

Knowledge of female genital cutting among parents in south west Nigeria

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Objective: To find out the knowledge of FGC among parents in south west Nigeria. **Study design:** Descriptive cross-sectional survey method was used to conduct the study. **Study period:** March 2009 to December 2009. **Sample size:** 536 parents from 3 selected state capitals in south west Nigeria. **Study variables:** Age, gender and educational status. **Statistical analysis:** Descriptive and inferential statistics (mean, standard deviation, t-test, Analysis of Variance (ANOVA) and Duncan Multiple Range Test (DMRT). **Results:** The study revealed that there is no significant difference in the knowledge of parents on FGC based on gender. The null hypotheses were not rejected, because the calculated value $t=1.91$ obtained, was less than the table value of 1.96 at 534 degrees of freedom at 5% level of significance. This shows respondents did not differ in their knowledge about FGC based on gender whereas, other null hypotheses were rejected, because there existed significant differences in the parents' knowledge of FGC based on age and educational status with calculated F-values 7.62 and 7.62, while the table values were 2.08 and 2.12 respectively. Duncan Multiple Range Test was employed to determine the significant differences existed between and within the group of means where ANOVA was used. **Conclusion:** On the basis of the findings, it was recommended that parents, community leaders, religious leaders as well as traditional rulers should be educated on the hazards of FGC and should inculcate in their people on how to stop harmful traditional practices. Government should enact a law to prohibit FGC; there should be public enlightenment campaign to the general public about consequences and health hazards of FGC on the victim. Also community health education should be organized for traditional circumcisers to stop this harmful practice among girls and women.

Keywords: Angurya, circumcision, clitoridectomy, genital, infibulation,

Introduction

Female genital cutting (FGC) is the term used to refer to the removal of part or all the female external genitalia. The most severe form is infibulation, also known as 'Pharaonic' circumcision¹. The procedure consists of clitoridectomy (where all or part of the clitoris is removed), excision (removal of all or part of the labia minora), and cutting of the labia majora to create raw surface, which are then stitched or held together in order to form a cover over the vagina. When they heal, a small hole is left to allow urine and menstrual blood to escape¹.

There are various reasons why cutting is being carried out most of the time, such as to curb promiscuity in woman (i.e. traditional or cultural beliefs). For instance, there is a traditional belief that an unmodified clitoris can lead to masturbation or lesbianism.

"A woman who is not circumcised is a dog and in the olden day was a slave", declares a well-known Nigerian traditional female circumciser, Stella Omorogie from Edo State in 2001². Religious belief also served as one of the reasons why FGC is being done to many victims. In countries where the predominant religion was Christianity, such as Ethiopia and Kenya, genital cutting is almost designed as if it were a compulsory religious rite. The same practice is totally applicable in muslim-dominated countries. Even in multi-faith countries there is no difference as it is often forced on girls whose families followed one of these faiths such as Animism and Hindus³. In a secular country like Nigeria, FGC was frequently practiced among both Muslims and Christians³.

Types of Female Genital Cutting (FGC)

Female genital cutting (FGC) is performed by a number of crude procedures, resulting in the excision (cutting) of a part of the whole of the external genital, such as, the clitoris the hood, labia minora (inner lip), labia majora (outer lip), virginals and urethral opening⁴. What is done in reality is cutting away whatever the operator can get hold of, part or all of the clitoris and often part of labia minora and labia majora⁴.

The World Health Organization identified four different types of female genital cutting (FGC), suggesting that, there are some variations, in the types in Nigeria vis-à-vis those identified by Toubia in 1994. By and large, three of the following four types identified by Okonofua are performed in Nigeria⁵⁻⁷:

Type I (Clitoridectomy)

The excision of the clitoral hood with or without the removal of the clitoris

Type II (Excision)

Removal of the clitoral hood and clitoris together with part or all the Labia minora (inner lip)

Type III (Infibulation)

Removal of part or all external genitalia (clitoris, labia minora and labia with or without stitching of the raw edges together leaving a small hole for urine and menstrual flow. In this case, narrowing of the virginal opening is prominent.

Type IV (Unclassified)

- Pricking, piercing or incision of the clitoris and /or labia
- Stretching of the clitoris and /or labia
- Cauterization by burning of the clitoris and surrounding tissues
- Scraping ("angurya" cuts) of the vagina
- Introduction of corrosive substances or herbs into the vagina to cause bleeding, tighten or narrow the vagina.
- Any other procedure that falls under the definition of female circumcision given above.

Basis for the practice of female genital cutting (FGC)

Amnesty International believed that Female genital cutting is done for many complex, poorly understood reasons. In some cultures, the practice is based on love and the desire to protect females because it is viewed as a culturally normal practice that has social significance for females⁸. Some societies support female genital cutting (FGC) because they consider it a "good tradition" or a necessary rite of passage to womanhood. In many cultures that practice FGC, a woman achieves recognition and economic security through marriage and childbearing, and FGC is often a prerequisite for qualifying for wifehood. Therefore, FGC affords economic and social protection.

Other rationale for FGC include beliefs that FGC enhances male sexuality, curbs female sexual desire; has aesthetic, purifying or hygienic benefits, prevents promiscuity and preserves virginity¹⁰. Some argue that FGC has religious significance, but the custom cuts across religions and is practiced by Muslims, Christians, Jews and followers of indigenous religions¹¹.

FGC is considered an important part of gender identity, which explains why many women and family members identify with and defend the practice. However, FGC is conducted in the broader context of gender discrimination. In cultures where FGC is practiced, men often control and perpetuate FGC by paying for their daughters to undergo the practice. They also may refuse to marry women who have not undergone FGC¹².

Esiet asserted the effects/consequences of female genital cutting (FGC) could be categorized into three specific groups, such as, physical effects; psychological effects; and effects on sexuality: Female genital cutting (FGC) has numerous negative health implications. Amnesty International also posited that these effects or consequences could be physical and psychological⁸. These consequences could be immediate or long-term depending on the extent of the cutting, the skill of the practitioner, the nature of the tools used, the environment and the physical condition of the girl. In addition, the physical side effects are much better understood than effects on girls' mental or sexual health at it is believed by those who practice female genital cutting that the clitoris may grow large and protrude between the leg. Thus, its excision to curtail its growth to avoid hypertrophic development of the clitoris and labia which may cause incessant embarrassment to the woman and may be disgusting to the male sexual partner¹⁴.

Hypotheses

1. There is no significant difference based on gender in the knowledge of parents about FGC.
2. There is no significant difference based on age in the knowledge of parents about FGC.
3. There is no significant difference based on educational status in the knowledge of parents on FGC

Materials and method

A multistage sampling technique was used to select 600 respondents who completed the 15- item questionnaires. The data collected were analyzed using both descriptive and inferential statistics. However, for the hypotheses, inferential statistics of t-test and analysis of variance (ANOVA) were employed at $\alpha = 0.05$ level of significance using SPSS 11.0 version.

Results

Table 1 shows the data of the respondents 536, 226 (42.2%) were males, 310 (57.8%) of them were females. The age distribution of respondents were shown thus; 15 – 24 yrs, 48 (9%); 25 – 34 yrs, 107 (20%); 35 – 44 yrs, 180 (33.6%); 45 – 54 yrs, 101 (18.8%) 55 – 64 yrs, 59 (11%), while 65 yrs and above 41 (7.6%). This table revealed numbers of parents based on their educational status. No school, 187 (34.9%); Primary school, 132 (24.6%); secondary school, 92 (17.2%); post-secondary school, 80 (14.9%) and university 45 (8.4%). The above table revealed that 302 (56.3%) respondents are Christians, while 234 (43.7%) are Moslems. There were no traditionalists among the respondents. In the above table, 326 (67.5%) of the respondents are Yoruba, 96 (17.9%) Fulani, 47 (8.8%) Hausa and 31 (5.8%) Nupe.

Table 1: Distribution of respondents based on gender, age, educational status, religions affiliation and ethnic group

Gender	Frequency	Percentage (%)
Male	226	42.2
Female	310	57.8
Total	536	100
Age (in years)		
15 – 24	48	9.0
25 – 34	107	20.0
35 – 44	180	33.6
45 – 54	101	18.8
55 – 64	59	11.0
65 and above	41	7.6
Total	536	100
Educational status		
No school	187	34.9
Pry. School	132	24.6
Sec. School	92	17.2
Post Sec. School	80	14.9
University	45	8.4
Total	536	100
Religion		
Christianity	302	56.3
Islam	234	43.7
Traditional	0	0
Total	536	100
Ethnic Group		
Yoruba	362	67.5
Fulani	96	17.9
Hausa	47	8.8
Nupe	31	5.8
Total	536	100

Table 2 revealed that 226 male and 310 female responded to the questionnaire. The male and female mean scores and were 2.45 and 2.64 and standard deviations were 0.61 and 0.66 respectively, thereby given a calculated t-value of which is greater than the table value of 1.96 with the degree of freedom 534 at 0.05 level of significance. The null-hypothesis was accepted hypothesis and upheld, which means no significance difference existed between male and female parents knowledge about FGC.

Table 2: t-test result for Ho 1 (knowledge of parents based on gender) N = 536

Variable	No.	Means (X)	S.D	Calc. t	Df	Table value	Decision on H ₀
Male	226	2.45	0.61	1.91	534	1.96	Accepted
Female	310	2.64	0.66				

P < 0.05

Table 3 showed that ANOVA calculated F-ratio of 7.73 is less than table value of 2.08. Therefore the null-hypothesis is rejected. This implies that the alternate hypothesis, there is significant difference based on age in the knowledge of parents about FGC is upheld. Since there existed significant differences in hypothesis 2, then table 4 showed where the significant differences existed between and within the groups using Duncan multiple range test. It was concluded thus;

A is significantly different from E, F, B, C & D
 E is significantly different from A, B, C & D
 F is significantly difference from A, B, C & D
 B is significantly difference from A, E, F, C & D
 C is significantly difference from A, E, F & B
 D is significantly difference from A, E, F & B

Although, no significant difference between E & F as well as between C&D.

Table 3: ANOVA result for Ho2 (Knowledge of parents based on age) N=536

Source	SS	Df	MS	F-ratio	Decision on H ₀
Between	23735.52	9	2637.28 347.99814	7.73	Rejected
Within	17399.907	50			
Total	41135.427	59			

Table value @ 0.05 F 9,50 = 2.08

Table 5 showed that ANOVA calculated F-ratio of 7.62 is greater than table value of 2.12 at 0.05F9,40 of significance. The alternate hypothesis is upheld, that is, there is significant difference based on educational status in the knowledge of parents on FGC. Since there existed significant differences in hypothesis 3, then table 6 showed where the significant differences existed between and within the groups using Duncan multiple range test. It was concluded thus;

A is significantly different from	C, B & E
D is significantly different from	C, B & E
C is significantly different from	A, D & E
B is significantly different from	A, D & E
E is significantly different from	A, D, C & B

Although, No significant difference existed between A & D, so also between C & B

Table 4: Duncan Multiple Range Test for H_{02}

	Group	Mean (X)
A	15 – 24 years	2.11
E	55 – 64 years	2.18
F	65 years & above	2.18
B	25 – 34 years	2.48
C	35 – 44 years	2.85
D	45 – 54 years	2.88

Table 5: ANOVA result for H_{03} (Knowledge of parents based on educational status).

Source	SS	Df	MS	F-ratio	Decision on H_0
Between	4838.04	9	537.56 70.5459	7.62	Rejected
Within	2821.8373	40			
Total	7659.8773	49			

Table value @ 0.05 F 9,40 = 2.12

Table 6: Duncan Multiple Range Test for H_{03}

	Group	Mean (X)
A	No school	2.61
D	Post sec. School	2.61
C	Sec. School	2.70
B	Pry School	2.72
E	University	2.76

Discussion

The analysis revealed that parents regardless of their gender have adequate knowledge about FGC. Both male and female have adequate knowledge that FGC is the same as female circumcision, this corroborates with Amnesty International who pointed out that, FGC has traditionally been called female circumcision, which implies that it is similar to male circumcision.⁸ The knowledge of parents about FGC are different according to age although, no difference was found in the knowledge of ages 55-64 years and 65 years and above with mean score of 2.18 apiece. Also, no significant difference existed between ages 35-44 years and 45-54 years with mean scores of 2.85 and 2.88 respectively. For instance, 100% the former have knowledge and responded that FGC involve the use of sharp objects to remove the clitoral hood and/or part of the labia minora as as-

serted by Komisaruk, Daniel and Clark that FGC is performed by a number of crude procedure, resulting in the excision (cutting) of a part of the whole of the external genital, such as the clitoris, the hood, labia minora (inner lip), labia majora (outer lip), vaginal and urethral opening⁴.

In the latter however, 89.6% apiece have knowledge that FGC and female circumcision is the same thing. This supported by Cook15 who stated that historically, the term female circumcision was used, but that "this procedure in whatever forms it is practised is not at all analogous to male circumcision. Although, generally across the different age groups the responses varied.

Parents' knowledge about FGC was quite difference based on educational status. Although, no differences between the respondents' knowledge from among the No school and post secondary school group. Also between the secondary and primary school groups. However, there are significant differences between the No school, secondary school and university on different types of FGC that can be done for a girl. This is in line with WHO, Toubia, Okonofua,⁵⁻⁷ that four types of FGC have been identified thus: Types 1, 2, 3 and 4.

Conclusions

The findings of this research showed that parents' knowledge factors generally influence their knowledge, attitude and perception of FGC.

From the findings, it was concluded that:-

1. No significant difference existed between male and female parents in their knowledge about FGC.
2. Significant differences existed between the knowledge parents on FGC based on age.
3. Significant difference existed based on educational status in the knowledge of parents about FGC.

Based on the conclusion, I wish to recommend the following:

1. That programme against FGC be fully integrated into primary health care services in the nation, states and local government to ensure FGC is completely eradicated or reduced to the barest minimum.
2. Efforts should be made, especially in south western States by authorities concerned to enforce the law against FGC. Offenders should be brought to book to serve as deterrent to others who refuse to abstain from it.
3. Health officers and non-governmental organizations (NGOs) working in the sphere of reproductive and family health should carry out advocacy programmes against this practices to the grassroots to prevail and encourage people at the local community level of the advantages of abandoning FGC.
4. Community health education is the best means of providing

health information and education to the people at every level of living. Thus, the necessity to strengthen health/education services at states and local government levels cannot be over-emphasized.

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