

ORIGINAL ARTICLE

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**KNOWLEDGE, ATTITUDE AND PRACTICE OF FEMALE GENITAL MUTILATIONS AMONG MALES AND FEMALES ATTENDING OUT PATIENTS AND MCH CLINIC OF ELDER DISTRICT RURAL HOSPITAL GALGADUD REGION SOMALIA**

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**ABSTRACT**

**Background :** Somalia is a country that still practices Female Genital Mutilation (FGM). Female genital mutilation (FGM) constitutes all procedures, which involve partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reasons.

**Methodology :** A cross-sectional community based study was conducted among males and females above 18 years of age attending the Out Patient Clinic and Mother & Child Clinic of Elder District, Rural Hospital Galgadud Region, Somalia in June 2006 using a structured questionnaire to access the respondents' knowledge, attitude and practice.

**Results :** Four hundred respondents were interviewed and male respondents were noted to be more knowledgeable than their female counterparts (p 0.004) and so does respondents with formal education (p <0.001) and had occupation (p <0.001). Majority of the female respondents (97.1%) favors the practices of FGM and reasons such as to protect virginity (p <0.001), increase marital opportunity (p <0.001) and religious recommendations (p <0.001) were noted to be the important factors in the continuation of FGM. All of the female respondents have had some form of FGM, giving the prevalence rate of 100% with 64.1% underwent the procedure at between the age of 5-10 years old and the commonest form of FGM were infibulations. Mother (69.4%) was the important decision maker for these women.

**Conclusion :** Aggressive education programme should be introduced targeting the women in this community. They should be well informed on the complication of FGM and its health effects. Providing clinics will help to alleviate some of the complications related to FGM. Law on protecting women from these practices should be introduced and enforced.

**Key Words :** female genital mutilation, knowledge, attitude, practice

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## **INTRODUCTION**

Ritual cutting and alteration of female genitals in infants, girls, and adolescents has been a tradition since antiquity. The spectrum of these genital procedures has been termed female circumcision, or more frequently, female genital mutilation (FGM) as a collective name describing several different traditional rituals that envisages the physical disfigurement associated with the practice<sup>1</sup>.

The definition of FGM, according to Amnesty International, is "the term used to refer to the removal of part, or all, of the female genitalia<sup>2</sup>. World Health Organization (WHO) defined FGM as all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons. According to WHO, they classified FGM into four broad categories which are Type 1 (Excision of the clitoral hood with or without removal of part or the entire clitoris), Type 2 (Removal of the clitoris together with part or all of the labia minora), Type 3 (Infibulations - removal of part or all of the external genitalia including clitoris, labia minora and labia majora followed by stitching and/or narrowing of the vaginal opening leaving a small hole for urine and menstrual flow and Type 4 (Unclassified - all other operations on the female genitalia, including pricking, piercing, stretching, or incision of the clitoris and/or labia, cauterization by burning the clitoris and surrounding tissues, incisions to the vaginal wall, scraping (angurya cuts) or cutting (gishiri cuts) of the vagina and surrounding tissues and introduction of corrosive substances or herbs into the vagina<sup>3</sup>).

WHO estimates that between 100 million and 140 million girls and women worldwide have been subjected to one of the first three types of female genital mutilation. Estimates based on the most recent prevalence data indicates that 91.5 million girls (above 9 years old) and women in Africa are currently living with the consequences of female genital mutilation<sup>3</sup>. There are 28 countries in Africa which practice FGM routinely and in Somali, the prevalence of FGM is about 95 per cent and is primarily performed on girls between the ages of four and 11. This traditional practice is embedded deep within Somali culture, and the belief is widely held that FGM is necessary to "cleanse" a girl child<sup>4</sup>.

A research done in Bere community, OyoState, Nigeria where 93% of women surveyed were circumcised noted that one hundred per cent of these circumcised women believed that FGM enhances women's fertility and safe childbirths. Male respondents noted to have better knowledge of the consequences of FGM than female respondents. Only 33.6% were aware of the health consequences of

FGM but most respondents (76%) were not willing to stop the practice<sup>5</sup>.

FGM health implication can be classified into physical-effects and obstetric complication. Among the physical-effects of genital mutilation are pain, shock, hemorrhage and death during the procedure. Subsequently they can develop serious urinary infection from urine retention. Use of the same instrument on several girls without sterilization can cause the spread of infection such as HIV. Infibulations can have even more serious long-term effects such as chronic urinary tract infections, stones in the bladder and urethra, kidney damage, reproductive tract infections resulting from obstructed menstrual flow, pelvic infections, infertility, excessive scar tissue, keloids and dermoid cysts. First sexual intercourse can only take place after gradual and painful dilation of the opening left after mutilation sometimes cutting is even necessary<sup>6,7,8</sup>.

There are many obstetric complications arising from FGM. However with careful planning, good antenatal, intrapartum and postpartum care, most of these can be avoided. Some of the main complications are delayed second-stage labor, perineal tearing, vesicovaginal fistula, low birth weight babies, difficult in fetal monitoring and assessing progress of labor, obstructed labor due to scar tissue, severe perineal tears due to loss of natural compliance of the tissue and higher risk of labour under caesarian sections. FGM also doubles the risk of mother's death during child birth and increases the risk of the baby being born dead by three or four times. Dysmenorrhea, dyspareunia and infertility are also other long-term consequences of FGM<sup>6,7,8</sup>.

The objectives of this study were to determine the knowledge, attitude and practice of the community towards the FGM and its associated factors

## **METHODOLOGY**

This was a cross sectional community based study among male and females above 18 years of age attending the Out Patient Clinic and Mother & Child Clinic of Elder District, Rural Hospital Galgadud Region, Somalia in June 2006.

All 400 respondents who attended the clinic were recruited using universal sampling method. They were interviewed with the aid of questionnaire which was divided into two parts. Part one consists of respondent's personal information while part two consists of information on knowledge, attitude and practice of FGM and its related health complications. This study was approved by the research and ethics committee, Universiti Kebangsaan Malaysia.

**RESULTS**

A total of 400 respondents were interviewed with 206 (51.5%) were female and 194 (48.5%) were male. Majority of the respondents were in the 18-27 age group that is 137 respondents (34.3%) followed by >27-37 age group (113 respondents or 28.3%). Most of the respondents never went to school which consist of 173 (43.3%), followed by primary school (91 respondents or 22.8%), secondary school (39 respondents or 9.8%) and only 0.8% (3) had higher

education levels. Some of the respondents opted for Islamic education (94 or 23.5%). In terms of their marital status, 338 or 84.5% of the respondents are married and only 28 (7.0%) are single.

Without any formal education, unemployment among the respondents is very high (120 or 30.0%). 85 (21.3%) of the respondents are housewives and 84 (21.0%) of them work as animal care taker as in table 1. Their primary source of income comes from their relatives 202 (50.5%) followed by credit (144 or 36.0%) and business (29 or 7.3%).

**Table 1 Sociodemographic of the respondents (n = 400)**

<b>Variable</b>	<b>Frequency</b>	<b>Percentage (%)</b>
<b>Gender</b>		
Male	194	48.5
Female	206	51.5
<b>Age Group</b>		
18 – 27	137	34.3
>27 – 37	113	28.3
>37 – 47	81	20.3
>47 – 57	40	10.0
>57	29	7.3
<b>Education Level</b>		
Never attended school	173	43.3
Islamic education	94	23.5
Primary	91	22.8
Secondary	39	9.8
Higher than secondary	3	0.8
<b>Marital Status</b>		
Married	338	84.5
Single	28	7.0
Widow	20	5.0
Divorced	13	3.3
Engaged	1	0.3
<b>Occupation</b>		
No work	120	30.0
House wife	85	21.3
Animal care taker	84	21.0
Farmers	45	11.3
Fisherman	29	7.3
Private business	28	7.0
NGO worker	5	1.3
Government worker	3	0.8
Others	1	0.3

**Knowledge**

The respondents' knowledge on FGM was tested and was given a knowledge score. The mean knowledge score of respondents was  $77.24 \pm 23.24$  with a minimum value of 6.98 and maximum value of 100.00. Subsequently, the knowledge score of

respondents were grouped into two categories which were good knowledge and poor knowledge, based on their knowledge score with a cut-off point of 69. There were 260 (65%) respondents with good knowledge and 140 (35%) respondents with poor knowledge.

**Table 2 Association between Knowledge Score and Sociodemographic factors (n=400)**

Factors	Knowledge		$\chi^2$	p
	Good	Poor		
<b>Gender</b>	140 (72.2%)	54 (27.8%)	8.50	0.004
Male	120 (58.3%)	86 (41.7%)		
Female				
<b>Age Group</b>			0.29	0.588
< 40	160 (64%)	90 (36%)		
> 40	100 (66.7%)	50 (33.3%)		
<b>Education Level</b>			142.35	<0.001
None	79 (37.8%)	130 (62.2%)		
Formal	181 (94.8%)	10 (5.2%)		
<b>Marital Status</b>			3.35	0.067
Married	98 (71%)	40 (29%)		
Not married (Single, Widow, Divorced, Engaged)	162 (61.8%)	100 (38.2%)		
<b>Occupation</b>			75.56	<0.001
Yes	220 (78.6%)	60 (21.4%)		
No	40 (33.3%)	80 (66.7%)		

Based on table 2, males were found to have better knowledge (72.2%) than female respondents (58.3%). The respondents who had formal education scored better than those who did not with 94.8% and 37.8% respectively. Respondents who were having an occupation (78.6%) scored better than those who were not working (33.3%). All of these factors were shown to be statistically significant with the p-value of 0.004, <0.001 and <0.001 respectively while age and marital status differences did not show any significant difference.

**Attitude**

Nearly 301 (75.3%) respondents had heard about health problems related to practice of FGM while 99 (24.8%) of them never heard of it. Their main source of information came from the radio and health workers with 129 (32.3%) and 114 (28.5%) respectively. Majority of the respondents had access to radio (267 or 66.8%) which explains how most of the respondents got their information from.

Information on respondents attitude on issues related to FGM is summarized in table 2. Despite knowing about the health problems related to FGM, majority of the respondents were still in favor of FGM (307 or 76.8%) than those who against it (93 or 23.3%). Female respondents (97.0%) were found to be in favor of FGM compared to the male respondents (55.2%) and it was statistically significant with p-value of <0.001. When asked about the reasons behind it, female respondents believed that FGM practice will protect virginity (53.4%), increase marital opportunity (48.5%) and improve genital hygiene (41.7%) compared to the male respondents and the differences was statistically significant with p-value of <0.001, <0.001 and 0.025 respectively. Other reasons such as FGM will increase family honor and increase sexual pleasure were found to be not significant between the male and female respondents.

Religion still have a major role in the continuation of FGM where 322 (78.0%) believed that religion recommends FGM. When we look at the difference

between male and female respondents, we noted that the 68.0% of the male respondents believed that religion recommends FGM compared to 92.2% of female respondents and the difference was statistically significant with p-value of <0.001. Nevertheless when ask about continuing FGM practices in the future, most of them were against it (315 or 78.8%) but only 73.3% of female respondents compared to 84.5% of male respondents were against

it and it was significant statistically with p-value of 0.006.

158 (81.55%) of female respondents believe that they will be rejected by the community if they were uncircumcised and only 38 (1.54%) believe that they have better chance in marriage if they were uncircumcised. Meanwhile, the male respondents still prefer circumcised women (158 or 81.44%) than uncircumcised women (33 or 17.0%). Only 3 (1.54%) of male respondents didn't mind either.

**Table 3 Association between Attitude and Gender (n=400)**

Factors	Gender		$\chi^2$	p
	Male	Female		
<b>Favors FGM</b>	107 (55.2%)	200 (97.1%)	98.453	< 0.001
Yes	87 (44.8%)	6 (2.9%)		
No				
<b>Reasons Favoring FGM:</b>				
<b>Protect virginity</b>				
Yes	34 (17.5%)	110 (53.4%)	55.801	< 0.001
No	160 (82.5%)	96 (46.6%)		
<b>Increase marital opportunity</b>				
Yes	22 (11.3%)	100 (48.5%)	65.237	< 0.001
No	172 (88.7%)	106 (51.5%)		
<b>Increase family honor</b>				
Yes	70 (36.1%)	73 (35.4%)	0.018	0.893
No	124 (63.9%)	133 (64.6%)		
<b>Improve genital hygiene</b>				
Yes	60 (30.9%)	86 (41.7%)	5.046	0.025
No	134 (69.1%)	120 (58.3%)		
<b>Increase sexual pleasure</b>				
Yes	37 (19.1%)	40 (19.4%)	0.008	0.930
No	157 (80.9%)	166 (80.6%)		
<b>Religion recommend FGM</b>				
Yes	132 (68%)	190 (92.2%)	37.249	< 0.001
No	62 (32%)	16 (7.8%)		
<b>Should continue FGM in future</b>				
Yes	30 (15.5%)	55 (26.7%)	7.536	0.006
No	164 (84.5%)	151 (73.3%)		

**Practice**

Practices of FGM among female respondents were summarized as in table 3. All female respondents claimed that they underwent circumcision. Most of them had circumcision at the >5–10 age group (131 or 64.1%) while the rest had their circumcision at 1-5

age group (44 or 21.36%) and >10-15 age group (31 or 15.0%). Mother (140 or 69.4%) plays the most significant factors in deciding their FGM practices followed by grandmother (36 or 17.5%) and father (20 or 9.7%). Regarding the type of FGM, 162 (78.6%) had infibulations, 28 (13.6%) had excision and 16 (7.76%) had Sunni's.

**Table 3 Practice of FGM among female respondents (n = 206)**

Factors	Frequency	Percentage (%)
<b>Circumcised</b>		
Yes	206	100.0
No	0	0.0
<b>Age group of circumcision in years</b>		
1 – 5		
>5 – 10	44	21.36
>10 - 15	131	64.1
	31	15.0
<b>Decision makers</b>		
Mother	140	69.4
Grandmother	36	17.5
Father	20	9.7
Relative	2	0.9
<b>Type of FGM</b>		
Infibulations	162	78.6
Excision	28	13.6
Sunni	16	7.76

**DISCUSSION**

This study assessed knowledge, attitude and practice of FGM among male and female respondents in Elder District Hospital-Somalia. It provides us with some insight on the issue of FGM among the 400 respondents which represent a spectrum of sociodemographic profile of this community.

In terms of knowledge, male respondents were noted to score better than their female counterparts and it was also statistically significant with p value of 0.004. Respondents with formal education and job also scored better on their knowledge test. The differences were also statistically significant with both variables had p-value of <0.001. The results were similar with previous studies where they found that male respondent and educated women have better knowledge on the consequences of FGM<sup>5,9</sup>. The reasons for this could be that the families preferred to send their sons to school compared to their daughters. As a result, men end up with better education and better job than female. With education they became more knowledgeable on issues related to FGM.

75.3% of the respondents have heard about health problems related to the practice of FGM. Their main source of information comes from the radio (32.3%). This may be due to the fact that radio was found to be the most accessible source of information (66.8%). Previous research also found out that electronic media were more accessible therefore it has an important role in educating the public regarding complications due to FGM<sup>9</sup>.

Despite knowing about the complications of FGM, 76.8% of the respondents were still in favor of

practicing FGM. Women tend to be more in favor of FGM compared to men and the difference was shown to be statistically significant. Women still believe that FGM will protect their virginity, increase marital opportunity and improve genital hygiene compared to the belief of their male counterparts and it has been shown to be statistically significant as well. This results were in contrast to previous research that showed male were 1.5 times more likely to support the practice of FGM, but the sample of that study were among university students and as a result females in an educated population are less likely to support FGM as compared to those in rural and/or uneducated populations<sup>9</sup>.

Religion still plays a major factor where 78.0 % of them agreed that religion recommends FGM. Their beliefs of being rejected by the community if they did not undergo genital mutilation were still very strong (81.55%). This was further enhanced by the fact that men preferences towards woman were affected on whether the women were circumcised or not. Nearly 81.44% of men prefer circumcised women than those who were uncircumcised. This results were in line with previous study as well where the main reasons FGM still continues today was that people still believe that it is part of religious obligations. In the study it showed that the respondents who believed that FGM has a religious basis were 2.31 times more likely to condone FGM<sup>9</sup>.

The study revealed that mother played an important role in the continuation of FGM practices. 69.4% of the respondents underwent genital mutilation after being decided by their mother. This could be because the women belief that FGM will preserve a girl's virginity, preventing immoral behavior and ensure

better marriage prospects for their daughter. The commonest type of FGM was found to be infibulations (78.8%) and the commonest age range was found to be 6-10 years (64.1%). This results are in line with previous data on FGM practices<sup>3,4</sup>.

## CONCLUSION

This study has provided us with some interesting findings related to FGM. Despite women being subjected to this practice, male respondents scored better on knowledge score. This could be due to the fact that men were exposed to schooling and education. Thus more should be done to educate women regarding issues pertaining to FGM. A detailed programme should be constructed aiming at educating the women regarding the health effects and complications of FGM. Since majority of the respondent have access to radio, it should be the main source of information regarding this matter and supported by dedicated and qualified health care workers. Armed with good programmes and tools, the level of understanding regarding FGM among female in Somalia could be improved.

Female have been the driving factor in the practice of FGM. This study has shown that mothers and grandmothers play an important role in making sure the practice is adhered. This is to make sure that their daughter is accepted by the society. Society's perception towards FGM practice is still deeply rooted. Being rejected by the community will have severe impact on the women who did not practice FGM. Making sure that their daughters will have greater chance in marriage probably is an important factor that drives these women to continue genital mutilation practice. Thus changing the community perception is also needed in order to stop the FGM practice. Leaders in the community must play an important role in educating the community to slowly change the perception on FGM. These leaders should be the target for health care worker so that they can be given adequate information on FGM.

Most of the respondents believe that FGM was related to religious believe. Religious factors play an important role in dictating the perception of a community. A research on religious teaching pertaining to FGM should be conducted. Experts on religious teaching should be brought in to educate the community regarding FGM. Believe and teaching of religion on this matter should be properly explained to the community.

Government should also be involved with FGM practice. Providing clinics for the community to have genital mutilation is needed to make sure that the procedure is carried out by professionals under a

sterile and safe environment. This will help to reduce complication arising from the procedure for those who choose to continue the practice. Law should be passed to stop unqualified personnel from doing the procedure. Law can also be passed to stop these practices.

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