

Original Research Article

Knowledge, attitudes and practices of female genital mutilation among health care workers in Somali region of Ethiopia

Olusola Oladeji*, Abdifatah Elmi Farah, Bukhari Shikh Aden

UNICEF Somali Field Office, Ethiopia

Received: 11 July 2021

Accepted: 19 August 2021

***Correspondence:**

Dr. Olusola Oladeji,

E-mail: ooladeji@unicef.org

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Background: Female genital mutilation (FGM) is a global challenge with estimated over two hundred million girls and women worldwide having undergone the procedure and another three million girls are at risk of being cut yearly. The prevalence of FGM among women and girls aged 15-49 years in Somali region of Ethiopia is 99% compared to the national average of 65%. The study assessed the knowledge, attitude, and practice of health care workers on FGM practices in the region.

Methods: The study was a cross-sectional descriptive survey and used quantitative method.

Results: 36 (17.8%) of the health workers believed FGM was a mandatory religious practice, while 158 (78.2%) regarded it as a cultural practice. All the respondents knew it caused health problems, 32 (15.8%) believed it was a good practice though 176 (87.1%) of the respondents believed it violated human rights of the girls/women and 99 (49%) wanted the practice to continue. 15 (40.5%) had conducted FGM on a girl before, 5 (13.5%) claimed medicalization made FGM practice safer and 5 (13.5%) of the respondents intended to circumcise their daughters in future.

Conclusions: Health care workers still have attitudes and practices that positively promote and could encourage FGM practices in spite of their knowledge of the health consequences and their acceptance as a violation of the rights of women and girls. This attitude has high tendencies of depriving the community members of access to accurate information that will enable them to make informed decision about FGM and efforts to eradicate the practice.

Keywords: Female genital mutilation, Health workers, Knowledge, Attitude, Practice

INTRODUCTION

FGM is a harmful practice that consists of all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons. All forms of FGM can cause immediate and long-term health risks, the risk, of both immediate and long-term, increases with the extent of the cutting.^{1,2}

FGM is a global challenge with estimated over two hundred million girls and women worldwide having

undergone the procedure and another three million girls are at risk of being cut yearly.² It is estimated that the prevalence may increase to sixty eight million by the year 2030 with a projection of nearly five million girls undergoing the procedure yearly if more actions are not taken towards eradicating the practice.³ The practice of FGM is concentrated mostly in Africa, Asia and the Middle East and it is characterised by the partial or total excision of the female external genitalia and associated with entrenched cultural practices in most communities in Sub-Saharan African countries.^{1,2,4}

In Ethiopia, 65 percent of women and girls aged 15-49 years were circumcised at national level though with notable disparities across regions and settings with Somali region having a prevalence of FGM of 99%.⁵ The government of Ethiopia has developed the National costed roadmap to end child marriage and FGM that ultimately aimed to bring about the complete abandonment of child marriage and FGM in Ethiopia by 2025 and this intervention included building the capacity of health workers at all levels of health care delivery to provide prevention and clinical care services on FGM.⁶

The study aimed to assess the knowledge, attitude and practice of health care workers on FGM practices in the region.

METHODS

Study population and setting

The study was conducted in Somali region of Ethiopia among health care workers in the health facilities in the region. There were 9 hospitals, 208 health centers and 1240 health post in the region with various categories of health workers including doctors, nurses, midwives and health extension workers.

Study design

The study was a facility based cross-sectional descriptive survey and used quantitative method.

Sample size calculation

The study was from a baseline assessment done for an interventional project and sample size of 202 used was calculated using sample size calculation methods for two independent proportions to determine the sample size of health facilities.⁷

Sampling technique

Stratified sampling design was used. In the first stage, health facilities were stratified into three categories, hospital, health centres and health posts.

In the second stage, a sample of health facilities were randomly selected from sampling frame-using proportional to population size (PPS) methods for each of the 11 zones per specific health facility category and 9 hospitals, 28 health centres and 165 health posts were selected.

In each of the health facility selected, the health workers in charge of the health facilities were interviewed who are mostly doctors at the hospital, nurse/midwives at the health centres and health extension workers at the health posts.

Data collection

Data was collected using structured questionnaire administered by trained enumerators between February and March 2021.

Data analysis

The extracted data were entered into a Microsoft excel spreadsheet and analysed using SPSS version 21. Univariate analysis was done by generating frequencies and proportions and presented in tables of the variables and bivariate analysis was done using Chi-square test association was used to compare the categorical variables among the three cadres of health care workers; at p value less than 5%.

RESULTS

The results are presented using three themes which are knowledge of FGM; attitudes towards the practice of FGM and practice of FGM by the respondents.

Knowledge of FGM

Reasons for practicing FGM

Thirty six 36 (17.8%) of the health workers interviewed believed FGM was a mandatory religious practice, while 158 (78.2%) believed the practice was a cultural practice and 44 (21.8%) of the respondents believe FGM was practiced as a rite of passage for girls into womanhood. 117 (58%) of the respondents reported the practice of FGM reduced rates of prostitution, while 55 (27.2%) of the respondents reported the practices helped to maintain virginity. There was no significant difference in the knowledge of the various cadres of health workers on reasons for practice of FGM in the study, $p > 0.05$ (Table 1).

Consequences of FGM

All the respondents (100%) knew FGM caused health problems. The common health problems included bleeding, difficulty during delivery and reduction in sexual feelings (Table 2).

Attitudes towards the practice of FGM

Only 32 (15.8%) of the respondents believe FGM was a good practice and 176 (87.1%) of the respondents believed the practice violates human right of the girls/women. However, 99 (49%) of the respondents wanted the practice to continue and 54 (26.7%) of the respondents reported that girls that had not undergone FGM should be discriminated. A total of 114 (56.4%) of the respondents believed the practice of FGM cannot be eliminated in the region. There was no significant difference in the attitude of the various cadres of health workers to FGM in the study, $p > 0.05$ (Table 3).

Table 1: Knowledge of health workers on reasons for practicing FGM.

Variables	Doctors; N=9	Midwives; N=28	Health extension workers; N=165	Total; N=202	Chi-square (χ^2) statistic (p value)
	N (%)	N (%)	N (%)	N (%)	
Mandatory religious practice					
Yes	1 (11.1)	2 (7.1)	33 (20.0)	36 (17.8)	$\chi^2=2.992$, p=0.224
No	8 (88.9)	26 (92.9)	132 (80.0)	166 (82.2)	
Cultural practice					
Yes	6 (66.7)	23 (82.1)	129 (78.0)	158 (78.2)	$\chi^2=0.9582$, p=0.619
No	3 (33.3)	5 (17.9)	36 (22.0)	44 (21.8)	
Rite of passage for girls into womanhood					
Yes	3 (33.3)	5 (17.9)	36 (22.0)	44 (21.8)	$\chi^2=0.962$, p=0.62
No	6 (66.7)	23 (82.1)	129 (78.0)	158 (78.2)	
Helps to maintain virginity					
Yes	3 (33.3)	5 (17.9)	47 (28.5)	55 (27.2)	$\chi^2=1.542$, p=0.46
No	6 (66.7)	23 (82.1)	118 (71.5)	147 (72.8)	
Reduces the rate of prostitution					
Yes	4 (44.4)	10 (35.7)	103 (62.4)	117 (58.0)	$\chi^2=7.71$, p=0.21
No	5 (55.6)	18 (64.3)	62 (37.6)	85 (42.0)	

Table 2: Knowledge of health workers on health complications of FGM.

Variables	Doctors; N=9	Midwives; N=28	Health extension workers; N=165	Total; N=202
	N (%)	N (%)	N (%)	N (%)
Causes health problems				
Yes	9 (100.0)	28 (100)	165 (100)	202 (100)
Common health problems				
Bleeding				
Yes	9 (100.0)	28 (100)	165 (100)	202 (100)
Difficult penetration during sex				
Yes	9 (100.0)	28 (100)	165 (100)	202 (100)
Difficulty during delivery				
Yes	9 (100.0)	28 (100)	165 (100)	202 (100)
Reduces sexual feelings				
Yes	9 (100.0)	28 (100)	165 (100)	202 (100)

Table 3: Attitude of health workers towards FGM.

Variables	Doctors; N=9	Midwives; N=28	Health extension workers; N=165	Total	Chi-square (χ^2) statistic (p value)
	N (%)	N (%)	N (%)	N (%)	
Good practice					
Yes	1 (11.1)	3 (10.7)	28 (17.0)	32 (15.8)	$\chi^2=0.8607$, p=-0.65
No	8 (88.9)	25 (89.3)	137 (83.0)	170 (84.2)	
Practice should continue					
Yes	5 (55.6)	13 (46.4)	85 (51.5)	103 (51.0)	$\chi^2=0.3264$, p=0.85
No	4 (44.4)	15 (53.6)	80 (49.5)	99 (49.0)	
Violation of human right					
Yes	7 (77.8)	27 (96.4)	142 (86.0)	176 (87.1)	$\chi^2X^2=3.029$, p=0.22
No	2 (22.2)	1 (3.6)	23 (14.0)	26 (12.9)	
Girls that have not undergone FGM should be discriminated					
Yes	3 (33.3)	14 (50.0)	37 (22.4)	54 (26.7)	$\chi^2=9.503$, p=0.0863
No	6 (66.7)	14 (50.0)	128 (77.6)	148 (73.3)	

Continued.

Variables	Doctors; N=9	Midwives; N=28	Health extension workers; N=165	Total	Chi-square (χ^2) statistic (p value)
Practice of FGM can never be eliminated in the region					
Yes	5 (55.5)	20 (71.4)	89 (54.0)	114 (56.4)	$\chi^2=2.98, p=0.23$
No	4 (44.5)	8 (28.6)	76 (46.0)	88 (43.6)	

Table 4: FGM practices among health workers.

Variables	Doctors; N=9 N (%)	Midwives; N=28 N (%)	Total; N=37 N (%)	Chi-square (χ^2) statistic (p value)
FGM is practiced in their family/household				
Yes	6 (66.7)	17 (60.7)	23 (62.2)	$\chi^2=0.11, p=0.75$
No	3 (33.3)	11 (39.3)	14 (37.8)	
Intend to circumcise her if they have a daughter in the future				
Yes	1 (11.1)	4 (14.3)	5 (13.5)	$\chi^2=0.06, p=0.81$
No	8 (88.9)	24 (85.7)	32 (86.5)	
Have ever carried out FGM on a girl as a health care provider				
Yes	5 (55.6)	10 (35.7)	15 (40.5)	$\chi^2=1.12, p=0.29$
No	4 (44.4)	18 (64.3)	22 (59.5)	
Medicalization makes the practice safer				
Yes	2 (22.2)	3 (10.7)	5 (13.5)	$\chi^2=0.77, p=0.38$
No	7 (77.8)	25 (89.3)	32 (86.5)	

Practices of FGM

Among health workers (doctors and midwives) in hospitals and health centers who were allowed to carry out surgical procedures and the health facilities equipped for it. 23 (62.2%) of the respondents reported FGM was done in their households and 5 (13.5%) of them intended to circumcise their daughters in future. A total of 15 (40.5%) of the respondents reported to have conducted FGM on a girl before and 5 (13.5%) of them claimed medicalization makes FGM practice safer. There was no significant difference in the practices of FGM among the various cadres of health workers in the study, $p>0.05$ (Table 4).

DISCUSSION

The study provided overview the knowledge, attitudes and practices of health workers on FGM.

In the study most of the health workers mentioned cultural practice as the major reason for FGM practice in the region much more than being a religious practice. This finding was similar to studies in Gambia and Nigeria among health care professionals where 96% of the respondents mentioned that FGM was practiced for cultural reasons while a study in Eastern Sudan reported a lower rate of 51.2% among the health care professionals studied.⁸⁻¹⁰ Similar to this study, most studies reported that religion was not a major reason for the practice of FGM, two studies in Nigeria reported that between 10% and 13% of the health workers studied considered religion as being reason for FGM practice in various settings unlike a study in Gambia where about 60% of the

health workers reported religion as reason for FGM practice.¹⁰⁻¹² The study found that 21% of the respondents reported FGM was performed to initiate young girls into womanhood which was however lower than around 40% reported in a study in Gambia.⁸ Other reason attributed to FGM practice was that it reduced rates of prostitution which was similar to studies in Nigeria and Egypt where half of the health care workers studied reported that FGM was practiced to prevent promiscuity.^{11,13,14}

Only few of the respondents in this study believed FGM helped to maintain virginity which was similar to a finding in a study in Nigeria where 28% of the respondents reported that FGM practices helped to preserve virginity.¹¹

All the participants in our study were aware of health consequences of FGM and identified bleeding, reduced sexual feeling and difficulty during delivery as major health complications of FGM. This was similar to finding in some studies carried out in Nigeria which reported that all the participants demonstrated a good knowledge of the health problems associated with FGM and almost all participants in these studies identified haemorrhage and painful coitus as complications of FGM.^{9,11,13,15} Similarly, studies conducted in Gambia reported that health care workers cited reduced sexual libido and difficult labor and delivery as harmful effects of FGM.^{8,12}

In this study 87% of the respondents agreed that FGM was a violation of the human rights of girls and women, which was similar to 77.9% reported in a study in Gambia while a study in Egypt, only 45% of the health workers

declared FGM to be a violation of the human rights of girls and women.^{8,14}

Despite the declaration that FGM was a violent act against women, half of the respondents in our study said the practice should continue, similar to studies in Sudan and Gambia where between 43% and 66% of the health workers studied supported the practice of FGM to continue mostly for cultural reasons.^{10,12}

In this study, 62% of the respondents reported that FGM was practiced in their households even though only 13.5% intended to circumcise their daughter in future, this was similar to study among health workers in Gambia where over 60% of participants stated that they belonged to families that routinely practice FGM and 47% of them reported their intention to subject their daughters to FGM.¹² This was similar to studies in Egypt where between 32% and 48% of the health care professional studied reported they would subject their future daughters to the practice.^{14,16}

In our study, (40.5%) of the health workers have conducted FGM on a girl before which was less than reported in a study in Sudan where 81% of the midwives reported they had performed FGM multiple times, however, among nurses and community midwives surveyed in Gambia, only 7.6% had performed the procedure.^{10,17} Among nurses surveyed in Nigeria, 7% currently practiced FGM, 14% had practiced in the past and 58% said they would perform FGM if required, while none of the nurses surveyed in a study Egypt had performed FGM, but 19.2% of Egyptian doctors surveyed had performed FGM.^{13,16}

In the study 13.5% of the health workers claimed medicalization makes FGM practice safer which was similar to study in Gambia where 43% of the health workers reported medicalizing FGM would make the practice safer and a study in Egypt where 91% of the health workers supported medicalization because it reduced pain and carried out under hygienic conditions and with anesthetic.^{12,14}

The study did not explore the reasons for the practice of medicalization of FGM among the health workers studies unlike other studies which reported safety, allegiance to cultural beliefs and financial gains as some of the motivation for the practice among health care professional studied.^{18,19}

The attitude and practices of some of the health care professionals showed that some were still deeply rooted in their cultural beliefs which may undermine their expected role of raising communities' awareness of the health risks of FGM and being change agents in their communities.

Limitations

The findings in our study are subject to response biases since we relied on the information provided by the respondents.

Further studies on the determinant of positive attitudes towards the practice of FGM among the health workers is suggested.

CONCLUSION

The study show that some health care workers still have attitudes and practices that positively promote and could encourage FGM practices in spite of their knowledge of the health consequences and their acceptance as a violation of the rights of women and girls. This attitude has high tendencies of depriving the community members of access to accurate information that will enable them to make informed decision about FGM and efforts to eradicate the practice. There is need for targeted social and behavioural change communication strategy for the health workers as part of the actions needed to eliminate the FGM practices in the region.

ACKNOWLEDGEMENTS

The authors wish to thank FRONTIERI, the consulting firm that coordinated the data collection as part of a baseline study and the field staffs that collected the data and all the health workers interviewed in the study.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES

1. WHO. Fact sheet: Eliminating female genital mutilation: an interagency statement, 2008. Available at: <https://apps.who.int/iris/handle/10665/43839>. Accessed on 28 May 2021.
2. UNICEF. Fact sheet: Female genital mutilation/cutting: a global concern. UNICEF's data work on FGM support for data collection data analysis and dissemination, 2016. Available at: https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf. Accessed on 28 May 2021.
3. United Nations Population Funds (UNFPA). Bending the curves: FGM Trends we aim to change, 2018. Available at: <https://www.unfpa.org/resources/bending-curve-fgm-trends-we-aim-change>. Accessed on 4 June 2021.
4. WHO. Fact sheet: Female genital mutilation: Key Facts, 2020. Available at: <https://www.who>

int/news-room/fact-sheets/detail/female-genital-mutilation. Accessed on 4 June 2021.

5. Central Statistical Agency (CSA), ICF. Ethiopia Demographic and Health Survey 2016: Key Indicators Report. Addis Ababa, Ethiopia. Rockville, Maryland: ICF; 2016.
6. Federal Democratic Republic of Ethiopia Ministry of Women, Children and Youth. The National Costed Roadmap to End Child Marriage and Female Genital Mutilation/Cutting (FGM). ECM; 2019.
7. Charan J, Biswas T. How to calculate sample size for different study designs in medical research? *Indian J Psychol Med*. 2013;35(2):121-6.
8. Marcusan K, Singla R, Laye M, Secka DM, Utzet M, Charles M. Female genital mutilation/cutting: Changes and trends in knowledge, attitudes, and practices among health care professionals in The Gambia. *Int J Womens Health*. 2016;8:103-17.
9. Ibrahim I A, Oyeyemi AS, Ekine AA. Knowledge, attitude and practice of female genital mutilation among doctors and nurses in Bayelsa state, Niger-Delta of Nigeria. *Int J Med Biomed Res*. 2013;2(1):40-7.
10. Ali AA. Knowledge and attitudes of female genital mutilation among midwives in Eastern Sudan. *Reprod Health*. 2012;9:23.
11. Ashimi A, Aliyu L, Shittu M, Amole T. A multicentre study on knowledge and attitude of nurses in northern Nigeria concerning female genital mutilation. *Eur J Contracept Reprod Health Care*. 2014;19(2):134-40.
12. Kaplan A, Hechavarría 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 Pub Health*. 2013;13(1):813-51.
13. Dike EI, Ojjiyi EC, Chukwulebe AE, Egwuatu VF. Female genital mutilation: Awareness and attitude of nursing and midwifery students in Afikpo, Nigeria. *J Gynecol Obstetr*. 2012;16(3):1-6.
14. Mostafa SRA, ElZeiny NAM, Tayel SES, Moubarak EI. What do medical students in Alexandria know about female genital mutilation? *East Mediterr Health J*. 2006;12(2):78-92.
15. Adekanle AD, Isawumi AI, Adeyemi A. Health workers' knowledge of and experience with female genital mutilation in Southwestern, Nigeria. *Sierra Leone J Biomed Res*. 2011;3(2):84-8.
16. Rasheed SM, Abd-Allah AH, Yousef FM. Female genital mutilation in Upper Egypt in the new millennium. *Int J Gynecol Obstet*. 2011;114(1):47-50.
17. Kaplan A, Forbes M, Bonhoure I, Utzet M, Martin M, Manneh M. Female genital mutilation/cutting in The Gambia: long-term health consequences and complications during delivery and for the newborn. *Int J Women's Health*. 2013;5(1):323-31.
18. Marie-Hélène D, Pallitto C, Groleau D. Understanding the motivations of healthcare providers in performing female genital mutilation: an integrative review of the literature. *Reproduct Health*. 2017;14:46.
19. Ejiroghene A, Adogho O, Hinsliff-Smith K, McGarry J. Healthcare professionals' knowledge, attitudes, and experiences of FGM in sub-Saharan Africa: a systematic scoping review. *Int J Afr Nurs Sci*. 2021;14:100270.

Cite this article as: Oladeji O, Farah AE, Aden BS. Knowledge, attitudes and practices of female genital mutilation among health care workers in Somali region of Ethiopia. *Int J Community Med Public Health* 2021;8:4191-6.