

Attitude toward female genital mutilation among Somali and Harari people, Eastern Ethiopia

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Background: Female genital mutilation (FGM) is a worldwide problem, and it is practiced by many communities in Africa and Asia as well as immigrants from those areas. This practice results in short- and long-term health consequences on women's health. Like many other developing countries, FGM is widely practiced in Ethiopia, especially among Somali and Harari ethnic groups. Despite intensive campaigns against FGM in Ethiopia, since 2011, it has been practiced in the aforementioned communities. There is no recent information as to whether these campaigns have an impact on the attitude and practice of the community regarding FGM. This qualitative research was aimed at exploring the attitudes of Somali and Harari people between 18 and 65 years toward FGM.

Methods: A purposive sampling technique was used to recruit 64 (32 in each region) participants. Data were collected from October to December 2015 in Somali and Harari Regions.

Results: The findings showed that there was a strong support for the continuation of the practice among female discussants in Somali region, whereas male discussants from the same region and the majority of the participants from Harari region had a positive attitude toward the discontinuation of the practice. Marriageability was the major reason for practicing FGM in Somali region, whereas making girls calm, sexually inactive, and faithful for their husbands were mentioned in Harari region. Although young men in both the regions prefer to marry uncircumcised girls, the study showed that there are some differences in the attitude toward the FGM practice between the people in the two regions.

Conclusion: The findings show that there is an attitudinal difference between the people in the two regions, which calls for behavioral change communication using women-centered approach and culturally appropriate strategies. As young people in both the regions had the intention to marry uncircumcised girls, there has to be a strong advocacy and multisectoral collaboration to stop FGM in both the regions.

Keywords: female genital mutilation, attitude, abandonment, health effect, reason

Background

According to WHO definition, female genital mutilation (FGM) refers to all procedures that involve partial or total removal of the external female genitalia, or other injury inflicted on the female genital organs, for reasons that are not medical.¹ WHO classified FGM into four major parts.¹ Type I: "Sunna"/clitoridectomy is the partial or total removal of the clitoris and/or the prepuce. Type II: Excision is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. Type III: Infibulation is the narrowing of the vaginal orifice with a creation of a covering seal by cutting and repositioning the labia minora and/or the labia majora, with or without excision of the clitoris. Type IV: All other harmful procedures to the female genitalia for nonmedical purposes (eg, pricking, piercing, incising, scraping,

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and cauterization).¹ The practice is mostly performed on girls between the ages of 0 and 15 years. In 30 African, the Middle East, and Asian countries where FGM is common, >200 million girls and women alive today have been cut, and 3 million are at risk for the practice each year in Africa.² The practice is internationally recognized as violation of the rights of both girls and women. It reflects a culturally deep-rooted inequality where there is an extreme form of discrimination between sexes.² All types of FGM have immediate (short-term) and long-term health complications depending on the type performed and the hygienic conditions.³ Immediate health complications include severe pain, excessive bleeding, genital tissue swelling, shock, and death.² Long-term health complications include urinary problems, infection, menstrual problems, sexual problems, psychological problems, increased risk of childbirth complications, and newborn deaths.² A study in six African countries also revealed that women who underwent infibulation type of FGM were more likely to have a caesarean section with extended hospital stay, postpartum hemorrhage, and perinatal death.³

Like many other developing countries, FGM is widely practiced in Ethiopia, and it is a major contributing factor for the high maternal mortality in the country.⁴ This practice is considered as a major national public health problem, as it affects not only the physical and mental well-being of more than half of the Ethiopian population but also the socioeconomic development of the country.⁴ According to the Ethiopian Demographic Health Survey, the estimated prevalence of FGM in girls and women (15–49 years) was 74.3%.⁵ However, there is a great variability in the prevalence of FGM among different regions in Ethiopia, ranging from 29% and 27% in Tigray and Gambela regions, respectively, to 82% in Harari and 97% in Somali regions.^{5,6} The prevalence of FGM in Harari and Somali regions is high regardless of national context. In fact, the prevalence of FGM in Somali region is similar to that of Republic of Somalia (98%) rather than that of Ethiopia.⁵ Similarly, the reason for the practice varies among ethnic groups in Ethiopia. Many Ethiopian ethnic groups perform FGM as a rite of passage.⁷ Contrastingly, the Somali and Afar ethnic groups perform FGM with the belief that it is required by religion and a means to ensure virginity.⁴ In Ethiopia, FGM is mainly carried out by traditional birth attendants or traditional “doctors,” normally old women, who are paid in cash, or in kind, for executing the process. Increased medicalization of the practice is also reported from some regions of Ethiopia.⁴

Several activities that are aimed at raising awareness on harmful consequences of FGM have been underway in highly prevalent regions like Somali and Harari. A range of initiatives and strategies including “Community Conversations,” revision of Criminal Code which specifically outlaws FGM, have been developed and implemented to combat FGM over the past decade at regional level.⁷ The Government of Ethiopia has also been supported by the United Nations International Children’s Emergency Fund to encourage abandonment of FGM at local level for several years.⁸ But there is no recent published data on whether these people’s positive attitudes toward the practice of FGM have been changed after the introduction of these programs. Nonetheless, FGM abandonment remains to be a huge challenge in highly prevalent areas like Somali and Harari regions of Ethiopia.⁹ Deeper understanding of the attitudes underpinning this pervasive practice is critical to design relevant intervention strategy. Therefore, the aim of this study is to explore the attitude toward the practice of FGM among communities of Somali and Harari regions. Exploring the attitude of different communities would help to inform policy makers to develop and implement intervention strategies to abandon FGM in the two regions.

Theoretical framework

Understanding FGM as a social convention provides insight as to why the practice is continued despite its harmful effect. According to the social convention theory, the decision-making in FGM is an interdependent process, which is affected by the choice of each family in the community. The theory offers an explanation for why daughters and their families want the continuation and not the discontinuation of the practice. An initial assumption with respect to the decision-making process would be parents’ love toward their daughters. This means as parents love their daughters, they want to do what is best for them. The social convention theory illustrates that in FGM practicing communities where FGM is considered as a criterion for marriage, no single family wants to abandon the practice because it affects the possibility of their daughters being married. The possible reason would be no benefit to the family if they deviate from the social expectation of cutting. The theory also illustrates that if all families agreed to choose not to cut their daughter, then FGM would not be a prerequisite for marriage. This would allow them to retain marriage and avoid harming the health of girls and violating their rights. The theory further stated that this is in an equilibrium state as no incentive will be gained by circumcising their daughters; they prefer not to cut than cutting. The challenge for families is to

accept the new culture than the existing one, from circumcising to not circumcising all girls. Therefore, abandonment is possible only by coordinating a collective abandonment effort within the intermarrying community.¹⁰⁻¹²

Materials and methods

Study area

This study was conducted in Somali and Harari regions of the easternmost ethnic divisions of Ethiopia. The Oromia region of Ethiopian borders the Somali region to the west and Somalia to the north, east, and south, while the Harari region is located between Oromia and the Somali regions. According to the Ethiopia Central Statistical Agency (2007), the Somali region has a total population of 4,445,219, with 2,472,490 men and 1,972,729 women,¹³ while the Harari region has a total population of 183,415, of whom 92,316 were men and 91,099 women.¹⁴ In Somali region, the majority of the ethnic groups are Somalis (97.2%), and Somali was spoken by 96.8% of the inhabitants.¹³ The Somali region is predominantly Muslim and shares many traits with its neighboring country Somalia.⁷ In Harari region, there is a mix of many ethnic groups who speak Harari (Aderegna).⁷ FGM is highly practiced in these two regions, with the prevalence of 97.3% in Somali and 82.2% in Harari regions, which is high regardless of national context.^{5,7}

Study design

Focus group discussion (FGD) was carried out in Somali and Harari regions from October to December 2015. An FGD is considered important to find the participants' attitude toward the practice of FGM and to understand the essence of persons' account of their perception and experiences. A purposive sampling technique was used to recruit 64 (32 in each region) participants between 18 and 65 years of age, with the participants recruited demonstrating diversity in terms of age, sex, and educational status. Four FGDs were conducted in each region with each FGD involving eight participants. The FGDs were disaggregated by sex with four FGD being men and four being women. To facilitate the group discussions, the principal investigator divided the groups by age in accordance with the definition of sub-Saharan Africa, where the age group from 15 to 30 years is deemed as young.¹⁵ Thus, the researcher allocated those ≤ 30 years in one group and >30 years in another group in both the regions. In qualitative studies, there is no claim to generalize to a larger population; it is the extent of understanding and trustworthiness of the findings that are important.¹⁶ The participants were chosen on the basis of their experience and knowledge of

FGM. The researcher used a nondirective style of questioning by using open-ended questions to allow probing in order to have adequate information regarding the subject matter of the discussion. Additionally, a more directive style of questioning was used when the researcher required more information than the participants were providing. In Somali region, the discussion was moderated by an experienced Somali nurse, and the principal investigator took a note when the moderator translated the responses, while in Harari region, the principal investigator moderated the discussion in Amharic and an assistant took a note. The discussions were made simple and clear to avoid misunderstanding. Prior to data collection, the objective of the study and the expected duration of the discussion were informed to the participants. FGDs took place at mutually agreed time, date, and location chosen by the participants. Several authors suggest that 90 minutes is the optimum length for FGDs.¹⁷ Therefore, the researcher informed the participants that the discussion could take approximately 1 hour, but they could go as long as they wish, they are not limited with what they wanted to share. Accordingly, the FGDs lasted from 1 to 1.5 hours, while one FGD lasted for 1 hour.

Ethical clearance

Ethical approvals were obtained from Jimma University Institutional Review Board (Ethiopia) and from the Norwegian Social Science Data Services (NSD), Norwegian National Research Ethics Committee. A formal letter was written from Jimma University Health Science College and permission was obtained from Administrative Offices of Somali and Harari regions. Verbal consent was obtained from participants, and they were told to withdraw from the study anytime without any consequences. The interview was tape recorded after consent was secured.

Content of FGD

During discussion, participants were asked to discuss and reflect upon the attitude toward continuation or discontinuation of the practice of FGM, the type of FGM practiced in their area, the major reason for continuation of the procedure, the relationship of FGM with religion, the health effect of FGM, the decision maker for FGM in their regions, FGM performers in their regions, and any efforts toward the abandonment of FGM in Somali and Harari regions.

Analysis

Data analysis was started immediately after the first data collection day, using inductive approach. To validate the content, the translated group answers from all interviews to each

question were transcribed verbatim after it was verified with the respondents. The transcripts were thoroughly examined and arranged in sequences to organize and classify answers into categories. Coding was used through adding, subtracting, and combining potential codes to classify text about the different themes. After recognizing important themes, the researcher used a thematic analysis and encoding it prior to interpretation. As Boyatzis writes, “thematic analysis is a process of encoding qualitative information.”¹⁷ But this paper aims first and foremost to be descriptive in nature, to allow for different attitudes to be presented. The themes identified through coding were divided into categories based on the participants’ attitude, knowledge, experience, and understanding of FGM. A wide range of ideas and experiences that can be verified against each other from diverse groups of FGDs have served to ensure the trustworthiness and credibility of the study results, and ultimately a rich picture of the attitude toward FGM had been gathered. Accordingly, seven themes were identified.

Results

Of the 64 study participants from the two communities, 32 (50%) were females and 32 (50%) males. With regard to their educational status, more than half (55%) of the study participants had attended primary school, while 40% had attended secondary school, and the remaining 5% had attended university education. Pertaining to the composition of the group, they were religious leaders, “Keble” (district or neighborhood) leaders, women’s affairs office representative, youth association members, students, housewives, and elderly people.

With regard to the participants’ responses, the results were categorized into seven themes.

Types of FGM practiced in the respective regions

The participants agreed that there are three types of FGM: excision, infibulation, and Sunna types. The majority of the participants responded that the excision and infibulation types date back almost 20–30 years in urban as well as in rural areas of both the regions. Furthermore, the participants reported that the majority of those who practice infibulations shifted to practice the less extensive or “Sunna” type in urban and rural areas of the Somali region due to its lesser health risk. In contrast, the majority of the FGD participants in Harari region expressed that the practice is diminishing with the exception of rural areas where “Sunna” type of circumcision is being practiced.

Nevertheless, although the research participants vary in their responses, the majority of the respondents confirmed that Sunna type is preferable than infibulation type of FGM.

While explaining the types of FGM, a 35-year-old female FGD participant from Harari stated the following:

It appeared that FGM was practiced before, but recently, males seem to show interest to marry uncircumcised girls, because they (the males) believe that the uncircumcised girls would be sexually active in terms of satisfying the males’ feelings regarding the maximum sexual gratification. Even if the males don’t get uncircumcised girls, they prefer girls who have undergone the “Sunna” type of circumcision.

Similarly, a 38-year-old male FGD participant from the Somali region stated the following:

Infibulations were common in 20 to 30 years ago. Nonetheless, in the advent of education, conditions started to change and males inclined towards getting married to females circumcised by “Sunna” type of circumcision; infibulated girls are not males’ preference since they are not believed to have an attractive sexual feeling.

Some of the research participants from Somali region, however, reported that some mothers do infibulations on their daughters due to the existing culture in their tribal groups. This was also substantiated by a 37-year-old Somali female who stated:

I ... cannot say there is no infibulations because I hear and see some mothers are practicing it.

Reasons for FGM

In Somali region, the most important reason reported regarding FGM is a requirement for marriage. The research participants reported that the community prefers the infibulation type for marriage. However, this finding indicated that in recent days, the majority of young discussant preferred to marry an uncircumcised girl while men who supported the continuation prefer the “Sunna” type. Those discussants who supported the infibulations type stated:

If the bride is not infibulated, the Somali man, after digging a hole in front of the door of the bride’s family, returns her to her parents. This is to mean “your daughter is open like this hole, so I don’t want open girl because she is not virgin and she will not be faithful to her husband.” This act totally disappoints the family and results in a heavy depression on their (the family’s) side. That is why the

society practices infibulations until recent time. [a 56-year-old male Somali]

A Somali man who lives in America came to marry a girl from Somali region. He asked his relative to find him a girl who has undergone infibulations believing that infibulations is the set criterion to select a girl for marriage. His father found him one beautiful girl and performed all the procedure that should be finalized before the marriage ceremony takes place. However, after the marriage ceremony was carried out, the father finally learned that she was uncircumcised; he soon returned her to her family. I still remember how much the girl's family were saddened. [a 55-year-old female Somali]

In Harari region, circumcision is not considered a criterion for marriage. The major reason for circumcision to be performed was claimed to make the girl calm and sexually inactive so that she can be faithful to her husband. However, the results of this study revealed that these days the vast majority of the Harari people are convinced that circumcision is unnecessary, and the majority of them claim that they will not circumcise their daughter in the future.

A 45-year-old male Harari who supported the reason stated:

I don't know what was in the past, but to my knowledge we did circumcision to calm the girl. If she is not circumcised, she will be sexually active, and as a result, she will not be faithful to her husband.

Nonetheless, some research participants argued against their counterparts with the following assertions:

Some people say that an uncircumcised girl is sexually active. Owing to this, they say that they practice circumcision to calm her. But, I personally don't agree because sexual feeling is natural. Why should we violate the girl's right by circumcising in an attempt to make her free of sexual feeling? It is really a crime. So, we have to fight against circumcision. [a 26-year-old male Harari]

What people say about FGM is simply that it is a harmful traditional practice the community performs without being aware of the consequences. I think what is said about the effect of circumcision on a girl (that it makes her calm and sexually inactive) is false. If it were true, an uncircumcised girl would exhibit extraordinary sexual behavior. [a 30-year-old male Harari]

Yes, it is not the clitoris, which makes girls active or not, it is the environment, the family, and the friends which control their behavior. If we need a better generation, we have

to work on the education of our girls. If they are educated, they know what to do and what not to do. I, personally, will not circumcise my future daughter, and I will teach to all my friends that it is a harmful culture which should be stopped. [a 26-year-old male Harari]

Since I am the member of the youth association of Harari region, what I hear and know is that young people don't focus on circumcision for marriage. Rather, they give due attention to love and beauty. [a 25-year-old male Harari]

FGM as a religious requirement

The majority of the participants believed that, except the "Sunna" type of FGM, excision and infibulations are not religious requirements. "Sunna" gained great support from the religious groups that follow or favor it. There were a lot of disputes or debates among groups on whether or not "Sunna" should be considered a religious requirement in Somali region. Nonetheless, after a long deliberation, they reached consensus as "Sunna" should be regarded as a religious requirement. The following assertions substantiate this:

In the Muslim religion, we believe that if we are not circumcised, we feel that we are totally against our religion. Allah will never accept us whatever we pray. This is the reason we allow our daughters to practice FGM. [a 56-year-old-female Somali]

The community believes that it is a good culture and they have to pass their daughters through circumcision. Even if "Sunna" is supported by our religion, the society believes that all circumcisions are considered religious requirements. The majority of the families in Somali region believe that they will not get benefits during marriage and their daughters will never get married unless they have gone under circumcision. [a 60-year-old male Somali]

One participant also expressed his feeling by saying:

"Sunna" is supported by our religion, but there is nobody who knows how to perform the "Sunna" type of circumcision. If we let the circumcisers do it, they will do the excision or the infibulations type because they are good in doing them (excision and infibulations). So, they can't do the "Sunna" type. "Sunna" type of circumcision deals with cutting the tip of the clitoris. Hence, it needs training. Therefore, I personally believe that circumcision of girls should be banned totally. [a 45-year-old male Somali]

The majority of the participants in Harari region confirmed the belief that FGM is not a religious requirement

and nothing is written about female circumcision in Quran and in the Bible.

Two participants stated that “Sunna” type of circumcision is not supported by religion.

I believe female circumcision is not a religious requirement; it is just a common tradition. As I am a member of the young generation, I have to teach the community. My friends and I do not believe that the “Sunna” type is a religious requirement. [a 27-year-old male Harari]

People say that the “Sunna” type is supported by religion. Since I am a religious leader, I know my religion very well and teach Quran, but I didn’t come across any text which supports “Sunna” as a type of circumcision that represents Islam. I was, even, asked in many training centers and I explained what I know. On my part, “Sunna” is not a religious requirement. Whatsoever the case might be, I don’t support any type of circumcision. [a 55-year-old male Harari]

Attitude toward continuation/ discontinuation of FGM

Attitude toward discontinuation of FGM

Some male participants from Somali region and the majority of the participants from Harari region had positive attitude toward the abandonment of FGM. Young discussants in both the regions had an intention to marry an uncircumcised girl and a positive attitude toward the discontinuation of FGM.

The discussants stated the following while expressing their support of discontinuation of the practice from Harari region:

Previously, we used to hear that girls did not want to be friends with uncircumcised girls thinking that it was a shame as it was regarded as disrespecting their religion, but these days the situation is changed. If a girl is circumcised, the uncircumcised ones ignore her and they don’t want to be her friends. I personally support the discontinuation of the practice. [a 25-year-old female Harari]

It is enough; let our daughters live healthy life. Why do we damage them? I strongly support the discontinuation of FGM from our region. [a 30-year-old female Harari]

Yes, I support the abandonment of FGM from our region. When I was a kid, my grandmother told me that FGM is a good practice for girls. But I hear and see that I and females in my age, in my village, are suffering a lot due to the harmful effect of FGM. We (the females) do not like it, but we are silent due to fear of the community. [a 28-year-old female Harari]

Likewise, Somali men expressed their feelings supporting the discontinuation of the practice as follows:

I personally learned a lot about the harmful effect of FGM. I have two daughters, 3 years and 7 years old. I did not want my daughters to go through this harmful traditional practice. But my wife took them far for vacation and did the circumcision without my knowledge. So, knowing the harmful effect has no meaning unless we all are united to abandon the practice from our region. [a 35-year-old male Somali]

What I wanted to say is we know that FGM is a well-established culture. We cannot say we can bring about a change within a short period of time. We Somali people believe that our daughters will not get husbands unless we do the required procedure. But I believe that today’s situation is by far better than that of the situation that existed long ago. So, let us work together and do our level best to bring about desirable and sustainable changes. [a 45-year-old male Somali]

Young male and female participants from both the regions had a positive attitude toward the abandonment of FGM.

As a member of the young generation, I think we do have the responsibility to abandon this harmful traditional practice. I know it might be difficult, but we need the support of government and other concerned bodies to ban this practice from our regions otherwise our sisters and our daughters will be in danger. (a 27-year-old male Somali)

I support the total abandonment of FGM. I will marry an uncircumcised girl. During circumcision, the sensitive genital tissues are cut. I would prefer [to marry] a girl who has all her tissues (uncircumcised). [a 25-year-old male Harari]

Previously we were told by our mothers and grandmothers that we will not get married unless we go through this harmful tradition, but these days some of our uncircumcised friends were married. We females do not need to be circumcised, we need the total abandonment of the practice. [a 20-year-old female Harari]

Considering culture and tradition as the main bottleneck for change, one young discussant strongly suggested on the behavioral change of mothers:

I agree on the discontinuation of FGM, but first, it is women who hold the key to ending the practice. [a 30-year-old male Somali]

Attitudes toward continuation of FGM (in Somali region)

The majority of female participants from Somali region strongly supported the continuation of the practice of FGM. Some discussants from the Somali region stated the following to express their support for the continuation of FGM practice:

We Somali women know the harmful effect of FGM. We are suffering throughout our life. Despite all this, no Somali mother wants her daughter left unmarried due to this existing culture, "Marriageability" that is why we support the continuation of FGM. [a 52-year-old female Somali]

It is our culture and supported by our religion. If you ask each family independently, nobody agrees with the abandonment, because it affects the family's honor. [a 42-year-old male Somali]

Yes, I am also supporting my friend's idea; it is difficult for the Somali people to abandon FGM within a short period of time. If we think FGM has severed health effect, let us shift it to the less harmful type (Sunna type). [a 45-year-old female Somali]

There are a few women who have a negative attitude toward the abandonment of FGM from Harari region. One of these women's expressions was:

I personally do not accept the total abandonment of FGM from our region, because it is our culture. [a 52-year-old female Harari]

Health risk of FGM

The majority of the study participants, as the finding showed, agreed that FGM does not have any benefit, but a lot of health risk. As examples of the bad consequences of mutilation, the participants cited some examples such as excessive bleeding, severe pain, absence of sexual feeling, impacts on health, economy, and social life of the females. They also revealed that a female who practiced FGM visits hospitals and clinics, most often, seeking aid that might give her relief.

The participants, too, expressed their sympathy to a girl who suffers from the threatening effects of mutilation as follows:

A mutilated girl who suffers a great, intolerable agony might not be able to afford to buy medicines and pay for the medical treatment she is likely to receive. Such a victim is unlikely to escape death since her chance of getting adequate and appropriate aid can be very minimal. [a 40-year-old female Harari]

In addition to the aforementioned responses and examples on circumcision, the experiences some research participants shared are presented as follows:

I was circumcised while I was a small kid. Since that time until marriage, I have suffered a lot during menstrual periods and during sexual intercourses that mostly resulted in severe pain and genital infections. Not only this, but another unforgettable incident also happened during my wedding day. A woman came to me with the blade and she forcefully opened the infibulated part. I suffered a lot and cried when I noticed that I was bleeding much and felt unbearable pain. With that all intolerable pain and profuse bleeds, my husband had sex with me compellingly. I suffered a lot beyond words can express. I never forget that disastrous day throughout my life. [a 26-year-old female Harari]

A Somali woman suffered a lot starting from the day she was infibulated up to her death. FGM is with us every day. The first suffering started on the day of circumcision that resulted in excessive bleeding and severe pain. The worst thing was that the infibulations was done whenever she delivered during which she lost a lot of blood. [a 60-year-old female Somali]

FGM has severe sufferings on women and girls. They might encounter grave difficulties such as vaginal infection, itchiness, back pain, menstrual period pain, and complexity during delivery. Lack of vigorous sexual feelings that kills the sense of enjoyment, because they cut parts of their (the girls' or women's) bodies which Allah created for their souls, are saddening effects of FGM. [a 40-year-old female Somali]

Decision maker and performer of FGM

The majority of the participants stated that FGM in Somali and Harari regions is performed only by traditional female circumcisers. Males are never involved in female circumcision. The majority of the participants from both the regions reported that the government gave them an alternative job, but still they are doing the practice.

One participant expressed her view as follows:

I heard that in Somali region the government has given other jobs to circumcisers though some of them refused the offer since their preference is circumcision. And those who insisted on performing circumcision are heard to shift their residence from urban to rural areas. [a 30-year-old female Somali]

In Harari region, the participants reported that the women's affairs offices took responsibilities to follow them.

In Harari region, the circumcisers were organized together and loan was given to help them create their own jobs. And the women's affairs office was given the responsibility to do the follow-up and report if a member does not work accordingly, to take the case to court. [a 40-year-old female Harari]

Concerning the decision making, the majority of the participants explained that mother plays a major role in female circumcision. And they go on saying that in Somali society mothers are responsible for females and fathers are responsible for males. The findings of this study revealed that mothers play a central role in female circumcisions in both the regions (Harari and Somali). Participants who supported the finding stated as follows:

I know some mothers encourage their daughters to go to circumcisers without informing their fathers. I remember that one of my friends had requested me to go with her to traditional female circumciser without the knowledge of the father. [a 30-year-old female Somali]

It is the mothers who have power when it comes to taking the decision. Even if the father does not want the daughter to be circumcised the mothers find ways to do it. [a 39-year-old female Somali]

Efforts toward abandoning FGM

The majority of the research participants stated that they were aware that there was a lot of work done in Somali region in the fight against FGM. Awareness raising seminars and workshops were organized for the community at school level through the youth and women's associations. The government also provided loans to circumcisers in order to enable them create other types of jobs for themselves. Furthermore, the government started to implement Articles 565 and 566 of the already existing penal code that makes FGM practice punishable by imprisonment from 3 months to 10 years.

The expression of some participants on FGM abandonment and their memory is as follows:

What comes to my mind is that female genital mutilation is a firmly constituted cultural practice in Somali Region. Due to this reason, it is difficult to stop it within a short period of time. Even if she is the daughter of a president, it is inevitable that she has to live under the influence of culture. It is the old belief or culture mothers uphold that makes them perform FGM without considering the danger and the problem it involves. Surprisingly, both the victimizers and victims of FGM are females. This reveals that

creating awareness, time and again, is extremely essential to bring about desirable behavioral changes on the society to achieve the desired goal pertaining to banning circumcision. [a 55-year-old male Somali]

In every village, via youth association, we teach males to get married to uncircumcised girls. But, we faced an unexpected problem. Because the circumcised girls and their families were not happy; they tried to accuse us. The circumcised girls opposed us aggressively and shouted at us on the roads by saying: Being circumcised is not our mistake; it is our families who should be condemned. How can we become victims? Why should we remain husbandless for the mere reason that we are circumcised without our consent? It was a shocking, memorable event which I never forget. We have to work hard to bring changes and find solutions for the mistakes committed with regard to circumcision. [a 26-year-old male Somali]

One participant expressed his fear on the process of abandoning FGM as follows:

In our discussions, I heard that creating awareness at all levels is very important. I agree to this proposition. But, I think it is difficult to marry only an uncircumcised girl because circumcision is usually done without the consent of the girl. Therefore, we are violating her rights. But, if the society is aware of this problem, it is possible to set a rule that can pave the way for civilized thinking. [a 35-year-old male Somali]

A 60-year-old male Somali expressed his memory on the harmful effect of FGM as follows:

Female genital mutilation was common in the old days. I remember there is a place which we call "YESETOCH MEKABIR" (Women's Grave). This is to mean 8 women had been circumcised on one day and all of them died on the same day, and were buried in one place. That is why the place is called "Yesetoch Mekabir" (Women's Grave). By showing this place and teaching the community the health risk that mutilation involves, we can bring about desirable behavioral changes.

The government of Harari carried out various activities through women's associations, youth associations, schools, and "kebeles" by establishing "BUNNA TETU" (Coffee ceremony) program, which is funded by "SAVE THE CHILDERN," a nongovernmental organization. In addition, schools were using girls' club and 1-5 strategies that are introduced by the Ministry of Education to create awareness in the students about the harmful effect of FGM.

Some expressions of the participant are as follows:

We don't hear about circumcision these days due to the provision of continuous awareness raising lessons. Nevertheless, rumors go that some mothers perform circumcision during vacation because the 1 to 5 programs established by the Ministry of Education (MOE) can help to easily identify the absent girls and it is difficult to perform FGM during school days. [a 30-year-old female Harari]

From my experience, the most effective ways of raising awareness are drama and music. People will be very interested in obtaining information or getting lessons communicated via drama and music to make audiences internalize the needed information. There are some shocking stories and places to be heard and seen where the harm of FGM was performed. So, it will be a good teaching aid and convincing strategy to use. [a 40-year-old male Harari]

Discussion

This qualitative study explored the attitude toward the practice of FGM among men and women at age ranges between 18 and 65 years in Somali and Harari regions. The findings of this study provide important information on the opportunities for intervention and to formulate efficient FGM programs. The results show that there are some instances where the Somali and the Harari people differ in their perceptions. The continuous awareness creation at different levels in the community may have helped the Harari people to adopt a more negative attitude to FGM. This finding is supported by the study performed with an attitude of Sudanese people toward FGM, which revealed that those who have negative attitude toward the practice are those better educated and/or young people.¹⁸ In line with this finding, a previous study in Harari, eastern Ethiopia also revealed that signs of change in the practice are evident due to continuous awareness creation programs.¹⁹ This may be a good initiation for abandonment. However, it does not mean that FGM problems are solved. In contrast, the majority of female participants in Somali region have a strong support toward the continuation of FGM. In a community where FGM is considered a culture, it is well known that women and girls are the main social group who suffers directly from this practice and hold the social pressure and the stigma in the community. Then, they (the women) prefer to pass through all the problems and the consequences of FGM, rather than being stigmatized by the community. Similarly, the previous study conducted in Ethiopia reported that women from Somali region were the major supporter of FGM because of social pressure and stigmatization toward uncircumcised women.⁶ A study by

the United Nations International Children's Emergency Fund also supported the present study by stating that FGM is performed in line with tradition and social norms and to uphold their status and honor of the entire family.²⁰ Therefore, in order to bring significant change, women are potentially the best agent in the abandonment of FGM if they are educated and empowered. On the other hand, this finding identifies that male participants in Somali region have a more positive attitude toward the abandonment of FGM than females. This could be due to the continuous awareness program given in the region where females are not usually volunteering in community conversation due to work overload at home. The other reason is training, workshops, and seminars that focus FGM are mostly given at school level, at the public gathering, and in the institutions, where women are not fully benefited compared to men. In FGM abandonment program, this study and other studies in African countries considered men as a major stakeholder, while a study done in the Hargeisa district (Somalia) contradicts by stating "men are more likely to support the continuation of the practice than females, and the vast majority of men preferred to marry circumcised women."²¹ This may be due to the reason that many religious leaders in Somalia defend the *Sunna* type is a religious requirement and is harmless, and their participation in awareness creation is minimal, considering FGM as women's issue.²¹

This study also investigated the relationship of religion with FGM. The majority of the participants from the Somali region reported that "Sunna" type of circumcision is supported by religion and hence discontinuing the practice is difficult. Accordingly, many of the study participants who supported the practice firmly believed that FGM is a religious precept. This finding is supported by previous studies performed in Ethiopia, Somali region, and Bale, which stated that religion was the major reason for the perpetuation of this practice.²²⁻²⁵ In such areas, FGM abandonment is difficult, unless involving religious and community leader in the campaign to fight the practice and strengthening of national laws against FGM. In contrast, majority of the participants from Harari region, who did not support FGM, stated that the practice was contrary to religious precepts and, moreover, had received information in mosques and churches in favor of the abandonment of FGM. This finding is consistent with other studies conducted in eastern Ethiopia, Gambia, and Egypt.^{19,26,27}

The present study stated that many people in Somali region consider marriage as the main reason to perform FGM. Despite the harmful effect of FGM, mothers in Somali region

allow their daughter to go through the procedure fearing the stigma and the discrimination. As Gele (2013) stated,

Where almost all the women have been circumcised, being uncut has become a social stigma, as uncut woman may have little chance of getting a husband. Thus, it is not surprising that there is pressure by mothers and relatives to allow their daughters to undergo female circumcision.²⁸

A similar study in Gambia stated that the reason for FGM to continue is due to strong ancestral sociocultural roots.²⁹ Another study in Kenya also revealed that mothers would fear the harassment by their male counterparts if their girls were not circumcised. Then they (the women) continued the practice by ignoring the harmful effect of the practice as a way of social acceptance and marriage.³⁰ Studies also showed that in Ethiopia and Somalia women still support the practice, believing the chance of uncircumcised women to be married is very low.^{25,31} This finding is also supported by other several studies in Africa.^{22,32–37} It implies that the family has to get a benefit, if not, no one marries the girl, and no benefit is likely to be gained on the side of the victim's family which considered a culture and a religious requirement. Due to this very reason, all families in the Somali community send their daughters to undergo infibulations. According to Gerry,

This highlights that when a social convention or a social norm is in place, decision-making is an interdependent process, in which a choice made by one family is affected by and affects the choices made by other families.¹⁰

This implies that parents choose what is best for their daughters and get them ready and prepared for a proper marriage. On the other hand, an uncircumcised girl will have a problem with getting married and socially rejected. Under these circumstances, FGM can be seen as the best way for the parents to ensure marriageability. Even the girls wish to be circumcised to get acceptance by the society.^{10,11,38} As the study reports earlier, as men are the major supporter of the discontinuation of the practice, their preference for marriage will be the uncircumcised girl. In this case, when cutting (circumcision) will no longer be a criterion for marriage, mothers will be free from stigma and discrimination by not doing the procedure. Then involving both male and female in the anti-FGM campaign is a priority issue in abandoning FGM from the region.

The underlying reason for the continuation of FGM in Harari region is the belief that it makes the girl calm. They (the Harari people) believe that cutting only the tip of the clitoris (Sunna type) makes the girl calm and sexually

inactive. This is because of the assumption of mothers who consider being uncircumcised makes a girl become sexually very active. As they believe that it is the clitoris which makes her sexually active, they agree with its removal. This finding is in agreement with the findings of other studies that stated similar reasons.^{19,22,23,33,39} Even though the present study shows circumcision is done due to deferent reasons, the majority of the participants from Harari region prefer not to circumcise their daughters, which should be encouraged and invites further intervention activities for the total abandonment of FGM from the region.

This study also revealed that mothers are the decision makers to female circumcision in both the regions. The majority of the participants explained that mother plays a major role in female circumcision. An initial assumption is that they (mothers) want to optimize their daughters' future prospects, and they do have a fear of violating the tradition. This finding is similar to another finding, which states that mothers or grandmothers were the major ones who organize circumcision to their daughters.^{12,19} Another similar study also supports this finding in which the majority of the circumcisers who circumcised women in secret places were women themselves.³⁰ In contrast to this finding, other studies noted that the decision is taken by husband's family after marriage,⁴⁰ and in Somalia and northern Nigeria, fathers are the one who took all decisions concerning their family.^{21,41} FGM in Somali and Harari regions of Ethiopia is performed only by traditional female circumcisers as it is believed to be their source of income. Because circumcision is regarded as the business and irreplaceable source of revenue, female circumcisers delegate their daughters to perform the procedure regarding circumcision. However, males are never involved in female circumcision. This finding is similar to other studies which stated that FGM is usually carried out by a traditional birth attendant, and older women without using anesthetic, analgesia, aseptic technique, or antibiotics.^{25,31,42–45}

One of the unexpected findings in both the regions was that young people have a negative attitude toward the practice. The majority of the young male discussants revealed in the FGD that they themselves do not want to marry a circumcised girl. The possible explanation could be circumcised girls lose their sexual feeling, as they (young men) learned from schools, community conversation, and intimate friends. They came to reach to a conclusion that the uncircumcised girl has better sexual feelings than the circumcised one. This could be a green light for halting the practice in the coming generation. On top of this, it is an important step in saving young girls from harmful consequences. This finding is similar to

the qualitative and quantitative study done among Somali immigrants in Oslo, which stated that the majority supported the discontinuation of the practice, and the vast majority of male participants want to marry uncut girls or uncircumcised women. The reasons put forth were uncircumcised women enjoy sex more and are healthier.^{46,47} In contrast to this study, a study conducted on young Somalis in Oslo reported that young men who have lived in Norway for <1 year believed the continuation of FGM, because they came from an environment that favors FGM and they migrate having a positive attitude toward FGM.⁴⁸ This study also shows that girls in Harari are unwilling to be circumcised and have a positive attitude to abandon FGM. This might be due to increased school enrolment and organizing girls clubs contributed in reducing the rate of circumcision as they (the girls) start to think about the harmful effect of FGM and resist through time.⁴⁹ This was supported by the unpublished study done in Harari primary school girls which reported that the prevalence of FGM is <5%. In contrast to this study, some parents insisted that their daughters are circumcised because they (their mothers) fear that they (their girls) otherwise may never marry and men prefer to marry only circumcised females.^{26,50} A study done in Hydia zone, southern Ethiopia, also contradicts the present study by stating that girls themselves demand to be circumcised to avoid shame and stigma.⁴³

This study states that the governments in both the regions conducted a lot of awareness creation programs. As all participants in both the regions confirmed, the practice of FGM seems to be a deep-rooted culture; it needs a collaborative work that involves all the community members, the government, and other organizations concerned. Many of the research participants particularly stressed the importance of involving women in every awareness creation program. As the prevailing socioeconomic dominance of men on women limits the ability of women to oppose FGM, a substantial change in women's attitude is likely to occur only through education and women empowerment. This study is in line with the study in Senegal, which stated that a women-centered approach has been most evident in the Community Empowerment Program. The program uses a community education approach for women based on human rights principles and has resulted in an abandonment of FGM in many communities across Africa.⁵¹ The present study also emphasized the relevance of religious leaders, key informants, and school teachers in terms of discharging their responsibilities with regard to bringing behavioral changes among the communities. Some studies suggested that programs that only supply or use information, education, and communication as

an independent intervention are insufficient: Because they do not attempt to change a deeply rooted social belief like FGM.⁵² There has now been a shift from IEC interventions to behavior change interventions, which work on understanding and changing the behavior and learned knowledge among the members of a particular community.⁵³ Approaches to end FGM need to consider culture that seems very useful to address behavioral changes through creating a common understanding among the entire community.⁴⁹ The stigma and discrimination that hold the practice to continue will be tackled by the social convention theory. According to the theory, it is described that performing FGM is an equilibrium state in which decisions made by one family is interdependent on decisions made by other intermarrying families in the communities.¹⁰ When this happens, we can say FGM is a social convention, it has become a social rule that all the people in this community have to follow, and it is based on the expectation that the other has done the same. It is difficult to abandon the practice alone because that will affect the future marriage prospect to the daughter. But if all families in one community choose to not support the FGM procedure, then circumcision would not be an issue for being marriageable, and they can avoid harming the girl's health. According to this statement, the challenge is for families to move together. Families will abandon FGM only when they believe that all others will make the same choice.^{10,54}

This study has limitations. The findings of the study reflect the attitude of a limited number of people who participated in the study and not necessarily the entire population of Somali and Harari regions. The failure to generalize the findings of this study to the population of both the regions is a general limitation of the qualitative methods used. However, that is not the aim of the qualitative research, but rather it is to explore the attitude and how people perceive the issues concerned. Most of the ideas and opinions that were repeatedly expressed among all male and female groups of the FGD have enhanced our confidence in the validity of the findings. Another limitation was the effect of the interpreter on the data, during interview due to insufficient research experience. This was tackled by using the experienced native translator.

Conclusion

The study shows that there is an attitudinal difference between the people in the two regions. The majority of females in Somali region support the continuation of FGM, which calls for behavioral change communication using women-centered approach, and culturally appropriate strategies. Conversely, there was a positive attitude among Harari region toward

the abandonment of FGM, which should be encouraged and invite interventional approaches to stop the practice. As young people in both the regions had the intention to marry the uncircumcised girl, this attitude must be encouraged through strong advocacy and multisectoral collaboration against the practice. Therefore, this study recommends a collaborative and strong effort among government, local organizations, community, and religious leaders to play a major role in the process to bring behavioral change within the entire community of Somali and Harari regions to stop FGM.

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Disclosure

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References

- World Health Organization. Eliminating female genital mutilation: an interagency statement *UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO*. Geneva, Switzerland: World Health Organization; 2008. Available from: www.who.int/reproductivehealth/publications/fgm/9789241596442/en/. Accessed September 14, 2016.
- World Health Organization. *Female Genital Mutilation: Fact Sheet, Updated February 2016*; Available from: www.who.int/mediacentre/factsheets/fs241/en/. Accessed February 17, 2016.
- GSN WT, Newsgroup GS, Feed GL. Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. *Lancet*. 2006;367(9525):1835–1841.
- Hussein MA, Adem AA, Mohammed MA. Knowledge, attitude and practice of female genital mutilation among women in Jigjiga Town, Eastern Ethiopia. *Gaziantep Med J*. 2013;19(3):164–168.
- Macro O. *Central Statistical Agency: Ethiopia Demographic and Health Survey 2005*. Calverton, MD: ORC Macro; 2006.
- Setegn T, Lakew Y, Deribe K. Geographic variation and factors associated with female genital mutilation among reproductive age women in Ethiopia: a national population based survey. *PLoS One*. 2016;11(1):e0145329.
- EGLDAM. *Old Beyond Imaginings: Ethiopia Harmful Traditional Practices*. 2nd ed. National Committee for Traditional Practices in Ethiopia (NCTPE); 2008.
- Population reference. Female genital mutilation/cutting; 2010. Available from: www.prb.org/pdf14/fgm-wallchart2014.pdf. Accessed September 14, 2016.
- Jones SD, Ehiri J, Anyanwu E. Female genital mutilation in developing countries: an agenda for public health response. *Eur J Obstet Gynecol Reprod Biol*. 2004;116(2):144–151.
- Gerry M. Female genital cutting the beginning of the end. In: Shell-Duncan B, Hernlund Y, editors. *Female Circumcision in Africa: Culture, Controversy, and Change*. Boulder, CO: Lynne Rienner Publisher; 2000.
- Alem E, Hailu E, Siyoum H-L, et al. Evaluation of progress with using community conversation as a strategy to encourage district level abandonment of female genital mutilation and/or cutting in 10 districts in Ethiopia. *Afr Evaluat J*. 2013;1(1):10.
- Mackie G, LeJeune J. Social dynamics of abandonment of harmful practices: a new look at the theory. *Special Series on Social Norms and Harmful Practices, Innocenti Working Paper*. 2009;6.
- Central Statistical Agency, English [eng], Ethiopia [eth]. Population and Housing Census Report – Somali Region – 2007. Available from: https://en.wikipedia.org/wiki/Somali_Region. Accessed September 29, 2016.
- Central Statistical Agency, English [eng], Ethiopia [eth]. Population and Housing Census Report – Harari Region – 2007. Available from: https://en.wikipedia.org/wiki/Harari_Region. Accessed September 29, 2016.
- Hervish A, Clifton D. Status report: adolescents and young people in sub-Saharan Africa. Opportunities and challenges. 2012. Available from: www.popline.org/node/574656. Accessed September 14, 2016.
- Parasuraman A, Berry LL, Zeithaml VA. Guidelines for conducting service quality research. *Market Res*. 1990;2(4).
- Boyatzis RE. *Transforming Qualitative Information: Thematic Analysis and Code Development*. London and New Delhi: Sage Publications; 1998.
- El Dareer A. Attitudes of Sudanese people to the practice of female circumcision. *Int J Epidemiol*. 1983;12(2):138–144.
- Missailidis K, Gebre-Medhin M. Female genital mutilation in eastern Ethiopia. *Lancet*. 2000;356(9224):137–138.
- Gupta GR. Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change. *Reprod Health Matters*. 2013; 21(42):184–191.
- Gele AA, Bo BP, Sundby J. Have we made progress in Somalia after 30 years of interventions? Attitudes toward female circumcision among people in the Hargeisa district. *BMC Res Notes*. 2013;6:122.
- Bogale D, Markos D, Kaso M. Prevalence of female genital mutilation and its effect on women's health in Bale zone, Ethiopia: a cross-sectional study. *BMC Public Health*. 2014;14:1076.
- Mitike G, Deressa W. Prevalence and associated factors of female genital mutilation among Somali refugees in eastern Ethiopia: a cross-sectional study. *BMC Public Health*. 2009;9:264.
- Mohammed GF, Hassan MM, Eyada MM. Female genital mutilation/cutting: will it continue? *J Sex Med*. 2014;11(11): 2756–2763.
- Mohamed M. *Assessment of Barriers of Behavioral Change to Stop FGM Practice among Women of Kebribeyah District, Somali Regional State, Eastern Ethiopia*. AAU; 2015. Available from: <http://etd.aau.edu.et/bitstream/123456789/6436/1/MOHAMED%20MOHAMUD.pdf>. Accessed September 14, 2016.
- Abolfotouh SM, Ebrahim AZ, Abolfotouh MA. Awareness and predictors of female genital mutilation/cutting among young health advocates. *Int J Women's Health*. 2015;7:259–269.
- Kaplan A, Hechavarria S, Bernal M, Bonhoure I. Knowledge, attitudes and practices of female genital mutilation/cutting among health care professionals in the Gambia: a multiethnic study. *BMC Public Health*. 2013;13:851.
- Gele AA, Bo BP, Sundby J. Attitudes toward female circumcision among men and women in two districts in Somalia: is it time to rethink our eradication strategy in Somalia? *Obstet Gynecol Int*. 2013;2013: 312734.
- Kaplan A, Hechavarria S, Martin M, Bonhoure I. Health consequences of female genital mutilation/cutting in the Gambia, evidence into action. *Reprod Health*. 2011;8(1):26.
- Muraya MW, Mau Mau War, female circumcision and social-cultural identity among the Agikuyu of Kiambu, Kenya. *Int J Culture History*. 2015;2(2):26.
- Mitike G, Deressa W. Prevalence and associated factors of female genital mutilation among Somali refugees in eastern Ethiopia: a cross-sectional study. *BMC Public Health*. 2009;9(1):1.

32. Bogale D, Markos D, Kaso M. Intention toward the continuation of female genital mutilation in Bale Zone, Ethiopia. *Int J Women's Health*. 2015;7:85–93.
33. Berg RC, Denison E. Effectiveness of interventions designed to prevent female genital mutilation/cutting: a systematic review. *Studies Family Planning*. 2012;43(2):135–146.
34. Almroth L, Almroth-Berggren V, Hassanein OM, et al. A community based study on the change of practice of female genital mutilation in a Sudanese village. *Int J Gynaecol Obstet*. 2001;74(2):179–185.
35. Isman E, Ekeus C, Berggren V. Perceptions and experiences of female genital mutilation after immigration to Sweden: an explorative study. *Sex Reprod Healthcare*. 2013;4(3):93–98.
36. Ashimi AO, Amole TG. Perception and attitude of pregnant women in a rural community north-west Nigeria to female genital mutilation. *Arch Gynecol Obstet*. 2015;291(3):695–700.
37. Abolfotouh SM, Ebrahim AZ, Abolfotouh MA. Awareness and predictors of female genital mutilation/cutting among young health advocates. *Int J Women's Health*. 2015;7:259.
38. Insight I. The dynamics of social change towards the abandonment of female genital mutilation/cutting in five African countries. Available from: https://issuu.com/unicefnorge/docs/towards_the_abandonment_of_fgm. Accessed September 14, 2016.
39. Akinsanya A, Babatunde G. Intergenerational attitude change regarding female genital cutting in Yoruba speaking ethnic group of Southwest Nigeria: a qualitative and quantitative enquiry. *Elect J Human Sex*. 2011;14.
40. Shell-Duncan B, Herniund Y. Are there “stages of change” in the practice of female genital cutting? Qualitative research finding from Senegal and the Gambia. *Afr J Reprod Health*. 2007;10(2):57–71.
41. Garba ID, Muhammed Z, Abubakar IS, Yakasai IA. Prevalence of female genital mutilation among female infants in Kano, Northern Nigeria. *Arch Gynecol Obstet*. 2012;286(2):423–428.
42. Yasin BA, Al-Tawil NG, Shabila NP, Al-Hadithi TS. Female genital mutilation among Iraqi Kurdish women: a cross-sectional study from Erbil city. *BMC Public Health*. 2013;13:809.
43. Tamire M, Molla M. Prevalence and belief in the continuation of female genital cutting among high school girls: a cross-sectional study in Hadiya zone, Southern Ethiopia. *BMC Public Health*. 2013;13:1120.
44. Johnson-Agbakwu CE, Helm T, Killawi A, Padela AI. Perceptions of obstetrical interventions and female genital cutting: insights of men in a Somali refugee community. *Ethnicity Health*. 2014;19(4):440–457.
45. Asekun-Olarinmoye EO, Amusan OA. The impact of health education on attitudes towards female genital mutilation (FGM) in a rural Nigerian community. *Eur J Contracept Reprod Health Care*. 2008;13(3):289–297.
46. Gele AA, Johansen EB, Sundby J. When female circumcision comes to the West: attitudes toward the practice among Somali Immigrants in Oslo. *BMC Public Health*. 2012;12:697.
47. Gele AA, Kumar B, Hjelde KH, Sundby J. Attitudes toward female circumcision among Somali immigrants in Oslo: a qualitative study. *Int J Women's Health*. 2012;4:7–17.
48. Gele AA, Sagbakken M, Kumar B. Is female circumcision evolving or dissolving in Norway? A qualitative study on attitudes toward the practice among young Somalis in the Oslo area. *Int J Women's Health*. 2015;7:933.
49. Andarge MY. *The Difficulties of Ending Female Genital Mutilation (FGM): Case of Afar Pastoralist Communities in Ethiopia*. 2014.
50. Nour NM. Female genital cutting: a persisting practice. *Rev Obstet Gynecol*. 2008;1(3):135–139.
51. Shell-Duncan B, Wander K, Hernlund Y, Moreau A. Legislating change? Responses to criminalizing female genital cutting in Senegal. *Law Soc Rev*. 2013;47(4):803–835.
52. World Health Organization. An update on WHO's work on female genital mutilation (FGM): progress report; 2011. Available from: www.who.int/reproductivehealth/publications/fgm/rhr_11_18/en/. Accessed September 14, 2016.
53. Chen J, Quiazon R. Literature review: best practice approaches to the prevention and abandonment of female genital mutilation/cutting. Melbourne: MCWH, 2014. Available from: www.netfa.com.au/downloads/NETFA-Literature-Review-2014.pdf. Accessed September 14, 2016.
54. Diop NJ, Askew I. The effectiveness of a community-based education program on abandoning female genital mutilation/cutting in Senegal. *Stud Fam Plan*. 2009;40(4):307–318.

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