Journal of Women's Health Care
ISSN: 2167-0420

Pashaei, J Women's Health Care 2012, 1:2
DOI: 10.4172/2167-0420.1000108

Research Article Open Access

Related Factors of Female Genital Mutilation (FGM) in Ravansar (Iran)

Pashaei T[1]*, Rahimi A[2], Ardalan A[1], Felah A[3] and Majlessi F[1]

[1]Department of Health education and Promotion, School of Public Health, Tehran University of Medical Sciences, Tehran, Iran
[2]Department of Epidemiology and Biostatistics, School of public health, Tehran University of Medical Sciences, Tehran, Iran
[3]School of Health, Kurdistan University of Medical Sciences, Tehran, Iran

Abstract

This study was performed to determine the prevalence and related factors of Female Genital Mutilation (FGM) in women visited at the health centers of the city of Ravansar In Kermanshah province, Iran. This cross-sectional study was conducted on 348 women who were visited at 5 health centers of the city of Ravansar. Data was collected using a structured questionnaire and women were examined about exist FGM.

The prevalence of FGM was 55.7% among Ravansars' women. It increases with age and about 54.4% were circumcised less than 7 years age. Almost all operations were performed by traditional circumcisers 85.7%. FGM was correlated with mothers' education level ($p<0.001$), age ($p<0.001$), women's level of education ($p=0.006$) and the level of knowledge and attitude toward mutilation ($p<0.001$).

FGM is a common practice in Ravansars' women. Improving the public knowledge regarding FGM and its consequences is extremely essential.

Keyword: Female genital mutilation; Custom; Iran

Introduction

Female Genital Mutilation/Cutting (FGM/C) is "the partial or total removal of the female peripheral genitalia or other damages to the female genital organs for cultural or other non-curative reasons" [1] and the term "mutilation" is applied because it clearly describes the severe physical impact of the practice [2]. The World Health Organization (WHO) has measured that between 100 to 140 million girls and women are living with the consequences of FGM worldwide and 3 million girls experience it per year [3]. Toubia has classified FGM into four main types depending on the amount of tissue removed [4].

FGM is usually performed by traditional practitioners, elderly women specially designated for this duty, or traditional birth attendants and is carried out with special knives, scissors, and scalpels; the instruments may be reused without cleaning. Anesthetics are not commonly used [2]. This procedure is mainly carried out on young girls sometime between the time of birth and 15 years of age [5].

The practice not only has no health benefits for girls and women but also imposes severe health risks such as bleeding, pain, infection, shock and reduced sexual desire [6].

There has been no perfect study on female genital mutilation in Iran and the findings of the present study might be helpful for evaluation and devising plans to reduce FGM in Iran.

The aim of this study was to find out the prevalence of FGM in Ravansar, a city in Kermanshah Province, west of Iran. This city is about 120 km far from the Iran-Iraq border and Kurdish is the language which is predominantly spoken in this region. FGM is performed in some parts of Iraqi Kurdistan and due to the proximity these two regions and cultural similarities, this tradition is also practiced in Iranian Kurdistan as well. The aim of our study was to evaluate the related factors that influence the practice of FGM and the attitude and knowledge of the Ravansar women toward FGM.

Method

This prospective comparative study was conducted in Ravansar in a period of 8 month from an august 2011 to February to determine the prevalence and related factors of FGM. The study population was the women referring to the 5 health centers of Ravansar; therefore, using a significant level of 0.05 and a power of 80%, the sample size was calculated to be 320 women who were distributed in the 5 health centers proportionate to the population that each covered. In this study, participants were selected by randomized sampling based on referral to the midwifery room.

The data collection tool was a questionnaire which had three sections. Section A included the demographic variables of the participants and questions about FGM such as age at time of FGM, reasons given to maintain and reject the practice, who performed the procedure, the consequences of FGM, and who made the decision to perform FGM. Section B included questions regarding the attitude of the women towards FGM and section C consisted of knowledge questions.

The scale B was structured along the Likert-type response format scoring including agree (1 points), disagree (-1), without comment (Zero points). Section C measured the participants' level of awareness regarding female genital mutilation. Questions considered the respondents' sources of information as True; I do not Know, and False. The higher the score of the knowledge scale was, the higher the knowledge level of information was. The instrument was content validated by three professors of Health Education and Medicine at Tehran University of Medical Sciences. The reliability yielded 0.80 and 0.83 coefficients for sections B and C, respectively.

Data were collected from the respondents by 5 educated midwives who worked in health centers. The interviewers were residents of the area who knew the culture and language of the people. A Two-day training course was conducted on how to complete the questionnaire

***Corresponding author:** Pashaei T, Department of Health education and Promotion, School of Public Health, Tehran University of Medical Sciences, Tehran, Iran, Tel: 98021888989134; E-mail: pashaeit@gmail.com

Received April 20, 2012; **Accepted** May 16, 2012; **Published** May 22, 2012

Citation: Pashaei T, Rahimi A, Ardalan A, Felah A, Majlessi F (2012) Related Factors of Female Genital Mutilation (FGM) in Ravansar (Iran). J Women's Health Care 1:108. doi:10.4172/2167-0420.1000108

and examine the participants to determine the type of FGM at the heath center. The training focused on interview techniques and completing the questionnaire. Also, we asked the interviewers to examine the genitalia of the respondents to determine the type of FGM and the rate of genital organ removal. After Data collection and coding, all statistical analyses were performed using the Statistical Package for Social Science (SPSS) version 16. First, the simple frequency, mean, standard deviation and range were calculated. Then, comparisons were made using Pearson's χ^2 test for categorical variables. Level of significance was set at P <0.05. Logistic regression was performed for analyzing the practice of FGM, attitude and knowledge, age, educational status and other socio-economic factors.

Results

The total number of interviewed females was 348; the prevalence of FGM among women was 55.7%. The majority of FGM operations (87.7%) had been perform by traditional local female circumcisers. The respondents were also asked about their intention of subjecting their daughters to FGM in the future. About 47% of the respondents replied that their daughters should undergo FGM. Educational level of the mothers and women were negatively correlated with FGM (P < 0.001) (Table 1 and 2). Keeping traditions (66.7%), cleanliness (17.2%), religious recommendations (2.7%) and sexual desire control (1%) were the main reasons for performing FGM. In the current study, the average age at which the procedure of FGM was performed was 9.2 ± 14.2 years. Partial or full clitoral cutting was reported in all circumcised responders. About 48.2 %of the circumcised women had experienced pain and bleeding because of FGM. Regarding the decision for FGM, 85.1% of the circumscribed females mentioned that their mothers and grandmothers were responsible in making the decision. When the women were asked whether the practice of FGM should continue, 34.2% agreed. The results of this study showed significant negative relationship between knowledge and attitude and FGM (P<0.001) (Table 3).

Upon application of logistic regression for analysis, the findings showed that the practice of FGM was significantly associated with age, religion, mother's education, women's knowledge level, and women's attitude level (Table 4).

Discussion

This study demonstrated that the prevalence FGM was 55.7% that is considerable as compared to other studies. The results of studies in different countries showed different prevalence rates of FGM: 50.3% [7], 22% [8] and 56.8% [9]. There is evidence that FGM practice is a very old tradition in some African countries [6] but it is only practiced in some parts of Iran.

The result of our study showed that the mean age of FGM was 9.2 ± 14.2 years; 54.4%were done before 7 years of age, 37.9% were performed between 7 and 14 years of age and 7.7% in individuals over the age of 14. This process is very painful because the girls can see the procedure of FGM, but WHO have been reported FGM practice is babies to 15 years [3]. Amazingly, in the present study, some of the girls received FGM after 18 or 21 years of age. The age at which FGM is performed on girls varies between countries and even from area to area within the same country; sometimes it is performed soon after birth and sometimes before marriage [3]. Our findings also indicated that the majority of the mutilations were performed by traditional midwives and old women (96.4%) who did not use anesthesia (100%); these findings were also reported in another study [7]. WHO has reported that FGM has health consequences including long-term and short-term complications [3]. Because many women undergo FGM in infancy, they may not experience any immediate adverse effects [2]. This study demonstrated that circumcised respondents suffered pain (48.2%) and bleeding (1.5%) after FGM.

When the respondents were asked about their intention to subject their daughters to FGM in the future, the answer was positive in about 34.2%.

This study revealed that the reasons for FGM were tradition and customs (66.7%), cleanliness (17.2%), religion (2.8%), health (2.6%) and control of the sexual desire (1%). It is clear that tradition, religion and social pressure were the main motives for performing FGM. In a study by Tag Elidin, the reasons for FGM were mainly religious (33.9%), cleanliness of the girls (8.9%), and social and cultural traditions (17.9% and 15.9%) [7].

Our finding is in line with a survey conducted by Robinson who reported that FGM was a social practice rather than a religious one [5]. Generally, there is no reason for FGM in Islam. It can be clearly seen that Islam forbids damage to the human body and there is no scriptural evidence in the religion to support of FGM [11].

In this study, 85.1% of the women who were circumcised said that their mothers and grandmothers were the main decision makers for this practice. Regarding the role of the mothers and grandmothers in FGM, the results are similar to those reported by Tag-Eldin et al. [7], Herieka and Dhar [9,10]. Therefore, according to our findings, interventional programs should put emphasis on women's education on FGM hazards.

It is worth mentioning that there is a significant relationship between education and FGM and that the attitude of the women with a low educational background toward FGM is more positive than those with a high educational back ground. Also, the more educated the mothers are, the less likely it is to have their daughters mutilated.

This finding was also reported by kandala et al. [8]. It is clear that the baby begins to socialize in the family where the child learns life skills and as a result, educated parents play an important role in transferring knowledge and attitude to the child through social learning [8].

Regarding the mothers' knowledge and attitude toward FGM, we found that only 13.2% of the women had good knowledge about FGM and its complications while the knowledge of the rest was medium or little. About 43.1% of the women had a negative attitude toward FGM and 57.2 believed that FGM led to cleanness [12-14].

In fact, women with low levels of knowledge on FGM had more positive attitudes toward this practice as compared to those with high knowledge levels. This finding was also reported by A. I. Aigbodion et al. The attitude towards old traditions change slowly and therefore strong educational interventions should be implemented [15].

Conclusion

Factors related to FGM are intricate and health education has a great impact on the attitude and knowledge of the women as FGM decision makers. An inseparable part of each educational intervention is attention to individuals' values and beliefs.

Religious leaders and elites should be involved in designing and conducting programs to change the attitude of the society toward FGM.

Culture is an important element determining people's behavior.

Culture is not static, people's behavior changes slowly; when people become aware of the hazards of unsafe practices and when they understand that it is possible to abandon harmful practices without neglecting significant aspects of their traditions.

Acknowledgement

In this article we used some information from study proposal number 132/142 which had been approved by the Deputy of Research of Tehran University of Medical Sciences. The authors are deeply indebted to Dr. Rezaei and Mrs. Lorestani at Ranvansar health center. This work would not have been possible without their support and help.

References

1. Mitike G, Deressa W (2009) Prevalence and associated factors of female genital mutilation among Somali refugees in eastern Ethiopia: a cross-sectional study. BMC Public Health 9: 264.
2. Morrone A, Hercogova J, Lotti T (2002) Stop female genital mutilation: appeal to the international dermatology community. Int J Dermatol 41: 253-263.
3. World Health Organization (2008) Female genital mutilation. Fact sheet N241.
4. Toubia NF, Sharief EH (2003) Female genital mutilation: have we made progress? Int J Gynecol Obstet 82: 251-261.
5. www.religioustolerance.org/fem_cirm.htm
6. Briggs LA (1998) Female Circumcision in Nigeria: Is it not time for Government intervention? Health Care Anal 6: 14-23.
7. Tag-Eldin MA, Gadallah MA, Al-Tayeb MN, Abdel-Aty M, Mansour E, et al. (2008) Prevalence of female genital cutting among Egyptian girls. Bull World Health Organ 86: 269-274.
8. Kandala NB, Nwakeze N, Kandala SN (2009) Spatial distribution of female genital mutilation in Nigeria. Am J Trop Med Hyg 81: 784-792.
9. Herieka E, Dhar J (2003) Female genital mutilation in the Sudan: survey of the attitude of Khartoum university students towards this practice. Sex Transm Infect 79: 220-223.
10. World Health Organization (2008) Eliminating female genital mutilation: an interagency statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO. Geneva, Switzerland.
11. Jones SD, Ehiri J, Anyanwu E (2004) Female genital mutilation in developing countries: an agenda for public health response. Eur J Obstet Gynecol Reprod Biol 116: 144-151.
12. World Health Organization (1992) International Federation of Gynecology and Obstetrics ZFIGO. Female circumcision.
13. Almroth L, Almroth-Berggren V, Hassanein OM, El Hadi N, Al-Said SS, et al. (2001) A community based study on the change of practice of femal genital mutilation in a Sudanese village. Int J Gynaecol Obstet 74: 179-185.
14. Snow RC, Slanger TE, Okonofua FE, Oronsaye F, Wacker J (2002) Female genital cutting in southern urban and peri-urban Nigeria: self-reported validity, social determinants and secular decline. Trop Med Int Health 7: 91-100.
15. Aigbodion AI, Imhonde HO, Aluede O (2004) A pilot study of the attitude of Nigerian university students towards female genital mutilation. Anthrologist 6: 247-252.