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Assessment of Knowledge, Attitude and Practice towards Female Genital Mutilation Among community of Agarfa Town, Southeast Ethiopia

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Abstract

Background: Above one hundred million girls and women worldwide have undergone the practice of female genital mutilation and more than three million girls mainly in Africa are estimated to be circumcised each year. In Ethiopia, the prevalence rate is 74% in women of reproductive age group (15-49 years).

Objective: The aim of this study was to assess knowledge, attitude and practice of the community towards female genital mutilation in Agarfa town, southeast Ethiopia.

Methods: A Community based cross-sectional house to house interviews on knowledge, attitude and practice of the community on female genital mutilation was conducted among 272 respondents in Agarfa town, Bale zone, Oromia, Southeast Ethiopia from May 01-05, 2013. Systematic sampling method was used to identify the respondents and data were collected using structured questionnaire on different aspects of FGM. The data were organized in percentage and frequency, and presented in table and graph.

Result: In this study around 86.1% of females were circumcised. Female genital mutilation was reported to be known by 93% of the participants and as to the attitude of the community towards the practice, 81.6% of the participants rejects its continuation. From these males and females were 82.4% and 81.6%, respectively. One fourths of them stated that FGM is currently being practiced in their village. About twenty percent were sure that there is no female circumcision currently. Majority reported that traditional circumcisers (83.3%) are the main operator of the practice. The main reasons for the practice were to respect culture (75.3%) and for religion (15.6%).

Conclusion and recommendation: The prevalence of Female genital mutilation was high. The study participants had good knowledge and negative attitude towards the practice of FGM. Majority of them had high degree of awareness about the complications of the practice. The main circumcisers were found to be traditional circumcisers. Thus, an effort should be made to change the knowledge, attitude and practice of traditional circumcisers by participating the community as whole.

Keywords: Female genital mutilation; Attitude; Knowledge

Background

Female genital mutilation/circumcision is an old age practice believed to be existed in central, eastern and northeast Africa and Middle East Asia, mainly in relation to social, cultural and religious reasons [1,2]. More than one hundred million girls and women worldwide have undergone the practice of FGM and more than three million girls mainly in Africa are estimated to be circumcised each year [2]. Estimated prevalence of FGM in 27 different countries across Africa ranged from 98% in Somalia, 74% in Ethiopia to less than 1% in Uganda [2,3]. In Ethiopia, FGM is practiced in almost all regions and ethnic groups. It is considered as part of social norms and value [4]. Most girls undergo the practice between the age of 6 and 14 years. Infibulations (pharonic) type is the most prevalent in some area of Ethiopia including Somali regional state [5]. Although, achievements so far has not been as desired, Ethiopia has made progress toward the reduction of FGM. According to 2000 and 2005 demographic and health survey (DHS) report of Ethiopia, the prevalence rate was found to be 84% and 74% respectively. This indicates the practice is deep rooted and declining slowly. The practice is more prevalent in the eastern part of the country, where it ranges from 85% to 97% [3,6]. Female circumcision is performed largely by traditional women circumciser, traditional birth attendant and some health professionals [6]. The reasons for circumcision are to respect tradition/culture, maintain cleanliness, for honourable marriage, discouraging promiscuity and for aesthetics purpose [7]. FGM which also known as female genital cutting (FGC) is defined by world health organization (WHO) as all procedures that involves partial or total removal of female genitalia, or other injury to female genital organs for non-medical reasons [2]. And it is classified in to four major types: Type 1 (Sunni): excision which is partial or total removal of clitoris and labia minora, with or without excision of labia majora. Type 2 (infibulation): narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning of the inner and outer labia with or without removal of the clitoris. Type 3 (clitoridectomy): this is defined as partial or total removal of clitoris and in a very rare case, only the prepuce. Type 4 (other): all harmful procedures to the female genitalia for non medical purpose. E.g. piercing, pricking, incising, scraping and cauterizing the genital area [8,9].

Internationally FGM is recognized as violation of human right. It reflects deep rooted inequality between sexes, and constitutes an extreme form of discrimination against women. Female circumcision related complications are more common among young girls, sometimes between infancy and fifteen years of age and occasionally on adult women. Beyond the extreme pain during the procedure, it has its own immediate and long term health consequences; the immediate health complications include severe bleeding, shock, urinary retention, infections and tetanus. It can also lead to long term effects on health like slow flow of urine and menstrual fluids, genital malformation, pain

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and bleeding during intercourse, recurrent urinary infections and development of cysts and obstetric problems which depend on the type of circumcision [2,8,9]. Despite a high level of knowledge regarding the complications of FGM and awareness of the global campaign against it, the prevalence of FGM in developing countries such as Yemen, Nigeria and Sudan is high. Yet, the highest global prevalence of FGC is reported in Sudan where 93% of the girls in urban and 89% in rural settings [9,10]. Amnesty International estimates that, over 140 million women worldwide have been affected by different form of female genital mutilation [10]. It is mainly practiced in 28 African countries, in a band that stretches from Senegal in west to Ethiopia on the east coast, as well as from Egypt in the northern to Tanzania in the south [11]. It's also increasingly found in Europe, Australia, New Zealand, Canada and United States, mostly among immigrants from cultures where FGM is a tradition [12]. The prevalence of FGM according to figures from African countries shows a prevalence of more than 70% in Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Guinea, Mali, Mauritania, northern Sudan and Somalia. However, there is a great variation in prevalence between and within countries, reflecting ethnicity and tradition. For example the prevalence rate is 92% in Mali as compared to with 28% in Senegal. As a study conducted in Egypt has shown that over all prevalence in rural schools was 62% as compared with 42% in urban schools [13].

In Ethiopia, according to a study conducted by the population reference bureau, FGM has a prevalence rate of 81% among women 35-39 yrs of age and 62% among women ages 15-19 years [14]. The 2005 DHS of Ethiopia noted that the national prevalence rate is 74% among women's of reproductive age group (15-49 years). The practice is high in the regions of Somali (97.3%), Dire Dawa (92.3%), Afar (91.6%), Oromia (87.2%) and Hariri (85.1%). And it is least prevalent in the regions of Tgray (29.3%) and Gambela (27.1%) [3]. Therefore, this study aimed to assess knowledge, attitude and practice towards FGM in Agarfa town, southeast Ethiopia.

Methods

Study design, area and period

A community based cross-sectional study was conducted in Agarfa town from December 01, 2012 to June 30, 2013. It is 31Km away from Bale Robe, the capital of Bale zone and 465Km away from Addis Ababa. The total population of the town is 25,765 and has 2074 households. Its climatic condition is 'Dega' and found 1000m above sea level. Oromo and Amharic are the dominant languages spoken. The town has 1 health centre, 1 health post, 1 TVET and 1 secondary and preparatory school.

Sample size determination

Single population proportion formula was used to determine the sample by assuming confidence interval at 95%, p of 50%, marginal error=0.05 and 10% non-response rate. The calculated sample was 272.

Data collection and sampling procedures

Data was collected using a structured questionnaire after getting oral consent form respondents. Both close and open ended questions were included. Data was collected by five members of the research group.

After first house hold selected by lottery method, Systematic sampling method was used. The maximum interval between each household that interviewed was: N/n=2074/272=8. This implied that the sequence of data collection was every 8th household. The first household was selected by lottery method.

Data management and analysis

The quantitative data from the respondents interview was cleaned, edited, and entered into Epi data version 3.1; then the data was exported to SPSS version 22; then the data were analysed, interpreted, and presented. After analysis, the data were described and presented using tables and graphs.

Ethical Considerations

A formal written letter from research and community service office of Madda Walabu University to the administrative bureau of Agarfa town was secure. The principal data collectors were explained the objective of the study and gotten informed oral consent during data collection. Confidentiality was kept both during data collection and analysis.

Results

Socio-demographic data

A total of 272 responses (100% response rate) were obtained. Among these 170 (62.5%) were females. The majority of respondents are lie 51(18.8%) were within the age group of 18-22 years (Table 1).

Source of information and of knowledge about FGM

Majority of the respondents 253(93%) had ever heard of FGM. The main sources of information identified by the respondents were television 193(42.5%), radio 88(19.3%) and 17(12.5%) health professional (Table 2).

Knowledge of the study population towards FGM

Two hundred fourteen (78.7%) knew that their religion didn't allow female circumcision, while 42 (15.4%) stated that their religion allows FGM and the rest 16 (5.9%) didn't know whether it allows or not. The majority, 232 (85.3%) said that female have the right not to be mutilated and 224 (82.4%) knew that the practice is harmful. Participants were asked about their knowledge of the complications of FGM. More than three forth, 208 (16.5%) of them had knowledge about the complications. Among these, 161(38.9%) said problem during delivery, 116 (28%), 65 (15.7%), 44 (10.6%) said excessive bleeding, sexual problem and pain during urination respectively. One hundred forty (51.5%) of the respondents knew the reason why people are practicing FGM and the rest 132(48.5%) didn't know. To respect the culture/tradition was the main 116 (75.3%) reason followed by for religion 24 (15.6%), better delivery 10(6.5%) and to decrease sexual desire 4(2.6%) (Table 3).

Practice of FGM in the community

More than half the respondents stated that FGM is not currently being practiced in their village and 75(27.6%) didn't know whether it is practicing or not. The majority proportion of FGM was performed by traditional circumcisers (83.3%) and the rest by traditional birth attendant (16.7%). Female (72.2%) was the main circumcisers. Forty eight (88.9%) were circumcised alone and majority were cut in their home (45, 83.3%) (Table 4 and 5).

Reasons to practice FGM

To respect the culture/tradition was the main 116 (75.3%) reason for practice followed by for religion 24(15.6%), better delivery 10(6.5%) and to decrease sexual desire 4 (2.6%) (Figure 1).

Characteristics		Male (%)	Female (%)
Age	18-22	16 (15.7)	35 (20.6)
	23-27	19 (18.6)	24 (14.1)
	28-32	18 (17.6)	30 (17.6)
	33-37	17 (16.7)	28 (16.5)
	38-42	15 (14.7)	21 (12.4)
	43-47	7 (8.9)	13 (7.6)
	48-52	3 (2.9)	9 (5.3)
	53-57	3 (2.9)	1(0.6)
	58-62	4 (3.9)	9 (5.3)
Occupation	Student	15 (14.7)	29 (17.1)
	Farmer	21 (20.6)	5 (2.9)
	Merchant	23 (22.5)	20 (11.8)
	House wife	**0**	91 (53.5)
	Gov't employee	27 (26.5)	17 (10)
	Daily worker	14 (13.7)	7 (4.1)
	Other	2 (2)	1 (0.6)
Educational status	Can't read and write	11 (10.8)	29 (17.1)
	Read and write	21(20.6)	45 (26.5)
	Primary	22 (21.6)	42 (24.7)
	Secondary	22 (21.6)	40 (23.5)
	Higher education	26 (25.5)	14 (8.2)
Religion	Muslim	49 (48.1)	77 (45.3)
	Orthodox	29 (28.4)	68 (40.0)
	Protestant	23 (22.5)	23 (13.5)
	Other	1(1)	2(1.2)
Ethnicity	Oromo	71 (69.6)	113 (66.5)
	Amhara	24 (23.5)	49 (28.8)
	Other	7 (6.9)	8 (4.7)
No. of female in the home	0-2	75 (73.5)	118 (69.4)
	5-Mar	25 (24.5)	43 (25.3)
	>5	2 (2)	9 (5.3)

Table 1: Socio-demographic statuses of participants in Agarfa town, southeast Ethiopia.

Characteristics* (n=456)	Frequency	Percent
Community leader	23	5
Religious leader	9	2
Health professional	57	12.5
Women's leader	21	4.6
Family member	47	10.3
Radio	88	19.3
TV	193	42.3
News paper	8	1.8
Leaf let	6	1.3
Others	4	0.9

Table 2: Distribution of the study population by their source of information in Agarfa, southeast Ethiopia.

			Female N (%)
Have you ever heard information about FGM?	Yes	94(92.2)	159 (93.5)
	No	8(7.8)	11 (6.5)
Doesyour religion allow FGM?	Yes	16(15.7)	26 (15.3)
	No	84(82.4)	130 (76.5)
	Don't know	2(1.9)	14 (8.2)
Does a female have a right not to be mutilated?	Yes	88(86.3)	144 (84.7)
	No	12(11.8)	17 (10.0)
	Don't know	2(1.9)	9(5.3)
Do you know FGM is harmful?	Yes	86(84.3)	138(81.2)
	No	16(15.7)	32(18.8)
Do you know complication of FGM?	Yes	80(78.4)	128(75.3)
	No	22(21.6)	42(24.7)
What effects do you know?*	Pain during healing process	17(10.6)	27(10.6)
	Pain during urination	4(2.5)	6(2.4)
	Pain during menstruation	3(1.9)	13(5.1)
	excessive bleeding during cutting	45(28.1)	71(27.9)
	Sexual problem	32(20.0)	33(13.0)
	Delivery problem	57(35.6)	104(10)
	Other	2(1.3)	0
Do you know the reasonwhy people arepracticing FGM?	Yes	48(47.1)	84(49.4)
	No	54(52.9)	86(50.6)

Table 3: Knowledge of the study participants towards female genital mutilation in Agarfa, Southeast,Ethiopia.

Characteristics		Male n (%)	Female n (%)
Is FGM practicing in your village currently?	Yes	22(21.6)	32(18.8)
	No	47(46.1)	96(56.5)
	Don't know	33(32.3)	42(24.7)
Who performs the procedure?	Traditional circumciser	19(86.4)	26(81.3)
	Traditional birth attendant(TBA)	3(13.6)	6(18.7)
What is the sex of the circumciser?	Male	9(40.9)	5(15.6)
	Female	13(50.1)	26(81.3)
	Don't know	0	1(3.1)
Is the circumcision done in group or alone?	In group	4(18.2)	2(6.3)
	Alone	18(81.8)	30(93.7)
Where is the circumcision done?	In the circumciser home	2(9.1)	2(6.3)
	In the circumcised home	18(81.8)	27(84.4)
	Another home	2(9.1)	3(9.3)

Table 4: Practice of the study population towards FGM in Agarfa, southeast Ethiopia.

Characteristics		Male n(%)	Female n (%)
Is FGM practicing in your village currently?	Yes	22 (21.6)	32 (18.8)
	No	47 (46.1)	96 (56.5)
	Don't know	33 (32.3)	42 (24.7)
Who performs the procedure?	Traditional circumciser	19 (86.4)	26 (81.3)
	Traditional birth attendant(TBA)	3 (13.6)	6 (18.7)
What is the sex of the circumciser?	Male	9 (40.9)	5 (15.6)
	Female	13 (50.1)	26 (81.3)
	Don't know	0	1 (3.1)
Is the circumcision done in group or alone?	In group	4 (18.2)	2 (6.3)
	Alone	18 (81.8)	30 (93.7)
Where is the circumcision done?	In the circumciser home	2 (9.1)	2 (6.3)
	In the circumcised home	18 (81.8)	27 (84.4)
	Another home	2 (9.1)	3 (9.3)

Table 5: Practice of the study population towards FGM in Agarfa, southeast Ethiopia.

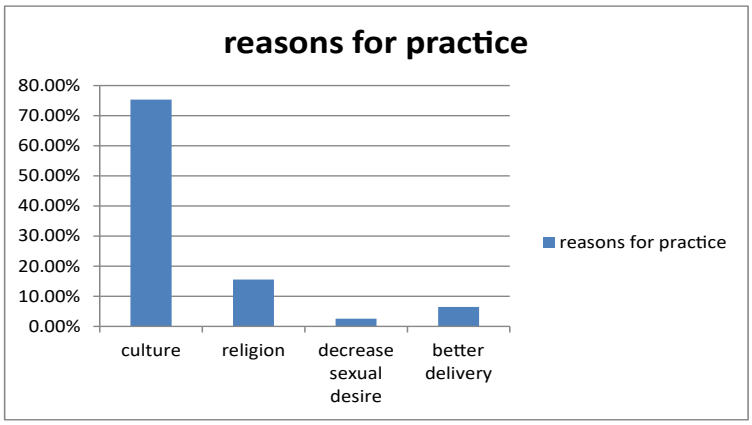

Figure 1: Reasons for practice of FGM in Agarfa town, southeast Ethiopia.

Discussion

In this study about 86.1% of females were circumcised. This figure is in line with the prevalence of Oromia regional state FGM prevalence [6]. This study showed that most of the respondents had high level of knowledge about FGM. Similarly, a study done in Somali Regional State showed that the majority of the study subjects had good knowledge about it [5]. Although more than 42% of the respondents knew FGM through TV, additional media is required that could provide evidence based information about the complications namely TV drama or video shows which can pass on proper message some of the participants stated that FGM is a religious obligation. But there is no doctrinal basis either in Islamic or Christian faiths. What is written in Quran and Bible is about male circumcision. More than three forth of the study subjects said that FGM as being harmful practice. And most of (76.5%) had the knowledge about the complications. Delivery problem excessive bleeding during cutting were the main complications stated them. In contrast knowledge about the complications was below 50% in a study done in Somalia refugees [15-18]. The discrepancy may associated with value the community give for this health burden, religion and educational status.

(75.3) of participants practice FGM. To respect culture was the main reason why people are practicing. For religion (15.6%), for better delivery (6.5%) and to decrease sexual desire (2.5%) was additional reasons stated in this study. Similarly many studies had cited the importance of culture and tradition in addition to religion (7,24). However, there is no scriptural evidence in the religious support of FGM [1]. As the attitude of the practice towards FGM, 81.6% were rejecting its continuation. In contrast, a study done in Jigjiga showed that 53-55.1% of the participants were rejecting the continuation [5]. This significance difference indicates that behavioural change had been taking place as a result of increased awareness towards discontinuation of FGM. In this study only 14.3% reported FGM prevent promiscuity, 12.4% didn't know if any relationship exist and the rest reported it doesn't prevent female promiscuity [19,20]. This is not different from the study conducted on Nigeria [21,22]. These are unacceptable reasons and thus legal measures should be taken to change such harmful beliefs.

In this study the intention to circumcise their daughters in future is less than 20%. This is similar to other study conducted in Tanzania [23-25]. More than half stated that FGM is not practicing in their village currently. Almost all of the practice had been performed by traditional women circumcisers. According to EDHS 200 more than 92% of the operator was traditional circumcisers [3]. In Egypt about 98% were performed by local circumcisers [26]. In Nigeria as well most circumcision was performed by herbalists and TBA.

Conclusion

In this study the prevalence of FGM was high. This study showed that the participants had good knowledge and negative attitude to the continuation of female circumcision. The vast majority had high degree of awareness about the complications and better access of information. Nevertheless, there is a no as such significant behavioural change. The main performer of FGM in Agarfa town was found to be traditional circumcisers, an issue which needs serious attention when designing a policy to combat the practice. The principal reason for practice was to respect tradition. Therefore, different interventions should be taken in order to eradicate this harmful practice.

Recommendations

In order to change the attitude, behaviour and practice of the community the following interventions are recommended.

- ✓ The people should be made aware of the penal code of criminals against FGC and evidence based health education should be given.
- ✓ Efforts should make to change the knowledge, attitude and practice of traditional circumcisers.
- ✓ Also, changing the perception of community on the myths associated with FGM and breaking the cultural chain attached to the practice may be the fundamental steps in its abolition.

Competing Interests

The authors declare that they have no any competing interests.

Authors' Contributions

All authors have contribution to the manuscript; all authors read and approved the final manuscript.

Authors' Information

AYM is an assistant professor at Madda Walabu University and ALW is an assistant professor at Madda Walabu University and TE is lecturer at Madda Walabu University.

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