation at age of seven days, seven years or during their teenage years. When FGM is practiced, girls who have not undergone the practice are ostracized and are considered unmarriageable in their community (Tewabech, 1994).

Muslims, Christian and Ethiopian Jews [felashas] practice FGM, where its prevalence is estimated at 90 percent (Toubia, 1995: 25), while there is no law that specifically refers to FGM, Article 35 of the 1994 constitution provides that 'women have the right to protection by the state from harmful customs and practices that oppress women or cause bodily or mental harm to them are prohibited'.

According to recent DHS result the practice of FGM is spread over the country-80 percent of women have been circumcised. The prevalence of genital mutilation is lower among women living in the Tigrai [36 percent] and Gambela [43 percent] regions, while it almost reaches 100 percent in Somali and Afar Regions. Urban-rural residence, education and work status do not

percent in Somali and Afar Regions. Urban-rural residence, education and work status do not make any notable difference in the practice of FGM. But it has been shown that the practice is slightly lower among younger women (CSA and ORC Macro, 2000). According to the baseline survey on harmful traditional practices which is carried out by NCTPE the estimated prevalence of female genital mutilation in Ethiopia can be seen as follows:

Figure 2. 1: Prevalence of Female Genital Mutilation (FGM) by region in Ethiopia, 1997.



Source: The Report on Baseline Survey on Harmful Traditional Practice in Ethiopia. NCTPE, 1998.

Sudan

In the northern Sudan, Eritrea, eastern Ethiopia, Somalia and Djibouti where the greatest concentrations of infibulated women are to be found and almost all the women have undergone the practice of genital mutilation (Carr, 1997).

Sudan has the largest history of efforts to overcome to the problem resulting from FGM over a period of 50 years; however even today more than 80 percent of Sudanese women continue to be infibulated (SDS and IRD Macro, 1991). Except for two regions, at least 95 percent of women throughout Sudan have undergone genital mutilation. Women in the Darfur region [65 percent] and, to a lesser extent, the eastern region [87 percent], are less likely to have undergone cutting. The lower prevalence levels in Darfur suggest that genital cutting is not a universal practice among some of this region's ethnic groups (Carr, 1997: 16).

Somalia

In Somalia the operation is carried out in hospitals under anesthetics, to eliminate the dangers of the damage and infection posed by the traditional operators. In deed, the official policy in Somalia has been to encourage the less harmful Sunna, which consists mainly of a mere pricking of the clitoris to release a drop of blood (Ismael, 1980). This is to win support for the eradication of the more drastic operation of infibulation. In Somalia, the operation has now been banned in all government hospitals (Dorkenoo and Elworthy, 1996: 32).

Eritrea

In Eritrea, the difference by ethnic group and region are minor. All groups have prevalence levels above 90 percent. Little variation in prevalence exists among women living in different parts of the country. At least nine of ten women throughout Eritrea are likely to have undergone genital cutting (Carr, 1997: 16).

East Africa

Kenya

Excision is widely reported in some east African countries, although infibulation seems only to be practiced in the remote areas where Kenya borders Somalia. In some part of Kenya FGM was accepted voluntarily rather than by coercion (Dorkenoo and Elworthy, 1996: 32; NCPD and CBS, 1999).

There is no low probability of genital mutilation; the prevalence in Kenya is estimated to be 50 percent (Toubia, 1995: 25). In 1990, the Assistant Minister for cultural and Social Services announced that the government had officially banned FGM, although the legislature did not pass any laws prohibiting the practice (Ladin, 1992: 11, 12).

West Africa

Nigeria

Various forms of FGM are practiced in West Africa although infibulation is found only in some areas of Mali and Senegal. There are also some accounts coming from Nigeria, the most populous state in the African continent, Seralione and Burkina Faso (Koso-Thomas, 1987). In Nigeria the practice of mutilating females cut across ethnic, religious, cultural and language barriers. Several hundred thousand excisions take place in Nigeria every year and it is a widely practiced tradition (Dorkenoo and Elworthy, 1996: 32).

Burkina Faso

Although infibulation is not practiced in Burkina, the attempt suppression of excision in all forms has met with strong resistance from a population consisting of 30 percent Muslims, 20 percent Catholic and 50 percent Animists. In 1983, the late president, Captain Thomas Sankara, in response to a visit by a French Human Rights Organization, gave the most radical

statement yet made by an African head of state against FGM. He appealed to Burkina women not to rely on, or expect, concessions from man but to have the determination to struggle for their liberation (Dorkenoo and Elworthy, 1996: 34).

Mali

A genital mutilation is nearly universal among Mali's most populous ethnic groups, including the Bambara, Sarakole and Peulh. The prevalence levels among women are higher than 85 percent in nearly all regions of the country, except for the two small, relatively isolated desert cities of Timbuktu and Gao. The majority of inhabitants in these cities are Sonrai. Women belonging to these ethnic groups are substantially less likely than others to undergo genital mutilation. Sonrai women, however, who reside outside of Timbuktu or Gao have higher prevalence levels. In Bamako, for instance, 75 percent of Sonrai women have undergone genital mutilation (Carr, 1997).

Ghana

The prevalence of FGM in Ghana is estimated to be high. Approximately 2.325 million women have undergone the procedure (Toubia, 1995: 25). The practice is common mostly in Muslim communities in the northern regions of the country and the northern migrant settlement of metropolitan area. Respondents to a study on FGM in Ghana stated that it is considered to be a precondition for marriage and is also regarded as a religious imperative (UNICEF, 1990: 65).

Despite its prevalence, FGM is a second-degree felony punishable by imprisonment. In addition, the constitution prohibits customary practices that harm one's physical and mental well being and would appear to grant women dejure protection from the practice [Ghana Constitution].

Cote D'ivoire

In most part of the country, prevalence ranges from 20 to 40 percent. Prevalence levels are exceptionally high in three regions, the West [79 percent], Northeast [88 percent] and North [85 percent], which neighbor Liberia, Guinea, Mali and Burkina Faso. The ethnic affliction, bordering countries or community norms may be strongly associated with the mutilation in the West, Northwest, and North. The predominant ethnic groups in these regions are the Senoufo, Malinke, Dan, Toura and WE (Carr, 1997: 15).

The Gambia

About 80 percent of women are mutilated in the Gambia. The most common type of mutilation practiced in Gambia is the excision of clitoris and the labia minora. However, migrants from neighboring countries Sierra Leone, Senegal, Guinea Bissau, Guinea Conakry and Mali bring along their practices. The age at which FGM is practiced in the Gambia varies from area to area and ethnic group to ethnic group. It ranges from 1st week of life, 1 to 12 months, 1 year to 10 years and above and some are mutilated after marriage or after the first baby (IPPF, 1999: 10).

Regionally, FGM is highest in Upper River Division [100 percent], lower River Division [89 percent], Western Division [83 percent], Central River Division [80 percent], Northern Bank Division [70 percent], Kanifing Municipal Council [68 percent] and Banjul Municipal Council [10 percent] (IPPF, 1999: 10).

Togo

The study on the prevalence and socioeconomic factors of FGM in Togo, which was produced in 1986 by the Demographic Research Unit of the University of Benin, forwarded reliable information on the magnitude and socio-cultural foundation of genital mutilation.

The study revealed that one out of eight Togolese women had undergone FGM, which represents a prevalence of about 12 percent. In numerical terms, approximately 110,000 women aged 15 years or above have undergone this operation in Togo. However, the prevalence of this traditional practice varies according to different parameters: tribe, geographical location, generation, religion, residence and level of education (IPPF, 1999: 14).

South – East Africa

Tanzania

It is estimated that 10 percent of Tanzanian women undergo FGM (Toubia, 1995: 25). FGM is practiced by communities in several regions of Tanzania and by Somali immigrants. Although there is no law that specifically mentions FGM, in 1990 a National Committee on Traditional Practice was created to work toward building awareness about FGM and improving the Status of women in general. FGM is practiced in a number of regions in Tanzania including Dodoma, Singida, Arusha, Klimanjaro and Mara (Smith, 1992: 134).

Some tribes in Morogoro and Iringa regions practiced partial removal of the labia minora, the most severe type of mutilation [infibulation] practiced by Somali ethnic groups who live in the Arusha region (Dorkenoo, 1994: 113).

2. 2. The Correlates of Female Genital Mutilation

Because of the scarcity of the materials written on the practice of genital mutilation under the Ethiopian context and the similarity of the mutilation procedures and health consequences, in this section a bit emphasis is given on the experience of other African countries who have got success stories in reducing or minimizing the trend.

According to Hamid Rushwan one of the most frequently offered reasons is that female genital mutilation is demanded by the Islamic faith. More than 50 percent of the male respondents in a survey conducted in Sudan in 1983 expressed the belief that female circumcision is a Muslim religion requirement (Rushwan, 1990).

According to Islam and Uddin, more highly educated and economically better women are less likely to be supportive in the two high prevalence areas of Sudan. Social custom is the most commonly cited reason for favoring continuation of the practice in both study sites Shendi and Hji-Yousif. Multivariate logistic regression analysis identified women's education, religion and household possessions score as significant predictors of attitudes towards FGM in both areas. For instance, each year of education decreases the odds that women would favor continuation of genital mutilation. In addition, Muslim women are significantly more likely to support mutilation than are Christian women in Haj-Yousif and Shendi, and support decreased with rising household possessions score in both areas (Islam and Uddin, 2001: 71-75).

In the study, which was conducted in Ghana 'Prevalence and Correlates of FGM in the Kassena-Nankana District of Northern Ghana' it has been analysed that 77 percent of women in this area are affected by this ritual practice. Contrary to other African populations where the practices usually conducted on girls under age 10, Kassena-Nankana women undergo FGM when they reach puberty and are ready to get married. Multivariate analysis reveals lower risks among followers of Monotheist religion [Christianity and Islam] while ethnicity is found to have no major effect. Schooling was found to be the most discriminating factor: not only does it delay FGM, but also prevents it when persuade beyond the primary level (Mbacke, et al, 1998: 13-24).

Studies made in rural Burkina Faso and Rural-Urban Mali have shown that there are positive relationships between most of the determinants, which are considered in this study, and FGM. Exploration of association between negative health outcomes with genital cutting status use logistic regression analysis. Selected socio-economic variables included in the analysis are age, education, marital status, and residence. Additional variables, including ethnicity and mother's and father's educational levels, were tested but not found to be significant (Jones, et al., 1999).

In one of the study conducted in Cote d'Ivoire it has been revealed that region of residence is a major factor in determining genital cutting status for women in the West, Northwest and North of the country. Logistic regression indicates that residence in these areas is strongly associated with genital cutting after controlling for age, education, and religion. Compared with those in the center region women are 25 times more likely in the west [odds ratio = 25.0: $p <$ .01], 15 times more likely in the North-West [odds ratio = 14.7: $p <$ .01], and 18 times more likely in the North [odds ratio = 18.3: $p <$ .01] to have undergone cutting (Carr, 1997: 15).

According to Carr, in Sudan the Muslim women are at least 51 times more likely to under go cutting than Christian women [odds ratio = 51.8; $p < 0.01$]. Similarly in Cote d'Ivoire, Muslim women were at least 17 times more likely to under go cutting [odds ratio = 17.4; $p < 0.01$] than Christian women.

Re-mutilation is increasingly practiced among educated women in the Arab world. It is generally performed after delivery for the purpose of tightening the vagina of mutilated women. After cutting away the tips of the pared scar tissue, the new edges of tissue are sewn together. To learn more about the socio-cultural determinants of this trend, 80 secondary

school teachers in Sudan's Khartoum State were interviewed. All respondents had been mutilated, but 67.5% indicated they were opposed to this custom and 40% did not want their daughters to undergo the procedure. The highest rate of re-mutilation (39.7%) was among teachers with university degrees, which is the lowest educational group in this sample (Khalif, 1994: 16-32).

A household survey, which was conducted in Chad among the Sara ethnic group third largest urban area, yielded valuable data on the cultural context of FGM. Among this ethnic group, genital mutilation has been an intrinsic part of the transition to adulthood since the mid-1800s. Leonardo states that out of the respondent 51.3% women indicated they would have their daughters circumcised, largely to comply with tradition and social pressure, and 10.0% were undecided. The 38.7% mothers opposed to genital mutilation cited the Protestant injunction against this practice and concerns about long-term health effects. The initiation involves rites that teach young women to endure pain and physical deprivation with dignity and to relinquish childlike pursuits (Leonard, 1996: 255-63).

In a survey conducted on FGM in guinea it had been observed that there was not statistically significant difference in the risk of a Christian verses a Muslim daughter having a radical circumcision. However, daughters of women from other religions (primarily animists and those with no religion) were 2.5 times more likely to have had a radical circumcision (excision). The model is controlling for ethnicity so that the majority of this difference is occurring in Kissi, Toma, Guerze, and other ethnic groups. This supports the finding noted earlier that a women's religious beliefs have little influence on her daughter's experience with circumcision (Yoder, et al., 2001).

Secondary education is significantly associated with a daughter's type of circumcision while primary education is in the expected direction but is not statistically significant. Women with secondary education were 55 percent less likely to have a daughter with a radical circumcision than women with no education (Yoder, et al., 2001).

The multivariate analysis suggests that there are significant differences in the type of circumcision a daughter receives based on her mothers socio-economic characteristics. The results indicate that mainstream religion (Christianity and Islam) is not a determinant of a daughter circumcision experience, that ethnicity is the important factor. Exposures to outside ideas (through education, radio, and urban residence) also influence the likely hood of a woman having a daughter with a radical circumcision (Yoder, et al., 2001).

CHAPTER THREE

DATA AND METHODS

3. 1. Source of Data

The main data source of the study was the community based primary survey on female genital mutilation, which had been carried out in Adama town the former Nazareth town. For the purpose of this study, a retrospective survey was conducted on women of the age group 15 to 49 and men of the age group 15 to 59 in Adama town.

According to the 1994 census of Ethiopia (CSA, 1996) Oromiya region's total population was found to be 18,732, 525 of which 9,361,297 were females who are exposed to different harmful traditional practices especially to female genital mutilation. The prevalence of female genital mutilation across the Oromiya region ranges from 76 to 100 percent (NCTPE, 1996).

Adama town is found in the Oromiya regional government and it is one of the largest towns in the region as well as in the country. According to the 1994 Population and Housing Census of Ethiopia, Adama's total population was 127,842 among this 65, 877 were female. There are 20 Kebeles♥ organized under three Woredas* and is now considered as the capital of eastern Shoa zone♣.

♥ The smallest administrative units in Urban Ethiopia.
* The immediate upper bodies of administrative structure next to the Kebele.
♣ Administrative unit next to Woreda

Adama is the crossroad to Addis Ababa, Harari, Somalia, Afar, Amhara, Arsi and Bale. As a result of migration from these areas it is observed that there are diversified cultural and traditional practices among different ethnic groups. Female genital mutilation was considered as a commonly practiced traditional experience.

Adama is considered as a study area due to the greater chance of obtaining a target population with diversified social and economic characteristics such as a relatively high concentration of different ethnic group including the Ethiopian Somali and the researcher's well familiarity with the study area. Its validity has been proved in this research.

3. 2. Research Design

The central concern of this study is to understand why among women aged 15 to 49 years, some women are mutilated and others do not. In the analysis of the level of genital mutilation and the approval of female genital mutilation, all married, single, divorced, widowed and separated women were incorporated. Based on this, listing of households was made to prepare the sampling frame from which eligible women and men are determined.

In order to draw sound generalizations and enhance representativeness, 720 women were selected using systematic random sampling technique and also 72 men [one man in ten women] were selected in an attempt to investigate men's attitude towards the custom. The number of households selected from each Kebele was dependent on probability proportional to size. Once the sample size and sampling technique were determined, the next employed step was arranging appropriate procedure for selecting the respondents.

The sampling Procedure, which was carried out during the data collection, was a two stage random sampling. That is, at the first stage selection of the Kebeles was made and at the second-stage the selection of households was done.

Probability sampling method was preferably applied here so that it can provide each member of the population under study with equal non-zero probability for being to be selected in the sample (Lapin, 1982).

The sampling frame for this study was constructed on the basis of the mapping and frame work of the 1994 Population and Housing Census, that is carried out by Central Statistics Authority projected population size of Adama town by Kebele for the year 2000 (CSA, 1996). The number of housing units, which belongs to the selected sample kebeles, were taken and used as a sampling frame for selection of households.

The Kebeles (Primary Sampling Units (PSU)) were chosen at the first stage of sample selection and the respondent (Elementary Sampling Units (ESU)) within a given household were chosen at the second stage.

To use the Probability Proportional to Size (PPS) selection procedures, the number of individual associated with each Kebele must be known. The statistical report of the 1994 Population and Housing Census on the Oromiya region does not provide the population distribution by age group for each Kebele of Adama town. Therefore in obtaining the number of target group per the PSU, the proportion of women aged 15-49 of Adama town and Adama Woreda was used to determine the estimated size of women aged 15-49 for each Kebele.

3. 3. Sampling Procedure

The sampling Procedure, which was carried out during the data collection, was a two stage random sampling. That is, at the first-stage selection of the Kebeles was made and at the second-stage the selection of households was done.

Stage One:

Since the statistical report of the 1994 population and housing census does not provide the number of women by age group associated with each Kebele. Therefore, the proportion of women aged 15 - 49 of Adama town is used to determine the estimated size of women age 15 - 49 for each Kebele.

i.e., let K_{Tj} = The size of women population of Kebele j in Adama town

P_w = Percentage proportion of women aged 15 - 49 years in Adama town

$$= \frac{\text{Totalsize of womenaged 15 - 49 yearsof Adamatown}}{\text{Totalsize of womenage 15 - 49 yearsof the Adamaworeda}} * 100$$

K_{wj} = The estimated size of women aged 15-49 years in Kebele j of the Adama town

$= K_{Tj} * P_w$

Following the above procedure the estimated size of women population aged 15 - 49 years in the sampled Kebele of Adama town, K_{wj} obtained to be:

Table 3. 1. The estimated size of women population aged 15 - 49 years in selected Kebeles, Adama, 2002.

Kebele, j	2	10	11	13	14	20
K_{wj}	1483	4890	5583	1702	1777	1590

Once K_{wj} was determined, selection of the sample kebeles was carried out using simple random sampling technique. Taking in to consideration the issue of Cost (in terms of money, time and effort) only six Kebeles, K-02, K-10, K-11, K-13, K-14, K-20 were chosen.

Stage two:

The number of women respondent aged 15 - 49 years were assigned to each selected Kebeles proportionally following the next procidure.

P_{wj} = Percentage proportion of women aged 15 - 49 years in Kebele j

$$= \frac{K_{wj}}{\text{Total estimated size of women aged 15 - 49 in all sample Kebeles.}} * 100$$

Then, the sample size of women aged 15 - 49 years (N = 720) was distributed proportionally to each selected kebele.

i. e., P_{wj} * 720 was the proportional sample size of Kebele j.

Table 3. 2. Sample size distribution per selected Kebele, Adama, 2002.

Selected Kebele	K-02	K-10	K-11	K-13	K-14	K-20
Sample size distribution	63	207	236	72	75	67

The steps considered in the selection of respondents from each Kebele were carried out through a systematic random sampling with PPS.

Step 1. The sampling frame was contracted. It contains the total number of sampled population (N = 720), Number of targeted population per each sample Kebeles and number of housing units and with the corresponding housing number in each sample.

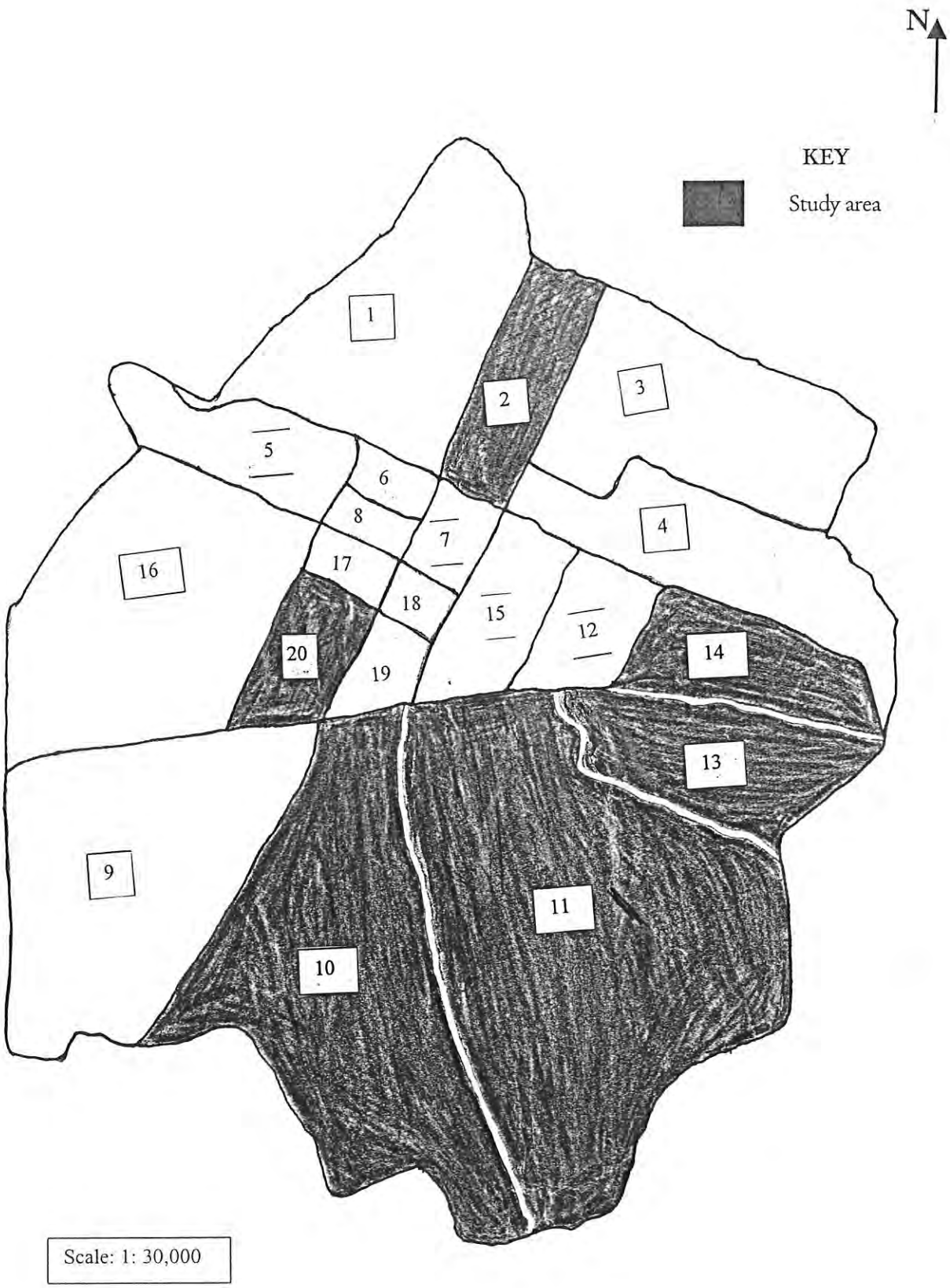
Step 2. The sampling interval (SI) was determined by dividing the total sample size (N = 720) by the sample size distribution of each Kebele.

Step 3. Selection of starting point between 1 and SI using simple random sampling method was made.

Step 4. The selected starting point was taken as the first housing number/ unit to be approached.

Step 5. Every SI^{th} house was chosen after the randomly selected house.

Figure 3. 1: Map of Adama town and the sampled Kebeles



3. 4. Data Collection

3. 4. 1. Development of the Instrument

The instrument used for the collection of the required data within the study was a questionnaire. So as to minimize potential complexities and data defects, many of the items were pre coded with a great deal of caution. The questionnaire was initially prepared in English and given to at least three professionals and principal advisor for comments. Necessary corrections were made and the final English version was prepared which is annexed to this report (See Appendices I and II). Since major circulating language was Amharic, the questionnaire had been translated into Amharic so as to avoid certain inconsistencies and communication barriers.

Two questionnaires, female and male questionnaires were administered in the survey. The questionnaires which were the major instruments to be used for generating the required information, consists 50 items in female's and 47 items in male's Questionnaires and categorised in the following manner:

- Socio-demographic information
- Economic information
- Opinion on FGM

3. 4. 2. Recruitment and Training of Data Collectors, Supervisors and Editor

The fact that interviewers and supervisors occupy the central position in this study, special attention was given to the recruitment and training. To collect the relevant information 18 data collectors [15 female and 3 male], 2 field supervisors and 1 editor were recruited from the study area. In addition to this, during the data collection, informants from each Kebele were assigned and involved in identifying the selected houses. Since the target populations were

women for whom some sensitive questions involving personal and sex related matters was to be posed, the choice of female enumerators was believed to generate more reliable information and the 3 male data collectors involved only to interview male respondents.

All the supervisors and the data collectors were having a two days training program covering both theoretical and practical session. The theoretical training session mainly focused on interviewing techniques and interviewing regulations and the practical training session, on the other hand, targeted on the field observation, pre testing the questionnaire in the field for its validity, sharing of experience among field investigators.

The quality of fieldwork [data collection] is one of the most important aspects of this research exercise. It is therefore, made certain that the supervisors will ensure that all the fieldwork controls are adhered to and all fieldwork is thoroughly checked and edited.

3. 4. 3. Pilot Survey

Once the training session was over, the Amharic version of the questionnaire was pre-tested on 30 women and 3 men of Kebele 15. The selection of the sample, which is carried out for the pre-test, was purposive. After the pre-test the team had a word on each and every individual member field experience and decided to make some rephrasing on some of the questions. During the pilot survey based on the time that takes to fill the whole questionnaire, the data collection schedule was set.

3. 4. 4. Field Work

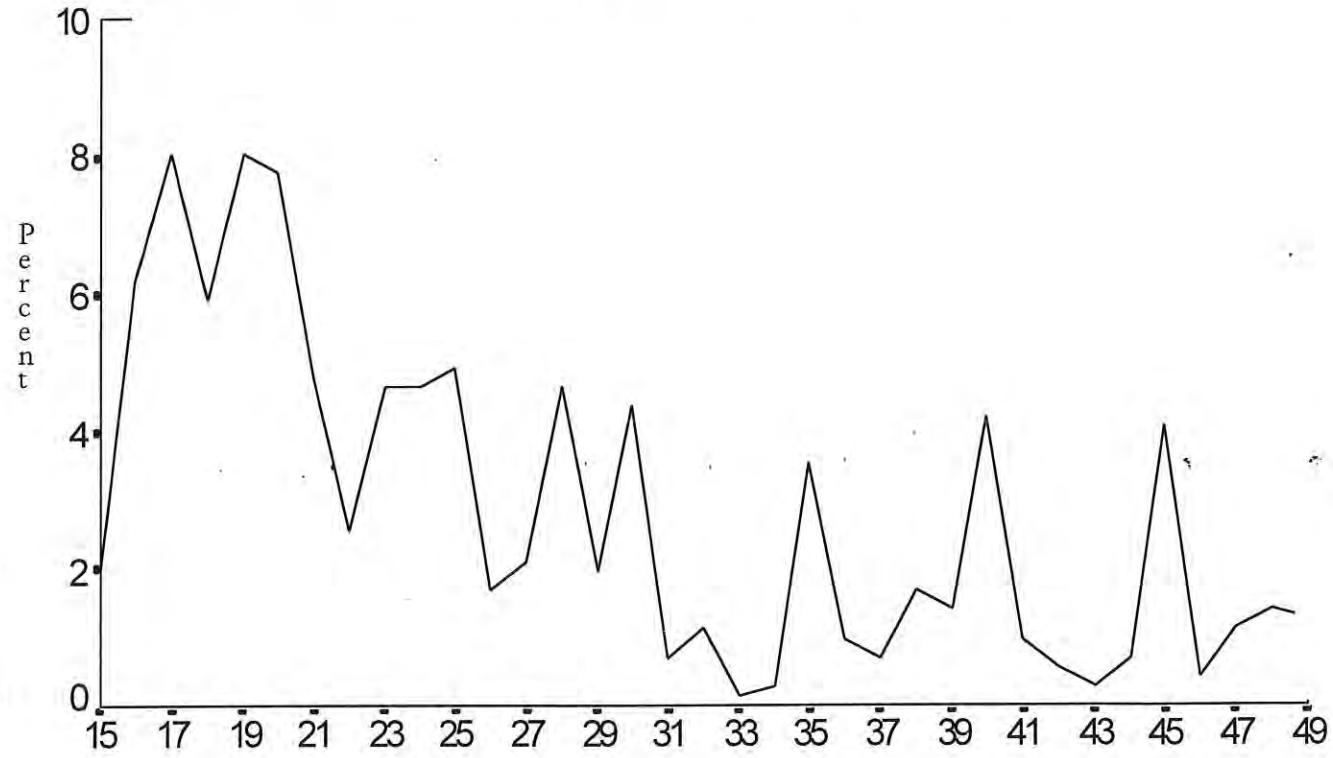
The fieldwork was began on the 18th of March and carried out for 12 consecutive days. In interviewing the women, the data collectors were told to go to the selected house (ESU) according the sampling frame and observe eligible respondents before selecting any for an

interview. The data collectors were also instructed that they need to familiarize themselves with the respondents so as to minimize hesitancy and discomfort. By and large, collecting information from 709 female respondents and 71 male respondents was successfully completed in the fieldwork. Unfortunately 11 female respondents and one male respondent were refused to seat for an interview and they were not replaced.

3. 4. 5. Data Quality

To assess the extent of miss-reported age an attempt was made using the method of assessing quality of data by graphic analysis. Following this method, the single age distribution of the respondents was graphically shown as follows.

Figure 3. 2: Graphical presentation of single year age distribution of women aged 15 - 49.



Source: Field survey, Adama, 2002.

The mean age of the sample observation is 26.384 years with standard error 0.335. The most frequent ages considered in the sample are 17 and 19 years and the median age is 24 years. The measure of dispersions variance and standard deviation are also obtained as 9.452 and 89.338 respectively. These measures are the most useful measures of dispersion, which take into consideration each value of the data and also as to how all the observations are distributed.

Since errors in the reporting of age needs to refine it has been given detailed examination. Errors in the tabulated data may arise either from failure to record age or miss reporting of age (Shryock and Siegel, 1971).

Even though a number of general indexes of digit preference have been proposed, in evaluating quality of data regarding age digit preferences Myers' blended index is applied. This index, similar to the others, will identify if there is age heaping within the collected data. The method yields an index of preference for each terminal digit, representing the deviation, from 10.0 percent of the proportion of the total population reporting on the given digit. A summary index, which is an estimate of the minimum proportion of persons in the population for whom an age with an incorrect final digit is reported, is derived as one half the sum of the deviation from 10.0 percent each taken with out regard to sign. If age heaping is non existent, the index would approximate zero (Shryock and Siegel, 1971). In general very small deviation from 10.0 percent will imply that the heaping of age is not existent and should be disregarded.

According to Shryock and Siegel, 1971, the abbreviated procedure to calculation calls for the following steps:

Step one: Sum of the populations ending in each digit over the whole range, starting with lower limit of the range (Example, 10, 20, 30, - - -, 80; 11, 21, 31, - - -, 81).

Step two: Ascertain the sum excluding the first population combined in step one (Example, 20, 30, 40, - - -,80; 21, 31, 41, - - -,81).

Step three: Weight the sum in step one and two and add results to be obtained a blended population (Example, weights 1 and 9 for the ten digit; weights 2 and 8 for the one digit).

Step four: Convert the distribution in step three in to percent.

Step five: Take the deviation of each percent in step four from 10.0, the expected value for each percent.

The results in step five indicate the extent of concentration or avoidance of a particular digit. The weights in step three represent the number of times the combination of ages in step one or two is included when the starting age is varied from 10 to 19.

Table 3. 3. Calculated preference indexes for terminal digits by Myers' Blended Method, for the study population, Adama, 2002.

erminal digit	*Population with terminal digit a*		*Weights for*		*Blended population*		*Deviations of percent from 10.0*
	Starting at age 10 +a	*Starting at age 20 +a*	*Column 1*	*Column 2*	*Number* (1)*(3)+(2)*(4)	*Percent distribution*	(6)-10.0
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
0	116	116	1	9	1160	17.62	7.62
1	46	46	2	8	460	6.99	3.01
2	30	30	3	7	300	4.56	5.44
3	36	36	4	6	360	5.47	4.53
4	40	36	5	5	380	5.77	4.23
5	103	59	6	4	854	12.98	2.98
6	66	9	7	3	489	7.43	2.57
7	85	43	8	2	766	11.64	1.64
8	97	40	9	1	913	13.87	3.87
9	90	35	10	0	900	13.67	3.67
Total					6582	100.00	39.56
Summary Index					-	-	19.78

Source: Field survey, Adama, 2002.

In this particular study, the summary index is obtained to be 19.78. By this index, age with incorrect final digit was reported by one fifth of the study population. However, since age is used in-groups the observed digit preference would not constitute a serious limitation in the analysis.

3. 5. Data Processing and Analysis

3. 5. 1. Data Entry and Cleaning

The questionnaires were made ready for data entry after data collection and data were entered into the computer using the SPSS software. The data entry totally took five consecutive days. Data cleaning and editing was done case by case and variable wise. The author did the cleaning and editing part for three consecutive days.

3. 5. 2. Data Analysis

For the purpose of this study, where the objective is to explore the relationship of a binary discrete variable to one or more independent variable, the application of appropriate statistical technique will be needed. To analyze the data bi-variate and multi-variate analytical methods were used. The data were analyzed using SPSS statistical package (Norusis, 1990).

A bi-variate test (Chi-square) was used to examine the association of each independent variable with the dependent variables. Only those having significant association (Pearson Chi-square P Value of $<= 0.05$) with the dependent variable were selected for multivariate analysis. Multivariate analysis (logistic regression) was used to examine the relative effect of each independent variable (predictor) on the dependent variables. About seven socio-economic and demographic variables were examined through the logistic regression (see Chapter Five).

The logistic regression model is selected to analyze the data only for it requires far fewer assumptions than alternative methods of analysis of cross - tabulated data; and even when the assumptions required for such analyses are satisfied, logistic regression still perform well (Norusis, 1990). Thus, the logistic regression model was applied to predict the binary dependent variable (Hosmer and Lemshow, 1989: 1). Therefore, two logistic models were fitted one for the prevalence of FGM and other for woman's approval of FGM.

The logistic regression model predicts the natural logarithm of the odds of the dependent variable by a linear function of the independent variable. The logistic regression model is given by: $p=\frac{e^{(\beta_0+\beta_1 x_{i1}+\beta_2 x_{i2}+---+\beta_k x_{ik})}}{1+e^{(\beta_0+\beta_1 x_{i1}+\beta_2 x_{i2}+---+\beta_k x_{ik})}}$

Where, p is the conditional probability that a respondent is exposed to FGM or it is the conditional probability that a respondent approval of the continuation of FGM.

The *odds Ratio* is given by $\frac{p}{1-p}$.

Where, $1-p$ is the conditional probability that a respondent is not exposed to FGM or it is the conditional probability that a respondent disapproval of the continuation of FGM. The natural logarithm of the odds ratio gives the logit transformation of the logistic regression and can be written as: $f(x)=\text{logit}\,(p_i)=\ln\left(\frac{p_i}{1-p_i}\right)=\beta_0+\beta_1 x_{i1}+\beta_2 x_{i2}+---+\beta_k x_{ik}$

Where, p_i = Chance of a woman to be exposed to genital mutilation or chance of a woman to approve the continuation.

$1-p_i$ = Chance of a woman not to be exposed to genital mutilation or chance of a woman to disapproval of the continuation.

$\frac{p_i}{1-p_i}$ = The risk or odds of genital mutilation or the risk or odds of approval of the continuation of the i[th] woman.

x_{ik} = This represents a continuous predictor variable $i = 1, ---, n$ and $k = 1, ---, m$; where n is the number observations and m is the number of predictor variables]

β_i = They are parameters, which were estimated by the maximum likelihood method that maximizes the probability of obtaining the observed set of data.

In terms of the odds, the logistic model, which will be fitted in this study, can be written:

$\frac{p_i}{1-p_i} = e^{\beta_0+\beta_1 x_{i1}+\beta_2 x_{i2}+---+\beta_k x_{ik}}$, which means that, [exp(β_i)] is the factor by which the odds to be mutilated or the odds to approve the continuation when the i^{th} independent variable changed by a unit increase.

Three conditions will be observed depending on the value β_i

A positive value of β_i means the value of the factor by which the odds change [exp (β_i)] is greater than one, implying an increase in the odds.

A negative value of β_i means the value of the factor by which the odds change [exp (β_i)] is less than one, indicating a decrease in the odds.

A zero value of β_i means the value of the factor by which the odds change [exp (β_i)] is equal to one, which means the odds remains unchanged.

3. 5. 3. Variables and Their Specification

The unit of analysis was a woman in the age group 15 - 49. Table 3. 4 provides the description of all variables where the outcome variables called the dependent variables were 'the probability of experiencing' and 'the probability of approving the practice of genital mutilation' which are both dichotomous [with two outcomes] variables and represented by "y_1 and y_2". The value label of the variable is going to be '1' if the respondent is mutilated or approves the continuation of the practice and '0' otherwise. The independent variables [often called covariates] incorporated in the study were classified as socio-demographic and economic factors such as Education, Ethnicity, Religion, Working Status, Age, and Marital Status of the respondent.

3. 6. Limitation of the Study

Even though one of the primary focuses of the study was to investigate the attitude of men and women towards genital mutilation, it suffers from problems and certain shortcomings that include: the author failed to conduct focus group discussions that make involve traditional circumcisers and community elders. The main reason was time and financial scarcity.

Table 3. 4: Description of variables used in the analysis

Variable name	Variable label	Description
FGM	FGM Status	1 if Mutilated, 0 if not Mutilated
	FGM Approval	1 if approved FGM , 0 otherwise
Age of the Respondent	15 - 29 years	1 if 15 - 29, 0 otherwise
Marital status	Ever Married	1 if ever married, 0 otherwise
Ethnicity of the Respondent	Oromo	1 if Oromo, 0 otherwise
	Amhara	1 if Amhara, 0 otherwise
	Somali	1 if Somali, 0 otherwise
	Gurage	1 if Gurage, 0 otherwise
	Other	1 if from other group, 0 otherwise
Religion of the Respondent	Christian	1 if Christian, 0 otherwise
	Muslim	1 if Muslim, 0 otherwise
	Other	1 if from other group, 0 otherwise
Educational Status of the Respondent	No Schooling	1 if never been to school, 0 otherwise
	Primary and Junior	1 if stopped at P or J, 0 otherwise
	Secondary and Above	1 if stooped at secondary or went beyond, 0 otherwise
Place of birth of the respondent	City	1 if City, 0 otherwise
	Town	1 if town, 0 otherwise
	Country side	1 if country side, 0 otherwise
Work Status of the resp't	Currently working	1 if Currently working, 0 otherwise
Respondent's duration of stay in Adama	10 years and above	1 if 10 years and above, 0 otherwise
	5 - 9 years	1 if 5 - 9 years, 0 otherwise
	0 -4 years	1 if 0 - 4 years, 0 otherwise
Birth history of the respondents	Ever give birth	1 if ever give birth, 0 otherwise
Income of the Respondent	0 - 120 Birr	1 if 0 - 120 Birr, 0 otherwise
	121 - 600 Birr	1 if 121 - 600 Birr, 0 otherwise
	600+ Birr	1 if 600+ Birr, 0 otherwise

CHAPTER FOUR

CHARACTERISTICS OF THE STUDY POPULATION

4. 1. The Prevalence of FGM

Table 4. 1 presents the prevalence of genital mutilation among women of reproductive age group by selected background characteristics. Table 4. 1 reveals that the practice is almost universal in Adama; out of ten women eight of them or 78.6 percent of all women within the age group 15 - 49 have been gone through genital mutilation.

In spite of the fears that genital mutilation brought on the health and rights of women, change is under way in Adama town. Comparing the prevalence of female genital mutilation among the younger and older women who belong to the age group 15 to 29 years and 30 to 49 years respectively it is observed that the percentage mutilated in the age group 15 - 29 years is lesser than those in the age group 30 - 49 years (Table 4. 1).

The percentage of mutilation decreases with the length of duration of stay in Adama town and the place of birth also plays a major role in an increment of genital mutilation. Those who were born in countryside are highly exposed to genital mutilation as compared with those who were born in town and city.

Educated and currently working women are slightly less likely than uneducated and not working women to have been mutilated. Income and the prevalence of genital mutilation are also related positively. However, it is realized that the observed differentials in the educational

level, working status of women and income indicators of the mutilated women can not be ascribed to their mutilated status as most of them were mutilated at infancy.

The pattern of variation with Ethnicity are evident in the observed ethnic group; Oromo, Amhara, Gurage, Somali and 'others' that includes Argoba, kambata, Hadiya, Silitiye, Worji and Sidama. The percentage of genital mutilation among Oromo, Amhara, Gurage, Somali and others has been noticed to be 81.3, 75.5, 88.4, 94.3 and 48.1 respectively.

The marital status and the experience of giving birth also show high percentage on the prevalence of circumcision. Overall, the prevalence of FGM is lower among women who belong to the Christian religion than who belong to Islamic religion. The percentage of Christian women of being mutilated is lower by approximately 21 percent than Muslim Women. Other religions include "Waqefeta♠" and Bahi• and their percentage are comparatively lower than that of other two religions.

♠ Believing in one God.
• Followers of Behahula

Table 4. 1: Number of women aged 15 - 49 years who have been mutilated, and their percentage according to selected background characteristics, Adama, 2002.

Characteristics	*Number of women*	*Percentage of women*	*Number of mutilated women*	*Percentage of women mutilated*
Adama				
Total	709	100.0	557	78.6
Age				
15 - 29 years	494	69.7	356	72.1
30 - 49 years	215	30.3	201	93.5
Duration of stay in Adama				
10 years and above	400	56.4	286	71.5
5 to 9 years	92	13.0	73	79.3
0 to 4 years	217	30.6	198	91.2
Place of birth				
City	321	45.3	208	64.8
Town	203	28.6	171	84.2
Countryside	185	26.1	178	96.2
Educational level				
No education	118	16.6	104	88.1
Elementary and junior school	315	44.4	225	81.0
Secondary school and Above	276	38.9	198	71.7
Working status				
Currently working	553	78.0	415	75.0
Not working	156	22.0	142	91.0
Ethnicity				
Oromo	235	33.1	191	81.3
Amhara	343	48.4	259	75.5
Gurage	69	9.7	61	88.4
Somali	35	4.9	33	94.3
Others	27	3.8	13	48.1
Birth history				
Ever give birth	379	53.5	323	85.2
Never give birth	330	46.5	234	70.9
Income				
Birr 0 to 120	166	23.4	143	86.1
Birr 121 to 600	182	25.7	144	79.1
Birr 601 and above	361	50.9	270	74.8
Marital status				
Ever married	397	56.0	370	93.2
Never Married	312	44.0	187	59.9
Religion				
Christian	501	70.7	368	73.5
Muslim	190	26.8	179	94.2
Others	18	2.5	10	55.6

Source: Field survey, Adama, 2002.

4. 2. Age at Mutilation

All mutilated women in the survey were asked if they remembered about their age at the time of mutilation. It was found that 57.1 percent of all mutilated women (318 women among 557 women) have gone through genital mutilation during infancy. From this we can learn that the majority of women were mutilated before the age of one, that shows the customary tendency is towards early circumcision. While 11.8 percent (66 women out of 557) were mutilated during child hood (2-5 years), 31.1 percent (173 women among all mutilated women) have experienced the practice when they were above child hood (6 years and above) (Table 4-2).

Table 4. 2: Number of women aged 15-49 years who have been mutilated and their percentage according to age at mutilation, Adama, 2002.

Age at mutilation	*No of Women*	*Percentage*
During infancy (0-1 years)	318	57.1
During childhood (2-5 years)	66	11.8
Above childhood (6 year and above)	173	31.1
Total	557	100.0

Source: Field survey, Adama, 2002.

4. 3. Women's Attitude toward FGM

In response to the question "Do you think female genital mutilation should continue?" at about two of respondents in ten women or 14.7 percent of the respondents in all the selected Kebeles approved the continuation of the practice (Table 4. 3). It has been a striking contrast between high prevalence of Female genital mutilation (78.6 percent) and low approval of the continuation of the practice (14.7 percent). Similarly, in Burkina Faso, while 72% of women aged 15 to 49 have undergone FGM, only 18 percent approve of the practice (PRB, 2001).

Table 4. 3 provides the percentage distribution of women favoring female genital mutilation by their background characteristics. It has been observed that the percentage of women who approve FGM within the age group 15-29 is slightly less likely than those within the age group 30-49. Similarly, staying in a big town has a positive impact in changing the attitude of a person as it has been seen that the approval of FGM significantly varies due to the duration of stay in Adama town. The percentages of women who stayed in Adama town 10 years & above, 5 to 9 years and 0 to 4 years and favored FGM are 4.3, 19.6 and 31.8 respectively.

Table 4. 3 also shows that the place of birth has a significant relationship with the approval of FGM. Educational level, working status and income of the women are negatively related with the approval of the continuation of the practice. As the level of education increases from no schooling to secondary and above the approval of female genital mutilation decreases. Similarly, currently working women and women whose income is greater than Birr 600 are also less likely to favor genital mutilation than their counter part.

The Somali women favor genital mutilation more likely than the women who belong to other than Somali group and no significant difference is observed between women among Amhara, Oromo & Gurage ethnic group in favor of FGM. Again there seem to be no much significant difference between those who gave birth and those who do not on the approval of FGM. The approval of FGM is to be seen comparatively very high among ever-married women than the never married women. Religion seems to have positive relationship with the attitude of a person to give approval for FGM. With this regard it has been observed that religion does not show any significant difference on the approval of the continuation of FGM.

Table 4. 3: Number of women aged 15 - 49 years who favored female genital mutilation and their percentage according to selected background characteristics, Adama, 2002.

Characteristics	*Number of women*	*Percentage of women*	*Number of women favored FGM*	*Percentage of women favored FGM*
Adama				
Total	709	100.0	104	14.7
Age				
15 - 29 years	494	69.7	61	12.3
30 - 49 years	215	30.3	43	20.0
Duration of stay in Adama				
10 years and above	400	56.4	17	4.3
5 to 9 years	92	13.0	18	19.6
0 to 4 years	217	30.6	69	31.8
Place of birth				
City	321	45.3	20	6.2
Town	203	28.6	22	10.8
Countryside	185	26.1	62	33.5
Educational level				
No education	118	16.6	40	33.9
Elementary and junior school	315	44.4	50	15.9
Secondary school and Above	276	38.9	14	5.1
Working status				
Currently working	553	78.0	58	10.5
Not working	156	22.0	46	29.5
Ethnicity				
Oromo	235	33.1	34	14.5
Amhara	343	48.4	46	13.4
Gurage	69	9.7	10	14.5
Somali	35	4.9	8	22.9
Others	27	3.8	6	22.2
Birth history				
Ever give birth	379	53.5	62	16.4
Never give birth	330	46.5	42	12.7
Income				
Birr 0 to 120	166	23.4	59	35.5
Birr 121 to 600	182	25.7	33	18.1
Birr 601 and above	361	50.9	12	3.3
Marital status				
Ever married	397	56.0	86	21.7
Never Married	312	44.0	18	5.8
Religion				
Christian	501	70.7	65	13.0
Muslim	190	26.8	36	18.9
Others	18	2.5	3	16.7

Source: Field survey, Adama, 2002.

4. 4. Women's Reasons for Attitude

Table 4. 4 present the reasons given by women toward their attitude for the approval and disapproval of FGM. The majority (42.3 percent) of women who support female genital mutilation state that they want the continuation of the practice because it is a good tradition. The second most common reason given is religious demand. In addition, some of the women say genital mutilation is good for cleanliness, preservation of virginity and others such as to stop the growth of clitoris (Aesthetic reason), for the good of women, avoidance of sexiness, to control women's emotion (Tranquilizer), to avoid shame (Obstralization).

Table 4. 4: Percentage of women who favor continuation of female circumcision, by reasons given for attitude, Adama, 2002.

Reason for attitude	*Number of women*	*Percentage*
Favor	*(N = 104)*	
Good tradition	44	42.3
Custom and tradition	14	13.5
Religious demand	16	15.4
Hygiene	8	7.7
Preservation of virginity	3	2.9
To please husband	2	1.9
To maintain good health	1	1.0
Others	16	15.4

Source: Field survey, Adama, 2002.

Table 4. 5 also reveals that among women who oppose the continuation of FGM 44.0 percent had given 'medical complication' as their part of reasons and the second most common reason given by these women was 'bad tradition' (28 percent). In addition, 10.2 percent of women who oppose genital mutilation said that it is better to abandon this harmful traditional practice because it is painful personal experience and 13 percent of women who support the continuation gave other reasons such as false status, limits education, etc.

Table 4. 5: Percentage of women who oppose continuation of female circumcision, by reasons given for attitude, Adama, 2002.

Reason for attitude	*Number of women*	*Percentage*
Oppose	*(N = 605)*	
Bad tradition	171	28.3
Against religion	13	2.1
Medical complication	266	44.0
Painful personal experience	62	10.2
Against dignity of women	3	0.5
Prevents sexual satisfaction	11	1.8
Others	79	13.1

Source: Field survey, Adama, 2002.

4. 5. Men's Attitude toward FGM

The total number of men interviewed in the survey were 71 and selected randomly following the procedure with 10 women, 1 man. They were incorporated in to the study just to know what was their attitude toward the practice of genital mutilation.

Table 4. 6 present the attitude of men respondents toward the approval of the practice genital mutilation. According to table 4. 6, about 3 men among 10 involved in the survey have had the attitude of supporting female genital mutilation, which is a bit larger than that of the women.

As we go from younger age group (15 - 29 years) to the older age group (30 - 59 years) it has been observed that the approval of genital mutilation has shown a significant increment from 20.5 percent to 33.5 percent. Similarly, duration of stay in a town or a city will have a positive impact in the transformation of once attitude. It has been evidently seen that a person who stayed in Adama town for ten and above years is significantly more likely oppose the continuation of female genital mutilation than a person who was migrated from neighboring countryside and stayed in Adama town only for zero to four years. The birthplace of the respondent has also shown a positive impact on the approval. The percentage distribution of

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Oppose	*(N = 605)*	
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Medical complication	266	44.0
Painful personal experience	62	10.2
Against dignity of women	3	0.5
Prevents sexual satisfaction	11	1.8
Others	79	13.1

Source: Field survey, Adama, 2002.

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those who are originated from the city, town, and country side and favored genital mutilation were 9.4, 22.2 and 52.4 respectively.

Educational level, working status and income of the respondent have also shown negative relationship with the approval of FGM. The percentage of men favored genital mutilation reduced from persons who had completed secondary school, currently working and better income to persons who had no education, not working and less income respectively.

It has also been observed that the persons who belong to the Amhara ethnic group have shown a slight increment toward the support than the other groups. Marital status of the respondents can also be appeared to be significant in determining the approval of genital mutilation. With respect to religious affiliation, Christian men were appeared to be supportive than the Muslim men.

Table 4. 6: Number of men aged 15 - 59 years who favored female genital mutilation and their percentage according to selected background characteristics, Adama, 2002.

Characteristics	*Number of men*	*Percentage of Men*	*Number of men favored FGM*	*Percentage of men favored FGM*
Adama				
Total	71	100.0	18	25.4
Age				
15 - 29 years	44	62.0	9	20.5
30 - 59 years	27	38.0	9	33.5
Duration of stay in Adama				
10 years and above	34	47.9	2	5.9
5 to 9 years	10	14.1	2	20.0
0 to 4 years	27	38.0	14	51.9
Place of birth				
City	32	45.1	3	9.4
Town	18	25.4	4	22.2
Countryside	21	29.6	11	52.4
Educational level				
No education	17	23.9	8	47.1
Elementary and junior school	27	38.0	5	18.5
Secondary school and Above	27	38.0	5	18.5
Working status				
Currently working	53	74.6	7	13.2
Not working	18	25.4	11	61.1
Ethnicity				
Oromo	19	26.8	6	31.6
Amhara	29	40.8	7	24.1
Gurage	14	19.7	3	21.4
Somali	7	9.9	2	28.6
Others	2	2.8	0	0.0
Income				
Birr 0 to 120	19	26.8	7	36.8
Birr 121 to 600	20	28.2	7	35.0
Birr 601 and above	32	45.1	4	12.5
Marital status				
Ever married	45	63.4	12	26.7
Never Married	26	36.6	6	23.1
Religion				
Christian	45	63.4	12	26.7
Muslim	24	33.8	5	20.8
Others	2	2.8	1	50.0

Source: Field survey, Adama, 2002.

4. 6. Men's Reason for Attitude

Table 4. 7 present the reasons given by men toward their attitude for the approval and disapproval of FGM. 44.4 percent of men among all who favor the continuation gave ""good tradition", 22.2 percent said that it is "religious demand". There are also other reasons given for the continuation of the practice, it includes custom and tradition (5.6 percent), hygiene (11.1 percent), preservation of virginity (5.6 percent).

Table 4. 7: Percentage of men who favor continuation of genital mutilation, by reasons given for attitude, Adama, 2002.

Reason for attitude	*Number of men*	*Percentage*
Favor	*(N = 18)*	
Good tradition	8	44.4
Custom and tradition	1	5.6
Religious demand	4	22.2
Hygiene	2	11.1
Preservation of virginity	1	5.6
Others	2	11.1

Source: Field survey, Adama, 2002.

Most of the respondents considered in the survey were stand against the continuation of genital mutilation. Among the reasons given by these people, bad tradition and medical complications was seen frequently. Overall, against religious demand, painful personal experience, against dignity of women and prevents sexual satisfaction were also mentioned as reasons to overcome the approval of genital mutilation (see Table 4. 8).

Table 4. 8: Percentage of men who oppose continuation of genital mutilation, by reasons given for attitude, Adama, 2002.

Reason for attitude	*Number of men*	*Percentage*
Oppose	*(N = 53)*	
Bad tradition	22	41.5
Against religion	3	5.7
Medical complication	22	41.5
Painful personal experience	1	1.9
Against dignity of women	1	1.9
Prevents sexual satisfaction	1	1.9
Others	3	5.7

Source: Field survey, Adama, 2002.

CHAPTER FIVE

CORRELATES OF FEMALE GENITAL MUTILATION

Different literatures revealed that social, demographic and economic characteristics of a woman are important predictors of the prevalence of female genital mutilation as well as the approval given by the woman to its continuation (Islam and Uddin, 2001; Mbacke, et al., 1998; Jones, et al., 1999; Carr, 1997; Khalif, 1994; Leonard, 1996; Yoder, et al., 2001; Toubia, 1995; CSA and ORC Macro, 2001; NCTPE, 1998; Hirut, 2000; Tewabech, 1994).

In this particular study it has been tried to see how some selected socio-demographic and economic characteristics of the woman can affect the prevalence of female genital mutilation in Adama town of Oromiya regional government and the approval given by the woman in support of its continuation. This has been shown through bivariate and multivariate relationships between the correlates described in table 3. 4 and the two possible outcomes; the status of FGM and the approval of its continuation.

5. 1. Bivariate Analysis

As it has been seen in the descriptive analysis conducted in chapter four it was identified that 78.6 percent of women are exposed to genital mutilation and only 14.7 percent of women are approving the practice from the total women who are involved in the study.

In this section it has been tried to carry out bivariate analysis using χ^2 (Chi-square) technique so as to show the overall features of the correlates of female genital mutilation. Thus, the

association of the explanatory variables and the two response variables are examined in the following two sections.

5. 1. 1. The Effect of Socio-demographic and Economic Factors on FGM

The bivariate results presented in Table 5. 1 revealed that among all the ten socio-demographic and economic correlates nine of them have shown significant association with the prevalence of female genital mutilation at less than 0.001 level. The variables that made strong influence are: age of the respondent (x_{i1}), respondents duration of stay in Adama town (x_{i2}), respondent's birth place (x_{i3}), educational status of the respondent (x_{i4}), Ethnicity of the respondent (x_{i5}), working status of the respondent (x_{i6}), birth history of the respondents (x_{i7}), marital status of the respondent (x_{i9}) and religion of the respondent (x_{i10}). Income of the household (x_{i8}) as one of the factors considered in the study found to have statistically significant association with the dependent variable at less than 0.1 level.

Even though there was significant association between the prevalence of genital mutilation and educational status of the respondent (x_{i4}), between the prevalence of genital mutilation and working status of the respondent (x_{i6}), it does not give any meaningful explanation because usually in Ethiopia female genital mutilation was performed during infancy or childhood. For example, among all women who have been participated in the study and gone through genital mutilation 57 .1 percent were mutilated during infancy (zero to one year) and 11.8 percent have undergone through genital mutilation during childhood (see Table 4. 2).

Table 5. 1: The ***prevalence*** of FGM among women aged 15 - 49 years by selected socio-demographic and economic variables, Adama, 2002.

Variable	*Number of women*	*Percent*		*P*
		Mutilated	*Not mutilated*	
Adama				
Total	709	78.6	21.4	
Age				
15 - 29 years	494	72.1	27.9	0.00000**
30 - 49 years	215	30.3	69.7	*
Duration of stay in Adama				
10 years and above	400	71.5	28.5	0.00000**
5 to 9 years	92	79.3	20.7	*
0 to 4 years	217	91.2	8.8	
Place of birth				
City	321	64.8	35.2	0.00000**
Town	203	84.2	15.8	*
Countryside	185	96.2	3.8	
Educational level				
No education	118	88.1	11.9	0.00052**
Elementary and junior school	315	81.0	19.0	*
Secondary school and Above	276	71.7	28.3	
Working status				
Currently working	553	75.0	25.0	0.00002**
Not working	156	91.0	9.0	*
Ethnicity				
Oromo	235	81.3	18.7	0.00002**
Amhara	343	75.5	24.5	*
Gurage	69	88.4	11.6	
Somali	35	94.3	5.7	
Others	27	48.1	51.9	
Birth history				
Ever give birth	379	85.2	14.8	0.00000**
Never give birth	330	70.9	29.1	*
Income				
Birr 0 to 120	166	86.1	13.9	0.01261
Birr 121 to 600	182	79.1	20.9	
Birr 601 and above	361	74.8	25.2	
Marital status				
Ever married	397	93.2	6.8	0.00000**
Never Married	312	59.9	40.1	*
Religion				
Christian	501	73.5	26.5	0.00000**
Muslim	190	94.2	5.8	*
Others	18	55.6	44.4	

*** $P < 0.001$

Source: Computed by the author, Adama, 2002.

5. 1. 2. The Effect of Socio-demographic and Economic Factors on the approval of FGM

Bivariate analysis on the approval of female genital mutilation revealed that: respondents duration of stay in Adama town (x_{i2}), educational level of the respondent (x_{i4}), working status of the respondent (x_{i6}), birth history of the respondents (x_{i7}), income of the household (x_{i8}) and marital status of the respondent (x_{i9}) are identified as correlates that have strongly influenced the attitude of respondent and were found to be statistically significant at the level less than 0.001 (table 5. 2).

It was also seen that age of the respondent has had a positive relationship with the response variable and its level of significance is obtained to be less than 0.01. Other correlates, such as ethnicity of the respondent (x_{i5}), birth history (x_{i7}) and religion of the respondent (x_{i10}) were identified to have no significant relationship with the response variable. Moreover respondent's birth place (x_{i3}) can not be easily explained in relation to the attitude of the study population toward the continuation of female genital mutilation because rather than the place of birth, the area in which one can grown up will have better effect in changing the attitude.

Table 5. 2: The *Approval* of the continuation of FGM among women aged 15 - 49 years by selected socio-demographic and economic variables, Adama, 2002.

Variable	*Number of women*	*Percent*		*P*
		Favor	*Not favor*	
Adama				
Total	709	14.7	85.3	
Age				
15 - 29 years	494	12.3	87.7	0.00812**
30 - 49 years	215	20.0	80.0	
Duration of stay in Adama				
10 years and above	400	4.3	95.8	0.00000***
5 to 9 years	92	19.6	80.4	
0 to 4 years	217	31.8	68.2	
Place of birth				
City	321	6.2	93.8	0.00000***
Town	203	10.8	89.2	
Countryside	185	33.5	66.5	
Educational level				
No education	118	33.9	66.1	0.00000***
Elementary and junior school	315	15.9	84.1	
Secondary school and Above	276	5.1	94.9	
Working status				
Currently working	553	10.5	89.5	0.00000***
Not working	156	29.5	70.5	
Ethnicity				
Oromo	235	14.5	85.5	0.47057
Amhara	343	13.4	86.6	
Gurage	69	14.5	85.5	
Somali	35	22.9	77.1	
Others	27	22.2	77.8	
Birth history				
Ever give birth	379	16.4	83.6	0.17278
Never give birth	330	12.7	87.3	
Income				
Birr 0 to 120	166	35.5	64.5	0.00000***
Birr 121 to 600	182	18.1	81.9	
Birr 601 and above	361	3.3	96.7	
Marital status				
Ever married	397	21.7	78.3	0.00000***
Never Married	312	5.8	94.2	
Religion				
Christian	501	13.0	87.0	0.13630
Muslim	190	18.9	81.1	
Others	18	16.7	83.3	

*** P < 0.001; ** P < 0.01

Source: Computed by the author, Adama, 2002.

5. 2. Multivariate Analysis

In this section of the report an attempt has been made determine the effect of the explanatory (independent) variables on the odds that the respondent exposed to the practice of genital mutilation or approval of FGM. The appropriate model for the problem at hand is the logistic regression model. In the logistic regression model, the variables, which are significantly affecting the dichotomous variables can be expressed in terms of the logarithm of the odds of an event as

$$\log it(p_i) = \ln\left(\frac{p_i}{1-p_i}\right) = \beta_0 + \beta_1 x_{i1} + \beta_2 x_{i2} + --- + \beta_{10} x_{i10} + \varepsilon$$

$i = 1, 2, \text{---}, n$ and $n = 709$

Where p_i: Chance of a woman to be exposed to genital mutilation or approval of the continuation.

$1-p_i$: Chance of a woman not to be exposed to genital mutilation or disapproval of the continuation.

β_i: The parameters, and are estimated by the maximum likelihood method that maximizes the probability of obtaining the observed set of data (Hosmer and Lemshow, 1989: 6, 39 Sharma, 1996: 320). x_i's are :

x_{i1}: age of the respondent x_{i2}: respondents duration of stay in Adama town

x_{i3}: respondent's birth place x_{i4}: educational status of the respondent

x_{i5}: Ethnicity of the respondent x_{i6}: working status of the respondent

x_{i7}: birth history of the respondents x_{i8}: income of the of the household

x_{i9}: marital status of the respondent x_{i10}: religion of the respondent and

ε: a vector for error terms.

The regression of y_i (y_1: The status FGM, and y_2: The approval of FGM) on the 9 explanatory variables is non-linear, as a result of which some of the basic assumptions of linear regression are violated. For example, the error terms are no longer distributed normally with mean and variance.

The stepwise backward elimination procedure is used to obtain the final logistic regression model. Backward elimination starts with all the variables in the model. Then at each step, variables are evaluated for removal. The process stops when no further variables can be removed from the model.

The extent of correct classification of the data by the final logistic model is assessed by use of classification table for the dependent variables. The -2LL (-2 Log Likelihood) statistic helps in verifying the goodness of fit of the model.

Results of the two logistic regression models used in the study are summarized as follows: At the first step 6 variables, that are tested out to be significant in the bivariate analyses are considered in both logistic regression models with y_i as the dependent variable. The classification table for the dependent variables y_1 and y_2 show that the overall percentages of correct classification are equal to 85.19% and 91.54% respectively (see Table 5. 3). The high percentage of overall correct classification indicates that the final logistic regression model performs well.

For the logistic regression models that contains only the constant for y_1 and y_2, the -2 Log Likelihood are obtained to be 736.94978 and 591.1874 respectively (Table 5. 4). The value of

-2LL for the final logistic models that corresponds to the two dependent variables are calculated to be 486.584 and 345.511 respectively (Table 5. 5).

The big difference between 736.94978 and 486.584 and between 591.1874 and 345.511 indicate that the factors (x_{i1}, x_{i2}, x_{i3}, x_{i9} and x_{i10}) and (x_{i2}, x_{i4}, x_{i5}, x_{i8}, and x_{i9}) explain the variability in y_1 and y_2 quite well respectively.

Table 5. 3: The classification Table, Adama, 2002.

Dependent Variable: y_1

Observed	*Predicted*		*% correct*
	0	1	
0	92	60	60.53
1	45	512	91.92
		Overall	85.19

Dependent Variable: y_2

Observed	*Predicted*		*% correct*
	0	1	
0	592	13	97.58
1	47	57	54.81
		Overall	91.54

Source: Computed by the author, Adama, 2002.

Also the Model chi-square statistic was obtained as follows:

Model chi-square (y_1) = -2LL for the model with only a constant minus -2LL for the model with β_1, β_2, β_3, β_9 and β_{10}

= 736.94978 - 486.584

= 250.365

Model chi-square (y_2) = -2LL for the model with only a constant minus -2LL for the model with β_2, β_4, β_5, β_8, and β_9

= 591.1874 - 345.511

= 245.676

Under the null hypothesis for both the prevalence model, H_0: $\beta_1 = \beta_2 = \beta_3 = \beta_9 = \beta_{10} = 0$ and for the approval model, H_0: $\beta_2 = \beta_4 = \beta_5 = \beta_8 = \beta_9 = 0$, the Model chi-square statistic has the chi-square distribution with 8 degrees of freedom. At the 0.005 level of significant, the value of chi-square with 8 degrees of freedom is equal to 22.0, which is a value far less than the calculated values of the Model chi-square. Hence, we reject the null hypothesis H_0 and conclude that the variables in the two final logistic regression models (x_{i1}, x_{i2}, x_{i3}, x_{i9} and x_{i10}) and (x_{i2}, x_{i4}, x_{i5}, x_{i8}, and x_{i9}) have explained the variability in y_1 and y_2 quite satisfactorily.

Table 5. 4: Estimates for the logistic model with only a constant, Adama, 2002.

Dependent Variable	y_1	
Beginning Block Number -2Log Likelihood	0 736.94978	Initial Log Likelihood Function
Dependent Variable	y_2	
Beginning Block Number -2Log Likelihood	0 591.1874	Initial Log Likelihood Function

Constant is included in the model.
Source: Computed by the author, Adama, 2002.

As a result of stepwise backward elimination procedure carried out in both the models, only 5 of the six independent variables (x_{i1}, x_{i2}, x_{i3}, x_{i9} and x_{i10}) turned out to show strong influence on y_1 and only 5 of the six independent variables (x_{i2}, x_{i4}, x_{i5}, x_{i8}, and x_{i9}) turned out to show strong influence on y_2.

Table 5. 5: Goodness of fit measure for the optimum logistic model, Adama, 2002.

Dependent Variable: y_1			
Statistic	*Chi-square*	*DF*	*Significance*
-2Log Likelihood	486.584		
Model Chi - Square	250.365	8	0.0000
Improvement	-6.558	4	0.1612
Goodness-of-fit	609.097		

Dependent Variable: y_2			
Statistic	*Chi-square*	*DF*	*Significance*
-2Log Likelihood	345.511		
Model Chi - Square	245.676	8	0.0000
Improvement	-0.369	1	0.5433
Goodness-of-fit	594.104		

Note: A negative chi - square value indicates that it has decreased from the previous step.
Source: Computed by the author, Adama, 2002.

5. 2. 1. The Effect of Socio-demographic and Economic Factors on FGM

Table 5. 6 provide the result of the multivariate logistic regression analysis. It identifies Age of the respondent, respondent's duration of stay in Adama town, place of birth, marital status, and religion of the respondent as significant predictors for the prevalence of genital mutilation in Adama town.

Comparison with other studies reveals that age of the respondents, religion, ethnicity, marriage and residence are significant predictors of the prevalence (Islam and Uddin, 2001; Mbacke, et al., 1998; Jones, et al., 1999; Carr, 1997; Khalif, 1994; Leonard, 1996; Yoder, et al., 2001).

Results of table 5. 6 revealed that the probability of being mutilated increases from the younger age group to the older age group. The older women within the age group 30 to 49 years are 2.9 times more likely to have undergone genital mutilation than those whose age belong to the age group 15 to 29 years.

According to Mbacke et al (1998) one additional year of age increases the probability of being mutilated. However, this effect is concentrated in the teen years, where the proportion mutilated is very high, and the prevalence of mutilation increases with age.

Duration of stay in Adama town is selected as one of the explanatory variables of the response so as to see the effect of being stayed and migrated from rural areas of Adama to the town. With this regard all the women who stayed shorter period (0 to 4 years) and came from countryside surrounding Adama town are observed 4.7 times more likely to have undergone genital mutilation than those stayed more years (10 years and above) and born there.

Place of birth has been identified as having a strong effect on the prevalence of female genital mutilation. Women who were born in country side or rural areas were 5.4 times more likely to experience the practice of female genital mutilation than those who were born in city.

Table 5. 1. Showed that 93.2 percent of all ever-married women involved in the survey were mutilated. It can possibly be concluded that there has been far higher prevalence rate of female genital mutilation among ever-married women at all ages. Everything else being constant, ever-married women are 7.4 times more likely to have undergone FGM than those who are still single.

Religion also has high significant effect over the prevalence of female genital mutilation. This has been shown in the bivariate analysis also. This variable has also carried out with others to see its relationship with the prevalence of genital mutilation using the multivariate logistic regression model. The likely hood of being mutilated is higher among Muslim women than

Christian women and the odds of being mutilated due to religion are increased by a factor approximately equal to 6.2.

Table 5. 6: Beta coefficients and odds ratio from logistic regression analysis of factors affecting female genital mutilation, Adama, 2002.

Variable	*Beta Coefficient*	*Standard Error*	*Odds Ratio*
Age			
15 - 29 years - RC	-	-	1.0000
30 - 49 years	1.0502	0.3468	2.8584**
Duration of stay in Adama			
10 years and above - RC	-	-	1.0000
5 to 9 years	0.0073	0.3686	1.0073
0 to 4 years	1.5454	0.3376	4.6897***
Place of birth			
City - RC	-	-	1.0000
Town	0.7025	0.3010	2.0188**
Countryside	1.6896	0.4487	5.4175***
Marital status			
Never married - RC	-	-	1.0000
Ever married	2.0038	0.2703	7.4169***
Religion			
Christian - RC	-	-	1.0000
Muslim	1.8186	0.3630	6.1635***
Others	-0.9355	0.6096	0.3924
Constant	2.3061	0.2880	

*** P < 0.001; ** P< 0.01;
RC = Reference Category
N = 709
Source: Computed by the author, Adama, 2002.

5. 2. 2. The Effect of Socio-demographic and Economic Factors on the approval of FGM

In the bivariate analysis when women's attitude towards female genital mutilation was examined using the chi-square test, it is revealed that the dependent variable has a strong interrelationship with Age, Duration of stay in Adama town, Place of birth, Educational level, Working status, Income of the household and Marital status.

The above variables except *place of birth* are taken to the final model because place birth can not explain the response variable logically. The results of the logistic regression model reveals that

all the variables except Age of the respondents are significant at the level less than 0.001. The findings in table 5. 7. shows that, controlling for the possible effect of other confounding variables, as respondents' duration of stay in Adam town changes from 10 years and above to 5 to 9 years and from 10 years and above to 0 to 4 years, the odds of support for the continuation of the practice increase by factors equal to 6.0219 and 17.0159 respectively.

Women's education is also identified as significant predictor of attitude towards female genital mutilation ($P < 0.001$). Decrement of educational level from high school and above to elementary and junior school and from high school to no schooling increases the probability of approval of FGM by factors 1.9268 and 6.5501 respectively.

In relation to the variable working status of the respondent the multivariate logistic regression analysis also reveals that the likelihood of supporting female genital mutilation decreases when we go from those who are currently working to those who are not currently working. The logistic regression results in Table 5. 7 can be interpreted as the support for the continuation of female genital mutilation by the women who are currently working is reduced by 67 percent as compared to those who are not currently working.

The effect of income of the household remains statistically significant at the level less than 0.001. The likelihood of favoring the continuation of female genital mutilation increases as we move from those whose household income is Birr 600+ to those whose household monthly income is between Birr 0 and Birr 120. In Table 5. 7 it was observed that women with a household income ranges from Birr 0 to Birr 120 and women with a household income ranges from Birr 121 to Birr 600 were 10.8827 times and 5.8142 times more likely to give support for

the continuation of the practice than those whose household income rises from Birr 600 respectively.

Marital status has also appeared as determining factors of the approval of female genital mutilation. Ever married women are at least 5.0544 times more likely to support the practice of genital mutilation than women who are never married.

Table 5. 7: Beta coefficients and odds ratio from logistic regression analysis of factors affecting women's approval of female genital mutilation, Adama, 2002.

Variable	*Beta Coefficient*	*Standard Error*	*Odds Ratio*
Duration of stay in Adama			
10 years and above - RC	-	-	1.0000
5 to 9 years	1.7954	0.4256	6.0219***
0 to 4 years	2.8341	0.3598	17.0159***
Educational level			
Secondary school and Above - RC	-	-	1.0000
Elementary and junior school	0.6558	0.3742	1.9268**
No education	1.8795	0.4186	6.5501***
Working status			
Not working - RC	-	-	1.0000
Currently working	-1.1251	0.2938	0.3246***
Income			
Birr 601 and above - RC	-	-	1.0000
Birr 121 to 600	1.7603	0.4098	5.8142***
Birr 0 to 120	2.3872	0.3848	10.8827***
Marital status			
Never married - RC	-	-	1.0000
Ever married	1.6203	0.3474	5.0544***
Constant	-1.9675	0.2034	

*** P < 0.001; ** P< 0.01; * P < 0.1;
RC = Reference Category
N = 709
Source: Computed by the author, Adama, 2002.

5. 3. Discussion

Having the stated objective and the hypotheses, the findings of the study have indicated that the prevalence of female genital mutilation is very high (78.6 percent). Contrary to this the magnitude of women who favor the continuation of the practice is surprisingly very low (14.7

percent). The rate of female genital mutilation is higher among women who belong to the age group 30 years to 49 years as compared to women in the age group 15 years to 49 years. The multivariate analysis result also asserts that the prevalence of female genital mutilation within women of the age group 30 - 49 years is 2.8584 times more likely than those in the age group 15 - 30 years. This finding might show that the practice is on its way to decline. Here, it is better to note that this trend might be obtained through ideological development and awareness towards the harmfulness of FGM.

Studies in Burkina Faso and Mali had shown that there is a positive correlation between most of the determining factors and the prevalence of genital mutilation. By applying the logistic regression Jones, et al (1999) had shown that age of the respondents determine the practice of female genital mutilation.

FGM research conducted in Kassena Nankana district of Ghana also revealed that Age as a significant predictor of the prevalence of FGM. The multivariate analysis result of the study shows that, from age 15 one additional year of age increases the probability of being mutilated by 42 percent on average (Mbacke, 1998).

Duration of stay in Adama town is appeared to be significant in the determination of the prevalence of FGM. Taking women, who stayed in Adama town 10 years and above, as reference category, the prevalence of female genital mutilations appeared to be high among women stayed short period of time in Adama town. The multivariate analysis asserted that women whose duration of stay 0 to 4 years are at least 5.4169 time more likely to undergo mutilation than the women in the reference category.

Comparison with other studies conducted in Burkina Faso and Mali shows that original residence has had positive relationship with the prevalence of genital mutilation (Jones, et al, 1999). Since most of the women who stayed in Adama town for a range of 0 to 4 years are migrated from neighboring rural areas and /or their original residence is rural area, the difference might come true. Similarly, in one of the study carried out in Cote d' Ivoire, resident of the respondents appeared to be significant predictor of FGM (Carr, 1997).

The place of birth also shows significant difference in this study. The multivariate analysis result with respect to the place of birth of the respondents also revealed that, compared with those women born in the city, women born in town are 2.0 times more likely and women born in countryside 5.4 times more likely to have undergone FGM. Possibly, it might have been related to Education, information and communication facilities in which they can easily accessed in the city than in the countryside. In this result we might perceive that urbanization and modernization might also affect the prevalence female genital mutilation.

The result obtained for marital status in relation to prevalence of genital mutilation is very strong and it proves the stated hypothesis "*Ever married women are more likely to undergo female genital mutilation than those who are single*". Both the bivariate (chi-square) and the multivariate (logistic regression) analyses identified marital status as strong predictors of the prevalence of the practice with the level of significance 0.0000 and < 0.001 respectively. For most of the women migrated from Arsi and Bale, female genital mutilation is a precursor to marriage. Even if a woman is not mutilated before marriage, she is very likely to be mutilated after marriage as pointed out by some of the respondents originated from Arsi and Bale regions. According to

the logistic regression out come, ever-married women are 7.4 times more likely to undergo female genital mutilation than those who are still single.

According to Jones, et al (1999), Marital status was explored to show positive relationship with FGM. Similarly, in the Kassena Nankana Distinct of Ghana, marriage was appeared to be significant determinant of female genital mutilation. Holding other variables considered in the model constant, ever-married women are 2.8 times more likely to have undergone genital mutilation than those women who are still single (Mbacke, 1998).

The findings of this study explored religion as one of the determining factor that varies the prevalence of genital mutilation among women. This finding had proven the hypothesis stated in the study. "*Muslim women are significantly more likely than other religious women to undergo mutilation*". In both bivariate & multivariate analyses result Muslim women are appeared to be highly prevalent to the ritual practice of female genital mutilation than women followed other religious doctrine. The multivariate analysis result exposed that Muslim women are 6.2 time more likely to practice female genital mutilation than Christian women (reference category). This result might be appeared due to the belief that female genital mutilation is demanded by the Islamic faith though it is not found in the faith.

Compared this results with other studies in Africa it has been seen that there is a coherence. For instance, according to the result of Kassena Nankana district study, Christian women are less likely to be mutilated than those who do not practice Christianity (Mbacke, et al, 1998). In Sudan, the Muslim women were at least 51 times more likely to under go genital mutilation than Christian women. Similarly, in Cote d'Ivoire Muslim women were at least 17 times more

likely to under go cutting than Christian women. These differences are significant at one-percent level. In Burkina Faso, CAR, Egypt, Eritrea, Mali, and Sudan, Muslim women are more likely to have undergone genital mutilation than Christian women and women practicing other religion (e.g. Animism) (PRB, 2001).

One of the most important finding obtained in this study towards the approval of female genital mutilation is the existence of striking contrasts between high prevalence of genital mutilation (78.6 percent) and low approval towards the continuation of female genital mutilations (14.7 percent). When women's attitudes toward the continuations of female genital mutilation assessed by the selected background characteristics, support for the continuation of the practice decreases as the duration of stay in Adama town increases. The multivariate analysis result revealed that women who stayed in Adama town 5 to 9 years are 6.0 times more likely to favor this ritual practice than the reference category, women who stayed in Adama town 10 years and above. Similarly, women who stayed in Adama town 0 to 4 years are 17.0 times more likely to favor female genital mutilation than those women who stayed 10 years and above. On the basis of this result we may generalize that being stayed longer in an area center for information, education and communication will have a strong effect to change the attitude and mentality of a person. In addition to these urbanization and modernization might have certain influence.

In this study it was also found that highly educated women are less likely to be supportive of the continuation of the practice. The hypothesis "*Higher the educational level of the women lower the support for the practice of female genital mutilation*" has been proved and the result obtained in multiple logistic regression pointed out women's education as significant predictors of attitudes

towards female genital mutilation. Women with no education are 6.6 times more likely to support genital mutilation as compared to women whose educational level are secondary school and above (reference category). Similarly, women whose educational level are elementary and junior school are 1.9 times more likely to supports the practice than those whose educational level are secondary and above. This result revealed that education has a highly significant effect.

Other studies conducted in different areas of Africa also revealed that education has strong relationship with the attitude towards genital mutilation. Islam and Uddin (2000) stated that more highly educated women are less supportive than women with no schooling. Multivariate analysis indicates that higher levels of education are significantly associated with the practice. One reduction year of education decreases the probability of being mutilated by 10 percent on average. According to Mbacke and et al (1998), the reduction of female genital mutilation is significant among those who succeeded to go beyond the primary level. Successes in school definitely strengthen the bargaining power of girls who do not want to be mutilated.

Both the bivariate (chi-square) and multivariate analyses also revealed working status of the women as significant predictor of the approval of female genital mutilation. According to the multivariate result the likelihood of giving support for the continuation of the practice decreases by almost 77.0 percent to women who are currently working relative to women who are not working. This might tell us increasing the participation of women on different working sectors might push them to give up traditional type of thinking.

As economic predictor income of the household has also been incorporated in the analysis. It appeared to be more significant in both models (bivariate and multivariate analysis). The logistic regression model revealed that as income of the house hold increases the approval of

genital mutilation decreases. The stated hypothesis "*Lower the economic status of the women higher the support for the practice of female genital mutilation*" has been proved successfully. Women whose household income ranges from Birr 0 to Birr 120 are 10.9 times more likely to support the continuation of female genital mutilation than women whose household income is Birr 601 and above. Similarly women whose household income ranges form Birr 121 to Birr 600 are 5.8 times more likely to give support for female genital mutilation than women whose household income is Birr 600 and above.

According to the study conducted in Sudan the household possession, as a proxy measure for household economic status, has also appeared to be significant determinant factor of the approval of genital mutilation. Support decreases with rising household possession scores (Islam and Uddin, 2001).

The approval of female genital mutilation also varies with the marital status of women. The approval of female genital mutilation has shown an increment from never married to ever married. This has been proved in the bivariate and multivariate analyses. The result obtained in the multivariate analysis revealed that ever married women are 5.1 times more likely to be supportive than never married women. This finding tell us that there might have been a higher prevalence of daughter's mutilation that goes to ever-married women than never married women.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6. 1. Summary

Female genital mutilation is one of the more harmful traditions still practiced in many parts of the country. The custom involves removing some or most of the external female genitalia. This report has examined how the selected socio-economic and demographic correlates of (see table 3. 4) and the two response variables the prevalence of female genital mutilations and the attitude of the practice are associated in Adama town of Oromiya region. A sample of 709 women of age 15 years to 49 years and men of age from 15 years to 59 years were considered from the study area through retrospective survey.

An attempt was made to give a background to the study, to identify the objectives and to determine the hypothesis on the basis of the framework of the study and the literature review. Based on the literature review and the framework of the study, the following hypothesis were proposed and tested for the significance using advanced statistical analysis.

Stated hypotheses:

- Lower the economic status of the women higher the support for the practice of FGM.
- Higher the education of the women lower the support for the practice of FGM.
- Muslim women are significantly more likely than other religious women to undergo mutilation.
- Ever married women are more likely to undergo FGM than those who are single.

The primary objective of this study is to understand about the continuing practice of female genital mutilation and identify the factors responsible for its continuation in the study area.

An extensive review of the literature relevant to female genital mutilation was also made. The main data source of the study was community based primary survey, which had been carried out in Adama town. Women of the age group 15 to 49 and men of the age group 15 to 59 were considered as eligible respondents for the study. Data quality with respect to age was checked using Myers' blended index and it was seen that one fifth of the study population were reported age with incorrect final digits. It was also explained that logistic regression was the methodology employed in the study.

Background characteristics of the study population in relation to the prevalence of female genital mutilation, women and men's attitude were presented thoroughly. Table 4. 1 reveals that the practice is almost universal in Adama town; eight in ten women of the age group 15 to 49 were mutilated. It was also observed that the percentage of total women who approve FGM is given 14.7 (Table 4. 3). Similarly, in table 4. 6 it is clearly seen that about three men among ten involved in the survey have had the attitude of supporting FGM.

An attempt was made to present the bivariate and multivariate results of the analyses. The bivariate results presented in table 5. 1, among all the ten socio demographic and economic correlates nine of them have shown significant association with the prevalence of FGM at $p < 0.001$ level. Among these 9 significant correlates only six that have valid and meaningful relationship with the prevalence of Female genital mutilation were selected for multivariate analysis. Finally, Five of these variables (Age of the respondent, duration of stay in Adama

town, place of birth, marital status and religion) were identified as significant determinants of FGM in Adama.

Bivariate results on the approval of FGM also revealed that seven out of ten socio-demographic and economic correlates were identified as factors affecting the attitude of respondent. Similarly among the seven correlates only six that have valid and meaningful relationship with the approval of FGM were selected for multivariate analysis. Again five of these variables (duration of stay in Adama town, educational level, working status of the respondents, income of the household and marital status) were appeared to be significant factor that can affect the approval of FGM.

6. 2. Conclusions

On the basis of the results obtained in this study, the following conclusions are drawn:
The overall percentage of women in reproductive age group who practiced FGM was obtained to be 78 .6. The percentage prevalence of genital mutilation of all women in the age group 15 - 29 and 30-49 were 72.1 and 93.5 respectively. Based this percentage distribution it is possible to conclude that the practice of female genital mutilation was in its way to decline. This might be due to awareness towards the harmfulness female genital mutilation.

According to the result obtained in the fitted logistic regression models age, duration of stay in Adama town, place of birth, marital status and religion were identified as factors that determine the *prevalence* and in the same way duration of stay in Adama town, educational level, working status of the women, income of the household and marital status were appeared to be significant correlates of the *approval.*

All the hypotheses were proved to be true. Based on the proven hypotheses and the results of the analyses the following conclusions are made.

- The older women within the age group 30 to 49 years are more likely to have undergone genital mutilation than those whose age belong to the age group 15 to 29 years.
- The women who stayed shorter period (0-4 years) and came from countryside surrounding Adama town are observed more likely to have undergone genital mutilation than those stayed more years (10 years and above) and born there.
- Women who were born in countryside or rural areas are more likely to experience the practice of female genital mutilation than those who were born in city.
- Ever-married women are more likely to have undergone FGM than those who are still single.
- The likely hood of being mutilated is higher among Muslim women than Christian women.
- Women who stayed in Adam town for 10 years and above are less likely to support the continuation of FGM than those who stayed 0-9 years.
- Decrement of educational level from high school and above to elementary, junior school and no schooling increases the probability of approval of the practice.
- The support for the continuation of female genital mutilation by the women who are currently working is less likely than those who are not currently working.
- The likelihood of favoring the continuation of female genital mutilation increases as we move from those whose household income is Birr 600+ to those whose household monthly income is between Birr 0 and Birr 600.
- Ever married women are more likely to support the practice of genital mutilation than women who are never married.

6. 3. Recommendations

According to the respondents participated in the survey the deeply rooted prevalence of female genital mutilation may not possible to get rid unless culturally acceptable policy is adopted.

Drastic changes in cultural social, political and economic norms are essential to bring about all forms of equality among society. However, these were not come to real automatically. National plans of action on the attitudes of genital mutilation, and its prevalence can provide important background information on possibility for intervention. In addition, concerned efforts on the part of many sectors of society are needed to help abolish the practice.

For this reasons and based on the stated findings of the study, it is recommend that:

Because of the reason that going through genital mutilation is not obligatory, national government need to activate public education to the grass root level. In particular educating mid wives and traditional birth attendants about dangers of the practice and enlisting their help in the campaign to abolish the practice will be the utmost importance. Winning the support of these people is very crucial advancement because most of them are financially dependent on the practice.

- The government needs to make functional the international instruments to which Ethiopia is a party to eradicate female genital mutilation. One of these laws is the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) articulated in 1979 and come into force in 1981. Ethiopia ratified in the same year.

In addition to this government must put into practice the draft penal code that pointed out FGM is a crime and punishable by six months of imprisonment. This legislation can demarcate right from wrong, provide official legal support for project activities against FGM, offer legal protection for women, and ultimately discourage genital mutilation.

- The role of religious leaders and community leaders is extremely important. For those who were consider female genital mutilation as religious demand, the leaders needs to tell them and educate them that religion has nothing to do with genital mutilation.

- The government needs to take action by supporting the non-governmental organizations and community based organizations for their active participation in promoting change in the prevalence and attitude toward the continuation. The excellent program models that the non-governmental organizations have carried out on a test basis need to reach to everyone. This might have been very useful to sustain programs. These days, most the efforts underway are not sustainable, and they have failed to curb the high prevalence of female genital mutilation.

- Research needs to proceed on the determinant factors that affect the prevalence and approval of female genital mutilation through which policy intervention could be promoted and encouraged. In this respect researches should be encouraged in conducting qualitative studies, which gives better idea about the reproductive studies.

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APPENDICES

APPENDIX I: Abbreviations and Acronyms

AJRH	= African Journal of Reproductive Health
CAR	= Central African Republic
CEDAW	= Convention on the Elimination of all forms of Discrimination Against Women
COFAP	= Consortium of Family Planning
CSA	= Central Statistical Authority
DHS	= Demographic and Health Survey
ESU	= Elementary Sampling Unit
FGM	= Female Genital Mutilation
IAC	= Inter Africa Committee
IFPP	= International Family Planning Perspective
IPPF	= International Planned Parenthood Federation
IWRAW	= International Women's Right Action Watch
MEDAC	= Ministry of Economic Development and Cooperation
MRG	= Minority Right Groups
NCTPE	= National Committee on Traditional Practice of Ethiopia
NOP	= National Office of Population
SNNPR	= Southern Nations, Nationalities and People Region
UNFPA	= United Nations Population Fund
UNICEF	= United Nations Children's Fund
USAID	= United State Aid for International Development
PRB	= Population Reference Bureau

APPENDIX II: Women Questionnaire

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

INSTITUTE OF DEVELOPMENT RESEARCH

DEMOGRAPHIC TRAINING AND RESEARCH CANTER

SURVEY ON FEMALE GENITAL MUTILATION

FOR USE WITH WOMEN AGED 15-49

Adama, 2002

INFORMED CONFIDENTIALITY AND CONSENT

I am working with _____

We are interviewing people here in order to find out about people's experience towards the practice of Female Genital Mutilation. The purpose of the study is to generate information necessary for the planning of appropriate interventions and to track the trend on the practice. Therefore your honest and genuine participation by responding to the questions is highly appreciated.

Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. This survey will take 20 minutes to ask the questions would you be willing to participate?

_____

[Signature of interviewer certifying that informed consent has been given verbally by respondent]

PART I

IDENTIFICATION

WEREDA	
KEBELE	
HOUSEHOLD NUMBER	

INTERVIEWER'S VISITS

	VISIT 1	VISIT 2	VISIT 3
TIME			
DATE			
INTERVIEWER'S NAME			
RESULT*			

* RESULT CODES:

1. COMPLETED
2. RESPONDENT NOT AVAILABLE
3. PARTIALLY COMPLETED
4. REFUSED
5. OTHER _____

[SPECIFY]

C. QUESTIONNAIRE IDENTIFICATION NUMBER |__|__|__|__|

D. HEAD OF THE HOUSE HOLD MALE |__|

FEMALE |__|

CHECKED BY SUPERVISOR: SIGNATURE _____ DATE _____

PART II

SOCIO DEMOGRAPHIC INFORMATION

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
A01	RELATIONSHIP TO THE HEAD OF THE HOUSEHOLD:	HEAD 1 WIFE , HUSBAND OR PARTNER 2 SON OR DAUGHTER 3 SON IN LAW OR DAUGHTER IN LAW 4 GRAND CHILD 5 PARENT 6 PARENT IN LAW 7 BROTHER OR SISTER 8 ADOPTEDOR FOSTER OR STEPCHILD 9 OTHER RELATIVE 10 NOT RELATED 11 DOES NOT KNOW 88	
A02	HOW OLD WERE YOU AT YOUR LAST BIRTHDAY?	AGE IN COMPLETED YEAR |__|__| DOES NOT KNOW 88 NO RESPONSE 99	
A03	WHERE WERE YOU BORN?	CITY 1 TOWN 2 COUNTRYSIDE 3	
A04	HOW LONG HAVE YOU BEEN LIVING CONTINUOUSLY IN ADAMA?	YEARS |__|__| ALWAYS 95 NO RESPONSE 96	---A06
A05	JUST BEFORE YOU MOVED HERE, DID YOU LIVE IN A CITY, IN A TOWN, OR IN THE COUNTRYSIDE?	CITY 1 TOWN 2 COUNTRYSIDE 3	

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
A06	HAVE YOU EVER ATTENDED FORMAL SCHOOL?	YES 1 NO 2	 ---A08
A07	WHAT IS THE HIGHEST GRADE YOU HAD COMPLETED?	GRADE |__|__| TECHNICAL/ VOCATIONAL CERT. 13 UNIVERSITY/ COLLEGE DIPLOMA 14 UNIVERSITY/ COLLEGE DEGREE 15	
A08	WHAT IS YOUR MARITAL STATUS?	MARRIED 1 SINGLE 2 DIVORCED 3 WIDOWED 4 SEPARATED 5	 ---A14
A09	AT WHAT AGE DID YOU GET MARRIED?	AGE IN COMPLETED YEAR |__|__| DOES NOT KNOW 8 NO RESPONSE 9	
A10	DID YOU MARRY MORE THAN ONCE?	YES 1 NO 2	 ---A12
A11	HOW MANY TIMES?	NUMBER OF TIMES |__|__| DOES NOT KNOW 8 NO RESPONSE 9	
A12	HAVE YOUR HUSBAND EVER ATTENDED FORMAL SCHOOL?	YES 1 NO 2	 ---A14
A13	WHAT IS THE HIGHEST GRADE HE HAD COMPLETED?	GRADE |__|__| TECHNICAL/ VOCATIONAL CERT. 13 UNIVERSITY/ COLLEGE DIPLOMA 14 UNIVERSITY/ COLLEGE DEGREE 15	
A14	HAVE YOU EVER GIVEN BIRTH?	YES 1 NO 2	 ---A17
A15	HOW MANY LIVING CHILDREN DO YOU HAVE? [*If none, record '|0|0|'.*]	NUMBER OF CHILDREN |__|__| DOES NOT KNOW 8 NO RESPONSE 9	IF |0|0| ---17

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
A16	HOW MANY OF THESE CHILDREN, TO WHOM YOU HAVE GIVEN BIRTH, ARE DAUGHTERS? [*If none, record '0'.*]	NUMBER OF DAUGHTERS |__|__| DOES NOT KNOW 8 NO RESPONSE 9	
A17	WHAT IS YOUR RELIGION?	ORTHODOX 1 CATHOLIC 2 PROTESTANT 3 MUSLIM 4 TRADITIONAL 5 OTHER _____ 6 [SPECIFY]	
A18	WHAT IS YOUR ETHNICITY?	OROMO 1 AMHARA 2 TIGRAWAY 3 SOMALI 4 AFAR 5 OTHER _____ 6 [SPECIFY]	
A19	WHAT IS YOUR HUSBAND'S RELIGION? [*Filter: if ever married* - A08]	ORTHODOX 1 CATHOLIC 2 PROTESTANT 3 MUSLIM 4 TRADITIONAL 5 OTHER _____ 6 [SPECIFY]	

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
A20	WHAT IS YOUR HUSBAND'S ETHNICITY? [*Filter: if ever married* - A08]	OROMO 1 AMHARA 2 TIGRAWAY 3 SOMALI 4 AFAR 5 OTHER _____ 6 [SPECIFY]	

ECONOMIC INFORMATION

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
B01	ARE YOU EMPLOYED?	YES 1 NO 2	---B03
B02	WHAT IS YOUR OCCUPATION?	PROFESSIONAL-TECHNICIAN 1 ADMINISTRATOR, MANAGER 2 SALES WORKER 3 FARMER 4 CRAFTS MEN, LABOURER 5 MILITARY 6 OTHER _____ 7 [SPECIFY]	
B03	IS YOUR HUSBAND EMPLOYED? [*Filter: if ever married* - A08]	YES 1 NO 2	---B05
B04	WHAT IS HIS OCCUPATION?	PROFESSIONAL-TECHNICIAN 1 ADMINISTRATOR, MANAGER 2 SALES WORKER 3 FARMER 4 CRAFTS MEN, LABOURER 5 MILITARY 6 OTHER _____ 7 [SPECIFY]	

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
B05	DO YOU HAVE ANY INCOME FOR YOUR HOUSEHOLD?	YES 1 NO 2	 ---B07
B06	HOW MUCH WAS YOUR TOTAL HOUSEHOLD MONTHLY INCOME?	AMOUNT IN BIRR |__|__|__|__| DOES NOT KNOW 8 NO RESPONSE 9	
B07	WHAT IS THE MAIN SOURCE OF DRINKING WATER FOR MEMBERS OF YOUR HOUSEHOLD?	*PIPED (TAPE)* PIPED INTO DWELLING 1 PIPED INTO COMPOUD 2 PIPED OUTSIDE THE COMPOUND 3 *OPEN WELL/SPRING* OPEN WELL 4 OPEN SPRING 5 COVERED WELL/SPRING COVERED WELL 6 COVERED SPRING 7 *SURFACE WATER* RIVER 8 POND/LAKE/DAM 9 RAINWATER 10 OTHER _____ 11 [SPECIFY]	
B08	WHAT KIND OF TOILET FACILITY DO MOST OF MEMBERS YOUR HOUSEHOLD USE?	FLUSH TOILET 1 *PIT TOILET/LATERINE* TRADITIONAL PIT TOILET 2 VENTILATED IMPROVED PIT LATERINE 3 NOT FACILITY/BUSH/FIELD 4 OTHER _____ 6 [SPECIFY]	

NO	QUESTIONS AND FILTERS	CODING CATEGORY			SKIP
B09	DOES YOUR HOUSEHOLD HAVE:		YES	NO	
	ELECTRICITY?	ELECTRICITY	1	2	
	A RADIO?	A RADIO	1	2	
	A TELEVISION?	A TELEVISION	1	2	
	A TELEPHONE?	A TELEPHONE	1	2	
	AN ELECTRIC MITAD?	AN ELECTRIC MITAD	1	2	
	A KEROSENE LAMP/PRESSURE LAMP?	A KEROSENE LAMP	1	2	
	A BED/TABLE?	A BED/TABLE	1	2	
B10	DOES YOUR HOUSEHOLD HAVE:		YES	NO	
	OWN THE HOUSE IT IS LIVING IN?	OWN HOUSE	1	2	
	HAVE CROPLAND?	CROP LAND	1	2	
	HAVE CATTLE/CAMELS?	CATTLE/CAMELS	1	2	
	HAVE HORSE/MULE/DONKEY?	HAVE HORSE/MULE/DONKEY	1	2	
	HAVE SHEEP/GOATS?	SHEEP/GOATS	1	2	
B11	WHAT TYPE OF FULE DOSE YOUR HOUSEHOLD MAINLY USE FOR COOKING?	ELECTRCITY 1 LPG/NATURAL GAS 2 BIOGAS 3 KEROSEN 4 CHARCOAL 5 FIREWOOD, STRAW 6 DUNG 7 OTHER _____ 6 [SPECIFY]			

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
B12	MAIN MATERIAL OF THE FLOOR. [*Record observation*]	EARTH/SAND 1 DUNG 2 WOOD PLANKS 3 REED/BAMBOO 4 PARQUET OR POLISHED WOOD 5 VINYL SHEETS/TILES 6 CEMENT 7 CEMENT TILES/BRICK 8 CARPET 9 OTHER _____ 6 [SPECIFY]	
B13	MAIN MATERIAL OF THE ROOF. [*Record observation*]	COROGATED IRON 1 CEMENT/CONCRETE 2 WOOD AND MUD 3 THACH 4 REED BAMBOO 5 PLASTIC SHEET 6 MOBILE ROOFS OF NOMADS 7 OTHER _____ 6 [[SPECIFY]	
B14	DOES ANY MEMBER OF YOUR HOUSEHOLD OWN: A BICYCLE? A MOTERCYCLE OR MOTER SCOOTER? A CAR OR TRUCK? A HORSE OR MULE FOR HUMAN TRANSPORT ONLY?	YES NO BICYCLE 1 2 MOTERCYCLE/SCOOTER 1 2 CAR/TRUCK 1 2 HORSE/MULE 1 2	

OPINION ON FEMALE GENITAL MUTILATION

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
C01	HAVE YOU EVER HEARD OF FEMALE GENITAL MUTILATION?	YES 1 NO 2	---▼
C02	HAVE YOU YOURSELF BEEN CIRCUMCISED?	YES 1 NO 2	---C04
C03	HOW OLD WERE YOU WHEN YOU WERE CIRCUMCISED?	AGE IN COMPLETED YEAR |__|__| DURING INFANCY 5 DOES NOT KNOW 8	
C04	HAS ANY OF YOUR DAUGHTERS BEEN CIRCUMCISED? [*Filter: if nº of daughters given* - A16]	YES 1 NO 2	---C11
C05	DURING THE MUTILATION OF YOUR DAUGHTERS, WHICH PART OF THE BODY WERE REMOVED? [*Record parts as reported*]	1. _____ 2. _____ 3. _____ DOES NOT KNOW 8	
C06	WHO INITIATED THAT SHE/THEY SHOULD GET CIRCUMCISED?	SELF 1 MOTHER 2 FATHER 3 GRAND MOTHER 4 AUNT 5 OTHER _____ 6 [SPECIFY]	
C07	WHO PERFORMED THE OPERATION?	GRAND MOTHER 1 TRADITIONAL CIRCUMCISER 2 TRADITIONAL BIRTH ATTENDANTS 3 HEALTH PROFESSIONALS 4 OTHER _____ 5 [SPECIFY]	

▼ Complete the questionnaire

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
C08	WHERE WAS THE MUTILATION PERFORMED?	OWN HOME 1 ANOTHER'S HOME 2 CIRCUMCISER'S HOME 3 OTHER _____ 4 [SPECIFY] DOES NOT KNOW 8	
C09	WERE SHE/THEY CIRCUMCISED ALONE OR WITH OTHERS?	ALONE 1 WITH OTHERS 2 DOES NOT KNOW 8 NO RESPONSE 9	
C10	WHICH INSTRUMENT WAS USED TO PERFORM THE OPERATION?	OWN BLADE/ RAZOR 1 SHARED BLADE/ RAZOR 2 SCALPEL 3 KNIFE 4 OTHER _____ 5 [SPECIFY] DOES NOT KNOW 8	
C11	DO YOU THINK GENITAL MUTILATION SHOULD BE CONTINUED, OR DISCONTINUED?	CONTINUED 1 DISCONTINUED 2 DOES NOT KNOW 8	---C13

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
C12	[*Filter: if continued* - C11] WHY DO YOU THINK FEMALE GENITAL MUTILATION SHOULD BE CONTINUED? [*Record all reasons mentioned*]	GOOD TRADITION 1 CUSTOM AND TRADITION 2 RELIGIOUS DEMAND 2 HYGIENE 3 PRESERVATION OF VIRGINITY 4 TO PLEASE HUSBAND 6 TO BELONG TO THE COMMUNITY 7 TO ENHANCE FERTILITY 8 TO INCREASE MATRIMONIAL OPPORTUNITY 9 TO MAINTAIN GOOD HEALTH 10 OTHER _____ 11 [SPECIFY]	
C13	[*Filter: if discontinued* - C11] WHY DO YOU THINK FEMALE GENITAL MUTILATION SHOULD BE DISCONTINUED? [*Record all reasons mentioned*]	BAD TRADITION 1 AGAINST RELIGION 2 MEDICAL COMPLICATION 3 PAINFUL PERSONAL EXPERIENCE 4 AGAINST DIGNITY OF WOMEN 6 PREVENTS SEXUAL SATISFACTION 7 OTHER _____ 8 [SPECIFY]	
C14	WHAT DOES YOUR HUSBAND THINK ABOUT THIS SUBJECT?	SUPPORTS TO BE CONTINUED 1 DOES NOT SUPPORT 2 DO NOT KNOW 88	
C15	WOULD HE AGREE WITH YOU NOT TO CIRCUMCISE YOUR DAUGHTERS?	YES 1 NO 2 DO NOT KNOW 88	
C16	WHAT WAS YOUR SUGESSTION TO ERADICATE FGM?	SPECIFY _____	

APPENDIX III: Men Questionnaire

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

INSTITUTE OF DEVELOPMENT RESEARCH

DEMOGRAPHIC TRAINING AND RESEARCH CANTER

SURVEY ON FEMALE GENITAL MUTILATION

FOR USE WITH MEN AGED 15-59

Adama, 2002

INFORMED CONFIDENTIALITY AND CONSENT

I am working with _____

We are interviewing people here in order to find out about people's experience towards the practice of Female Genital Mutilation. The purpose of the study is to generate information necessary for the planning of appropriate interventions and to track the trend on the practice. Therefore your honest and genuine participation by responding to the questions is highly appreciated.

Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. This survey will take 20 minutes to ask the questions would you be willing to participate?

_____

[Signature of interviewer certifying that informed consent has been given verbally by respondent]

PART I

IDENTIFICATION

WEREDA	
KEBELE	
HOUSEHOLD NUMBER	

INTERVIEWER'S VISITS

	VISIT 1	VISIT 2	VISIT 3
TIME			
DATE			
INTERVIEWER'S NAME			
RESULT*			

* RESULT CODES:

1. COMPLETED
2. RESPONDENT NOT AVAILABLE
3. PARTIALLY COMPLETED
4. REFUSED
5. OTHER _____

[SPECIFY]

C. QUESTIONNAIRE IDENTIFICATION NUMBER |__|__|__|__|

D. HEAD OF THE HOUSE HOLD MALE |__|

FEMALE |__|

CHECKED BY SUPERVISOR: SIGNATURE _____ DATE _____

PPART II

SOCIO DEMOGRAPHIC INFORMATION

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
A01	RELATIONSHIP TO THE HEAD OF THE HOUSEHOLD	HEAD 1 WIFE OR HASBAND OR PARTNER 2 SON OR DAUGHTER 3 SON IN LOW OR ĐAUGHTER IN LAW 4 GRAND CHILD 5 PARENT 6 PARENT IN LAW 7 BROTHER OR SISTER 8 ADOPTEDOR FOSTER OR STEPCHILD 9 OTHER RELATIVE 10 NOT RELATED 11 DOES NOT KNOW 88	
A02	HOW OLD WERE YOU AT YOUR LAST BIRTHDAY?	AGE IN COMPLETED YEAR |__|__| DOES NOT KNOW 88 NO RESPONSE 99	
A03	WHERE WERE YOU BORN	CITY 1 TOWN 2 COUNTRYSIDE 3	
A04	HOW LONG HAVE YOU BEEN LIVING CONTINUOUSLY IN ADAMA?	YEARS |__|__| ALWAYS 95 NO RESPONSE 96	---A06
A05	JUST BEFORE YOU MOVED HERE, DID YOU LIVE IN A CITY, IN A TOWN, OR IN THE COUNTRYSIDE?	CITY 1 TOWN 2 COUNTRYSIDE 3	
A06	HAVE YOU EVER ATTENDED FORMAL SCHOOL?	YES 1 NO 2	---A08

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
A07	WHAT IS THE HIGHEST GRADE YOU HAD COMPLETED?	GRADE |__|__| TECHNICAL/ VOCATIONAL CERT. 13 UNIVERSITY/ COLLEGE DIPLOMA 14 UNIVERSITY/ COLLEGE DEGREE 15	
A08	WHAT IS YOUR MARITAL STATUS?	MARRIED 1 SINGLE 2 DIVORCED 3 WIDOWED 4 SEPARATED 5	--A14
A09	AT WHAT AGE DID YOU GET MARRIED?	AGE IN COMPLETED YEAR |__|__| DOES NOT KNOW 8 NO RESPONSE 9	
A10	DID YOU MARRY MORE THAN ONCE?	YES 1 NO 2	--A12
A11	HOW MANY TIMES?	NUMBER OF TIMES |__|__| DOES NOT KNOW 8 NO RESPONSE 9	
A12	HAVE YOUR WIFE EVER ATTENDED FORMAL SCHOOL?	YES 1 NO 2	--A14
A13	WHAT IS THE HIGHEST GRADE SHE HAD COMPLETED?	GRADE |__|__| TECHNICAL/ VOCATIONAL CERT. 13 UNIVERSITY/ COLLEGE DIPLOMA 14 UNIVERSITY/ COLLEGE DEGREE 15	
A14	HAVE YOU EVER GOT A CHILD?	YES 1 NO 2	--A17
A15	HOW MANY LIVING CHILDREN DO YOU HAVE? [*If none, record* '|0|0|'.]	NUMBER OF CHILDREN |__|__| DOES NOT KNOW 8 NO RESPONSE 9	IF |0|0| --17

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
A16	HOW MANY OF THESE CHILDREN ARE DAUGHTERS? [*If none, record* '|0|0|'.]	NUMBER OF DAUGHTERS |__|__| DOES NOT KNOW 8 NO RESPONSE 9	
A17	HAVE YOU GOT SISTERS?	YES 1 NO 2	---A19
A18	HOW MANY LIVING SISTERS DO YOU HAVE? [*If none, record* '|0|0|'.]	NUMBER OF SISTERS |__|__| DOES NOT KNOW 8 NO RESPONSE 9	
A19	WHAT IS YOUR RELIGION?	ORTHODOX 1 CATHOLIC 2 PROTESTANT 3 MUSLIM 4 TRADITIONAL 5 OTHER _____ 6 [SPECIFY]	
A20	WHAT IS YOUR ETHNICITY?	OROMO 1 AMHARA 2 TIGRAWAY 3 SOMALI 4 AFAR 5 OTHER _____ 6 [SPECIFY]	
A21	WHAT IS YOUR WIFE'S RELIGION? [*Filter: if ever married* - A08]	ORTHODOX 1 CATHOLIC 2 PROTESTANT 3 MUSLIM 4 TRADITIONAL 5 OTHER _____ 6 [SPECIFY]	

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
A22	WHAT IS YOUR WIFE'S ETHNICITY? [*Filter: if ever married* - A08]	OROMO 1 AMHARA 2 TIGRAWAY 3 SOMALI 4 AFAR 5 OTHER _____ 6 [SPECIFY]	

ECONOMIC INFORMATION

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
B01	ARE YOU EMPLOYED?	YES 1 NO 2	--B03
B02	WHAT IS YOUR OCCUPATION?	PROFESSIONAL-TECHNICIAN 1 ADMINISTRATOR, MANAGER 2 SALES WORKER 3 FARMER 4 CRAFTS MEN, LABOURER 5 MILITARY 6 OTHER _____ 7 [SPECIFY]	
B03	IS YOUR WIFE EMPLOYED? [*Filter: if ever married* - A08]	YES 1 NO 2	--B05
B04	WHAT IS HER OCCUPATION?	PROFESSIONAL-TECHNICIAN 1 ADMINISTRATOR, MANAGER 2 SALES WORKER 3 FARMER 4 CRAFTS MEN, LABOURER 5 MILITARY 6 OTHER _____ 7 [SPECIFY]	

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
B05	DO YOU HAVE ANY INCOME FOR YOUR HOUSEHOLD?	YES 1 NO 2	 ---B07
B06	HOW MUCH WAS YOUR TOTAL HOUSEHOLD MONTHLY INCOME?	AMOUNT IN BIRR |__|__|__|__| DOES NOT KNOW 8 NO RESPONSE 9	
B07	WHAT IS THE MAIN SOURCE OF DRINKING WATER FOR MEMBERS OF YOUR HOUSEHOLD?	*PIPED (TAPE)* PIPED INTO DWELLING 1 PIPED INTO COMPOUD 2 PIPED OUTSIDE THE COMPOUND 3 *OPEN WELL/SPRING* OPEN WELL 4 OPEN SPRING 5 *COVERED WELL/SPRING* COVERED WELL 6 COVERED SPRING 7 *SURFACE WATER* RIVER 8 POND/LAKE/DAM 9 RAINWATER 10 OTHER _____ 11 [SPECIFY]	
B08	WHAT KIND OF TOILET FACILITY DO MOST OF MEMBERS YOUR HOUSEHOLD USE?	FLUSH TOILET 1 *PIT TOILET/LATERINE* TRADITIONAL PIT TOILET 2 VENTILATED IMPROVED PIT LATERINE 3 NOT FACILITY/BUSH/FIELD 4 OTHER _____ 6 [SPECIFY]	

NO	QUESTIONS AND FILTERS	CODING CATEGORY			SKIP
B09	DOES YOUR HOUSEHOLD HAVE:		YES	NO	
	ELECTRICITY?	ELECTRICITY	1	2	
	A RADIO?	A RADIO	1	2	
	A TELEVISION?	A TELEVISION	1	2	
	A TELEPHONE?	A TELEPHONE	1	2	
	AN ELECTRIC MITAD?	AN ELECTRIC MITAD	1	2	
	A KEROSENE LAMP/PRESSURE LAMP?	A KEROSENE LAMP	1	2	
	A BED/TABLE?	A BED/TABLE	1	2	
B10	DOES YOUR HOUSEHOLD HAVE:		YES	NO	
	OWN THE HOUSE IT IS LIVING IN?	OWN HOUSE	1	2	
	HAVE CROPLAND?	CROP LAND	1	2	
	HAVE CATTLE/CAMELS?	CATTLE/CAMELS	1	2	
	HAVE HORSE/MULE/DONKEY?	HAVE HORSE/MULE/DONKEY	1	2	
	HAVE SHEEP/GOATS?	SHEEP/GOATS	1	2	
	GROW CASH CROPS?	CASH CROPS	1	2	
B11	WHAT TYPE OF FULE DOSE YOUR HOUSEHOLD MAINLY USE FOR COOKING?	ELECTRCITY 1 LPG/NATURAL GAS 2 BIOGAS 3 KEROSEN 4 CHARCOAL 5 FIREWOOD, STRAW 6 DUNG 7 OTHER _____ 6 [SPECIFY]			

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
B12	MAIN MATERIAL OF THE FLOOR. [*Record observation*]	EARTH/SAND 1 DUNG 2 WOOD PLANKS 3 REED/BAMBOO 4 PARQUET OR POLISHED WOOD 5 VINYL SHEETS/TILES 6 CEMENT 7 CEMENT TILES/BRICK 8 CARPET 9 OTHER _____ 6 [SPECIFY]	
B13	MAIN MATERIAL OF THE ROOF. [*Record observation*]	COROGATED IRON 1 CEMENT/CONCRETE 2 WOOD AND MUD 3 THACH 4 REED BAMBOO 5 PLASTIC SHEET 6 MOBILE ROOFS OF NOMADS 7 OTHER _____ 6 [[SPECIFY]	
B14	DOES ANY MEMBER OF YOUR HOUSEHOLD OWN: A BICYCLE? A MOTERCYCLE OR MOTER SCOOTER? A CAR OR TRUCK? A HORSE OR MULE FOR HUMAN TRANSPORT ONLY?	YES NO BICYCLE 1 2 MOTERCYCLE/SCOOTER 1 2 CAR/TRUCK 1 2 HORSE/MULE 1 2	

ATTITUDE ON FEMALE GENITAL MUTILATION

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
C01	HAVE YOU EVER HEARD OF FEMALE GENITAL MUTILATION?	YES 1 NO 2	—♥
C02	ARE ALL FEMALES IN YOUR FAMILLY CIRCUMCISED?	YES 1 NO 2	
C03	HAS ANY OF YOUR DAUGHTERS BEEN CIRCUMCISED? [*Filter: if nº of daughters given* - A16]	YES 1 NO 2	
C04	DID YOU HERE ANY WOMAN COMPLAING OF MUTILATION COMPLICATIONS?	YES 1 NO 2	
C05	DO YOU THINK THAT MUTILATION HAS ANY EFFECT ON CHILDBIRTH?	YES 1 NO 2	
C06	DO YOU THINK GENITAL MUTILATION SHOULD BE CONTINUED, OR SHOULD IT BE DISCONTINUED?	CONTINUED 1 DISCONTINUED 2 DOES NOT KNOW 8	—C08
C07	WHY DO YOU THINK FEMALE GENITAL MUTILATION SHOULD BE CONTINUED? [*Record all reasons mentioned*]	GOOD TRADITION 1 CUSTOM AND TRADITION 2 RELIGIOUS DEMAND 2 HYGIENE 3 PRESERVATION OF VIRGINITY 4 TO PLEASE HUSBAND 6 TO BELONG TO THE COMMUNITY 7 TO ENHANCE FERTILITY 8 TO INCREASE MATRIMONIAL OPPORTUNITY 9 TO MAINTAIN GOOD HEALTH 10 OTHER _____ 11 [SPECIFY]	

♥ Complete the questionnaire

NO	QUESTIONS AND FILTERS	CODING CATEGORY	SKIP
C08	WHY DO YOU THINK FEMALE GENITAL MUTILATION SHOULD BE DISCONTINUED? [*Record all reasons mentioned*]	BAD TRADITION 1 AGAINST RELIGION 2 MEDICAL COMPLICATION 3 PAINFUL PERSONAL EXPERIENCE 4 AGAINST DIGNITY OF WOMEN 6 PREVENTS SEXUAL SATISFACTION 7 OTHER _____ 8 [SPECIFY]	
C09	WHAT DOES YOUR WIFE THINK ABOUT THIS SUBJECT?	SUPPORTS TO BE CONTINUED 1 DOES NOT SUPPORT 2 DO NOT KNOW 88	
C10	WOULD SHE AGREE WITH YOU NOT TO CIRCUMCISE YOUR DAUGHTERS?	YES 1 NO 2 DO NOT KNOW 88	
C11	WHAT WAS YOUR SUGESSTION TO ERADICATE FGM?	SPECIFY? _____	

DECLARATION

I, the undersigned, declare that the thesis is my original work, has not been presented for a degree in any other university and that all sources of material used for the thesis have duly acknowledged.

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