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Prevalence and associated factors of female genital mutilation among reproductive age women's of Damot Gale Woreda, Wolaita Zone, Southern Ethiopia: A cross-sectional study, 2018

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Female genital mutilation (FGM) is estimated to have been practiced on at least 200 million girls and women in 30 countries around the world. Clitoridoctomy is the most common type of FGM in Ethiopia. The aim of the study was to assess the magnitude of Female Genital Mutilation and associated factors among women's in Damot Gale Woreda of Wolayita zone. A quantitative community-based cross-sectional study was used. Face-to-face interviews with prepared questionnaires were used to collect data. SPSS version 20 software was used to analyze the data. The prevalence of FGM was determined using descriptive statistics. The researchers utilized a bivariate and multivariate logistic regression model to find independent determinants of FGM. 296 women were circumcised out of a total of 333, indicating that FGM is prevalent in the research area (88.9%). Mother education (AOR: 0.454, 95% CI: 0.209-0.984), age (AOR-1.86, 95% CI: 0.42-0.98)), knowledge that FGM causes health problems (AOR: 0.356, 95% CI: 0.145-0.877), and support for tradition (AOR: 14.595, 95% CI: 3.391-6.807) were all independently linked to FGM. Prevalence of FGM was associated with age, education, knowledge of health problems and tradition.

Key words: Associated factors, female genital mutilation (FGM), prevalence, Wolayita zone.

INTRODUCTION

Female genital mutilation (FGM) is defined by the World Health Organization as any procedure that involves partial or entire removal of the external female genitalia, or other harm to the female genital organs for no medical reason. The practice is usually carried out by women who are often involved in other important aspects of their communities, such as attending childbirths. Health care providers, on the other hand, execute more than 18% of all FGM, and the tendency toward medicalization is growing (WHO Fact Sheet, 2019). At least 200 million girls and women worldwide have been subjected to FGM in 30 countries, including Ethiopia, Kenya, Somalia,

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Tanzania, and Uganda. They are also becoming more common in Europe, Australia, New Zealand, Canada, and the United states, mostly among immigrants from cultures where FGM is a common practice (UNFPA-UNICEF, 2019).

Out of a total population of 205 683 girls aged 0-18 originating from countries where female genital mutilation is prevalent, it is estimated that 12 to 21% of girls in France are at danger of female genital mutilation (European Institute for Gender Equality, 2018). Teixeira and Lisboa calculated that nearly 6,500 immigrant women 15 years and older had been circumcised in Portugal, while 1,830 girls under 15 years are likely to or have been circumcised, according to the study by Odukogbe et al. (2017) report. The practice is founded in traditional beliefs, values, and attitudes, and is regarded as a rite of passage into femininity and child marriage in many nations (WHO, 2016).

FGM/C is prevalent in more than 70% of African countries, according to estimates from Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Guinea, Mali, Mauritania, Northern Sudan, and Somalia. However, because of ethnicity and culture, there is a wide range of frequency between and within countries. Mali, for example, has a frequency of 92%, compared to 28% in Senegal. The most severe form of FGM (infibulations), which involves the sewing and narrowing of the vaginal hole, is estimated to have been performed on 15% of all circumcised women. However, in Djibouti, Somalia, and Sudan, this method of circumcision accounts for about 80 to 90% of all circumcisions (The European Institute for Gender Equality, 2015).

FGM is a type of gender-based violence that has been identified as a harmful practice and a violation of girls' and women's human rights. In the 28 African nations and Yemen where FGM is performed, over 125 million girls and women have had FGM, and 3 million girls are projected to be at danger of FGM each year (Unicef Anual Report, 2013). According to an Ethiopian demographic and health survey, 65% of women between the ages of 15 and 49 are circumcised. Female circumcision is most common in Somalia (99%) and least common in Tigray (24%), whereas it is most common in Wolayita (92.3%).

Clitoridoctomy is the most common kind of FGM in Ethiopia. Without having their vaginal area sowed, 96.2% of women and 96.5% of daughters have undergone some sort of circumcision. Infibulations is the most extreme type of FGM/C, involving the excision of genitalia and the closing of the vaginal hole with stitching. It has been experienced by 2.9% of Ethiopian women and 3.4% of daughters. This is because it suggests that some women who have never had infibulations want to have their daughters circumcised in the most severe way possible. Ethiopia has one of the highest rates of infant girls who are subjected to any type of female genital mutilation (Unicef Anual Report, 2013).

The study's goal was to determine the prevalence of female genital mutilation in the study area, as well as the factors that contribute to the continuation of female genital mutilation.

MATERIALS AND METHODS

Study area and period

The research was carried out in Damot Gale Woreda, in the Wolayita zone of Southern Ethiopia. Damote Gale was around 302 km south of Addis Ababa, through Butajira's major road, and 138 km from Hawassa. There are 30 rural kebeles in the woreda. The population of Damot gale Woreda was estimated to be 154,610 in the 2008 E.C census (Damot Gale Wored Static Bureau, 2008). The research was carried out between the months of June and August. Area map of Damot Gale was shown in (Figure 1).

Research design

A community-based cross-sectional quantitative design was conducted at Damot Gale Woreda, Wolayita Zone.

Source population

Women residing in Damote Gala Woreda served as the study's source population.

Study population

The study population was drawn from all reproductive-age women in the household.

Sample size determination

The investigation of Woreda Damot Gale was chosen on purpose because FGM is a widely performed area. Then, at random, eight rural Kebeles from the Woreda's 30 Kebeles were chosen. The sample size was then proportionally allocated to each of the selected Kebeles based on the number of homes in each. The computed sample size was then proportionally allocated to each of the eight Kebeles based on the number of households in each Kebele. Finally, the Kebele lottery method was used to choose study subjects using family folder numbers. Women from chosen families were eligible to participate in the interview as respondents. The sample size was calculated using a single population proportion formula. According to the EDHS, the current prevalence of FGM in Southern Ethiopia was 62% (Ethiopian Public Health Institute Addis Ababa, 2019).

d=Margin of error 5%
- Z=1.96 at desired confidence level 95%
$n = (z\alpha/2)^2 P (1-P)/d^2$
- 10% of non-response rate
n= [1.96×1.96]0.62[1-0.62]/0.05×0.05
n=315 then add 10% non-response rate gives
Final sample size is 347 respondents.

Sampling procedure

Damot Gale administrative Study Keble was selected by using

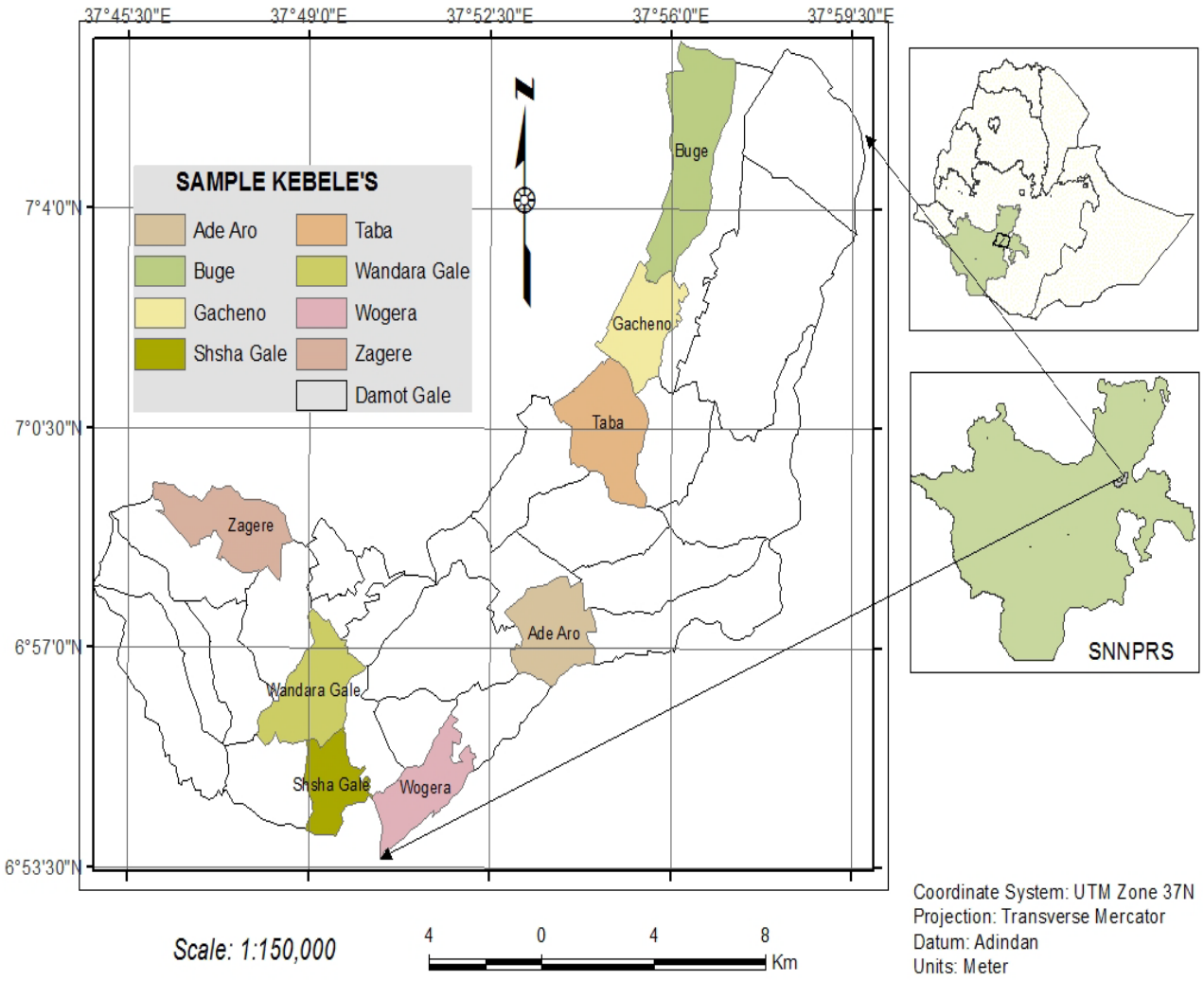

Figure 1. Map of the study area.
Source: Ethiopian GIS and RS team WWDSE (2013).

Schematic picture below in (Figure 2).

Data collection procedures

Data was obtained by face-to-face interviews using prepared questionnaires after a two-day training for four female nurses with at least a diploma. The majority of the training included the goal of the study, each portion of the questionnaire, consents, the right to participate or not participate, the ability to withdraw at any moment, confidentiality, and how to approach the study. The data collection method was overseen by two trained supervisors and the primary investigator at each step daily to assure data quality. The data was gathered between March 1 and March 15, 2018.

The primary data sources were responses from married women aged 18 to 49 who were interviewed in their homes. Secondary data was acquired from several zonal and Woreda offices, on the other hand.

To ensure that the data was of good quality, the following actions were done. The surveys were composed entirely in English. A fifth of the sample size was pre-tested for the questionnaire in another woreda near Damot gale. Woreda (sodo zuriya) was done prior to data collection, and equipment changes were made as appropriate. On a daily basis, the supervisors and the lead investigator checked the data for completeness, clarity, and consistency. The total activity was overseen by the principal investigator, who was also in charge of data collection. Finally, data was double-entered into Epi-data 3.1 program for verification.

Data analysis

At the end of each data collection day, the collected data was reviewed for completeness and consistency. It was also cleaned, edited, coded, and entered into Epi data program version 3.1. The data is then exported to SPSS 20.0 for analysis. The frequency distribution and percentage of different variables were generated during the analysis phase to define and summarize the main socio-demographic chasm.

To give a fast overview of the variables, the results were presented in the form of frequency tables, pie charts, and graphs. To describe the prevalence of FGM in the Woreda study population

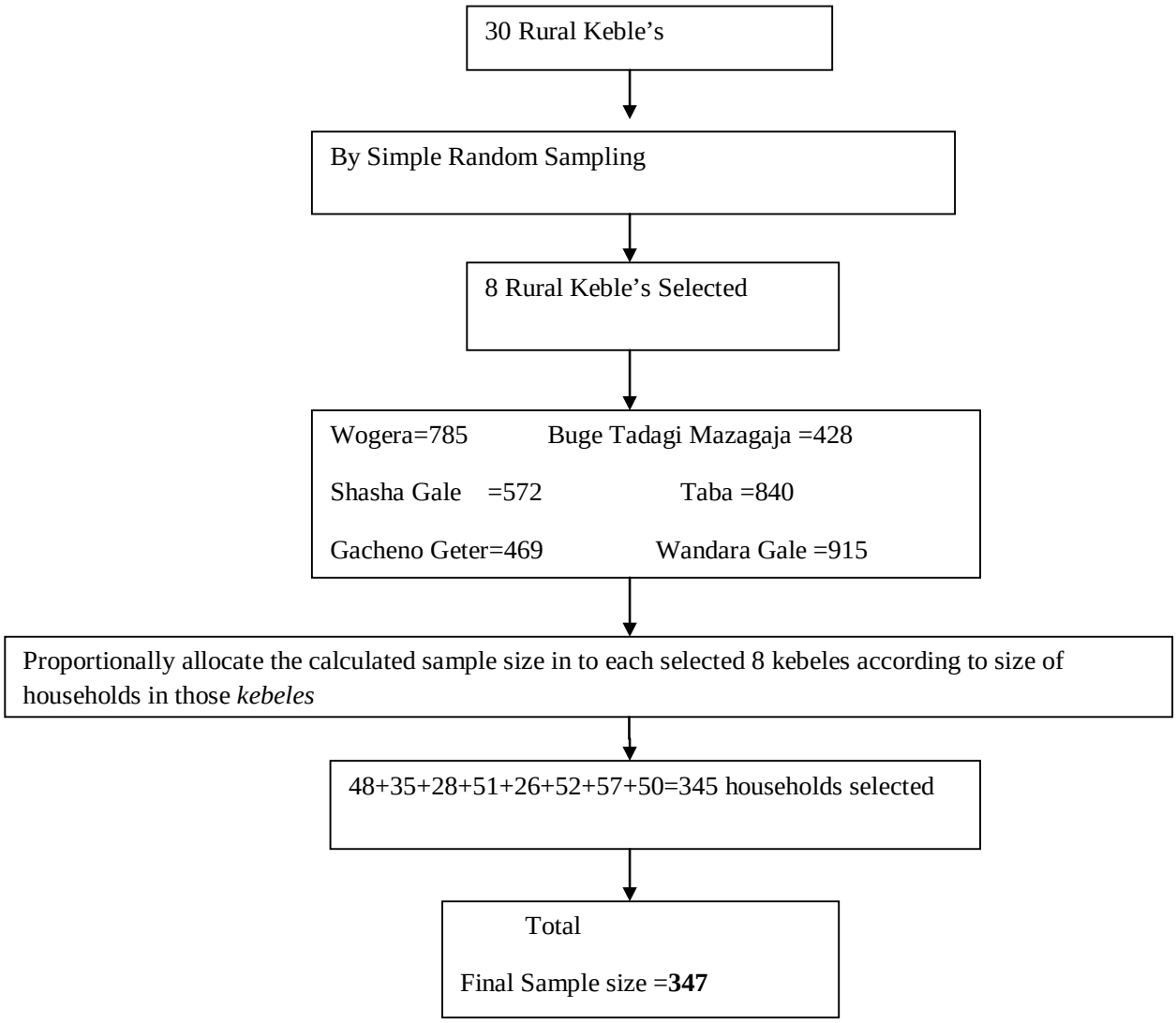

Figure 2. Schematic representation of sampling procedure.

in relation to pertinent variables, descriptive statistics such as frequencies, proportions, and summary statistics were utilized. To assess the relationship between different predictor factors and the dependent variable, researchers performed bivariate and multivariate analysis with logistic regression models.

A binary logistic regression analysis was used to evaluate the bivariate association between each independent variable and the outcome variable. For multivariate logistic regression, variables that exhibited a significant correlation on bivariate analysis with a p-value of 0.05 were employed. To reduce the impact of confounding variables and identify FGM factors, multivariate logistic regression analysis was employed. The adjusted odds ratio with 95% confidence interval and p-value of 0.05 as cut point were used to analyze the strength of the link between dependent and independent variables.

Ethical consideration

The nature and purpose of the study were explained to the respondents and Woreda administration. Following ethical permission from the Damot Gale Woreda administrative office, the Woreda delivered an official letter to the sampled Kebeles and concerned offices. Afterall, verbal consent to participate in the study was gained from the respondents. The survey participants were given an open and honest explanation of the survey's goal, a description of the benefits, and the opportunity to ask any questions they had. They were also told that they might withdraw their agreement and quit participation at any time without fear of being labeled chauvinists. The privacy and confidentiality of the information acquired were ensured throughout the operation.

RESULTS

Socio-demographic characteristics of respondents

A total of 333 women took part in the survey, with a 96% response rate. Due to incompleteness, fourteen questionnaires (3.4%) were rejected. Daughters in this

Table 1. Socio-Demographic Characteristics of women's of Damot Gale Woreda, Wolayita Zone, Southern Ethiopia 2018.

Variable	Frequency	Percentage
Age of the respondents		
Age 18-22	30	9
Age 23-27	78	23.4
Age 28-32	95	28.5
Age 33-37	46	13.8
Age >38	84	25.2
Religion of the respondent		
Protestant	166	49.8
Orthodox	111	33.3
Muslim	42	12.6
Catholic	14	4.2
Ethnicity of the respondent		
Wolayita	270	81.1
Amhara	48	14.4
Oromo/Kambata/Hadiya/Other	15	4.5
Educational status of the respondent		
Illiterate	208	62.5
Literate	125	37.5
Literacy status of the father		
Literate	143	42.9
Illiterate	190	57.1
Literacy status of the mother		
Literate	121	36.3
Illiterate	212	63.7

study ranged in age from 18 to 49 years old. The average age was 34.05 years (SD 7.9). In terms of religious affiliation, 166 respondents (49.8%) were Protestant, 111 (33.3%) were Orthodox, and 42 (12.6%) were Muslims. The ethnicity of almost all of the interviewees was Wolayita 270 (81.1%). In terms of education, 208 (62.5%) of respondents were literate, while 125 (37.5%) had no formal education. In terms of familial educational background, the vast majority of research participants were uneducated. Formal schooling was followed by 212 (63.6%) and 121 (36.4%). Husbands of respondents 143 (42.9 percent) had some level of education, while others had no formal education (Table 1).

The majority of the respondents (324, or 97.3%) were married, while some (8, or 2.4%) were divorced, and one was widowed (0.3%). Ninety-two percent (57.7%) of fathers were farmers, whereas 151% (45%) of moms worked as housewives. In terms of respondents' wealth, sixty-eight (20.4%) were judged to be in the second quintal index level, while about the same proportion (19.8%) were in the highest quintal index level. As a result, we concluded that the amount of wealth among respondents is not considerably different (Table 2).

Figure 4 depicts the frequency distribution of female genital mutilation in relation to respondents' educational status. Their educational background ranges from uneducated (no formal schooling) through grade twelve. In a nutshell, the graph showed that as educational levels rose, so did the prevalence of female genital mutilation (Figure 3).

Prevalence of the female genital mutilation

Two hundred and ninety-six (88.9%) of the total responders were circumcised, whereas just 37 (11.1%) were not circumcised. The majority of circumcisions were done on children aged 1 to 5, accounting for 171 circumcisions (51.4%). Despite the fact that all types of circumcision were used in the studied area, Clitoridoctomy

Table 2. Marital status and socio economic characteristics of women of Damot Gale Woreda, Wolayita Zone, Southern Ethiopia 2018.

Variable	Frequency	Percentage
Marital status		
Married	324	97.3
Divorced	8	2.4
Widowed	1	0.3
Occupation of the husband		
Farmer	192	57.7
Civil servant	14	4.2
Merchant	84	25.2
Other	43	12.9
Occupation of the mother		
Housewife	151	45.5
Civil servant	9	2.7
Farmer	98	29.4
Merchant	61	18.3
Other	14	4.2
Wealth quintal		
Lowest	66	19.8
Second	68	20.4
Middle	66	19.8
Fourth	67	20.1
Highest	66	19.8

286 (85.8) is the most common kind of FGM. Traditional circumcisers 131 performed the majority of the circumcisions at home 282 (95.5%). When asked who made the decision to circumcise their daughters, the majority decided by moms 182 (54.6%), dads 139 (41.7%), and 12 (3.6%) by the daughter herself (Table 3).

Factor associated with FGM

Circumcision is regarded as a good tradition and typical practice by 154 (46.2%) of the total respondents, whereas FGM is regarded as the best practice for the cleanliness of female genitals by 24 (10.5%) of the total respondents. Eighty-one (24.3%) of the women would like to continue circumcision because they believe it is a positive custom. When asked about their plan to circumcise their daughters, the majority of respondents (84%) said they would continue the practice.

In terms of FGM treatment, around 183 (35.4%) and 66 (19.8%) of women believe that legislation enforcement and women's access to education are the best approaches to prevent FGM, respectively, whereas only one (0.3%) respondent believes that dads should take the effort to prevent FGM. Even though the vast majority of respondents 216 (64.9%) are aware of the dangers of female genital mutilation, nearly half of them 154 (46.2%) confirm the practice's continuation because it is seen as a positive custom 81 (24.3%) (Table 4). Qualitative data, such as uncircumcised women in a focus group discussion, backs it up.

As Figure 4 indicated in the findings of this study, out of those who face the complication of FGM, 31.8, 56.8 and 11.4% went to health institution, traditional healer and other places to cure from the defect, respectively (Figure 5)

When females were asked if they had ever heard of Female Genital Mutilation, nearly 299% (89.8%) said they had recently learned of FGM in the research region. While nearly 10% of respondents had no access to information regarding FGM, 121 (36.3%) acquire their knowledge via the radio. Furthermore, 250 (75.1%) of the women are aware of written laws against female genital mutilation. When asked about female genital circumcision and its impact on women's rights, the majority of respondents (71.5%) were unaware of the legal status of FGM, while just 28% of women believe circumcision violates women's human rights (Figure 5).

Despite the fact that several measures to prevent FGM were carried out in the research area, the prevalence of

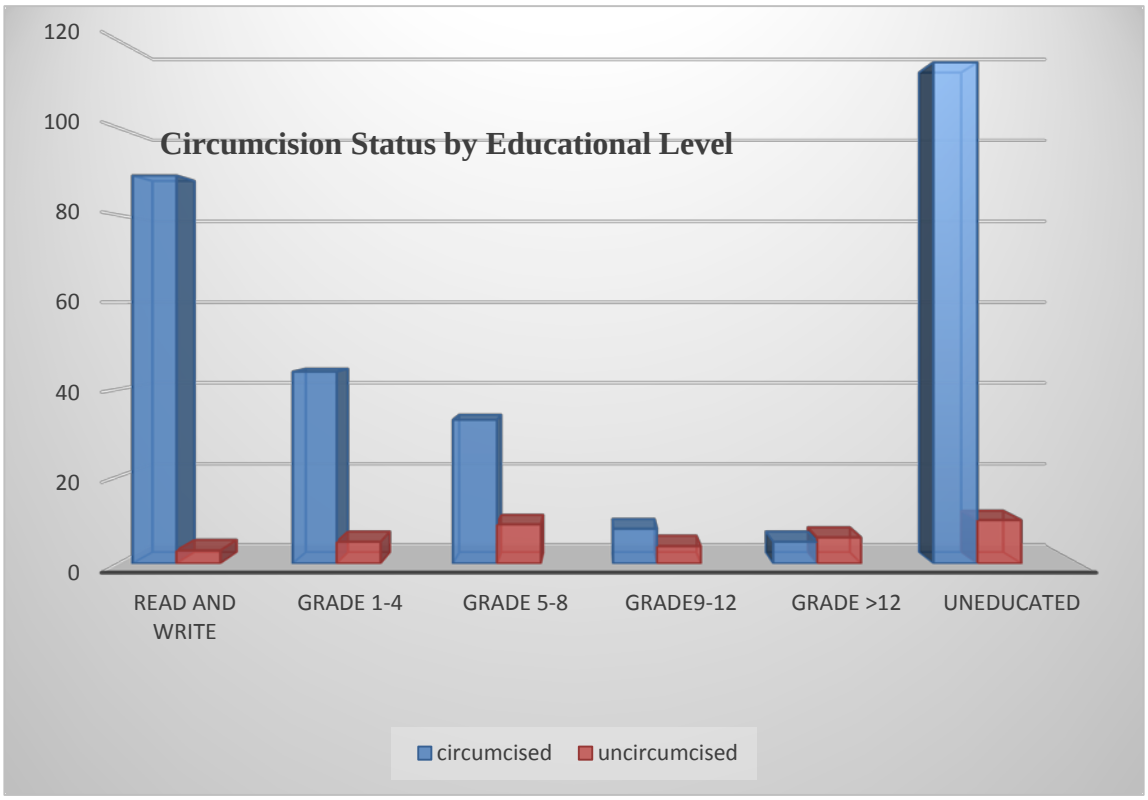

Figure 3. Circumcision statuses by educational level.

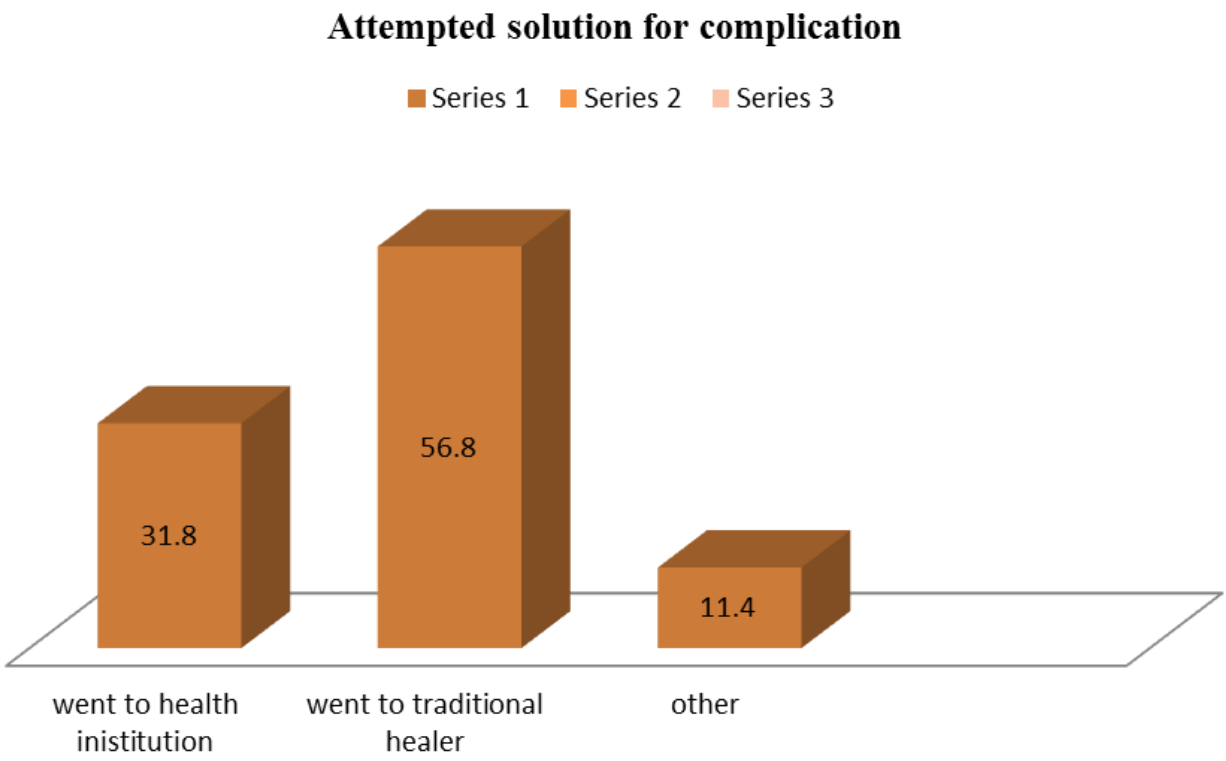

Figure 4. Attempted solutions for health complications.

Table 3. Characteristics of Women's Genital Mutilation of women's of Damot Gale Woreda, Wolayita Zone, Southern Ethiopia 2018.

Variable	Frequency	Percentage
Circumcision status		
Circumcised	296	88.9
Uncircumcised	37	11.1
Age at circumcision		
1-5	171	51.4
6-10	86	25.8
11-15	34	10.2
16-20	3	0.9
21-25	1	0.3
>25	1	0.3
Type of circumcision		
Clitoridoctomy	286	85.8
Infibulations	3	0.9
Other	7	2.1
Place of circumcision		
At home	282	95.5
Private clinic	3	0.6
Other	11	3.3
Decision power on FGM		
Husband	139	41.1
Wife	182	54.9
Daughter	11	3.3

FGM remains high due to insufficient law enforcement and community resistance (Table 5). This is in line with a qualitative study in which the majority of focus group discussants stated that punishment was ineffective and that the community was resistive to anti-FGM efforts.

Analysis of factors associated to female genital mutilation

Bivariate analysis

Bivariate analysis revealed the following: maternal education (COR: 0.467, 95% CI: 0.212, 1.029), age of daughters (COR 1.92, 95% CI: 0.53, 1.25) household wealth index quintal (COR: 0.768, 95% CI: 0.550, 1.072), father's educational status (COR: 1.135, 95% CI: 0.808, 1.595), good tradition COR: 9.895, 95% CI: 2.213, 4.251). At a p-value of 0.25, knowledge of FGM health complications (COR: 0.339, 95% CI: 0.134, 0.859) and knowledge of FGM law (COR: 0.042, 95% CI: 0.005, 0.349) were candidate variables for a multivariate logistic regression model (Table 6).

Multivariate analysis

During crude analysis, factors were adjusted using multiple logistic regressions to predict variables related with Female Genital Mutilation. At a p-value of 0.05, variables such as age, maternal education, traditional FGM, and knowledge of health complications connected to FGM were significant.

The odds of experiencing FGM were nearly 45% higher in mothers who did not educate than in mothers who did [AOR: 0.454, 95% CI: 0.209, 0.984]. The odds of experiencing FGM were about two times higher in younger daughters than in elder daughters [AOR: 0.454, 95% CI: 0.209, 0.984]. Women who accept FGM because of tradition [AOR: 1.86, 95% CI: 0.42, 0.98] have 14 times higher odds of performing it than women who oppose it [AOR: 14.595, 95% CI: 3.391, 6.807]. Moreover, FGM in the household which mothers did not know about any of the health complication of FGM were

Table 4. Factors associated to FGM of women's of Damot Gale Woreda, Wolayita Zone, Southern Ethiopia 2018.

Variable	Frequency	Percentage
FGM should continue		
Yes	154	46.2
No	179	53.8
Main reasons FGM continued		
Good tradition	81	24.3
Cleanliness	36	10.8
Reduction of female sexual hyper sensitivity	10	3.0
Better marriage prospect	16	4.8
To prevent female from early initiation of sex	9	2.7
Prevention of virginity	2	0.6
Participate FGM intervention activity		
Yes	240	72.1
No	93	27.9
Best way to stop FGM		
Enforce legislation	118	35.4
Sexual education	37	11.1
Education to women	66	19.8
Improve status of women	22	6.6
Father responsibility	1	0.3
Knew FGM cause health problems		
Yes	216	64.9
No	117	35.1
Health problems on circumcised women		
During sexual intercourse	85	28.7
During menstrual flow	58	19.5
Obstructed labor	73	24.6
Bleeding due to procedure	74	25
Other	6	2.2
Continue to circumcise daughters		
Yes	280	84.1
No	53	15.9

35% more at risk of performing FGM as compared to in the household in which mothers knows about the health complication of FGM [AOR: 0.356, 95% CI :0.145, 0.877] (Table 7).

DISCUSSION

In Damot Gale Woreda, Wolayita Zone, and Southern Ethiopia, researchers looked into the incidence of female genital mutilation and the factors that contribute to it. FGM was found to be prevalent in 89% of the sample population, and it was closely linked to age, maternal education, traditional support, and a lack of information about the health consequences. Despite many interventions in Damote Gale Woreda and Wolaita Zone, the practice of female genital mutilation (FGM) has remained implying that the practice is still going on even if there is access to appropriate health information (Ethiopian Public Health Institute Addis Ababa, 2019). The prevalence was lower than that of a research conducted in Ethiopia's East Gojjam Zone, Amhara

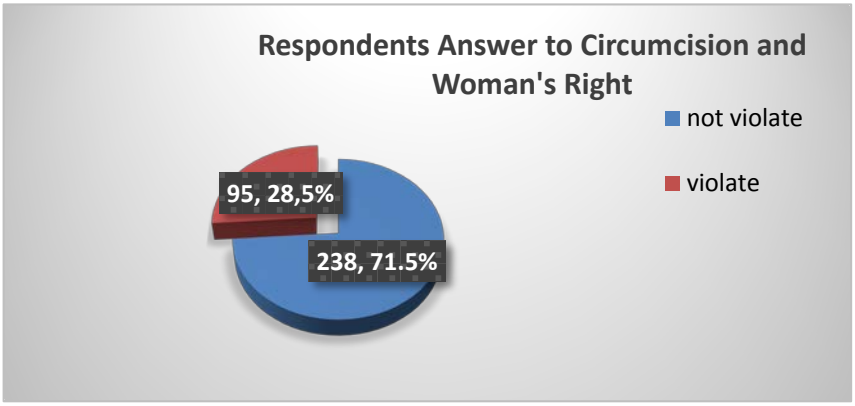

Figure 5. Respondents thought about FGM law.

Region, in 2012, which found a prevalence of 62.7% (The European Institute for Gender Equality, 2015). When compared with EDHS in the same region report with prevalence of 71% and lower than the same area, the present value is greater (92.3%) (Ethiopian Public Health Institute Addis Ababa, 2019). In comparison to a community-based survey done in Kersa district, Eastern Hararge Zone, the current finding was lower (93%) (Ethiopian Public Health Institute Addis Ababa, 2019).

FGM was found to be 87.1% (10%) in a cross-sectional survey done in Somali refugees in eastern Ethiopia in 2017, which is lower than this study. Also, a study conducted on the Bale zone of Ethiopia and the Pusiga district of northern Ghana found prevalence rates of 78.5 and 61%, respectively, which is lower than our findings. This could be due to differences in study locations and socioeconomic status (Yirga et al., 2012; Abdisa et al., 2017).

This study found that education changed people's minds on the practice of female genital mutilation. This study found that when people's educational levels rise, they are less likely to endorse the practice of female genital mutilation (FGM). That is, the more educated people are, the more they reject the continuance of FGM (64 and 36% rejection of FGM by those with formal education and those with no education, respectively), which is similar with findings from other studies (Sakeah et al., 2018; Mitike and Deressa, 2009; Karmaker et al., 2011). FGM was more common in households where the mothers were uneducated than in those where the mothers were educated. Getting an education preserves women's lives by roughly 45% compared to those who do not. Similarly, a mother's educational level appears to have a significant impact on a daughter's likelihood of being circumcised; 56% of daughters of moms with no formal education are circumcised, compared to 26% of daughters of women with at least some secondary education (Gajaa et al., 2016).

Similar studies on characteristics linked with perceived continuation of Female Genital Mutilation Ethiopia in terms of education status found that individuals with a primary education were 0.65 times less likely to favor the continuation of FGM than those with no formal education level. Similarly, those with higher education level were 0.14 times less likely to support for the continuation of the practice than those with no formal education (Uchenna et al., 2019). The findings contradict those of a study conducted in eastern Hararge, which found no link between parental education and FGM (UNICEF, 2013). This could be explained by the expectation that women with higher education would have more access to and exposure to media and advocacy messaging, as well as a stronger understanding of the human rights implications.

Another important factor was age; the magnitude of Female Genital Mutilation in this study area was significantly associated with age, with magnitude decreasing as age increased. This could be due to the fact that as daughters grow older, their thinking matures and they can identify what is best for their future lives, so they may refuse circumcision. Result shows the odds of experiencing FGM were about two times more in younger daughters than older daughter (AOR-1.86, 95%CI; 0.42, 0.98). This result was in the same line with the research done in Bale Ethiopia (Yirga et al., 2012). But this result was opposite to the result of the study which was conducted in Afar, Ethiopia that shows being higher age had an association to the prevalence of female Genital Mutilation at the study area (AOR, 11.56; 95% CI: 2.56, 48.39) and also similar result was seen in a research at Bawku municipality and Pusiga district of northern Ghana with result of (AOR: 4.24; 95% CI: 2.62-6.85) (Abdisa et al., 2017; Fikrie, 2011; Pashaei and Rahimi, 2012). This variation with the current finding was due to inhabitants are from a different country which could have a different socio cultural differences. And according to Ethiopian Demographic and Health Survey circumcised women at the age category of 15-49 nearly half of women (49%) reported that they were circumcised when they were

Table 5. Knowledge about Persistence of FGM of women's of Damot Gale Woreda, Wolayita Zone, Southern Ethiopia 2018.

Characteristics	Participants	Frequency
Heard messages on existence of FGM		
Yes	300	90.1
No	33	9.9
Sources of information about FGM		
Radio	121	36.3
Religion leader	19	5.7
Community conversation	81	24.3
Educated children	6	1.8
Anti-FGM committee	11	3.3
Health extension	61	18.3
Women's affair	1	0.3
Knowledge of circumcision as crime		
yes	250	75.1
No	83	24.9
Do you know anyone who punished by FGM		
Yes	171	51.6
No	161	48.3
Do you expose any action which promote FGM		
Yes	228	68.4
No	105	31.5
If no why		
Fear of Social exclusion	17	5.1
Good Tradition	62	18.6
Lack of commitment	11	3.3
I have no information	12	3.6
Fear of religious leader	3	0.9
Is there any activity in your community to stop FGM		
Yes	228	68.5
No	104	31.2
Why FGM exist in your community		
Weak implementation of law	135	58.2
Community resistance to anti-FGM activity	89	38.4
Other	8	3.4

younger than age 5, 22% between ages 5-9, 18% between ages 10-14, and 6% at age 15 or older (Ethiopian Public Health Institute Addis Ababa, 2019). This shows that prevalence decreases with the age.

The determining factor on the prevalence of FGM in this research was knowledge about the health problems of FGM. Moreover, FGM in household which mothers did not know about any of the health complication of FGM were 65% more at risk of performing FGM as compared to the household in which mothers know about the health complication of FGM. This is same percent as research finding done on school girls in Addis Ababa. Factors associated with perceived continuation of Female Genital Mutilation showed that those who have knowledge of avoiding HIV/AIDS was 60% (Uchenna et al., 2019). Knowledge of women in this study with four major complication areas such as excessive bleeding (22.2%), obstructed labor (21.9%), menstrual disturbance (17.4%)

Table 6. Bivariate Analysis of Factors associated with FGM of women's of Damot Gale Woreda, Wolayita Zone, Southern Ethiopia 2018.

Characteristics	FGM		P value	COR
	Yes	No		
Maternal education				
Literate	121	36.3	1	1
Illiterate	212	63.7	0.049	0.467
Age at circumcision				
1-5	171			
6-10	86			
11-15	34	-	0.0482	0.92
16-20	3			
>21	2			
Wealth quintile				
Lower quintile	66	19.8		
Second quintile	67	20.2		
Middle quintile	66	19.8	0.121	0.768
Fourth quintile	67	20.2		
Highest quintile	66	19.8		
Husband education				
Educated	143	42.	1	1
No education	190	57.1	0.165	1.135
Good tradition				
Yes	152	45.6	1	1
No	180	54.4	0.003	9.895
Knew FGM cause health problems				
Yes	216	64.9	1	1
No	116	34.8	0.023	0.339
Knowledge towards FGM law				
Yes	250	75.1	1	1
No	81	24.3	0.103	0.042

and sexual problems (25.5%) is similar with a study which is done at Gambia with higher prevalence of long-term health problems such as dysmenorrhea and vaginal pain problems related to anomalous healing such as keloid and sexual dysfunction. Women with FGM/C were also much more likely to suffer complications during delivery for example, perineal tear, obstructed labor, and episiotomy (Abeya et al., 2017). Other complications secondary to FGM according to the study conducted at Bale zone Ethiopia adds excessive bleeding at the time of the procedure, infection, urine retention and swelling of genital organ (Yirga et al., 2012; Karmaker et al., 2011).

The main other reason in this study for the higher prevalence of FGM in this study is the perception of community members about FGM practice as a tradition. The long persistence of FGM is partly ascribed to the dominant role of men played in influencing the society as a whole. In which majority of participants claimed a tradition was the main reason for a long term persistence of FGM in the study area supported due to good tradition of FGM showing that women who support FGM as a good tradition were 14 times more likely circumcised than women who oppose the practice. This is also supported by a community-based cross-sectional survey conducted in Kersa district Eastern Hararge in which societal beliefs played a major role. This was the main reason given for Genital Cutting which was to reduce "female hyperactivity" in sexual practice, and was the response of 60% of the women, while a quarter of the women responded that it was done to prevent early initiation of sexual activity

Table 7. Multivariate Analysis of factors associated with FGM of women's of Damot Gale Woreda, Wolayita Zone, Southern Ethiopia 2018.

Characteristics	FGM		P value	COR	AOR
	Yes	No			
Maternal education					
Literate	121	36.3		1	1
Illiterate	212	63.7	0.045	0.467	0.454
Age at circumcision					
1-5	171				
6-10	86				
11-15	34				
16-20	3	-	0.0423	1.92	1.86
21-25	1				
>25	1				
Good tradition					
Yes	152	45.6	0.000	9.895	14.595
No	180	54.4	-	1	1
Knew FGM cause health problems					
Yes	216	64.9	-	1	1
No	116	34.8	0.025	0.339	0.356

(Ethiopian Public Health Institute Addis Ababa, 2019).

CONFLICT OF INTERESTS

The authors have not declared any conflict of interests.

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