Female Genital Mutilation: Knowledge, Attitude and Practice among Nurses

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Background: Female genital mutilation (FGM) and cutting is a subject of global interest, with many countries of the world still practicing it despite efforts by the WHO and other agencies to discourage the practice. The highest known prevalence is in Africa.

Objectives: To determine the knowledge, attitude and practice of FGM among nurses in the ancient metropolis of Benin in a Nigerian state where FGM is illegal.

Results: One-hundred-ninety-three nurses in the study hospital were recruited in the study out of which 182 (94.3%) appropriately filled and returned the questionnaires. The average age of respondents was 37 years, and the average duration of postgraduation experience was 14.5 years. Most respondents are of Bini (36.8%) and Esan (34.1%) ethnic origin. All respondents identified at least one form of FGM, but only 12 respondents (6.6%) could correctly identify the four types of FGM. The harmful effects of FGM identified by the majority of respondents include hemorrhage, difficult labor/childbirth, genital tears, infections and scar/keloid formation. Forty-four (24.2%) of respondents were of the opinion that some forms of FGM are harmless.

Eighty nurses admitted to having undergone FGM, for a prevalence of 44%. Five respondents (2.8%) view FGM as a good practice and will encourage the practice. Twelve respondents (6.6%) routinely perform FGM out of which seven (58.3%) viewed FGM as a bad practice. Nurses performing FGM routinely were those who had spent >20 years (59%) and 11–20 years (41%) in the profession. Another 26 (14.3%) had performed FGM before, though not on a routine basis. Of this latter group, 15 will perform FGM in the future when faced with certain circumstances. Reasons for FGM practice were mainly cultural. Eight of the respondents would have their daughters circumcised.

Conclusion: Nurses perceive FGM in Benin as cultural. Almost half have had FGM themselves, and a small percentage recommend it to their daughters. Discouraging FGM practice will require culturally sensitive education of the healthcare providers and the population at large on the ill effects of FGM, including the risk to health and violations of human rights.

Key words: genital mutilation ■ nurses ■ females ■ human rights

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INTRODUCTION

Female genital mutilation (FGM) constitutes all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other nontherapeutic reasons.[1] Four types of FGM have been identified by a WHO working group.[1] Type 1 is the partial or total excision of the clitoris, type 2 is the excision of the clitoris and the labia minora, while type 3 is the excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation). Type 4 is the unclassified type and refers to any other mutilation performed on the external genitalia such as gishiri cut, piercing and massaging of any part of external genitalia.

It is regrettable to note that despite all efforts by the WHO and other governmental and nongovernmental organizations to discourage FGM, it is still being practiced in many countries of the world—Africa being the continent where the practice is most prevalent. It is estimated that around the world there are between 100–132 million girls and women who have been subjected to FGM.[2] Each year, a further 2 million girls and women are estimated to be at risk of the practice. Most of them live in 28 African countries, a few in the Middle East and Asian countries, and increasingly in the developed countries.[2] Types 1 and 2 are the most commonly practiced (80%), while type 3 constitutes approximately 15%.[1] In Nigeria, the situation is not different. The prevalence of FGM in Nigeria averages 50%[3,4] but ranges from 0% in parts of Kogi and Ogun states to 100% in Benue and Kebbi States.[5] Of great importance is the fact that healthcare providers, especially nurses,

still perform FGM despite the campaign against it.[6,7]

Several complications of FGM have been recognized. Among the immediate complications are hemorrhage, shock, infection, urinary retention and injury to adjacent tissue.[2,8] The long-term identifiable complications are menstrual dysfunction;[4,9,10] fistulae formation;[11,12] infertility; psychosexual problems/sexual dysfunction.[2] This usually results from gynatresia, scar neuroma, giant epidermoid cyst of the vulva,[13,14] formation of vulval abscess, keloids and hypertrophic scar formations. These growths are disfiguring and psychologically distressful and may discourage sexual intercourse. They may also cause pain during sexual intercourse (dyspareunia). The possible obstetric complications include difficulty in performing vaginal examinations,[15] prolonged/obstructed labor,[16] perineal tears[17,18] and postpartum hemorrhage.[18,19] The risk of these obstetric complications, however, depends on the type of FGM, being almost limited to the severe form (infibulation).[20,21] Other than the above physical complications, FGM is associated with great psychosocial problems. From a group discussion with some women who were genitally mutilated, some feel physically incomplete and depressed. Recognized psychosocial complications include psychological trauma leading to lack of confidence and feeling of inadequacy, phobia for sex, neurosis and razor phobia.[22,23]

Because of the health risks, the WHO views female genital cutting as a form of violence against girls and women that have serious physical and psychosocial consequences that adversely affect health. Furthermore, it is a reflection of discrimination against women and girls.[1] It also violates the rights of women to health and freedom of choice.

Table 1. Sociodemographic characteristics of respondents

Characteristics	Number (n=182)	Percentage
Age (Years)		
≤20	0	0.0
21–30	48	26.4
31–40	70	38.5
41–50	53	29.1
>50	11	6.0
Ethnic Group		
Bini	67	36.8
Esan	62	34.1
Etsako	11	6.0
Others	42	23.1
Religion		
Christianity	168	92.3
Islam	8	4.4
Traditional	0	0.0
Others	6	3.3
Years Postgraduation		
≤10	59	32.4
11–20	87	47.8
21–30	31	17.0
>30	5	2.8

In most communities where FGM is the accepted norm, traditional birth attendants or traditional practitioners usually perform the operation. However, with increasing awareness of the adverse health consequences of FGM, health workers have become involved in performing FGM, which has led to the "medicalization" of the procedure in a number of countries—for example, Egypt.[2] This move is contrary to the efforts made by the WHO and other nongovernmental agencies to discourage FGM. A study in southwest Nigeria (1994–1995) showed that hospitals were the most popular location for performing FGM, and nurses/dispensers were the circumcisers in 39% of cases.[24]

In Nigeria, an effort has been made to discourage FGM. Midwives and nurses held mass demonstrations in Benin City in 1989 against female circumcision regarding aesthetic and obstetric complications, as well as the added risk of spreading tetanus and AIDS by unsanitary procedures.[25] In 1994, the Nigerian Department of Women's Affairs, headed by a female minister, succeeded in getting the government to issue a decree outlawing FGM. Similarly, in 1999, a bill to abolish FGM was passed into law in Edo State. Despite all this, it is surprising to note that FGM is still prevalent in Edo State with healthcare providers, especially nurses, perpetuating the act.[6,7]

As a result of the wide gap in the body of knowledge among various health practitioners, FGM poses a serious public health challenge requiring widespread community mobilization and education to eradicate it. However, no study has been done in Nigeria to assess the knowledge and attitude of healthcare providers, particularly nurses, towards FGM. Therefore, the aim of this study is to assess the knowledge and attitude of nurses towards FGM and relate them to the practice of FGM among nurses. This will enable the development of a strategy, such as targeted mass education, to further reduce this practice.

METHODOLOGY

Nurses in Central Hospital, Benin City (CHB) (Edo State capital), were used for the study between September 1, 2001 and November 30, 2001. The hospital is located centrally in Benin City and serves as a referral center for all satellite, state-government-owned and private hospitals within Edo State. It also serves as a focal point through which all the staff (including nurses) of Edo State Hospital's management board rotates. This can be considered representative of the nurses' population within the state.

However, because FGM is related to culture, it is probable that a different picture will be obtained from nurses practicing in rural communities. Nurses practicing in rural areas are therefore more likely to perform and encourage FGM because of the strong cultural influence operating there.

Data was collected using a structured questionnaire, which was self-administered confidentially. The questionnaire was pretested among 24 nurses in another tertiary hospital in Benin City and validated by a pilot study. Information sought in the questionnaire included sociodemographic characteristics of respondents such as age, sex, religion, ethnicity, years of postgraduation experience and knowledge of the FGM types and harmful effects. Respondents were also asked about whether they routinely practice FGM, have performed it in the past or will perform it in the future when faced with some circumstances. Those who practiced FGM were asked for their reasons for performing FGM. The general attitude of all respondents towards FGM was also assessed. There were a total of 204 nurses in CHB. Nurses in various sections of the hospital, such as obstetrics and gynecology, surgery, pediatrics, internal medicine and family medicine, were first visited and informed of the aims of the study. They were highly motivated to complete the questionnaires. Eleven of the nurses were absent during the study period. A total of 193 questionnaires were distributed. All nurses practicing at CHB were eligible.

RESULTS

Of the 193 questionnaires that were distributed, 94.3% were appropriately filled and returned for analysis. The respondents were females. A greater proportion of the respondents (38.5%) were aged 31–40 years (Table 1). The youngest respondent was 22 years and the oldest 54 years (mean 37 years). Most (92.3%) of respondents were Christians, while eight (4.4%) were Muslims and (3.3%) practiced other forms of religion, such as Eckankar, Amorc, etc. The predominant ethnic groups were Bini (36.8%) and Esan (34.1%).

Others included Kwale, Owan, Urhobo, Yoruba, Ibo and Ijaw. A majority of respondents (67.6%) had over 10 year's postgraduation experience. Nurses performing FGM routinely were those who had spent

Table 2. Knowledge, attitude, perception and practice of FGM

	Response		
	Yes Number (%)	No Number (%)	Don't Know
Are all forms of FGM harmful	131 (72.0)	44 (24.2)	7(3.8)
The possible complications of FGM are:			
Hemorrhage	178 (97.8)	0 (0.0)	17 (2.2)
Difficult labour /childbirth	146 (80.2	26 (14.3)	10 (5.5)
Genital tears during childbirth	152 (83.5)	18 (9.9)	12 (6.6)
Infection	148 (81.3)	15 (8.2)	19 (10.4)
HIV transmission	98 (53.9	19 (10.4)	65 (35.7)
Infertility	38 (20.9))	48 (26.6)	96 (52.8)
Scar and keloid formation	101 (55.5)	52 (28.6)	29 (15.9)
Attitude and Perception of Respondents			
Is FGM a good practice?	5 (2.8)	156 (85.7)	21 (11.5)
Does FGM decrease promiscuity?	17 (9.3)	156 (85.7)	9 (5.0)
Does FGM decrease sexual pleasure?	126 (69.2)	47 (25.8	9 (5.0)
Does it cause sexual dysfunction? (dyspareunia, frigidity, psychosexual disorders)	108 (59.3)	53(29.1)	21(11.5)
FGM makes genitalia more attractive	18 (9.9)	164 (90.1)	0 (0.0)
Will you encourage FGM?	5 (2.8)	172 (94.5)	5 (5.0)
Should FGM be legislated against?	167 (91.8)	15 (8.2)	0 (0.0)
Practice of FGM among Respondents			
* Are you circumcised?	80 (44.0)	81 (44.5)	21 (11.5)
* Do you routinely perform FGM?	12 (6.6)	170 (93.4)	0 (0.0)
* Have you ever performed FGM in the past?	26 (14.3)	156 (85.7)	0 (0.0)
# Will you perform FGM in future when compelled by certain circumstances?	15 (57.7)	11 (42.3)	0 (0.0)
* Will you have your daughter circumcised?	8 (4.4)	169 (92.2)	5 (2.7)

* n=182, # n=26

more than 20 years (59%) and 11–20 years (41%) in the profession. The range of work experience spanned from 1–32 years with a mean of 14.5 years.

There was a relatively high level of awareness of FGM practices, since all the respondents identified at least one form of FGM; however, 37.9% identified types 1 and 2 only as FGM. There was a general paucity of knowledge of the classification of FGM—as only 12 respondents (6.6%) could correctly identify the four types of FGM.

Table 2 illustrates the knowledge, attitude, perception and practice of respondents of the possible harmful effects of FGM. While 72% of respondents identified all forms of FGM as being harmful, 24.2% were of the opinion that some forms are not harmful. Of the possible complications, hemorrhage was identified by almost all respondents (97.8%); the remaining 2.2% did not know whether hemorrhage could complicate FGM. Other complications identified in large proportion by respondents include genital tears (83.5%), infections (81.3%) and difficult labor/childbirth (80.2%). Nineteen respondents (10.4%) affirmed that FGM does not increase the risk of HIV transmission, while 35.7% did not know. A majority of the respondents (52.8%) did not know whether or not infertility could complicate FGM, while 26.4% affirmed that it does not cause infertility.

Nearly all of the respondents (85.7%) identified FGM as a bad practice, while 2.8% viewed it as a good practice and stated that they will encourage the practice. Most respondents (85.7%) were of the opinion that FGM does not decrease promiscuity, while 9.3% felt it decreases promiscuity. A majority of respondents were of the opinion that FGM decreases sexual pleasure (69.2%) and causes some form of sexual dysfunction (59.3%).

Among the 182 female respondents, 44.0% were circumcised, giving the prevalence rate of FGM to be 44%; 44.5% were not circumcised, while the rest (11.5%) did not know whether they were circumcised or not. Some 6.6% of respondents routinely practice FGM, while another 14.3% had performed FGM before though not on a routine basis. Of the latter group, 57.7% will still perform FGM when faced with certain circumstances, particularly when there is much pressure from patient's family and also when the financial benefit is high. The vast majority of respondents (92.9%) would not have their daughters circumcised. Reasons given by respondents for practicing FGM were mainly cultural (Table 3). On other occasions, some did it because it yields money. Only three of the respondents who practiced FGM did so to forestall the patients' going to the traditionalists, where the incidence of complications is high. Seven (58.3%) of the respondents that routinely perform FGM view it as a bad practice but still perform it for the reasons mentioned earlier.

Table 4 shows a sample questionnaire.

Table 3. Reasons for performing FGM among respondents that routinely perform FGM

	No	Percentage
Cultural	10	83.3
Finances	6	50.0
To avoid patient going to traditionalist	3	25.0

DISCUSSION

FGM is a subject of global interest, with many countries of the world still practicing it despite efforts by the WHO and other agencies to abolish the practice. Regrettably, the prevalence is highest in Africa.[2] In Nigeria, Edo State is one of the states where FGM is practiced.[26] Though the findings of this survey indicate that there tends to be a high level of awareness of FGM among nurses, nearly all judged the practice as bad. There was also a paucity of knowledge on the classification of FGM. This was similar to the study in Alexandria, where 6.7% of nurses could correctly identify the three types of FGM.[6] While most of the nurses identified all forms of FGM as being harmful, nearly one-fourth (24.2%) felt that some forms are not harmful, contrary to the high risk of complications.[2] There is no doubt that hemorrhage could complicate FGM (WHO, 1996) as was rightly identified by the majority (97.8%) of respondents. This finding is much higher than that in the Alexandria study, where only 20.7% mentioned hemorrhage as a complication. Studies have shown that FGM could cause prolonged/obstructed labor,[16] though not conclusively. Also, it is becoming more evident that women who have FGM are more likely to suffer more perineal tears during delivery compared with nonmutilated women.[17,18] Most respondents were of the opinion that FGM predisposes to genital tears and also difficulties with childbirth. It is, however, surprising to know that 10.4% of respondents affirmed that FGM practice does not constitute a risk factor for HIV transmission, while another 35.7% do not know if FGM is a risk factor for HIV transmission. There is already a rising scourge of HIV/AIDS in Africa, and FGM will increase its spread by unsanitary conditions. The role of FGM as a risk factor for infertility is still controversial and no systematic study in Nigeria has conclusively documented the effects of FGM on female fertility. It is therefore not unexpected that the majority of the respondents (52.8%) did not know if infertility could complicate FGM. While 26.4% said it does not cause infertility, 20.9% said it does cause infertility.

It is a widely held opinion in Nigeria that

FGM decreases promiscuity;[24,27] however, Okonofua et al.,[28] in a cross-sectional study, established that FGM did not attenuate sexual feelings and that it may predispose women to adverse sexuality outcomes, including early pregnancy and reproductive tract infections. A more systematic community-based study needs to be conducted to establish the actual relationship between FGM and female sexuality. In this study, only 9.3% of the nurses reported that FGM decreased promiscuity, 5% did not know if any relationship exists and 85.7% reported that it does not decrease promiscuity.

The prevalence of FGM among nurses in this Nigerian hospital is relatively high, as 44% of them are circumcised (self-reporting). Twelve (6.6%) of the respondents routinely perform FGM and another 26 (14.3%) have performed FGM before. Older nurses routinely perform FGM in this study as in an earlier study.[6] Reasons given for FGM practice were not different from those established by Myers et al.[26], the WHO[2] and Caldwell et al.[24] Most of the reasons are culturally rooted. Sociocultural reasons were also found in the study among Sudanese midwives.[7] It is surprising to note that a greater percentage (58.3%) of those who routinely perform FGM view it as a bad practice; therefore, it is apparent that their knowledge does not positively influence their practice. However, a vast majority had never and will not perform FGM. Qualitative research into elucidating in-depth knowledge on why some nurses continue the practice of FGM is required.

FGM is an issue of concern with recognized implications for the health and human rights of women and girls. In communities where FGM is a traditional practice, it is paradoxically performed as an indication of love and care for a daughter and, unlike other

Table 4. Questionnaire on female genital mutilation: knowledge, attitude and practice amongst nurses

Kindly answer the following questions by ticking in the appropriate box or filling the spaces provided. Please do not write your name anywhere. Information provided will be treated as strictly confidential.

1. Age at last birthday
2. Ethnic group: [ ] Benin [ ] Esan [ ] Etsako [ ] Others
3. Religion: [ ] Christianity [ ] Islam [ ]Traditional [ ] Others
4. Number of years post graduation. [ ] <10 [ ] 11–20 [ ] 21–30 [ ] >30
5. The following are types of FGM:
   Type 1 is partial or total excision of clitoris: [ ] Yes [ ] No [ ] Don't know
   Type 2 is excision of clitoris and labia minora: [ ] Yes [ ] No [ ] Don't know
   Type 3 is the excision of part or all of the external genitalia and stitching/narrowing of the vagina opening (infibulation): [ ] Yes [ ] No [ ] Don't know
   Type 4 is unclassified and refers to any other mutilation performed on the genitalia such as gishiri cut, piercing and massaging of any part of external genitalia: [ ] Yes [ ] No [ ] Don't know
6. Are all forms of FGM harmful? [ ] Yes [ ] No [ ] Don't know
7. Possible complications of FGM are:
   Hemorrhage: [ ] Yes [ ] No [ ] Don't know
   Difficult labor/childbirth: [ ] Yes [ ] No [ ] Don't know
   Genital tears during childbirth: [ ] Yes [ ] No [ ] Don't know
   Infection: [ ] Yes [ ] No [ ] Don't know
   HIV transmission: [ ] Yes [ ] No [ ] Don't know
   Infertility: [ ] Yes [ ] No [ ] Don't know
   Scar and keloid formation: [ ] Yes [ ] No [ ] Don't know
8. Is FGM a good practice? [ ] Yes [ ] No [ ] Don't know
9. Does FGM decrease promiscuity? [ ] Yes [ ] No [ ] Don't know
10. Does FGM decrease sexual pleasure? [ ] Yes [ ] No [ ] Don't know
11. Does FGM cause sexual dysfunction (dyspareunia, frigidity, psychosexual disorders)? [ ] Yes [ ] No [ ] Don't know
12. FGM makes genitalia more attractive: [ ] Yes [ ] No [ ] Don't know
13. Will you encourage FGM? [ ] Yes [ ] No [ ] Don't know
14. Should FGM be legislated against? [ ] Yes [ ] No [ ] Don't know
15. Are you circumcised? [ ] Yes [ ] No [ ] Don't know
16. Do you routinely perform FGM? [ ] Yes [ ] No [ ] Don't know.
17. Have you ever performed FGM in the past? [ ] Yes [ ] No [ ] Don't know.
18. Will you perform FGM in future when compelled by certain circumstances? [ ] Yes [ ] No [ ] Don't know
19. Will you have your daughter circumcised? [ ] Yes [ ] No [ ] Don't know.

What are your reasons for performing FGM? [ ] Cultural [ ] Financial gains [ ] To prevent patient from going to traditionalist [ ] Others

public health problems, FGM may not be seen as a health issue. The complications of FGM are numerous, particularly when performed by untrained personnel. When performed by medical or paramedical trained personnel, these complications can be reduced and even when they occur, they can be managed or referred appropriately. However, the participation of medically/paramedically trained personnel will further compound the issue, as people will be misdirected in perpetuating the act. Legislation against FGM might not be the final solution to eliminating FGM, as evident in this study, rather a redirection of focus to create more awareness among healthcare providers on the ill effects of FGM. Adequate education and awareness among the general populace will go a long way in changing attitudes and perceptions towards FGM in a positive direction.

CONCLUSION

Our findings suggest that most nurses have a high level of awareness of FGM and view FGM as bad practice and a few routinely perform FGM for mainly social and economic reasons. A worse picture may be found among rural nurses, as the practice is more prevalent and occurs at alarming proportion due to strong cultural influence. Public health complications include hemorrhage, infections such as HIV, posttraumatic stress disorder and memory problems,[29] and injury to adjacent tissue. The identifiable long-term complications are menstrual dysfunction; fistulae formation; infertility; psychosexual problems/sexual dysfunction, usually resulting from gynatresia, scar neuroma, giant epidermoid cyst of the vulva, vulval abscess and keloids, and hypertrophic scar formations. These growths are disfiguring and psychologically distressful and may discourage sexual intercourse. They may also cause pain during sexual intercourse (dyspareunia). There fore, there is an urgent need for targeted mass education and mobilization of nurses on the public health implications so as to reduce the practice. Nursing and self-help groups in the campaign against FGM should be formed; professional guidelines on FGM for healthcare providers should be defined. Also, changing the perception of the community on the myths associated with FGM and breaking the cultural chain attached to the practice may be the fundamental step in its abolition.

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