Research Article

It Medical Team
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Health Science Journal
ISSN 1108-7366

2022
Vol.16 No.11:1004

Assessment of Female Genital Mutilation and its Health Related Problems in Jimma University Medical Center, 2020

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Received date: May 27, 2020, Manuscript No. IPHSJ-20-4328; **Editor assigned date:** June 01, 2020, PreQC No IPHSJ-20-4328; **Reviewed date:** June 16, 2020, QC No. IPHSJ-20-4328; **Revised date:** October 03, 2022, Manuscript No. IPHSJ-20-4328 (R); **Published date:** October 18, 2022, DOI: 10.36648/1108-7366.16.11.1004

Citation Gemeda TL, Damto SG (2022) Assessment of Female Genital Mutilation and Its Health Related Problems in Jimma University Medical Center, 2020. Health Sci J Vol:16 No:11

Abstract

Background: Female genital mutilation is any surgical modi ication of the female genitalia, comprising all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or non-therapeutic reasons. Female Genital Mutilation (FGM) involves the removal of some or all of the external female genitalia and is usually performed on children by traditional birth attendant, midwives or an old woman who traditionally performs this practice in the community (traditional circumcisers).

Objective: The objective of this study was to assess the prevalence and health related problems of female genital mutilation.

Methods: Institution based cross-sectional study was employed from December 01 to 10, 2019. Study was conducted on women of reproductive age visiting Jimma medical center during study period. Data was collected by using interview which prepared in english version questionnaire which developed a ter reviewing related literatures. The collected data was compiled by tally sheet and analyzed manually by using scienti ic calculator. Descriptive statistics like frequency and percentages was calculated.

Result: The total number of women studied was 350 with a non-response rate of 9.32%. The majority of respondents were Muslim (41.7%), Oromo (48.9%) and literate (64%) of the total 350 respondents 281 (80.3%) were genitally mutilated while only 50(14.3%) were non-mutilated; the rest 19 (5.4%) did not know whether they were mutilated or not. Of the 281 genitally mutilated women, 9 (3.2%) were infibulated (FGM type III), 242 (86.1%) had their clitoris partially or completely cut (FGM type I/II, non-infibulated) and the rest 30 (10.7%) could not tell the type of mutilation they had undergone.

Conclusion: About four i th 80.3%of respondents were genitally mutilated of the 281 genitally mutilated women, 242 (86.1%) had their clitoris partially or completely cut (FGM type I/II, non-in ibulated) and the rest 30 (10.7%) could not tell the type of mutilation they had undergone. About 70% of women knew that FGM was associated with health problems. More than half of the interviewed women (53.7%) had a female child and a slight majority of them (58%) had mutilated or were planning to mutilate their daughters. women were also asked what they think was the best ways to eradicate female genital mutilation and the majority (52.9%) suggested an Enforced legislation. About 18% was mentioned by educational campaign to women. Only 7.7% of women mentioned that encouragement of fathers to take more responsibility was the best way.

Keywords: Prevalence; Health related risk; Female genital mutilation

Introduction

Female genital mutilation is any surgical modification of the female genitalia, comprising all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or non-therapeutic reasons [1]. Female Genital Mutilation (FGM) involves the removal of some or all of the external female genitalia and is usually performed on children by traditional birth attendant, midwives or an old woman who traditionally performs this practice in the community (traditional circumcisers). It is one of the deeply rooted, harmful traditional practices that are still prevalent in a number of countries especially in developing countries. It is primarily practiced among various ethnic groups in more than 28 countries in Africa [2]. The practice is deep rooted and heavily prevalent mostly in the countries that have a strong connection to the Islamic religion [3]. Between 100 and 140 million girls and women worldwide are estimated to have undergone the practice of female genital mutilation [4].

Female genital mutilation is performed for the following reasons; sexual, sociological, hygienic and aesthetic reasons, health and for religious reasons [5]. In Africa, about 101 million girls age 10 years and above are estimated to have undergone female genital mutilation in the northeast Africa, where the practice ranges from 80 to 97%, while in East Africa is markedly lower and ranges from 18 to 32% [6,7]. Female genital mutilation is practiced in all regions in Ethiopia, but the magnitude varies considerably from region to region ranging

from less than 30% in Gambella and Tigray to over 90% in Afar, Dire Dawa and Somali [8]. For example almost 100% prevalence rate was reported for the Somali National Regional State (SNRS) in the Demographic and Health Survey (DHS) 2000 of Ethiopia. In Ethiopia the FGM national prevalence ranges 74 to 85% [9].

Materials and Methods

Study area and period

Jimma medical center is one of the oldest public hospitals in the country. It was established in 1930 E.C (1922 G.C). Geographically it is located in Jimma city 352 km southwest of the capital Addis Ababa and above sea level 1780 m and it has latitude and longitude of 7°40′N 36°50′E. Previously, it has been governed under Ethiopian government by the name of "Ras Desta Damtew Hospital" and later "Jimma Hospital" during dengue regime and currently named as Jimma university medical center. The hospital with 800 beds is expected to provide health services for more than 20 million peoples living in south western of Ethiopia and also give services for south Sudan and neighboring countries. Besides of this, the hospital will serve as teaching and research center [10,11].

Studydesign

A cross-sectional survey was the design of the study.

Study population/subjects and sampling

Source population: The sample for the study was drawn from women of reproductive age visiting Jimma medical center.

Study subjects: The study subjects was randomly selected from all women of reproductive age who's first born was or would have been 5 years or less. The age limit was included to minimize recall difficulties [12,13].

Sample size and sampling technique/sampling procedures

Sample size: Sample size was determined by using single population proportion formula by considering proportion of female genital mutilation is 50% (p=0.05), assumes a 95% confidence level [14,15].

Sample size estimate using the following assumption like:

$$n = \frac{\left(Z\frac{\alpha}{2}\right)^2 P(1-P)}{d^2}$$

Where, n=minimum sample size Zα/2=Z value at (α=0.05)=1.96 d=Margin of error (0.05).

$$n = \frac{(1.96)^2 0.5(1-0.5)}{(0.05)^2} = 384.16 \sim 384$$

In Jimma city the composition of the population in terms of ethnicity is in is different. Furthermore, the Jimma university medical center is also serving community from different regions like Gambella and Southern nations. Therefore, the sampling procedure is deliberately design to include female from different ethnicity groups. Because based on their socio-culture the degree/magnitude of genital mutilation might be different and hence their impact on birth complication. The number of women's selected from different ethnicity is based on proportional sampling. Women's selected from the same ethnicity is based on simple random sampling or simple lottery method [16,17].

Inclusion and exclusion criteria

Inclusion and exclusion criteria are meant to ensure patients safety during the study, provide data (justification) of subject appropriateness for the study, to minimize withdrawal (also costs) and ensure that primary end-points of study are reached. Inclusion criteria are characteristics that the prospective subjects must have if they are to be included in the study, while exclusion criteria are those characteristics that disqualify prospective subjects from inclusion in the study. In this sense, inclusion and exclusion criteria are usually written in a positive way: if a participant has inclusion criteria, they are in; if they have an exclusion criterion, they are out [18,19].

Inclusion criteria: The inclusion criteria include females within reproductive age and gave birth and are in normal health status. Especial focus is given to their mental case.

Exclusion criteria: The exclusion criteria include females within reproductive age and gave birth and are not in normal health status. Especial focus is given to exclude women who are not mentally health.

Study variables

Socio-demographic characteristics: Age, religion, ethnicity, schooling, level of school attainment, place of birth, marital status, marital type (in terms of polygamous versus monogamous union), parental education and parental religion.

Reproductive characteristics: Age at first marriage, age at first pregnancy, age at first birth, gravidity, parity, abortions, stillbirth, female genital mutilation [20,21].

Operational definition

- Infibulated women are those genitally mutilated women whose vaginal area is sewn closed (FGM Type III)
- Non-infibulated women are those genitally mutilated women whose vaginal area is not sewn at all (FGM Types I and II)

First and second pregnancy/delivery characteristics: ANC follow-up, place of delivery, history of bad pregnancy outcomes and birth complications (episiotomies, perineal tearing,

instrumental delivery, obstructed/prolonged labor, caesarian deliveries, severe hemorrhage, postnatal problems) [22,23].

- Episiotomy included both anterior (defibulation) and posterolateral incisions of the vulva during delivery.
- Labor was labeled as prolonged when it lasted longer than 16 hours for primps and 12 hours for multips.
- Postnatal period was considered to be problematic (complicated) when one or more of the following complications had been reported by the respondents: heavy bleeding, foul-smelling discharge, urinary incontinence, rectal incontinence, generalized fever, or wound infection [24,25].

Data collection procedures (Instrument, personnel, data collection technique)

After questionnaires developed, individual interviewers was made in Jimma medical center by the researcher. In some case interviewers was recruited or translators hired when women interviewed not speak Amharic or Afan Oromo. The data collectors or translator was given training for some days (some days before and some days after the pre-testing). The training was focus on discussing the overall purpose of the study and securing verbal consent from each study participants, emphasizing the issue of confidentiality, and administering the questionnaires in full and to eligible respondents using the appropriate questionnaire and language [26,27].

Data was collected in December 2019. The overall activity of data collection was supervised and coordinated by the principal investigator. The principal investigator is responsible for managing and coordinating the overall field activities and onsite checking of the quality of the data collected before leaving medical center. Any missing or inconsistent data detected was sent back for immediate correction while still in the medical center.

Data management, analysis and interpretation

After pre-coding of all the study variables and giving appropriate variable names, the raw data was entered into computers. This will be done by the principal investigator together with a person who has the expertise in data entry. Customized check file was developed and automatically used to check for ranges, skip (jump) and legal values during the data entry processes. Computer printouts of frequencies were used to check for outliers. Logical and consistency errors also checked after completing data entry. Any error identified at this stage is corrected after revision o f t he o riginal questionnaire retrieved using the corresponding record number.

The data was exported to SPSS for windows statistical package for the purpose of analysis. Analysis is done using both statistical packages. Frequencies, proportions and summary statistics were used to describe the study population in relation to relevant self and parental variables. Customized Check file was developed and automatically used to check for ranges, skip (jump) and legal values during the data entry processes. Computer printouts of frequencies were used to check for outliers. Logical and consistency errors also checked after completing data entry. Any error identified at this stage is corrected after revision of the original questionnaire retrieved using the corresponding record number.

Ethicalconsiderations

Verbal consent of subjects to participate in the study was secured before conducting the interview. This done with a page of consent letter attached to the cover of the questionnaire which stated the general purpose of the study, the need and benefits of conducting the study, and issues of confidentiality. The interviewers was briefly discussed the contents of letter before proceeding to the interview. Participants were informed that they have the right to refuse to participate in the study or to discontinue the interview at any time they want to. A formal letter was written by Jimma University, institute of health, faculty of health science school of nursing and midwifery explaining the relevance of the study.

Results

Socio demo graphic characteristics of respondents

The total number of women studied was 350 with a non-response rate of 9.32%. The majority of respondents were Muslim (41.7%), Oromo (48.9%) and literate (64%). The majority of subjects were younger than 25 (46.6%). Most women, 57.4%, were born in rural settings. Two hundred forty nine (71.1%) of the subjects were married and concerning occupational status 56.6% were housewives. One hundred seventeen (33.4%) families earned an average monthly income of more than Birr 2501 (Table 1).

Table 1: Frequency distribution of socio demographic characteristics respondents, 2019.

Socio-demographic and economic characteristics	Frequency	Percent
Place of your birth		
Rural	201	57.4
Urban	149	42.6
Age (in years)		

15-24	163	46.6
25-34	153	43.7
35-49	34	9.7
Religion		
Muslim	146	41.7
Orthodox christian	98	28
Protestants	58	16.6
Others	48	13.7
Ethnicity		
Oromo	171	48.9
Amhara	55	15.7
Tigre	19	5.4
Others	105	30
Education		
Illiterate	126	36
Literate	224	64
Read/Write only	119	34
Elementary/Junior	82	23.4
Secondary/Higher	23	6.6
Marital Status		
Single	86	24.6
Married	249	71.1
Widowed	7	2
Divorced	8	2.3
Occupation		
Housewife	198	56.6
Merchant	51	14.6
Civil servant	21	6
Daily laborer	37	10.6
Student	41	11.7
Private Employee	2	0.5

Income (Birr)		
<1000	59	16.9
1000–1500	46	13.1
1501–2000	28	8
2001-2500	100	28.6
>2501	117	33.4
Household possessions (Wealth)		
Low	133	38
Medium	153	43.7
High	64	18.3

Reproductive health status

Of the total 350 respondents 281 (80.3%) were genitally mutilated of the 281 genitally mutilated women, 242 (86.1%) had their clitoris partially or completely cut (FGM type I/II, non-infibulated). Majority of respondents (83.6%) were mutilated in less than 6 years. The majority (81.5%) were mutilated by a Traditional Birth Attendant (TBA) or a traditional circumciser. About 113 (44%) of respondents had been pregnant 2-4 times and most of respondents 168 (65.4%) were got pregnancy in between of 21-30 years old. About 6 (2.3%) were had still birth and 8 (3.1%) were miscarriage/abortion (Table 2).

Table 2: Frequency distribution of reproductive health status of respondent's in JUMC, 2019.

Variables	Categories	Frequency	Percentage
How many times have you been pregnant? (Gravidity) (N=257)	Only once	49	19.1
	2-4 times	113	44
	Five and above	95	36.9
What was your age at your first pregnancy?(N=257)	15-20 yrs.	32	12.5
	21-30 yrs.	168	65.4
	31-40 yrs.	35	13.6
	41-49 yrs.	22	8.5
Number of children do you have (N=257)	One	79	30.7
	2-4	148	57.6
	More than five	30	11.7
Did you ever have a still birth? (N=257)	Yes	6	2.3
	No	251	97.7
Did you ever have miscarriage/ abortion? (N=257)	Yes	8	3.1
	No	249	96.9
Are you circumcised? (N=350)	Yes	281	80.3

	No	50	14.3
	Don't know	19	5.4
How old were you at the time of your circumcision? (N=281)	1-6 years old	235	83.6
	7-10 years old	31	11
	Don't know	15	5.4
Which type of circumcision do you think was performed on you? (N=281)	Infibulation	9	3.2
	Excision/Clitoridectomy (Sunna)	242	86.1
	Don't know	30	10.7
Who did the operation?(N=281)	Traditional birth attendants	229	81.5
	Health profession	3	1.1
	Don't know	49	17.4

Knowledge, attitude and practice of female genital mutilation

In general, 70% of women knew that FGM was associated with health problems. The majority of women (74%) claimed that female genital mutilation wasn't good practice. The majority (86.9%) of respondents did not support the continuation of the practice. Among the women who supported continuation of FGM, the majority (32.6%) of them stated that they wanted the practice to be continued because it was a tradition and custom of the society. Among women who thought the practice of female genital mutilation should not be continued, the overwhelming majority (70.3%) cited medical complications. These women were also asked what they think was the best ways to eradicate female genital mutilation and the majority (52.9%) suggested an Enforced legislation (Table 3).

Table 3: Frequency distribution of knowledge, attitude and practice of respondents toward female genital mutilation JUMC, 2019.

Variables	Categories	Frequency	Percentage
Do you have a girl child?	Yes	188	53.7
	No	162	46.3
Are you planning to circumcise her?	Yes	109	58
	No	79	42
Do you think female circumcision is a good practice?	Yes	91	26
	No	259	74
Do you know that female circumcision can cause health problems?	Yes	245	70
	No	105	30
Do you think female circumcision should continue?	Yes	46	13.1
	No	304	86.9
Which type of female circumcision	Infibulation	6	13
	Excision/Clitoridectomy (Sunna)	40	87

Why do you think it should continue?	Good tradition	12	26.1
	Cleanliness	8	17.4
	Religious demand	9	19.6
	Good custom	3	6.5
	Protect virginity	6	13
	Greater pleasure of husband	3	6.5
	Never thought about reason	5	10.9
Why do you think it should not continue?	Religious prohibition	14	4
	Painful personal experience	29	8.3
	Medical complication	246	70.3
	Sexual dissatisfaction	15	4.3
What is your husband's opinion about the continuation of female circumcision?	Favor	28	8
	Oppose	169	48.3
	No opinion	85	24.3
	Don't know	68	19.4
What do you think is the best way to stop female circumcision?	Enforced legislation	185	52.9
	Educational campaign to women	63	18
	Improvement of status of women	53	15.1
	Fathers should take more responsibility	27	7.7
	Sexual education	22	6.3

Pregnancy and delivery outcomes

The majority of women had attended Antenatal Care (ANC) during their pregnancies (69.3% during the first and 100% during the second). More than half of women during both of their pregnancies visited ANC for routine check-up. During both pregnancies, the more than half had made four or more visits to the ANC. Two hundred fifteen (83.7%) of the first and 95.2% of the second pregnancies were delivered at health institutions. Episiotomies occurred among 34.6% of women who were delivering for the first time and 17.8% of women delivering for the second time. The Cesarean section rate was found to be 26.5% and 19.7% during the first-time and second-time deliveries respectively (Table 4).

Table 4: Frequency distribution of respondent's pregnancy and delivery outcomes in JUMC, 2019.

Variables	Categories	First pregnancy		Second pregnancy	
		Frequency	Percentage	Frequency	Percentage
Did you go for antenatal care	Yes	178	69.3	208	100
	No	79	30.7	0	0

during your pregnancy?						
What month of pregnancy was your first visit?	1st trimester	96	54	113		54.3
	2nd trimester	64	35.9	75		45.7
	3rd trimester	18	10.1	20		9.6
Why did you first attend the antenatal care?	Routine checkup	97	54.5	108		51.9
	Problem with pregnancy	44	24.7	42	20.2	
	Vaccination	22	12.4	32	15.4	
	Don't remember	15	8.4	26	12.5	
How many times in total did you go for Antenatal care during this pregnancy?	Only once	18	10.1	24		11.5
	Two times	30	16.9	37		17.8
	Three times	35	19.6	41		19.7
	More than three times	95	53.4	106		51
Did you have any of the following problems during this pregnancy?	Diabetes mellitus	16	6.2	20		9.6
	Hypertension	46	17.9	56		26.9
	Vaginal bleeding	39	15.2	32		15.4
	Febrile illness	12	4.7	6		2.9
	Jaundice	5	1.9	1		0.5
	Swelling of the face	14	5.5	18		8.7
	Cardiac problems	43	16.7	50		24
	Nothing	82	31.9	25		12
Where did you deliver your baby?	Hospital	129	50.2	159		76.4
	Health center	86	33.5	39		18.8
	Home	42	16.3	10		4.8
Did you have episiotomy?	Yes	89	34.6	37		17.8
	No	168	65.4	171		82.2

Did they use instruments to help the baby out? (forceps or vacuum)	Yes	76	29.6	26	12.5
	No	181	70.4	182	87.5
Did they c/ section you to bring the baby out?	Yes	68	26.5	41	19.7
	No	189	73.5	167	80.3
What was the outcome of the labor?	Alive and healthy baby	193	75.1	190	91.3
	Alive but sick baby	57	22.2	16	7.7
	Dead baby	7	2.7	2	1
How did you estimate the weight of the baby at birth?	Very small	18	7	3	1.4
	Small	21	8.1	11	5.3
	Normal	156	60.7	143	68.8
	Big	40	15.6	34	16.3
	Very big	22	8.6	17	8.2
Did you have any genital trauma? (perianal tearing/ lacerations)	Yes	73	28.4	39	18.7
	No	184	71.6	169	81.3
How was your bleeding during and just after the labor	Wet my clothes	168	65.4	165	79.3
	Wet the bed	50	19.5	25	12
	Wet the floor	5	1.9	2	1
	Don't know	34	13.2	16	7.7
Did you have any of the following problems after the completion of the labor?	Excessive vaginal bleeding	2	0.8	3	1.4
	Foul smelling vaginal discharge	3	1.2	5	2.4
	Urine leakage wetting the underwear	0	0	0	0
	Stool leakage through the vagina	0	0	0	0

	Febrile illness	2	0.8	4	1.9
	Wound infection	2	0.8	2	1
	Nothing	219	85.2	178	85.6
	Don't know	29	11.3	16	7.7
How long did this first labor last?	One day or one night	227	88.3	198	95.2
	A day/a night and a half	8	3.1	2	1
	A day and a night	5	2	2	1
	Two days and a night	0	0	0	0
	Two days and two nights	0	0	0	0
	Don't know	17	6.6	6	2.8
How long after the birth of the child was the placenta delivered?	Less than 30 minutes	203	79	183	88
	30 minutes -1 hour	10	3.9	3	1.4
	More than 1 hour	5	1.9	2	1
	Don't know	39	15.2	20	9.6

Discussion

The practice of female genital mutilation is a very deeply rooted harmful tradition that dates back centuries in most African and some Arabian countries. Apart from being a form of violence against females it has debilitating and long lasting health hazards. Its ill effects are associated with the very nature of the practice. It is interference to a normal human body part on the one hand and it is mostly performed in an unhygienic environment by a person who is illiterate to the anatomy of the female genitalia on the other. In addition, unintended damage is often caused because of the crude tools, poor light, and poor eyesight of the practitioner compounded by the struggles of the girls or women during the procedure.

For a variety of reasons people at different corners of the world are practicing it. In our study area, 80.3% of the women interviewed had undergone the operation with fewer 3.2% of them severely mutilated with the most devastating type of FGM–infibulation. The prevalence figure is lower when compared with a study conducted in around Gonder of Amhara region in Ethiopia found to be 94.99% during 2006, a study from Jigjiga town of Somali region during 2005 found 97%. And it is much higher than the 2013 national prevalence (74%) report by WH. The prevalence figure is lower with the one reported in the DHS 2016 of Ethiopia. However, the proportion of women with FGM Type III is very much lower than that reported for EDHS 2016. This is because this type is mainly practiced Jimma was FGM Type I and II. This difference may be due to difference of cultural, religious and perception of the community towards female genital mutilation.

In this study finding the majority (81.5%) were mutilated by a Traditional Birth Attendant (TBA) or a traditional circumciser. Medical personnel were reported in 3 (1.1%) of cases. This result was relatively consistent with a study conducted in Bale zone shows that majority of them are Traditional circumcisers and traditional birth attendants 484 (78.2%), and old age people, 42 (6.8%) were identified by the study participants as an operators of FGM in the study area. The rest, 93 (17%) of the respondents did not know the person performing the procedure. This might be due to cultural malpractice which mainly practiced by traditional birth a ttendants/circumcisers.

In this study finding shows that the majority (86.9%) of respondents did not support the continuation of the practice. Among the women who supported continuation of FGM, the majority (32.6%) of them stated that they wanted the practice to be continued because it was a tradition and custom of the society. The second most common reason given by 19.6% of women was that it was a religious demand but 41.7% of women

who gave this reason were Muslims. In addition, some 13% of women said that female genital mutilation protects virginity. This result consistent with study conducted in A study conducted in Kebirbeyah Town, Somali Region shows that the overwhelming proportion 198 (61.8%) of study participants reported that they are practicing FGM to reserve virginity followed by 58 (18.1%) and 43 (13.4%) practicing FGM for religious and as well as to avoid sex related problems respectively. This is due to socio cultural relatively similar and similarity of religious view.

Significant majority of the respondents 106 (33.2%) strongly agreed that FGM should be stopped while nearly half of them 128 (40.0%) do agree with the idea about FGM should not be stopped. And also it is low when compared with a study conducted in Dale Wabera high school and preparatory students shows that the majority of the respondents (77.7%) agreed with the idea of stopping the practice while 22.3% of them supported to perform FGM in the future. Among the total study participants who supported the continuation of FGM, majority of them (97.3%) responded that it is a respect for culture and about 78% of them said that the practice avoids stigmatization in the community. Others responded that they support the practice for that it avoids shame (68.2%), it is required by religion (63.5%), for hygiene (56.1%), avoidance of promiscuity (41.9%) and other reasons (22). This discrepancy may be due difference of communities awareness and health risk related to FGM, difference of cultural background of communities, difference in educational status between students and communities.

This study revealed that first labor last for one day/one night 227 (88.3%) in first pregnancy and 198 (95.2%) in second pregnancy. This result was agree with an earlier review study by Renaud, et al. in ivory coast it was observed that the length of the second stage of labor in women with mainly FGM was the same as in women without FGM. However, intervention with an instrumental delivery was reported in the study in all labors where pushing had been going on for more than 30 minutes. Thus the rates of instrumental delivery were stated to be twice as high in those women with FGM as those without FGM (26). This may be due the type of FGM practiced in Jimma mainly FGM type I and II However, the same picture of mechanics (obliterated vulva) can occasionally follow types I and II due to infection and inflammation at the time of mutilation leading to vulvar adhesions which effectively narrow or completely obliterate the vaginal opening rather than primary effect FGM.

Conclusion

Out of the total 350 respondents 281 (80.3%) were genitally mutilated while only 50 (14.3%) were non-mutilated; the rest 19 (5.4%) did not know whether they were mutilated or not. Of the 281 genitally mutilated women, 9 (3.2%) were infibulated (FGM type III), 242 (86.1%) had their clitoris partially or completely cut (FGM type I/II, non-infibulated) and the rest 30 (10.7%) could not tell the type of mutilation they had undergone. About 70%of women knew that FGM was associated with health problems. More than half of the interviewed women (53.7%) had a female child and a slight majority of them (58%) had mutilated or were planning to mutilate their daughters. women were also asked what they think was the best ways to eradicate female genital mutilation and the majority (52.9%) suggested an Enforced legislation. About 18% was mentioned by educational campaign to women. Only 7.7% of women mentioned that encouragement of fathers to take more responsibility was the best way.

Acknowledgments

First and foremost, I would like to thank the almighty God without whom this work would have ended a day dream. I would like to thank Jimma University School of nursing and midwifery and Student Research Project (SRP) for giving us the opportunity for conducting this research. Also my heart-felt gratitude goes to school of nursing and midwifery for their good to undertake this study. Lastly, not least thanks to my friends and family for their important inputs throughout my work.

Disclosure

The author reports no conflicts of interest in this work.

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