TRIDHA
Journal of Clinical Cases & Reports
Volume 2024, Issue 3, 9 pages
https://doi.org/10.46619/joccr.2024.7-1166



**CLINICAL RESEARCH**

# Cause, Practice and Belief Status of Females (15-49-year-old) on Female Genital Mutilation in Tigray, Ethiopia, 2020

Genet Tekle Asgedom[1], Kiros Demoz Ghebremedhin[2*], and Ataklti Gebreyesus Gebregziabher[1]

*[1]Mekelle University, Institution of Population and Development, Mekelle, Tigray, Ethiopia*
*[2]Tigray Health Research Institute, Department of Research Monitoring, Training and Publication, Mekelle, Tigray, Ethiopia*

Correspondence should be addressed to Kiros Demoz Ghebremedhin, Tigray Health Research Institute, Department of Research Monitoring, Training and Publication, Mekelle, Tigray, Ethiopia

Received: 01 May 2024; Accepted: 31 May 2024; Published: 18 June 2024



## ABSTRACT

### AIM

There is evidence on the cause, practice and poor status of female genital tract mitigation in Tigray, Ethiopia. The aim of this study was to assess the cause, practice and believing status of females regarding genital mitigation in Tigray, Ethiopia.

### METHODS

A quantitative, community-base, cross-sectional study was conducted among reproductive aged girls and women in eastern Tigray, Ethiopia. A purposive sampling technique was used to select the study area (Atsbi District) from the Tigray Region 93 districts. A simple random sampling technique used to select four local administrations and 201 study participants. The data were collected using pre-tested structured questionnaires, and the data were entered into SPSS Version 23 for analysis. Descriptive statistics were used to describe the characteristics of the study subjects. The frequency, percentage, and graph ware used.

### RESULTS

In this study, 78 (38.8%) of the study participants had ever been circumcised, 36 (29%) had genital mutilation practiced at under 5 years of age, and 55 (44.8%) had female genital mutilation performed by traditional methods, 168(83.6%) had FGMP performed using razor blades and 102 (50.7%) had sociological and cultural causes.

### CONCLUSION

Females' and parents' health education; should be strengthened, IEC/BCC materials should be expanded in different areas, religious leaders' involvement in awareness creation regarding FGMPs should be strengthened,

and further study should be performed.

**KEYWORDS**

Cause; Female; Genital Mutilation; Practice; Belief; Tigray

## ABBREVIATIONS

FGMP : Female Genital Mitigate Practice Youth Friendly Service;

HIV : Human Immuno deficiency Virus

IEC : Information Education Communication

IRB : Institutional Review Board

SPSS : Statistical Package For Social Science;

## INTRODUCTION

### *Background*

Female genital mutilation (FGM) is the removal of external female genitalia (injury) to female genital organs for no medical purposes. The age at which FGM is performed varies across cultures but the procedure is generally performed when girls are between the ages of 0 and 15 years [1].

Global estimates indicate that; 100 to 140 million girls and women are at risk for FGM annually and that approximately 3 million girls are estimated to be at risk of FGM annually and that there are up to 6,000 new cases of FGM every day [2]. In Africa, it is prevented and still has a high prevalence. It is estimated that 91.5 million girls and women above the age of 9 have been affected by FGM [3].

FGM is widespread across Ethiopia and occurs in the majority of regions and ethnic groups, with the highest prevalence in the Afar region at a rate of 91.6% [3] or 87.4% [4]. Additionally, the Somali region has a percentage of 97.3% [3] or 70.7% [4]. The region with the lowest rate is Gambela, with a rate of 27.1% [3].

FGM has no health benefits and can be harmful to girls and women. According to the World Health Organization [1], FGM can cause immediate complications such as severe pain and bleeding, shock, tetanus or sepsis (bacterial infection), open sores in the genital region and injury to nearby genital tissue, and problems urinating and long-term consequences can include recurrent bladder and urinary tract infections, cysts, infertility, an increased risk of childbirth complications and newborn deaths, and the need for later surgeries [1].

Girls and women are often under strong social pressure, including pressure from their peers and risk victimization and stigma if they refuse to be cut. FGM is always traumatic [2]. FGM violates human rights and is a widespread public health issue [1].

The aim of this study was to assess the causes, practices and beliefs regarding genital mutilation in Tigray, Northern Ethiopia which is crucial for filling the gap in current and evidence-based information regarding female genital mutilation practices and its impact on Tigray. The results of this study will enable planners and program managers, decision makers and policy makers to establish appropriate interventions for female genital mutilation practices in the region.

## METHODS AND MATERIALS

### *Study Design, Population and Setting*

Descriptive community-based cross-sectional quantitative studies were conducted in the Atsbi district from February-March, 2020 among reproductive aged (15-49-year-old) girls and women. According to the 2007 GC National Population Census, the total population of Atsbi is estimated to be 137,133. A total of 31167 (4.4%) were households, and 32226 (23.5%) were girls and women of reproductive age (15- 49-year-old). The district is located in the eastern zone Tigray Region in the northern Ethiopia. Atsbi is bordered in the south by the Debub Misraqawi (Southeastern) Zone, in the west by Kilte Awulaelo, in the north by Saesi Tsaeda emba, and in the east by the Afar Region. The district was administratively divided into 18 local administrations (Atsbi District Health Office). Each local administration was further divided into sub-zones. The district is the basic administrative unit, and Kebele is the low-level administrative unit.

### *Sample Size Determination and Sampling Procedure*

Because of the relatively high Female Genital Mutilation/FGM practices, the district and its four local administrations (Enda Silasie, Hayk Meshal, Michael Amba and Adi Mesanu) were selected purposively; According to the administration of the Atsbi Wemberta district, the population of women in the four kebeles had 15,998 of these women: Enda Silasie 5,437, Hayk Meshal 2,112, Michael Amba 4,158 and Adi Mesanu had 4,291 people. Thus, Yamane's (1967:886) simplified formula used to determine the sample size is:

$$n = \frac{N}{1 + N(e)^2}$$

where; n = the sample size

N = is the population size, and e is the level of precision.

$$n = \frac{N}{1 + N(e)^2} = 15{,}998 = \frac{201}{1 + 15998(0.07)^2}$$

A totally 201 people were included, and the sample size of the study was determined.

The study samples were proportionally allocated to the women population residing in the selected 4 local administrations. Then, households were randomly selected, one woman was randomly selected from each selected household, and replacement was made for absences on the first visit.

**Table 1:** Quota sampling for each selected local administration.

| S.N. | Kebeles | Population | Sample size |
|---|---|---|---|
| 1 | Enda silasie | 5,437 | 68 |
| 2 | Hayk meshal | 2,112 | 27 |
| 3 | Michael amba | 4,158 | 52 |
| 4 | Adi mesanu | 4,291 | 54 |
| **Total** | | 15,998 | 201 |

Note: Source Population used for sample size: District Health Office.

***Study Variables***

The dependent variables for this study were cause, practice and beliefs of females on female genital mutilation, and the independent variables were sociodemographic variables (age, sex, religion, residence, marital status and educational status); and decision-making for female genital mutilation practice.

***Data Collection Tool and Procedure***

The data were collected using an interviewer-administered structured questionnaire adapted from the literature. The survey included information on socio demographic characteristics, knowledge, cause, practice and beliefs of females on female genital mutilation. The questionnaire was initially prepared in English, translated into the local language Tigrigna, back translated into English, and checked for consistency.

***Data Collection Instrument and Quality Management***

A standardized data collection instrument was used to maintain data quality. Training was provided to the data collectors and supervisors on the objectives of the study, interview techniques, informed consent and confidentiality. Moreover, 5% of the questionnaire was pretested and necessary amendments were made. During the data collection period, completeness and consistency were checked by the investigators immediately and daily. Owing to the sensitive nature of the questions, the interviewers were of the same sex.

***Data Analysis and Processing Analyses***

The data were entered into Epi-Data software version 3.1 and then transferred to the Statistical Package for Social Sciences (SPSS) version 23 for analysis. Data cleaning and editing were performed before the analysis. Descriptive statistics such as frequency distribution tables and graphs were used to present the findings.

## RESULTS

***Socio Demographic Characteristics of the Study Participants***

In this study, 201 respondents participated, for a response rate of 100%. Most of the respondents were aged 94 (25-35) years, with a minimum of 15 years and a maximum of 46 years. Overall, 100 % of the respondents; were females, were in the Tigraway Ethnic group, and lived in rural areas. Of the 201 participants, 137 (68.2%) were Orthodox Christian followers. Regarding marital status, 135 (67%) of them were married. The majority of the respondents (67, 33.3%) were unable to write or read (Table 2).

**Table 2:** Socio demographic status.

| Socio-demography characteristic | **Frequency** | **Percentage** |
|---|---|---|
| Sex | | |
| Male | 0 | 0 |
| Female | 201 | 100 |
| Total | 201 | 100 |
| Marital status | | |
| Single | 30 | 15 |
| Married | 135 | 67 |
| Divorced | 13 | 7 |
| Widowed | 23 | 11 |
| Total | 201 | 100 |
| Age | | |
| 15- 24 | 26 | 12.9 |
| 25- 35 | 94 | 46.8 |
| 36- 45 | 38 | 18.9 |

| | | |
|---|---|---|
| 46+ | 43 | 21.4 |
| Total | 201 | 100 |
| Residence | | |
| Rural | 201 | 100 |
| Town | 0 | 0 |
| Total | 201 | 201 |
| Religious | | |
| Orthodox | 137 | 68.2 |
| Catholic | 0 | 0 |
| Muslim | 61 | 30.3 |
| protestant | 3 | 1.5 |
| Total | 201 | 100 |
| Ethnicity | | |
| Tigraway | 201 | 100 |
| Erob | 0 | |
| Afar | 0 | 0 |
| Others specify | 0 | 0 |
| Total | 201 | 100 |
| Socio demography characteristic | Frequency | Percentage |
| educational status | | |
| unable to write and read | 67 | 33.3 |
| able to write and read | 40 | 19.9 |
| Elementary (1- 8) school | 41 | 20.4 |
| Secondary (9-10) and preparatory (11-12) school | 41 | 20.4 |
| College and above | 12 | 6 |
| Total | 201 | 100 |

**Source:** Field data.

***Awareness about Genital Mutilation, Eastern Zone, Tigray***

Of the 201 study participants, 174 (86.6%) had heard about FGMP, and 175 (87.1%) of the participants were aware of it. The study revealed that 163 (81.1%) of the participants had Knowledge of the presence of policy and legal frameworks to mitigate the impact of FGMPs, and 103 (51.2%) understood about FGMP harmfulness from the age of 11-20. This study revealed that for 162 (51%) participants, female genital tract mitigation practices were needed. Regarding the effect of FGMPs, 66 (32.8%), 63 (31.3%), 45 (22.4% ) and 19 (9.5%) participants indicted that FGMPs had fertility problems, problems during giving birth, problems during sex and ministration, respectively (Table 3).

**Table 3:** Awareness, Knowledge and beliefs about Criminality of the FGMP.

| Response | Frequency | Percentage |
|---|---|---|
| Have you ever heard of female genital mutilation? | | |
| Yes | 174 | 86.6 |
| No | 17 | 13.4 |
| Total | 201 | 100.0 |
| Response | Frequency | Percentage |
| Aware | | |
| Yes | 175 | 87.1 |
| No | 26 | 12.9 |
| Total | 201 | 100.0 |
| Knowledge on the presence of policy and legal frame works to mitigate the impact of FGMP | | |
| Yes | 163 | 81.1 |
| No | 38 | 18.9 |
| Total | 201 | 100 |
| Female understanding about harmfulness of FGMP | | |
| before 10 -year-old | 15 | 7.5 |
| 11- 15 | 43 | 21.4 |
| 16-20 | 60 | 29.8 |
| 21-25 | 51 | 25.4 |

| | | |
|---|---|---|
| 26- 30 | 32 | 15.9 |
| Total | 201 | 100 |
| believe/stand on eradication of FGMP | | |
| Yes | 162 | 81 |
| No | 39 | 19 |
| Total | 201 | 100 |
| Option on FGNP | | |
| Need Continued | 18 | 9 |
| Need discontinued | 183 | 91 |
| Total | 201 | 100 |
| Knowledge of the effect of FGMP | | |
| Menstrual problem | 19 | 9.5 |
| Problem during sex | 45 | 22.4 |
| Fertility Problem | 66 | 32.8 |
| Problem during giving birth | 63 | 31.3 |
| I do not know | 8 | 4 |
| Total | 201 | 100 |

**Source:** Field data.

***Female Genital Mutilation Practice, Eastern Zone, Tigray***

Of the total 201 participants, 78 (38.8%) practiced female genital mutilation. Fifty- two (42%) genital mutilations practiced by females were circumcised at the infant's age, and 55 (44.8%) female genital mutilations were performed by Traditional methods (Table 4).

**Table 4:** Female genital mutilation practices.

| | | |
|---|---|---|
| Are you circumcised? | | |
| Yes | 78 | 38.8 |
| No | 123 | 61.2 |
| Total | 201 | 100 |
| If yes, how old were you when you were circumcised? | | |
| Under 5 year | 52 | 42 |
| I do not Know | 71 | 58 |
| Total | 123 | 100 |
| Who performed the circumcision? | | |
| Traditional | 55 | 44.8 |
| I do not Know | 68 | 55.2 |
| Total | 123 | 100 |

**Source:** Field data.

The study findings showed, that 102 (50.7%), 50(24.9%), 37 (18.4%) and 12 (6%) FGMPs had sociological and cultural causes, Hygiene and Aesthetic causes, Religious and Psychosexual causes, and 168 (83.6%) FGMPs had been performed using razor blades (Table 5).

**Table 5:** Reasons and instruments used to perform FGMP.

| Response | Frequency | Percentage |
|---|---|---|
| Reason for FGMP | | |
| Sociological and Culture | 102 | 50.7 |
| Hygiene and Aesthetic | 50 | 24.9 |
| Religious | 37 | 18.4 |
| Psychosexual | 12 | 6 |
| Total | 201 | 100 |
| Instrument used to perform FGMP | | |
| Special Knife | 4 | 2 |
| Scissors | 22 | 10.9 |
| Pieces of Glass | 7 | 3.5 |
| Razor Blades | 168 | 83.6 |
| Total | 201 | 100 |

**Source:** Field data.

## DISCUSSION

The study findings revealed; that 38.8% of the participants practiced female genital mutilation. This percentage was lower than 65% in Ethiopia, Afar region (88%), the Amhara region (50%), Somalia (95%), and the Beneshangul Gumuz Region (43%) [5] and higher than that in Gambela region (24%), Kenya (21%), Uganda (0.3%), and Tanzania (10%) [5] and similar to that in Addis Ababa (39%) [5]. This discrepancy could be due to differences in the study period, sample size, and socio-cultural factors.

In the study area, 52% of genital mutilations occurred in individuals under the age of 5-years. These findings were greater than those in Ethiopia (44%), Harari (10%), Somalia (21%), and SNNPR (22%) [5], and lower than in Amhara (96%), Afar (84%), Addiss Abeba (65%), and Benishangul Gumuz (83%) [5]. This difference could be due to socio cultural factors, access to media and educational reasons.

The findings revealed that 44.8% of female genital mutilation in this study area was performed by traditional practitioners. This percentage is greater than that in Jijjiga [6]; and lower than in Ethiopia (44%), the SNNPR (90%) [5], Eritrea (92%) (Africa, 2015), and Djibouti (94%) (Africa, 2015). Regarding the reason for the FGMP in the study area, 50.7% of the FGMPs had sociological and cultural causes, which is higher than that of Hadiya (25%) [7]; and lower than that of Bale (74.8%) [8]/ This discrepancy could be due to socio cultural differences.

In the study area, 86.6% of the study participants had heard about FGMP, and (87.1%) of the participants were aware of it. This finding is lower than that in Jijiga (91.3%) [6] and higher than that in Amhar (56.6%) [6]; and Tanzania (56.51%) [9]. This difference could be due to the period of study, sample size and socio-cultural differences.

Fifty-one percent of participants in the study area needed to stop female genital mitigation practices. This percentage is lower than that in Ethiopia (87%) [5], and Amhara (54.2%) [6]; and higher than that in Egypt (44%) [10]; and Tanzania (31.2%) [9]. The difference could be due to the study period, sample size, educational status and access to media.

### Limitations and Strengths of the Study

The data were exclusively dependent on self-reports of female genital mitigation practices; thus, there may be a social bias, and because the study was cross sectional, it may not be strong enough to demonstrate direct causes. Furthermore, it was performed in one district and selected local administrations, and the results did not show the entire Tigray. However, this study provides evidence that females in rural areas, benefit program managers, service providers, decision and policy makers, and stakeholders.

## CONCLUSION

The study findings showed that; the magnitude of female genital mutilation is high among females in the Atsbi district, which is the eastern zone of the Tigray region in, northern Ethiopia. Therefore, strengthening female and parent health education, expanding IEC/BCC materials in different areas, strengthening religious leaders' involvement in awareness creation regarding FGMPs, and further study should be performed.

## ACKNOWLEDGMENTS

We would like to extend our appreciation to the Regional Women Affairs and Atsbi Wemberta Women Affairs office, who have contributed in diverse ways to ensuring the successful completion of this work during the study. We would like to acknowledge the ethical clearance of the Mekelle University institute of population studies and Tigray Health Research Institute researchers for providing valuable comments and suggestions for conducting this study.

## DECLARATION

### *Author Contributions*

All authors made significant contributions to the study conception, study design, execution, acquisition of data, analysis and interpretation of the data; participated in drafting , revising or reviewing the article critically; gave final approval of the version to be published; agreed on the journal to which it would be submitted; and agreed to be accountable for all aspects of the work.

### *Funding*

The study had no funding.

### *Disclosure*

The authors declare that they have no competing interests.

### *Ethical Consideration*

Ethical approval was sought and granted from the Mekelle University Institute of Population Studies Ethical Clearance Committee with reference number 204/MUIP-6/20. The clearance letter was summited to the Atsbi Wemberta Woreda Association Office, and then the cooperating letters were taken from the office. It was distributed to concerned bodies and district health office experts to gain access and collaboration. The respondents were informed of the objective of the study and verbal consent was obtained from each respondent. They were also informed that they were free to decline or withdraw from the study at any time. Privacy and confidentiality were ensured during the interviews.

### *Data Sharing Statement*

The dataset analyzed in the current study is available from the corresponding author upon reasonable request

### *Availability of Data and Material*

Available upon request to corresponding author

## REFERENCES

1. World Health Organization. (2008). Eliminating female genital mutilation: an interagency statement - OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. World Health Organization.
2. UNICEF (2016) United Nations Children’s Fund. Female genital mutilation/cutting: A global concern.

3. Stanley YP, Khan S (2008) Numbers of women circumcised in Africa: the production of a total. Demographic and Health Survey program DHS Working Papers No. 39. Calverton, Maryland, USA: Macro International.
4. National Committee on Traditional Practices of Ethiopia (2003). Old Beyond Imaginings: Ethiopia, Harmful Traditional Practices. National Committee on Traditional Practices of Ethiopia pp. 372.
5. https://www.unicef.org/ethiopia/reports/profile-female-genital-mutilation
6. Melese G, Tesfa M, Sharew Y et al. (2018) Knowledge, attitude, practice, and predictors of female genital mutilation in Degadamot district, Amhara regional state, Northwest Ethiopia, 2018. BMC Womens Health 20(1): 178.
7. Tamire M, Molla M (2013) 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 13: 1120.
8. Bogale D, Markos D, Kaso M (2014) Prevalence of female genital mutilation and its effect on women's health in Bale zone, Ethiopia: A cross-sectional study. BMC Public Health 14: 1076.
9. Mwanja CH, Herman PZ, Millanzi WC (2023) Prevalence, knowledge, attitude, motivators and intentional practice of female genital mutilation among women of reproductive age: a community-based analytical cross-sectional study in Tanzania. BMC Womens Health 23(1): 226.
10. Mohammed ES, Seedhom AE, Mahfouz EM (2018) Female genital mutilation: current awareness, believes and future intention in rural Egypt. Reproductive Health 15(1): 175