International Journal of Medicine and Biomedical Research
Volume 2 Issue 1 January – April 2013
www.ijmbr.com

Original Article

Knowledge, attitude and practice of female genital mutilation among doctors and nurses in Bayelsa state, Niger-Delta of Nigeria

Ibrahim I.A[1*], Oyeyemi A.S[2], Ekine A.A[1]

[1]Department of Obstetrics and Gynaecology, [2]Department of Community Medicine, College of Health Sciences, Niger-Delta University, Amassoma, Bayelsa, Nigeria.

*Corresponding author: daddayzee@yahoo.com

Received: 07.10.12; Accepted: 12.01.13

ABSTRACT

Background: Female genital mutilation (FGM) is a harmful traditional practice that is deep-rooted in Africa. It has been outlawed in Bayelsa state of Nigeria but there is evidence that its performance by traditional circumcisers and health professionals continues. **Aim:** The study aimed to determine the knowledge, attitude and practice of FGM among doctors and nurses/midwives practising in public secondary and tertiary hospitals in Bayelsa state. **Methods:** One hundred and ninety seven (197) structured questionnaires were administered to all available doctors and nurses/midwives in the study hospitals for self-completion. Epi-Info version 3.5.1 was used to analyse data. **Results:** All the respondents were aware of FGM. A higher proportion of nurses/midwives than doctors had ever been asked and had ever treated patients with complications of FGM. More than 90% of respondents said it was not a good practice. Out of the 70 female respondents, 19 (27.1%) said they were circumcised. Only one nurse/midwife admitted to performing FGM presently. **Conclusion:** Doctors and nurses/midwives practicing in the study hospitals were well aware of FGM and were favourably disposed towards its elimination. Efforts should be made to reinforce this position.

Key words: Female genital mutilation, knowledge, attitude, practice, doctors, nurses/midwives

INTRODUCTION

Female genital mutilation (FGM) also known as female genital cutting (FGC), female circumcision, or female genital mutilation/cutting (FGM/C), is defined by the World Health Organization as all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.[1] The various terms emerged in an attempt to balance varying views and opinions on the practice and to appeal to all stakeholders in the elimination of the practice.[1, 2]

The WHO divides the procedure into four major types. Type I is the partial or total removal of the clitoris and/or the prepuce,

Type II is partial or total removal of the labia minora and clitoris with or without excision of the labia majora, Type III is narrowing of the vaginal orifice with creation of a covering seal by cutting and repositioning the labia minora and/or the labia majora, with or without excision of the clitoris. It is called infudibulation and is also known as pharaonic circumcision.[1,3] Type IV is all other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization.[1,3]

According to the WHO, about 100- 140 million girls and women worldwide are currently living with the consequences of FGM.[4] In Africa, an estimated 91.5 million girls and women aged 9 years and above have undergone the procedure and about three million girls are at risk for it annually.[4]

FGM is performed largely by traditional practitioners (traditional circumcisers and traditional birth attendants) and worrisomely and increasingly by health professionals mainly doctors and nurses/midwives.[5,6] Involvement of health care providers is a violation of both the rights of the girls and women and also the fundamental ethical principle to 'do no harm'.[7] Proponents of medicalization of FGM argued inter alia that when trained health professionals perform the procedure, there will be a reduction at least in the immediate risks associated with it.[8-10] Other reasons why health professionals perform FGM include economic gain,[10-12] personal belief in the propriety of the procedure[11,12] and pressure to satisfy the cultural demands of the community where they practice.[10-12] Several measures have been taken internationally, regionally and at national levels to increase awareness and eliminate FGM. For example in 2003, the African Union adopted the Maputo Protocol promoting women's rights including an end to FGM.[13] This went into force in November 2005, and by July2010, 25 member countries had ratified and deposited the Maputo Protocol.[14]

According to the Nigeria Demographic and Health Survey (NDHS) of 2008, the prevalence of FGM in the country was 29.6%, ranging from 2.7% in the North-East to 53.4% in the South-West.[15] It was 25.9% in Bayelsa state.[15] Traditional circumcisers performed 63.7% of the procedure, trained nurse/midwives did 7.1% and doctors were responsible for 1.7% of the procedure.[15] In Bayelsa, the traditional circumcisers, trained nurse/midwives and doctors performed 80.8%, 5% and 0.9% of the procedure respectively.[15] Even though there is no national law against the practice, several states including Bayelsa have promulgated law against FGM.[16] However, as shown by NDHS 2008, FGM cannot be said to be a done deal in Bayelsa state. Of greater concern is the fact that health professionals were still implicated in the practice. These professionals are needed to educate the individuals and the communities they serve about the harmful effects of FGM and the benefits of discontinuing the practice. To play this role effectively, they have to personally believe in and actively support the campaign. To our knowledge, no study has been done in Bayelsa state to determine the attitude of health personnel towards FGM, hence the decision to conduct this study to assess the knowledge, attitude and practice of doctors and nurses/midwives concerning the topic. Findings of this study will shed more light on the subject and guide the design of appropriate interventions that will support the elimination campaign.

METHODOLOGY

This was a cross-sectional study conducted amongst doctors and nurses practising in the two tertiary in Bayelsa state (Niger Delta University Teaching Hospital, Okolobiri and Federal Medical Centre, Yenagoa) and the two secondary health institutions (General Hospital Amassoma and Diete koki Memorial Hospital Yenagoa).

Sample size was determined as described in previous studies.[17] A self-administered questionnaire was given to the professionals in these hospitals in February/March 2012. Efforts were made to reach every doctor and nurse on the lists of these health professionals obtained from each hospital. The questionnaire elicited information about socio-demographic characteristics of respondents, knowledge and perception of FGM including associated complications, and practice of FGM.

Statistical analysis

Data entry, cleaning and analysis were performed with Epi-Info version 3.5.1. Chi-

square test was used to test association between categorical variables at a confidence level of 95% and a *P*- value of <0.05 was considered statistically significant.[18-20] The management of each institution was intimated with the objectives of the study and they gave their permission for the conduct of the study. Individual consent was obtained from all respondents.

RESULTS

One hundred and ninety seven questionnaires were distributed by hand and 118 were returned giving a response rate of 59.9%. Respondents comprised 66 doctors (55.9%) and 52 nurses (44.1%). Table 1 shows the socio-demographic characteristics of respondents. Their mean age was 35 ± 9.4 years with a range of 18 - 63years. Most of the respondents (70/59.3%) were practicing in the two tertiary hospitals in the state.

All the respondents were aware of FGC. The most common type seen in their practice was Type 1 (24/20.3%), while 29/24.6% (14 nurse/midwives,

15 doctors) had ever treated patients with complications of FGC. The most common complications associated with FGC mentioned by respondents were haemorrhage (97/82.2%), HIV infection (82/69.5%) and scar formation (80/67.8%) (Table 2). The most important reason for performing FGC as stated by 114 (96.6%) respondents was cultural. This was followed by religion (15/12.7%), beautification (4/3.4%) and hygiene (3/2.5%).

Table 1: Socio-demographic characteristics of the respondents

Characteristic	Frequency (N=118)	Percentage (%)
Age		
<25	3	2.5
25 – 34	58	49.2
35 – 44	25	21.2
45 – 54	9	7.6
≥55	5	4.2
No response	18	15.3
Sex		
Female	70	59.3
Male	48	40.7
Religion		
Christianity	115	97.5
Islam	3	2.5
Ethnicity		
Ijaw	57	48.3
Igbo	29	24.6
Hausa	2	1.7
Others	22	18.6
No response	8	6.8
Designation		
House officer	13	11.0
Medical officer	20	16.9
Resident doctor	23	19.5
Consultant	10	8.5
Nurse/Midwife	52	44.1
Place of Practice		
Secondary	48	40.7
Tertiary	70	59.3

Table 2: Complications of female genital mutilation as stated by respondents

Complication	Frequency	Percentage (%)
HIV	82	69.5
Haemorrhage	97	82.2
Difficult delivery	62	52.5
Scar/keloid	80	67.8
Clitoridal cyst	46	39.0
Tetanus	73	61.9
Perineal laceration	33	28.0

Table 3: Opinion of respondents about female genital mutilation

Question posed about FGC	Yes n (%)	No	Don't know	No response
It makes external genitalia attractive	6 (5.1)	94 (79.7)	16 (13.6)	2 (1.7)
It decreases sex	60 (50.8)	27 (22.9)	28 (23.7)	3 (2.5)
It can lead to sexual disorders	89 (75.4)	9 (7.6)	17 (14.4)	3 (2.5)
It can lead to infertility	28 (23.7)	50 (42.4)	2 (1.7)	38 (32.2)
It can lead to death	96 (81.4)	13 (11.0)	6 (5.1)	3 (2.5)
It decreases promiscuity	11 (9.3)	85 (72.0)	20 (16.9)	2 (1.7)

Table 4: Attitude of respondents towards female genital mutilation

Attitudinal question	Yes	No	Don't know	No response
Is FGC a good practice?	5 (4.2)	110 (93.2)	3 (2.5)	0
Will you encourage FGC?	6 (5.1)	109 (92.4)	2 (2.5)	1 (0.8)
Should it be criminalized?	87 (73.7)	16 (13.6)	11 (9.3)	4 (3.4)
Would you have your daughter circumcised?	3 (2.5)	113 (95.8)	1 (0.8)	1 (0.8)
Do you think government and NGOs are doing enough to fight against FGC?	33 (28.0)	68 (57.6)	15 (12.7)	2 (1.7)

Table 5: Association between sex of respondents and attitude toward female genital mutilation

Attitude to FGC	Female	Male	Total	X^2	*P*-value
All forms are harmful					
Yes	58 (84.1)	34 (77.3)	92 (81.4)	1.25	0.535
No	5 (7.2)	6 (13.6)	11 (9.7)		
Don't know	6 (8.7)	4 (9.1)	10 (8.8)		
Total	69 (100.0)	44 (100.0)	113 (100.0)		
It is a good practice					
Yes	3 (4.3)	2 (4.2)	5 (4.2)	0.07	0.965
No	65 (92.9)	45 (93.8)	110 (93.2)		
Don't know	2 (2.9)	1 (2.1)	3 (2.5)		
Total	70 (100.0)	48 (100.0)	118 (100.0)		
Will encourage the practice					
Yes	3 (4.3)	3 (6.4)	6 (5.1)	0.34	0.844
No	66 (94.3)	43 (91.5)	109 (93.2)		
Don't know	1 (1.4)	1 (2.1)	2 (1.7)		
Total	70 (100.0)	47 (100.0)	117 (100.0)		
It should be criminalized					
Yes	54 (80.6)	33 (70.2)	87 (76.3)	1.68	0.431
No	8 (11.9)	8 (17.0)	16 (14.0)		
Don't know	5 (7.5)	6 (12.8)	11 (9.6)		
Total	67 (100.0)	47 (100.0)	114 (100.0)		
Will have daughter circumcised					
Yes	1 (1.4)	2 (4.3)	3 (2.6)	1.90	0.389
No	68 (97.1)	45 (95.7)	113 (96.6)		
Don't know	1 (1.4)	0 (0.0)	1 (0.9)		
Total	70 (100.0)	47 (100.0)	117 (100.0)		

Table 3 shows perception of respondents about FGM while Table 4 shows the attitude of respondents toward FGC. More than 90% said it was not a good practice, would not encourage it, and would not have their daughters circumcised. More than a half (68/57.6%) felt the government and NGOs were not doing enough to fight FGM. Out of the 70 female respondents, 19 (27.1%) were circumcised and three (4.3%) did not know if they were circumcised or not. Only one (a nurse/midwife) out of all the 118 respondents admitted to performing FGM in the past and was still performing it. Three respondents in all (2.5%) said they have their daughters circumcised.

Table 5 shows that there was no statistically significant association between male and female respondents in their attitude to FGC. Between doctors and nurses and their attitude to FGC, significantly more doctors said they would encourage the practice of FGC (X^2=7.32, *P*=0.026) (Table 6).

DISCUSSION

This study assessed the knowledge, attitude and practice of FGM among doctors and nurses working in tertiary and secondary hospitals in Bayelsa state, Nigeria. A response rate of 59% in

this study is much lower than 94.3% reported in a similar but older Nigerian study.[10] A low response rate obtained in this study is not unusual with self-administered questionnaire among health professionals. A comparable rate of 62%[21] and much lower rates of 46.1%[22] and 28.4%[23] were reported in similar studies. These low rates may be attributed to lack of interest in the subject and probably to the notion that a dying practice was not worth a slot on their busy schedule. All the respondents were aware of FGC and displayed an appreciable knowledge of the practice as evident from their responses. This universal knowledge is comparable to that found in
similar studies.[10,24] FGC is still a major public health challenge and even though it may no longer be a topical issue in the state, majority of the respondents were old enough to have remembered the campaigns that led to a decline in the practice and culminated in the ban of the practice in some states in Nigeria including Bayelsa state.[16]

Table 6: Association between professional group (Doctors vs. Nurses) and attitude towards FGM

Attitude to FGM	Doctors	Nurse/Midwives	Total	X^2	*P*-value
All forms are harmful					
Yes	49 (79.0)	43 (84.3)	92 (81.4)	0.55	0.759
No	7 (11.3)	4 (7.8)	11 (9.7)		
Don't know	6 (9.7)	4 (7.8)	10 (8.8)		
Total	62 (100.0)	51 (100.0)	113 (100.0)		
It is a good practice					
Yes					
No	2 (3.0)	3 (5.8)	5 (4.2)	1.21	0.546
Don't know	63 (95.5)	47 (90.4)	110 (93.2)		
Total	1 (1.5)	2 (3.8)	3 (2.5)		
	66 (100.0)	52 (100.0)	118 (100.0)		
Will encourage the practice					
Yes	6 (9.2)	0 (0.0)	6 (5.1)	7.32	0.026*
No	58 (89.2)	51 (98.1)	109 (93.2)		
Don't know	1 (1.5)	1 (1.9)	2 (1.7)		
Total	65 (100.0)	52 (100.0)	117 (100.0)		
It should be criminalized					
Yes	49 (76.6)	38 (76.0)	87 (76.3)	2.28	0.320
No	7 (10.9)	9 (18.0)	16 (14.0)		
Don't know	8 (12.5)	3 (6.0)	11 (9.6)		
Total	64 (100.0)	50 (100.0)	114 (100.0)		
Will have daughter circumcised					
Yes					
No	3 (4.6)	0 (0.0)	3 (2.6)	5.17	0.075
Don't know	62 (95.4)	51 (98.1)	113 (96.6)		
Total	0 (0.0)	1 (1.9)	1 (0.9)		
	65 (100.0)	52 (100.0)	117 (100.0)		

The health professionals demonstrated a positive attitude towards the elimination of this harmful practice, and this is irrespective of their gender or professional category. This is a step in the right direction and suggests that doctors and nurses in Bayelsa state do not approve of medicalization or any other strategy that may perpetuate the practice. Evidence abounds for an increasingly positive attitude in support of elimination campaigns among health professionals and the general population worldwide.[10,15,25-28] Seven out of the eight respondents who had ever been asked to perform FGM were nurses/midwives and a higher proportion of them too had treated patients with complications of FGM . Only one nurse/midwife admitted to an ongoing performance of FGC. This compares with findings of similar studies[6,15,24] and showed that most of the FGM performed by health personnel were done by nurses/midwives.

Compared to the 44% prevalence in the study in Benin City in the same zone (South-South),[10] 27.1% of female respondents in this study were circumcised. This buttresses the declining prevalence of FGM in the state and in Nigeria at large as reported in the 2003[29] and 2008[15] NDHS and globally.[5]

There are noteworthy limitations to this study. The findings may not wholly represent the true picture among the study population, as those that failed to respond may have a different perspective on the subject. The low response rate among the nurses also calls for caution in interpreting the results. A higher proportion of nurses/midwives were given the questionnaire but more doctors than nurses responded. Could there be something fundamentally different among the nurses/midwives in their perception of the subject that limited their interest and response?

CONCLUSION

The study revealed a high level of awareness of FGM among doctors and nurses/midwives working in public hospitals in Bayelsa state. It also showed their aversion and favorable disposition towards the elimination of the harmful practice. We recommend that seminars and other avenues be encouraged in the respective hospitals to reinforce this position. These professionals form a pool of change agents and can be used to reach out to the communities in the campaign to end FGM in the state and beyond. In view of the low response rate among the nurses/midwives, we recommend further studies on the subject among this group.

REFERENCES

1. World Health Organization. Eliminating female genital mutilation: an interagency statement. Geneva 2008:1-47.
2. Alexia Lewnes. Changing a harmful social convention: female genital cutting/mutilation. Innocenti Digest (Florence, Italy: Giuntina) 2005;1–2.
3. World Health Organization. Female genital mutilation, Report of a WHO Technical Working Group, Geneva:WHO 1995.
4. WHO. Female genital mutilation and other harmful practices. Cited online on 9 September 2012 at http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/index.html
5. WHO. Female genital mutilation and other harmful practices: trends in female genital mutilation. http://www.who.int/reproductivehealth/topics/fgm/fgm_trends/en/index.html (accessed 9 September 2012).
6. Satti A, Elmusharaf S, Bedri H, Idris T, Hashim MSK, Suliman G, Almroth Lars. Prevalence and determinants of the practice of genital mutilation of girls in Khartoum, Sudan. Annals Trop Paed Int Child Health 2006;26:303-310.
7. WHO. Global strategy to stop health-care providers from performing female genital mutilation. 2010: WHO/RHR/10.9
8. Shell-Duncan B. The medicalization of female "circumcision": harm reduction or promotion of a dangerous practice? Social Sci Med 2001;52:1013-1028.
9. Christoffersen-Deb A 2005. Taming tradition: medicalized female genital practices in western Kenya. Med Anthro Quart 2005;19:402−418.
10. Onuh SO, Igberase GO and Umeora JO. Female Genital Mutilation: Knowledge, Attitude and Practice among Nurses. J Natl Med Assoc 2006;98:409-14.
11. Refaat A. Medicalization of female genital cutting in Egypt. East Mediterr Health J 2009;15:1379-88.
12. Berggren V, Abdel Salam G, Bergström S, Johansson E, Edberg AK. An exploratory study of Sudanese midwives' motives, perceptions and experiences of re-infibulation after birth. Midwif 2004;20:299-311.
13. African Union. Protocol To The African Charter On Human And Peoples' Rights On The

Rights Of Women In Africahttp://www.africa-union.org/root/au/Documents/Treaties/Text/Protocol%20on%20the%20Rights%20of%20Women.pdf (accessed 18 August 2012).
14. African Union. List of Countries which have signed, ratified/acceded to the protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. http://www.africa-union.org/root/au/Documents/Treaties/List/Protocol%20on%20the%20Rights%20of%20Women.pdf (accessed 9 September 2012).
15. National Population Commission (NPC) [Nigeria], ICF Macro. Nigeria Demographic and Health Survey 2008. Abuja, Nigeria: National Populaton Commission and ICF Macro. 2009.
16. United States Department of State. Nigeria: Report on Female genital mutilation (FGM) or female genital cutting (FGC). http://www.state.gov/g/wi/rls/rep/crfgm/10106pf.htm (accessed 18 August 2012).
17. Envuladu E.A, Agbo H.A, Mohammed A, Chia L, Kigbu J.H , Zoakah A.I. Utilization of modern contraceptives among female traders in Jos South LGA of Plateau State, Nigeria. Int J Med Biomed Res 2012;1:224-231.
18. Inyang-Etoh E.C, Umoiyoho A.J. The practice of episiotomy in a university teaching hospital in Nigeria: How satisfactory? Int J Med Biomed Res 2012;1:68-72.
19. Mardi T.G, Lutfi M.F. Risk factors for gestational diabetes mellitus in Sudanese pregnant women. Int J Med Biomed Res 2012;1:79-84.
20. Shubair M.K, Lutfi M.F, Bolad A.K, Ali A.B, Saeed E.S. IL-1β level in Sudanese patients with atherosclerotic coronary heart disease. Int Int J Med Biomed Res 2012;1:73-78.
21. Kaplan-Marcusan A, Toran-Monserrat P, Moreno-Navarro J, Fàbregas MJC, Muñoz-Ortiz L. Perception of primary health professionals about Female Genital Mutilation: from healthcare to intercultural competence. BMC Health Services Research. 2009, 9:11.
22. Leye E, Ysebaert I, Deblonde J, Claeys P, Vermeulen G, Jacquemyn Y, Temmerman M. Female genital mutilation: Knowledge, attitudes and practices of Flemish gynaecologists. Eur J Contracept Reprod Health Care.2008;13:182-190.
23. Tamaddon L, Johnsdotter S, Liljestrand J, Essén B. Swedish health care providers experience and knowledge of female genital cutting. Health Care Women Int 2006; 27:709-22.
24. Adekanle AD, Isawumi AI, Adeyemi AS. Health workers' knowledge of and experience with female genital cutting in Southwestern Nigeria. Sierra Leone J BMR 2011;3:84-88.
25. Asekun-Olarinmoye EO, Amusan OA. The impact of health education on attitudes towards female genital mutilation (FGM) in a rural Nigerian community. Eur J Contracept Reprod Health Care 2008;13:289-97.
26. Dalal K, Lawoko S, Jansson B. Womens attitudes towards discontinuation of female genital mutilation in Egypt. J Inj Violence Res 2010;2:41-47.
27. Johnsdotter S, Moussa K, Carlbom A, Aregai R, Essén B. Never my daughters: A qualitatitive study regarding attitude change toward female genital cutting among Ethiopian and Eritrean families in Sweden. Health Care W Int 2009;30:114-133.
28. Tag-Eldin MA, Gadallah MA, Al-Tayeb MN, Abdel-Aty M, Mansour E,Sallem M. Prevalence of female genital cutting among Egyptian girls. Bull World Health 2008;86:269-274.
29. National Population Commission (NPC) [Nigeria] and ORC Macro. Nigeria Demographic and Health Survey 2003. Calverton, Maryland: National Population Commission and ORC Macro. 2005.

doi: http://dx.doi.org/10.14194/ijmbr.218

How to cite this article: Ibrahim I.A, Oyeyemi A.S, Ekine A.A. Knowledge, attitude and practice of female genital mutilation among doctors and nurses in Yenagoa, Niger-Delta of Nigeria. Int J Med Biomed Res 2013;2(1):40-47

Conflict of Interest: None declared