Knowledge and attitude of female genital mutilation among mothers living in afao community, Ekiti state

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Abstract

This descriptive study was carried out to find out Knowledge and Attitude of Female Genital Mutilation among mothers in Afao Community Ekiti, Ekiti State. The broad objectives were to access the knowledge and identify the attitude of the respondents towards Female Genital Mutilation. Findings of this study can be utilized by the government. Sample size of 110 was used. The instrument for data collection was structured questionnaire using simple random sampling techniques. The data were analysed using statistical package (SPSS) version 12. Research findings shows that 60% of respondents accepted that the female child must not undergo FGM, 53% of the respondents have heard information on Female Genital Mutilation, 70% respondent have good attitude towards the Female Genital Mutilation, 66% of the respondents say no to the circumcision of female child, 60% of the respondents said the practice is acceptable in their culture, 35% of the respondents supported the practice. It was concluded that Mothers living in Afao Ekiti have good attitude toward it. Though a good percentage of the respondents have knowledge about FGM, but some of them do not practice it because of their cultural believe. The recommendations are that there should be more awareness about female genital mutilation.

Keywords: female genital mutilation, obstetrical complications, clitoris**,** labia minora, clitoridectomy

Introduction

Female genital mutilation comprises of any procedure involving partial or total removal of the external female genitalia or other injury of the female genitalia organs for cultural, religious or other non-therapeutic reason (WHO, 2019) [24].

According to World Health Organisation, it was estimated that more than 135 million women and girls worldwide are currently living with the consequences of female genital mutilation, while in Africa an estimation of 92 million girls and women have already undergone female genital cuttings. The practice of Female Genital Mutilation (FGM) is persistent in many parts of the world particularly in developing countries where it is firmly anchored on culture and tradition.

In Nigeria, Female Genital Mutilation (FGM) is practiced in four categories, Type I-IV. The age at which this is done varies across ethnic and linguistic groupings. For instance, majority of the Yorubas perform theirs at infancy and early childhood (Ogechi, 2020) [13]. The fact remains that Female Genital Mutilation does not serve any useful purpose, rather it subjects the girl child to unnecessary pain and exposes her to a number of medical complications as stated earlier.

Statement of problem

Female Genital Mutilation has obstetrical complications which impose serious side effect on the reproduction, physical and emotional health of girls and women. It is a procedure performed on women in developing countries which involves cutting or altering the female genitalia. The health consequences of FGM include bacterial and viral infections, obstetrical complications, psychological problems to mention just a few. Despite the fact these medical complications are prevalent among circumcised females, the practice is still prevalent today commonly in developing countries such as Nigeria. This poses the question; what could be the factor that still preserves the continuity of this in Nigeria?

Objectives of the study

- To assess the knowledge of mothers towards Female Genital Mutilation in Afao community.
- To assess the attitude of mothers toward Female Genital Mutilation in Afao community.
- To identify the factors influencing the practice of Female Genital Mutilation among women in Afao Ekiti, Ekiti state.

Significance of the study

This study will provide the necessary facts needed on the knowledge and attitude of Female Genital Mutilation among mothers in Afao Community.

Findings of this study would be a useful tool in increasing the awareness of Nurses towards the practice, the consequences,

how to eradicate it and to further educate mothers and girl child on Female Genital Mutilation. It will also increase the knowledge of community members towards the dangers associated with this practice. This study will provide an individual with the proper information needed and how to make their informed choices as regards female genital mutilations.

Research question

1. What is the knowledge of mothers towards Female Genital Mutilation in Afao Ekiti, Ekiti State?
2. What is the attitude of mothers towards Female Genital Mutilation in Afao Ekiti, Ekiti State?
3. What are the factors influencing the practice of Female Genital Mutilation in Afao Ekiti, Ekiti State.

Scope of study

This study is delimited to mothers in Afao Ekiti, Ekiti state to know their knowledge and attitude of female genital mutilation.

Operational definition of terms

Knowledge

Refers to what mothers in Afao Town understands about Female Genital Mutilation

Attitude

Behaviour of the people towards the belief of female circumcision.

Mothers

Women of child bearing age.

Female genital mutilation

Tearing or cutting of any external part of the female reproductive organ. It may involve partial or total removal of the external female genitalia or injury inflicted on the female genital organs for reasons perceived to be medical or not.

Review of literature

The prevalence of Female Genital Mutilation in Nigeria was estimated 170 million in 2012 Nigerian Demographic Health Survey reported the prevalence of FGM among girls and women aged 15-49 years was 30%. Among girls aged 15-19 years, the percentage reported to be circumcised was 21.7%. the practice was found to be most common in the south west (53.4%) and south east (52.8%). The prevalence of FGM in the remaining four geographical regions are as follows: south-south (34.2%), North-west (19.6%), north central (11.4%) and north east (2.7%). Ahanonu and Victor (2014) [5].

The prevalence of Female Genital Mutilation in Ekiti state by the United Nation Children Emergency Fund (UNICEF) says female genital mutilation (FGM) is on the increase in Ekiti State and has reached an alarming rate of 72% cases reported in Ekiti State ranking the state high in the prevalence of harmful practice (ICIR 2018) [11].

Conceptual review

(Durodola 2016) [10] states that Female Genital Mutilation is one of the old practices that is found among the Hittites, Ethiopians and Egyptians. She adds that in ancient Egypt, traces of infibulations are still found on the Egyptians mummies. She further argues that in the 19th century, FGM was practiced by gynaecologists in the UK and the USA to cure from insanity and masturbation.

According to WHO 2018, Female Genital Mutilation is recognised internationally as a violation of the human rights of girls and women. The declaration and program of the ICDP also clearly calls for the prohibition of FGM and characterizes FGM not only as a violation of basic human rights and a major lifelong risk to women's health but describes it as coercive and discriminatory United Nations Population Fund (UNFPA, 2017) [22].

The World Health Organisation classified female genital mutilation into four types.

Type 1: Partial or total removal of the clitoris or the prepuce (clitoridectomy).

Type 2: Partial or total removal of the clitoris and the labia minora with or without excision of the labia majora (excision).

Type 3: Narrowing of the vaginal orifice with creation of a covering seal by cutting and positioning the labia minora and/or the labia majora, with or without excision of the clitoris(infibulation).

Type 4: all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

The impact of all types of FGM on girls and women is wide-ranging. The practice compromises the enjoyment of human rights including the right to life, the right to physical integrity, the right to the highest attainable standard of health (including maturity, reproductive and sexual health), as well as the right to freedom from physical or mental violence, injury or abuse).

Health consequences of female circumcision

An estimation 100-140 million girls and women worldwide are currently living with the consequence of FGM. In Africa, about 3 million girls are at risk of FGM annually. Despite the increased international and little national attention, the prevalence of FGM overall has declined very little (WHO, 2019) [24]. The procedure has no health benefit for girls and women.

Adverse consequences of female circumcision are

- Shock from pain and haemorrhage
- Infection
- Acute urinary retention
- Damage to the urethra or anus in the struggle of the victim during the procedure
- Chronic pelvic infection
- Dysmenorrhoea
- Cysts
- Sexual difficulty with anorgasmia

Other complications are

- Implantation demond cysts and keloids
- Sexual dysfunctions

Obstetric complications include

- Perineal laceration
- Defibulation with bleeding injury to urethra and bladder
- Injury to rectum
- Puerperal sepsis
- Prolonged delayed in second stage
- Obstructed labour leading to fistulae formation
- Increased prenatal morbidity and mortality

Fetal complications are

- Excessive molding of the head
- Hypoxia
- Foetal distress
- Intrauterine death

The mental and psychological agony attached with female circumcision is deemed the most serious complication, because the problem does not manifest outwardly for help to be offered. The young girl is on constant fear of the procedure and after the ritual she dread sex because of anticipated pain and dreads childbirth because of complication caused by female circumcision. Such girls may not complain by end up becoming withdrawn resulting in mental disharmony.

Empirical review

In the work of Jacinta K., Suellen M. and Jose M (2016) on The ongoing violence against women: Female Genital Mutilation/Cutting, the scholars posited that the practice of FGM/C is highly concentrated in a band of African countries from the Atlantic coast to the Horn of Africa, in areas of the Middle East such as Iraq and Yemen, and in some countries in Asia like Indonesia. The study predicted that by 2050, nearly 1 in 3 births worldwide will occur in the 30 countries in Africa and the Middle East where FGM is concentrated, and nearly 500 million more girls and women will be living in these countries than there are today.

A study by Dorkenoo (2019) [9] on combating Female Genital Mutilation, revealed that the practice is a rooted traditional practice that adversely affects the health of girls and women. At present, it is estimated that 120 million girls and women have undergone some form of FGM and that 2million girls per year are at risk. Most of the girls and women affected live in African countries where the prevalence of FGM is estimated to range from 5% to 72%. It was therefore now concluded that the elimination of FGM will not only improve girl's and women's health, it will also promote gender equity and women's empowerment in the community where the practice persists.

In a research carried out by Abubakar (2017) [2] at Aminu Kano Teaching Hospital, result shows that 16% of the respondent wished FGM should continue mainly due to cultural or religious reason, this opinion was associated with low (20.5%) level of education.

Rigmor and Eva (2020) [17] studied on the effects of FGM stated that it has negative health consequence ranging from pain, bleeding and shock due to infections. Around 140 million girls and women live with the negative consequences of FGM of which 92 million girls and women are in Africa. FGM is undoubtly a cultural issue and something that holds the society together.

According to Okechukwu (2019) [14], the highest prevalence rate of 72% is found in Somalia and Djiboutin, the horn of Africa, while Nigeria has the highest absolute number of cases of FGM in the world which is about 115-130 million girls and women. FGM is usually performed in infancy and in ages between 4-10 years.

Theoretical framework

Health belief model

The health belief model is one of the first theories of health behaviour. It was developed in 1950 by social psychologists Hochbaum, Rosenstock and others in a group of USA public health service. The social psychologists who wanted to explain why so few people are participating in programs to prevent and detect diseases. (Abraham C. and Sheeran P. 2015) [3]. This theory is based on the belief that person's willingness to change their behaviour is primarily due to the following factors are: Perceived Susceptibility, Perceived Severity, Perceived Benefits, Perceived Barriers, Motivation

1. **Perceived susceptibility:** People will not change their behaviour unless they believe they are at risk. Those who do not think they are at risk of acquiring HIV from unsterilized instrument used during circumcision are unlikely to stop the practice. (Abraham C. and Sheeran P. 2015) [3].
2. **Perceived severity:** The probability that a person will change his or her health behaviour to avoid a consequence depends on how severe he or she considers the consequence of the practice.
3. **Perceived benefit:** It is difficult to convince people to change their behaviour if there is not something in it for them. A smoker will not stop smoking if he does not know that doing so will improve his or her life.
4. **Perceived barriers:** One of the major reason people don't change their health behaviours is that they think by doing so is going to be hard. Sometimes, it is not just a matter of physical difficulty but social difficulty as well as changing on health behaviour can cost money, effort and time.
5. **Motivation:** Is a driving force that makes one to do what he is aroused to do. Therefore, if people are properly motivated, certain level of success can be achieved in changing health behaviour.

Diagrammatic representation of health belief model

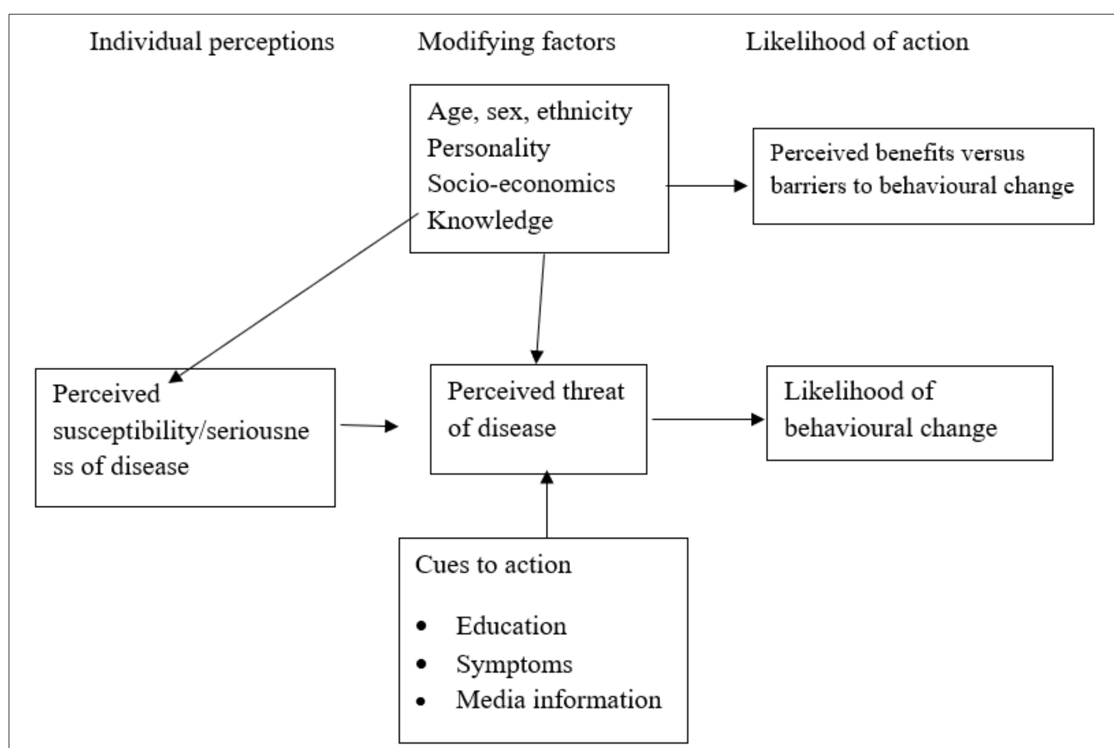

Fig 1: Diagrammatical Explanation of health belief model (Nola, 2012)

Application of health belief model to the study

Perceived susceptibility

It refers to the perception of women of child bearing age on the related health effect of female circumcision, their ability to recognize those who are at risk which is their girls and they themselves will improve their behaviour towards the eradication.

Perceived severity

Even when one recognizes personal susceptibility action will not occur unless the individual perceives the severity of the effect to be high enough to have serious physical, psychological and social complication.

Perceived benefit

This have to do with their believe that female circumcision has no good benefit as they thought and their ability to accept that the practice is harmful to their life will help them to work towards the eradication.

Perceived barriers

In a community where FGM is being practices, people might not be willing to change as a result of social stigmatization and taboos that are attached to such practice. It is very difficult to change the perception and practice such as FGM.

Motivation

It recognizes the fact that sometimes, wanting to change health behaviour is not enough to actually make someone do it and incorporate two or more elements about what it actually takes to get an individual a leap. (Premala S., Amy P., and Elizabeth E. 2015) [16].

Research methodology

This section discusses the following: research design, research setting, target population, sampling techniques, instrument of data collection, method of data collection, procedure for data collection, method for data analysis and ethical consideration.

Research design

This research employs a non-experimental descriptive design aiming at assessing the knowledge and attitude of Female genital mutilation among mothers in Afao community, Ekiti State.

Research setting

The research setting that was used is Afao Community, Ekiti State, Nigeria. Afao community is located off Iworoko Road. Afao community consists of Christian, Muslim and traditional worshippers. Majority of the residents are Yorubas and few are Igbira and Hausa. Residents are mostly civil servants, farmers, students, business men and women and petty traders. The commonest language among residents is Yoruba language. The latitude and longitude of Afao Ekiti is 7.7167⁰ and 5.3000⁰ respectively

Target population

The target population are mothers living in Afao Community, Ekiti State.

Sample size

The sample size for the study will be derived using Taro

Yamane method (1966).

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

Where;
n = sample size
N = population size
e = Level of precision or sampling which is 5%

$$n = \frac{153}{1+153(0.05)^2}$$

$$n = \frac{153}{1+153(0.0025)}$$

$$n = \frac{153}{1+0.3825}$$

$$n = \frac{153}{1.3825}$$

n = 110

Sampling technique

Using a purposive sampling technique, the desired numbers of respondents was selected from part of the mothers living in Afao Community.

Instrument for data collection

The instrument that was used for this study is a self-structured questionnaire divided into sections.
Section A: Demographic data of the respondents.
Section B: Knowledge of female genital mutilation.
Section C: Attitude of female genital mutilation.
Section D: Factors promoting female genital mutilation.

Method of data collection

Questionnaire was distributed to the respondents on one on one basis after their consents has been taken. Assistance was rendered to the respondents who were not able to interpret the questionnaire.

Method of data analysis

The questionnaire was sorted out using SPSS (Statistical Package for Social Sciences) and analysed using frequency table and percentages.

Ethical consideration

Data was collected through administration of questionnaire from respondent after taking the permission and consent from the local government of the community and also from respondents. The purpose and benefits of the study was explained to the respondents and they were assured of confidentiality.

Results

This section presents the analysis of the data, which include answering of research questions and the narrative. The questionnaires administered to one hundred and ten (110) purposively selected mothers in Afao community, Ekiti State. The results of the analysis were described using descriptive statistics like frequency count, central tendency and measure of dispersion. Tables were used to present the data analysis that answered the research questions. A response rate of 100% (110) was achieved for the study as the all the questionnaires were retrieved.

Socio-demographic characteristics

Table 1: Demographic data of the respondents

Variables	Categories	Freq	(%)
Age	17-20	19	17.3
	21-25	44	40.0
	26-30	31	28.2
	31 years and above	16	14.5
Mean ± SD Age			
Marital status	Single	43	39.1
	Married	47	42.7
	Widowed	11	10.0
	Divorced	9	8.2
Religion	Christianity	60	54.5
	Islam	30	27.3
	Traditional	14	12.7
	Others	6	5.5
Educational status	Non formal education	5	4.5
	Primary	9	8.2
	Secondary	24	21.8
	Tertiary	70	64.8
	Trading	69	63.9
Occupation	Housewife	20	18.5
	Civil servant	24	22.2
	Farming	13	12.0
	Others	28	25.9
	Yoruba	69	63.9
Ethnic group	Igbo	22	20.4
	Hausa	11	10.2
	Other	6	5.5

N=110

The socio-demographic data of selected mothers living in Afao community were presented in Table 1. Between the age of 17-20years were 19(17.3%) mothers, between the age of 21 and 25 were 44(40.0%) mothers, while 16(14.5%) were between the age of 26 and 30 years. Only 16(14.5%) were between 31 and above years. The mean age was calculated to be 25.086 ±4.57. Almost half 47(42.7%) were married and 43(39.1%) claimed to be single. More than half 60(54.5%) of the respondents were Christians and again, 30(27.3%) were Muslims. The occupation of the mothers was assessed and it was revealed that 69(63.9%) mothers were traders 20(18.3%) of the mothers were full housewives, while 24(22.2%) were

civil servants. Those that engaged in farming were 13(12.0%). The majority 69(63.9%) of the mother selected were Yoruba by tribe. One-fifth were from the Eastern part of the country but just 11(10.2%) were from the northern part of Nigeria.

Research question 1: What is the knowledge of mothers towards Female Genital Mutilation in Afao Community, Ekiti State?

Table 2: Knowledge of female genital mutilation

Scores		Frequency	Percent	Level	Mean	Standard dev
Valid	.00	2	1.8	Poor knowledge 17(15.6%)	5.95	±2.11
	1.00	3	2.8			
	2.00	6	5.5			
	3.00	6	5.5			
	4.00	7	6.4	Fair knowledge 34(31.2%)		
	5.00	9	8.3			
	6.00	18	16.5			
	7.00	29	26.6			
	8.00	30	26.6	Good knowledge 59(53.2%)		
	Total	110	100.0			
Total		110	100.0			

N=110

Table 2 presented the knowledge level of mother in Afao community on genital mutilation. Those mother with poor knowledge were 17(15.6%), 34(31.2%) had fair knowledge while majority 59(53.2%) were knowledge about female genital mutilation. The mean score was 5.95 and the standard deviation value was ±2.11.

Research Question 2: What is the attitude of mothers towards Female Genital Mutilation in Afao Community, Ekiti State?

Table 3: Attitude of mothers toward genital mutilation

Attitude	SA	A	SD	D	Remark
Have you made attempt to support the practice	13(11.8%)	13(11.8%)	68(71.9%)	16(4.5%)	PA
All forms are harmful	50(45.5%)	34(39.9%)	20(`18.2%)	6(5.5%)	PA
I will have my daughter circumcised	6(5.5%)	17(15.5%)	66(60.0%)	21(19.1%)	PA
Will you encourage female genital mutilation	9(8.7%)	17(15.5%)	66(60.0%)	18(16.4%)	PA

N=110, A= Positive attitude

Table 3 described the attitude of selected mothers in Afao community concern female genital mutilation. The mean percentage of mothers that disagreed to attempt the support of the practice is 38.2%. The mean percentage of that agreed that all forms are harmful is 65.45%. The mean percentage of that disagreed that they will have their daughter circumcised is 39.55%. The mean percentage of that disagreed that they will encourage female genital mutilation is 38.2%. The findings revealed that most of the mother had positive attitude toward female gentile mutilation of which none of the item displaced negative attitude.

Research Question 3: What are the factors influencing the practice of female genital mutilation in Afao Community, Ekiti State?

Table 4: Factors influencing practice of female genital mutilation

Items	Yes	No	Remark
Is female genital mutilation accepted in your culture?	46 (41.8%)	64 (58.2%)	Not a factor
Is female genital mutilation supported by your religion?	19 (17.3%)	91 (82.7%)	Not a factor

N=110

Table 4 indicated the factors responsible for practice of female genital mutilation in Afao community. 58.2% of mothers in Afao community agreed that Female Genital Mutilation is not accepted in their culture. 82.7% of mothers in Afao community agreed that Female Genital Mutilation is not supported by their religion. The researcher was surprised that religion and cultural value among selected mothers did influence practice of female gentile mutilation in Afao community.

Discussion of findings

The knowledge of mothers towards Female Genital Mutilation showed that mothers in Afao were knowledgeable about Female Genital Mutilation and that they also have good attitude towards its eradication. The factors influencing the practice of Female Genital Mutilation was found out to be in agreement with the study of Abubakar (2017) [2] at Aminu Kano Teaching Hospital, result shows that 16% of the respondents wished

FGM should continue mainly due to cultural or religious reason, this opinion was associated with low (20.5%) level of education.

Also, Dorkenoo (2019) [9] on combating Female Genital Mutilation which revealed that the practice is a rooted traditional practice that adversely affects the health of girls and women. Most of the girls and women affected live in African countries where the prevalence of FGM is estimated to range from 5% to 72%. It was therefore now concluded that the elimination of FGM will not only improve girl's and women's health, it will also promote gender equity and women's empowerment in the community where the practice persists

Implications of findings to nursing

Findings of the study revealed that respondents had good knowledge of Female Genital Mutilation. It also revealed that majority of the respondents were aware of Female Genital Mutilation. Nurses need more effort to enlighten mothers about Female Genital Mutilation through health education and mass awareness programmes via mass media, radio, televisions etc.

Limitations of the study

The researchers encountered some challenges in the cause of carrying out this work. The mothers were mostly illiterate and interpretation of the questionnaire to most of them was inevitable without inferred with the thoughts and responses of the respondents. Because of the sensitivity of the topic some mothers out rightly declined to participate may be due to fear of myths surrounding Female Genital Mutilation. However, all these challenges did not in any form affect the accuracy of the study.

Summary

The research work was carried out with the aim to assess knowledge and attitude of female genital mutilation among mothers in Afao community. The sampled mothers had good level of knowledge of genital mutilation 59(83.0%). It was a non-experimental descriptive research design with sample size of one hundred and ten. The respondent displayed good attitude toward eradication of female genital mutilation but factors such as cultural belief and religion practice did fully function as determinant of the female genital mutilation.

Conclusion

It could be concluded that participants have good knowledge of Female Genital Mutilation and right attitude towards its eradication. Religious and cultural believes no longer influence the practice of Female Genital Mutilation.

Recommendations

In view of the findings of the study the following are hereby recommended:

1. Public awareness on the negative effects of Female Genital Mutilation should be intensified.
2. The government should prosecute anybody that engage in Female Genital Mutilation.
3. Problems associated with practice of Female Genital Mutilation should be regularly preached in religious gatherings.

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