



LUNDS UNIVERSITET



Title of thesis: knowledge, attitude and practice of female genital mutilation among traditional birth attendants in Mogadishu-Somalia



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List of abbreviation

FGM: female genital mutilation

WHO: world health organization

TBA: traditional birth attendances

KAP: knowledge, attitude and practice

MCH: maternal and child health care

SPSS: statistical package for social science

S/C: south-central

Abstract

Background: Female genital mutilation (FGM) is a public health problem and harmful traditional practice that violates women's rights and threatens their health. Today the practice is still being reported in 30 countries in Africa and in a small number of countries in Asia and the Middle East. Somalia, 98% of the female population aged between 15 and 49 had undergone FGM. There is limited researches done to assess knowledge, attitudes and practices of FGM among traditional birth attendances in Mogadishu, Therefore, this study will assess the knowledge, attitude and practice of FGM among traditional birth attendances in Mogadishu.

Methodology: A cross-sectional study with quantitative method was conducted among traditional birth attendants in Mogadishu from November 2017 to April 2018. Raosoft sample size determination was used. Non response rate of 10% was used so the total sample size was 292. 10 out of 17 districts of Mogadishu was randomly selected by lottery method and 292 respondents was obtained through snowball sampling and community direction such as health workers of MCHs in which TBAs may have some communication. Data was entered, cleaned and analyzed by SPSS version 21 package and excel. Descriptive statistics were used to summarize socio-demographic characteristics of study participants and all other variables. Knowledge and practice towards FGM were determined using Bloom's taxonomy for cut of point. While the attitude scores was calculated using median. Chi square test was used for bivariate analysis and Statistical significance will be declared at p-value less than 0.05.

Results: In this study, the overall KAPs about FGM among TBAs showed the majority of respondents had low level of knowledge, neutral attitude and high level of practice. the majority of the respondents 114(39.2%) were aged above 46 years old, findings on respondent's educational level shows that half of respondents 142 out of 291 (48.8%) were illiterate, 209(71.8%) believe that FGM don't causes Hemorrhage, 231 out of 291 of respondents mentioned that FGM don't causes difficult labor birth.

Conclusion and Recommendation: female genital mutilation (FGM) is one of the worst types of violence against little girls and women practiced in the name of religion, tradition and culture and its elimination requires to enhance the awareness of TBAs about FGM complications on girls and women lives, change their attitudes and to stop its practice through legislation against FGM.

1. Introduction

Female genital mutilation (FGM) is not only a public health predicament, but also a detrimental traditional practice that violates women's rights and threatens their health. In most cases Female genital mutilation (FGM) involves all procedures of removal exclusively or partially the external genitalia except with serious injuries to female genital or reproductive organs for non-medical reasons (1).

Despite, it is known internationally the FGM's violation to human rights and enormous legislations were put in place against it, unfortunately, the procedure is still common in many countries. Thus, FGM practice is still being reported in 30 countries of Africa and in a small number of Asia and the Middle East countries (1, 2).

Over the last decades, FGM practice has attracted the researchers and bigger attention was given by policy makers. This was as a result of continuation of high FGM prevalence despite massive efforts intended to end (3).

Globally, it was estimated that more than 200 million women and girls are living today with Female Genital Mutilation in the countries where the practice is profoundly widespread. Further, more than half out of this number live in three countries which are Indonesia, Egypt and Ethiopia. Yet again, 44 million out of 200 million are girls below age of 15 (4). Annually, an estimation of 3 million girls is at risk to undergoing Female Genital Mutilation. This is evidenced by the fact the majority of girls are circumcised before they reach 15 years old (5).

In Africa; The FGM is mostly practiced in 28 countries of Africa and some other countries in Asia (6, 7). The historical justification and when the people have started to practice FGC is not yet not clear. Nonetheless, it is believed that the both Christianity and Islamic people have practiced FGC thousands of years. There are some literature documents indicating an Ancient Egyptian had performed FGM as far back as the fifth century BC (8). Some individuals forward their scholarly estimate that FGM has its starting point in the Egyptian culture. Others suggested that FGM might be begun in societies where the women were subordinate to the men (9). In spite of its origin, FGM has been practiced by Animists, Muslims and Christians (10). FGM/C practice was also common in Europe and United States of America in early 19th century where

cutting of genitals was used to prevent masturbation as well as “clitoral enlargement” and treat psychological disorders (8).

Somalia has the highest prevalence of women and girls who have been cut. Currently , 98% of the female population between the ages of 15 and 49 have been undergone FGM (11). However, FGM trends reveal that the practice is more common among women 45-49 (99 %) than girls 15-19 (97%). About 80 % of female children and women have undergone the most severe form of FGM known as infibulation or Type 3 because they have had their genitalia sewn closed. (12). In Benadir region and Arabic communities it is often common to perform Sunna type circumcision habitually known as Type 1+2 (13).

The practice of FGM/C is a cultural phenomenon deeply rooted in custom of Somali society and accepted expansively in S/C Somalia (14). In the Somali context, Type 3, (infibulation) is called “Gudniinka fircooniga ah”or “Gudniin Fadumo”as interpreted from term Pharaonic Circumcision. Despite various types are used, yet again all FGMs are consistent to be explained to a terminology known as “Halalayn” (15). Traditionally, in Somalia like many African and Eastern countries’ culture, the circumcision was done by traditional circumcisers such as traditional birth attendants (TBAs) who have no skills and health qualifications background.

1.1 Problem statement

FGM practice is a worldwide challenge especially in the countries of sub-Saharan Africa and the Arab world. Somalia, 98% of the female population aged between 15 and 49 had undergone FGM (11). Though many programmes were instigate intended to elevate community awareness against FGM practices, yet again traditional birth attendants still practice such type of Female Genital Mutilation (FGM). Further, limited researches were done to assess knowledge, attitudes and practices of FGM actors, particularly; traditional birth attendants in Mogadishu, on this respect, this study will assess the knowledge, attitude and practice of FGM among traditional birth attendances in Mogadishu.

1.2 Hypothesis

Knowledge of traditional birth attendants towards FGM is low, their attitude is positive and their practice is high.

1.3 Research objectives

1.3.1 General Objectives

To identify facts about knowledge, attitude and practice of female genital mutilation among traditional birth attendants in Mogadishu in order to explore and come up with strategies to eventually eradicate.

1.3.2 Specific Objectives

To determine the demographic characteristics of traditional birth attendants in Mogadishu

To explore knowledge of FGM among traditional birth attendants in Mogadishu

To assess the attitude of traditional birth attendants in Mogadishu towards female genital mutilation

To identify the practice of traditional birth attendants in Mogadishu towards female genital mutilation

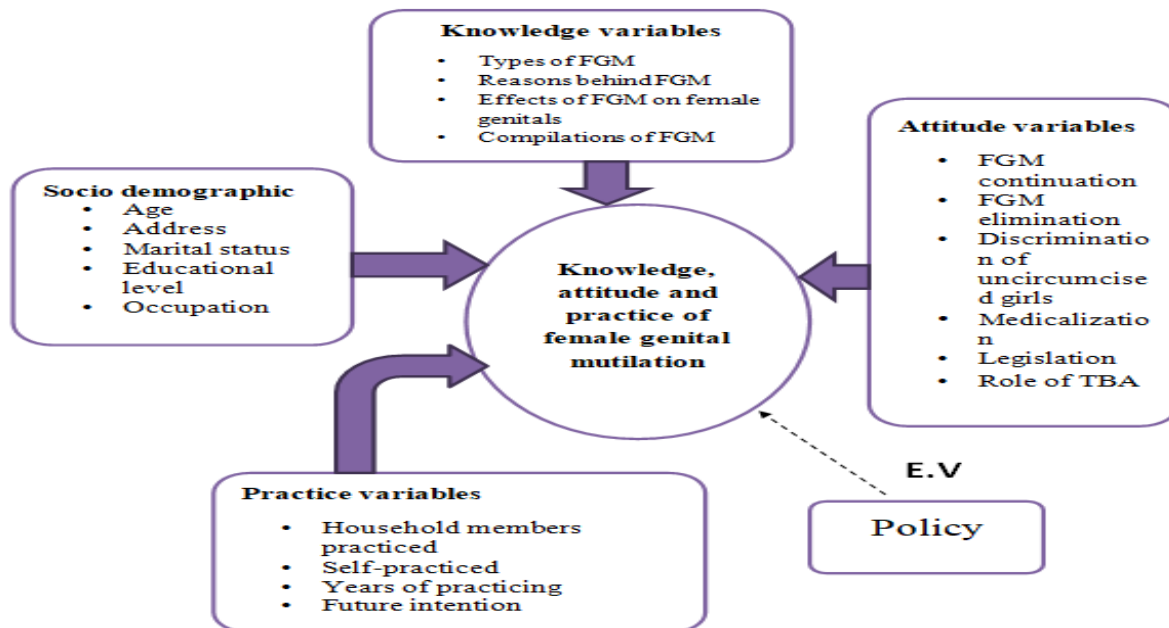
1.4 Significance of the study

In Somalia, there are a number of awareness programs intended to enhance knowledge of FGM and how it affects the life of more women but there is no evidence as to whether or not these programs have enhanced people's knowledge attitudes especially traditional birth attendants toward the practice of FGM, the aim of this study is to identify the level of knowledge, attitude and practice of traditional birth attendants towards FGM. In addition, the study outcome will help policy makers, local government, public health practitioners and other interesting organizations to design appropriate intervention to enhance awareness of FGM and to stop FGM practice for the future female generation. Moreover, it serves as baseline for further researches.

1.5 Scope of the study

This study was conducted in Mogadishu city, Somalia, from November 2017 to April 2018 and the study focused on knowledge, attitude, and practices of FGM among traditional birth attendants in Mogadishu

1.6 Conceptual framework



2. LITERATURE REVIEW

2.1 General knowledge of FGM

2.1.1 Definition of FGM

Female genital mutilation (FGM) consists of all procedures that involve the removal of external genitalia totally or partially or other injury to the female genital or reproductive organs for non-medical reasons (1).

2.1.2 Types of female genital mutilation

World Health Organization (WHO) classified female genital mutilation in to four types

Type 1 – Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and/or in very rare cases only, the prepuce (the fold of skin surrounding the clitoris).

Type 2 – Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the ‘lips’ that surround the vagina).

Type 3 – Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner or outer labia, with or without removal of the clitoris.

Type 4 – Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area (16).

2.2 The practice of FGM

Globally, between 100 and 140 million women and girls has been performed one of the first common three types of female genital mutilation according to WHO estimation (17). In addition the most recent prevalence data of FGM indicates that 91,5 million girls and women aged above 9 years old in Africa are now living with the complications of female genital mutilation (18). Every year, 3 million girls living in Africa are estimated to be at risk of undergoing female genital mutilation (19). The first three types (I, II and III) female genital mutilations have been documented to be practicing in 28 countries in Africa and in a few countries in Asia and in Middle East. Further, some forms of female genital mutilation have been reported from other

countries, such as certain ethnic groups in South and Central America. Growing migration has increased the number of girls and women living outside their country of origin who have undergone female genital mutilation or who may be at risk of being subjected to the practice (19).

FGC is mostly done in unsanitary conditions in which circumcisers such as traditional birth attendance uses unclean sharp instruments such as razor blades, kitchen knives, scissors and pieces of glass. Same instruments are used on several girls frequently in succession and are rarely cleaned, causing the transmission numerous infections and viruses such as the HIV virus. Anesthesia and Antiseptic techniques are not used generally.

This is similar to a health staffs that uses the same surgical instrument on a number of women at the same time without sterilization or at least cleaning sensibly any of them (20).

2.3 Reasons and attitudes towards FGM

FGM is practiced for a variety of reasons including socio-cultural reasons, varying from one ethnic group and region to another but the primary reason is that it is part of the cultural tradition and history of the community. Moreover, many cultures, it constitutes a rite of passage to adulthood and is also performed in order to confer gender identity and a sense of ethnic within the community. In many contexts, social acceptance is also one of the primary reasons for continuing the practice. Other reasons include ensuring fidelity after marriage, safeguarding virginity before marriage, providing a source of income for circumcisers, promoting marriageability (i.e. to be deserved to marriage or increasing a girl's chances of finding a husband), , preventing rape, as well as aesthetic reasons (cleanliness and beauty) (21).

In spite, some communities believe that FGM is a religious obligation, clearly, this practice is not revealed in the Quran or even the Bible. In fact, FGM predates Islam and is performed in some Christian communities whilst it is not practiced in many Muslim countries (21).

Whatever the reason, FGM reflects deep-rooted inequality between the sexes. This aspect and the fact that FGM is surrounded by socio-cultural factors have made its complete elimination and eradication extremely challenging. Nonetheless, the efforts to combat and gradual strategies to ultimately eradicate FGM worldwide must continue. In addition to acknowledge and assist girls

and women who already struggle with FGM consequences whose health needs are currently huge currently but not yet fully met.

2.4 Health risks from FGM

FGM is detrimental state that affects the moral youth females without having any positive health impacts. Girls and women who have undergone FGM are at great risk of suffering its consequences throughout their lives. The procedure is traumatic and painful and is often performed under unsterile equipments and is conducted in areas environmentally unfortunate by traditional practitioner who has little knowledge of female anatomy and unable to manage possible emergencies when adverse events occurs (22). Moreover, the removal of or damage to healthy genital tissue interferes with the natural function of female reproductive organs.

2.5 Consequences of female genital mutilation

2.5.1 Health consequences

Definitely, there are no any health advantages for FGM. It damages and eliminates normal healthy functional female genital tissue. The situation is exacerbated as the procedure interferes the natural and physiological functions of girls' and women's bodies. Traditional circumcisers including TBAs use a various tools to perform such as knives and razor blades. The procedure is very cruel and painful when it is carried out and anesthesia is used during operations.

An estimated 18% of all FGM is performed by health-care providers, who use anesthetic and surgical scissors (23). All forms of FGM can cause immediate pain and bleeding and are also associated with risk of infection; as the extent of the cutting, the risk of both immediate and long-term complications increases. The immediate health risks of FGM include hemorrhage (i.e. excessive bleeding), sepsis, and difficulty in passing urine, severe pain, shock, unintended labia fusion, Infections and psychological consequences, as well as death while Long term health risks of female genital mutilation include; infections (e.g. abscesses, cysts, and genital ulcers, urinary tract infections chronic pelvic infections,), chronic pain, keloids (i.e. excessive scar tissue), need for surgery, urinary and menstrual problems, painful sexual intercourse and poor quality of sexual life, reproductive tract infections, psychological consequences, such as fear of posttraumatic stress disorder, depression, anxiety, and increased risk of cervical cancer (though more research is needed), Infertility (24). Furthermore Female genital mutilation has some

obstetric complications/risks which include; extended maternal hospital stay, infant resuscitation, postpartum hemorrhage, caesarean section and also stillbirth or early neonatal death (25). Moreover there are Conditions often considered to be associated with FGM but for which evidence is equivocal or shows no link which include HIV (in the short term), obstetric fistula and incontinence.

2.5.2 Social consequences

Although, there are few accurate and rigorous studies on the social impact of FGM, some researchers have recognized the potential negative consequences for girls, women and families, of abstaining from FGM. This practice is done in response to strong social principles and supported by key social norms. In this connection, failure to accept and implement FGM may often cause aggravation, exclusion from support networks and important common events, as well as discrimination by peers. Eventually, the girl will be victimized and her dignity is degraded. Unless, there is a common compliance is developed within a larger group, families and individuals to balance and consider the social risks to be greater than the mental and physical health risks to girls of FGM and adhere to make a change. However, the legal limitations against FGM may be seen as less important than the restrictions that can be forced by the community for nonconformity with the practice (26, 27).

Chapter three: Methodology

3.1 Study design

A cross-sectional study with quantitative method was conducted among traditional birth attendants in Mogadishu from November 2017 to April 2018.

3.2 Study area

The study was conducted in Mogadishu city; it is the capital and most populous city of Somalia. Located in the coastal Banadir region on the Indian Ocean, the city has served as an important port for millennia. As of 2017, it had a population of 2,425,000 residents (28). It consists of 17 districts.

3.3 Study population

The study population was all traditional birth attendants live in Mogadishu city. They are an estimated number of 850 TBAs live in Mogadishu. This means an average or approximately 50 TBAs in each district as reported Somali Midwives Association (SOMA). This Association is attempting to record all TBAs available in Mogadishu to ensure safety deliveries and eliminate FGM.

3.4 Study variables

3.4.1 Dependent variables

Knowledge, attitude and practice of FGM

3.4.2 Independent variables

Age, Address, Educational level, Occupation and Marital status, types of FGM, reasons behind FGM, effects of FGM on female genitals and complications of FGM and also FGM continuation, FGM elimination, discrimination of uncircumcised girls,

medicalization, legislation against FGM and role TBAs, as well as household members undergone with FGM, Self circumcised, Number of years practicing and Future intension

3.5 Inclusion criteria and Exclusion criteria

3.5.1 Inclusion criteria

All traditional birth attendants living in Mogadishu city were included.

3.5.2 Exclusion criteria

Those critically ill and those started to attend universities to learn midwifery, nursing and etc was excluded from this study.

3.6 Sample size and its determination

Raosoft sample size determination was used, assuming confidence level of 95%, marginal error of 5%, population of 850 and response distribution 50% was used, therefore 265 is obtained. Non response rate of 10% was used so the total sample size was 292.

3.7 Sampling method

10 out of 17 districts of Mogadishu was randomly selected by lottery method which are Abdiiaziz, Yaqshid, Hodan, Dayniile, Dharkenley, Wadajir, Warta Nabadda, Waberi, Kaxda and Heliwa, and 292 respondents was obtained through snowball sampling and community direction such as health workers of MCHs in which TBAs may have some communication.

3.8 Data Collection Procedure and tool

Data was collected by 20 trained female local data collectors who completed bachelor degree of health science and medicine and had previous experience in data collection using face to face interviewer administered questionnaire which was developed from reviewing others studies and modified according to variables. The questionnaire used in this survey was addressed socio-demographic characteristics of respondent, knowledge related to FGM, types and side effect of FGM, attitude, practice, and intention to FGM practice as well. Questions were asked to assess knowledge of FGM and correct answer was given score 1 while the incorrect answer was given score 0.

The overall knowledge of the study participants was assessed using the sum score of each outcome of fifteen questions based on Bloom's cut-off point. The scores were classified into 3 levels as follow:

- High level knowledge: - Knowledge scores that fell 12-15 points (above 80 %)
- Moderate level knowledge: - Knowledge scores that fell 9-11 points (60%-79%)
- Low level knowledge: - Knowledge score below 9 points (0-59%)

The overall practice of the study participants was assessed using the sum score of each outcome of eight questions based on Bloom's cut-off point. The scores were classified into 3 levels as follow:

- High level of practice: - Practice score that fell 7 - 8 points (above 80%)
- Moderate level of practice: - Practice score that fell 5 - 6 points (60% - 79%).
- Low level of practice: - Practice score that fell less than 5 points (0-59%).

The overall attitude of the study participants was assessed using likert scaled questions by computing the median score of each outcome of ten questions. The scores were classified into 3 levels as follow:

- Positive attitude: - attitude scores that their median fell above (4)
- Neutral attitude: - attitude scores that fell (3)
- Negative attitude: - attitude score below (3)

Measuring an intention for this study, those have no plan to circumcise their daughter in the future were consider as "intention to stop FGM" while those planned to circumcise were labeled as "intention to continue FGM".

3.9 Quality control

Two days of training was given for data collectors and supervisor on collection technique and objective of the study, Questionnaire, sampling methods and securing informed verbal consent from the study participants at Mogadishu district by investigator. The questionnaire was translated in to the local language (Somali) and then back translated in to English.

The questionnaire was pre-tested on 10% of total sample size at some traditional birth attendants those were excluded & the necessary arrangements & corrections were made to standardize &

ensure its validity. The principal investigator supervised all field work, check for completeness and accuracy of data collection daily.

3.10 Data analysis

Quantitative data was entered, cleaned and analyzed by using SPSS version 21 package and excel. Descriptive statistics were used to summarize socio-demographic characteristics of study participants using frequency tables showing frequency counts and percentage distributions.

Knowledge and practice towards FGM were determined using Bloom's taxonomy for cut of point. While the attitude scores was calculated using median. Chi square test was used for bivariate analysis and Statistical significance will be declared at p-value less than 0.05.

3.11 Ethical consideration

Ethical approval was sought from Ministry of health and ethical board of the Benadir University, and also Informed consent forms was signed from each participant.

3.12 Dissemination plan

The result of this study was presented to Somali Swedish Research Cooperation members (SSRC) and was submitted to Benadir University, Ministry of Health and Human Services. The study outcome was shared with other interested bodies and potential stakeholders. Importantly, an attempts will made for this study to be published in both national and international journals.

4. Results

A total of 292 respondents were to be studied. Then however 291 were interviewed successfully with the response rate of 99.6%.

4.1. Socio-demographic characteristics of the respondents

4.1.1: Age of the respondents

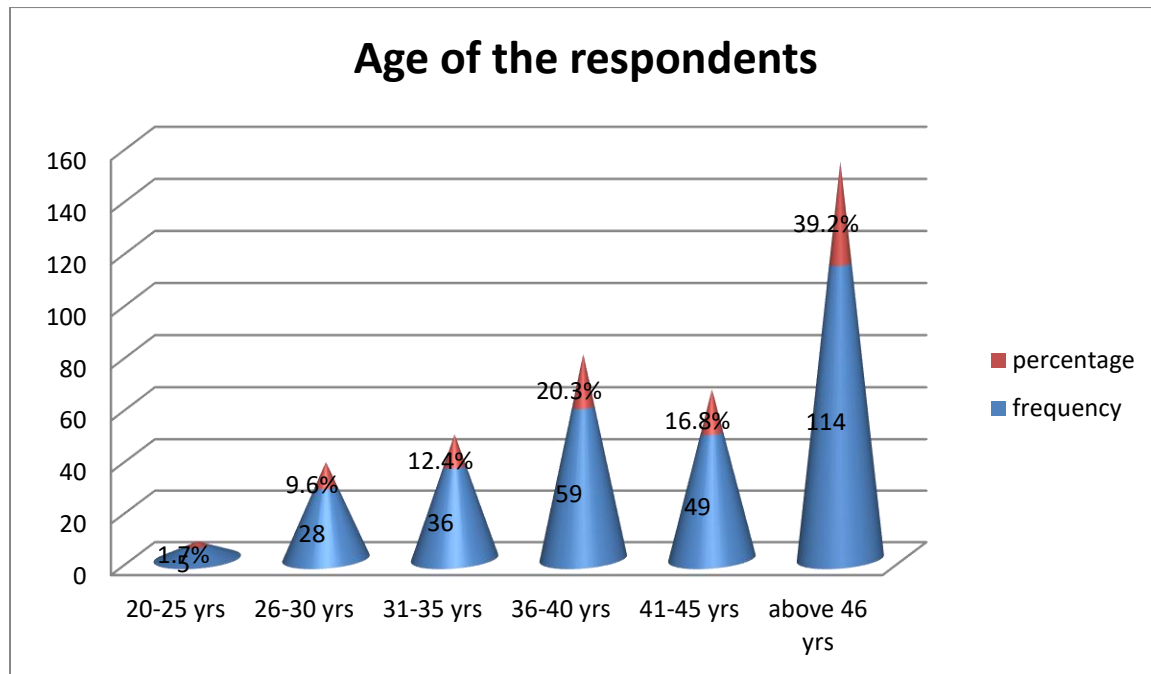
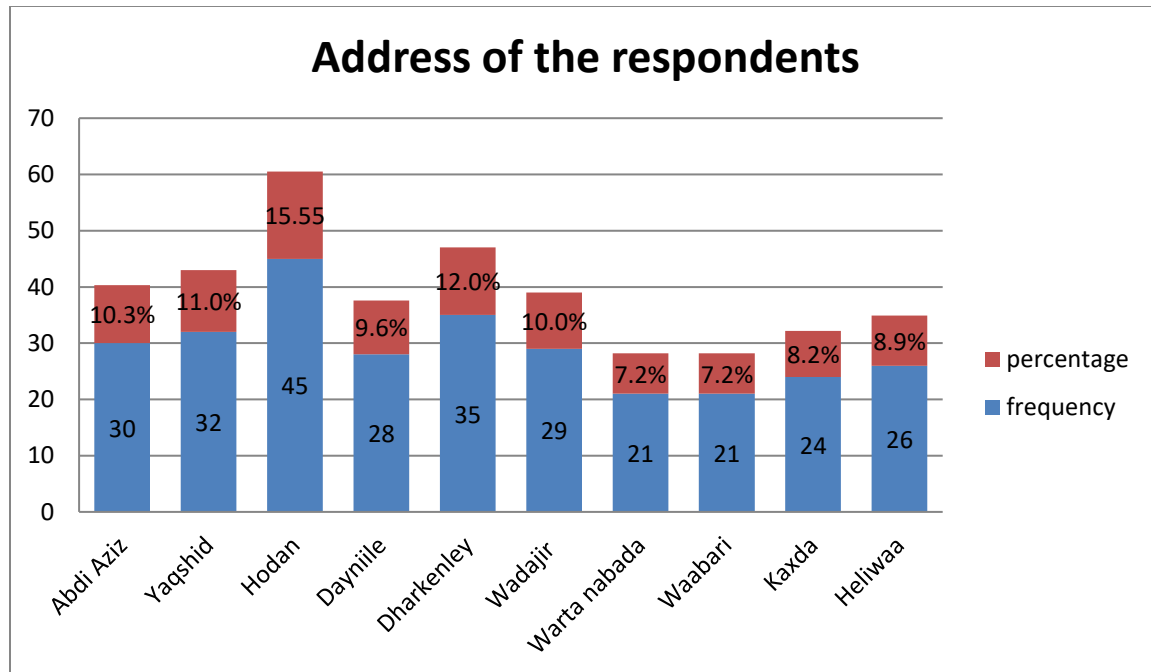


Figure 4.1 shows that majority of the respondents 114(39.2%) were aged above 46 years old, 59 (20.3%) respondents were 36-40 years old, while 49 (16.8%) were aged 41-45 years old. This indicates that majority of age range of respondents were above 46 years old, thus belonging to the old age group.

4.1.2: Address of the respondents



Most of respondents 45(15.5%) were residents in Hodan district, 35(12.0%), were living in dharkeynley districts, 30(10.3%), were living in a/aziz district: 29(10.0) were wadajir residents, 28(9.6%) were Dayniile residents, 26(8.9%) were Heliwa residents, while Warta Nabadda and Waberi were 21(7.2%) which means same number of residence and the last and least surveyed respondents were Kaxda Residence 24 (8.2%).

4.1.3: Marital status of respondents

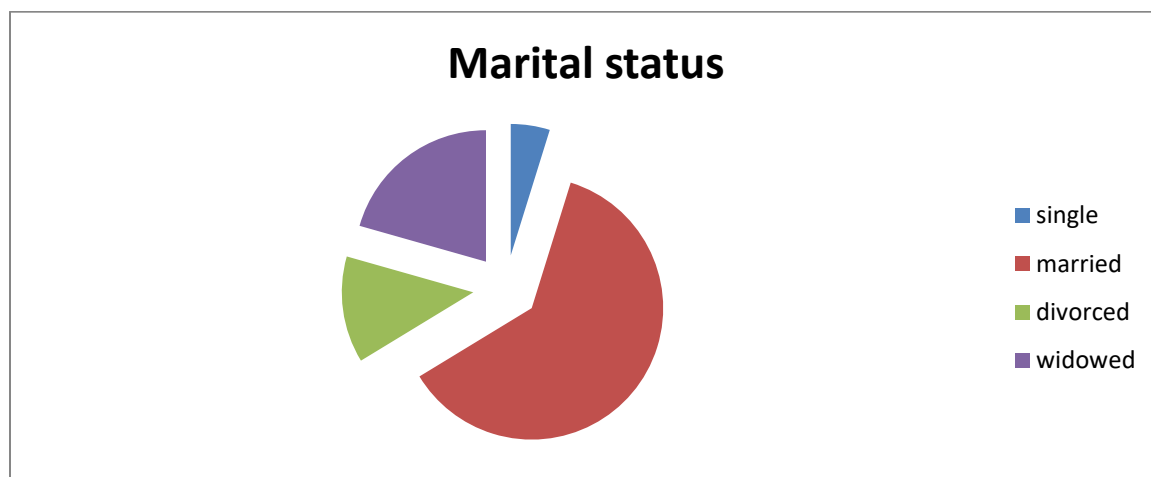


Figure 4.3: shows that 179(61.5%) were married and 60 (20.6%) were Widowed.

4.1.4: Educational level of respondents

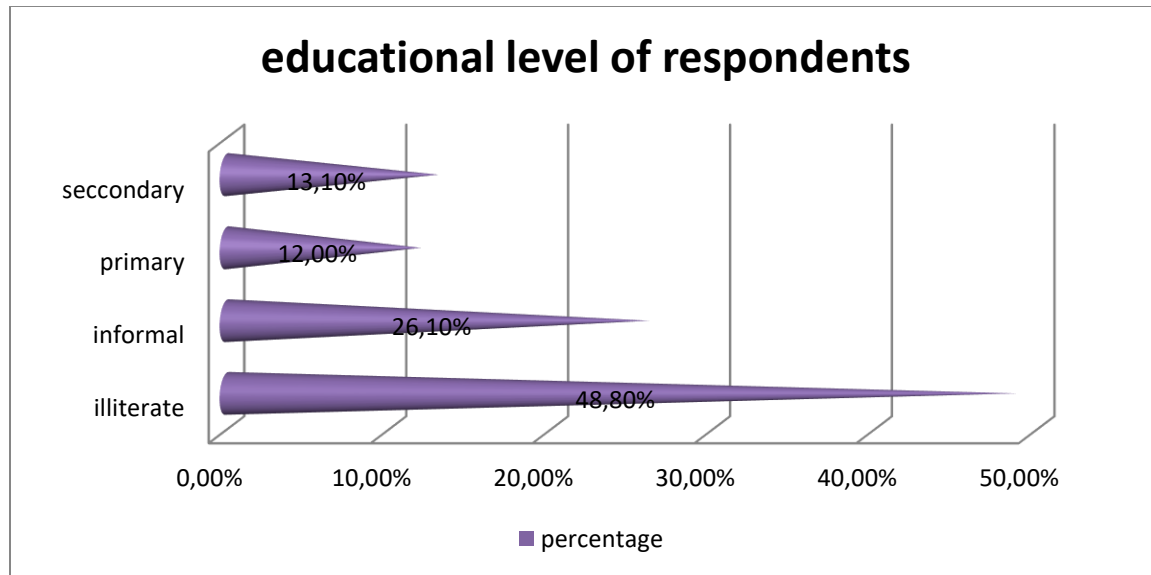


Figure 4.4 shows that almost half of respondents 142 (48.8%) were illiterate while 76(26.1%) were attended informal schools.

4.1.5: Occupational status of respondents

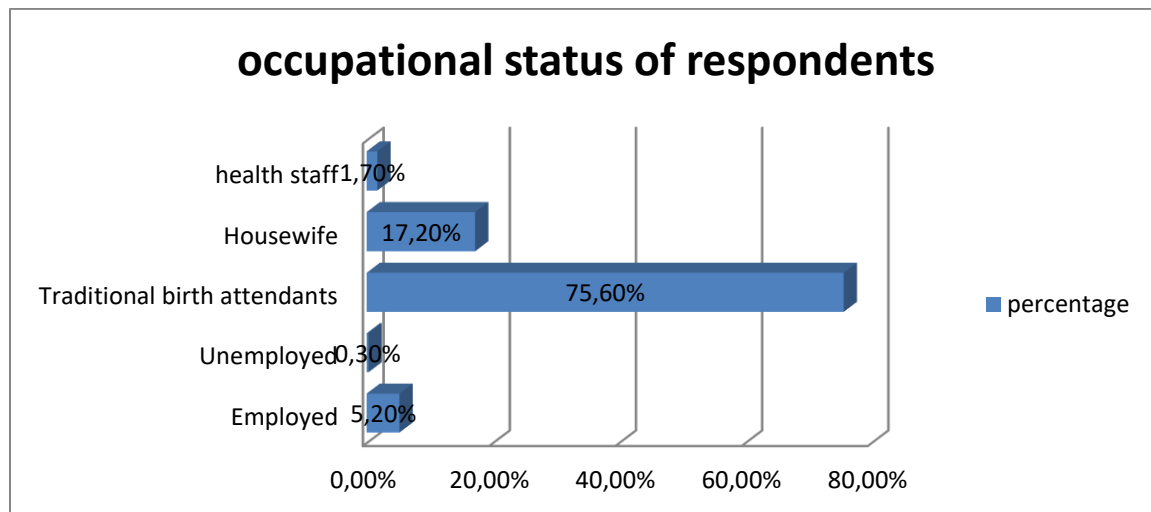


Figure 4.5: shows that more than two third of respondents 220(75.6%) were traditional birth attendants while 50(17.2%) were housewives.

4.1.2 Knowledge of TBAs towards FGM

Majority of respondents 277(95.2%) out 291 had knowledge of FGM. among theses respondents more than (164 out of 277) knew type II: excision. And More than two third of respondents mentioned the reasons behind FGM is related to religious perception. Most of respondents 282(96.9%) believe that FGM is cultural aspects. 203 out of 291 of respondents believe that FGM trim down sexual desires and helps women avoid sexual outside marriage circle sexual feelings.

Most of respondents 223 (76.6%) mentioned that FGM is rite of passage for girls into women. Majority of respondents 218(74.9%) mentioned that FGM practice helps virginity of the girls. 174 out 291 of surveyed respondents believe the FGM reduces prostitution.

Majority of respondents 209 (71.8%) believe that FGM doesn't causes Hemorrhage. 231 out of 291of respondents mentioned that FGM doesn't causes difficult labor birth. Majority of respondents 230 (79%) said that FGM can't cause tears on female genitals during labour. Most of respondents 198 (68%) believed that FGM doesn't cause infection. Most of respondents 194 (66.7%) responded that FGM can't causes HIV. Most of respondents 191(65.6%) responded that FGM victims did not complain infertility. Most of respondents 218 (75%) said that FGM doesn't cause scar and keloid formation on reproductive organs.

Table 4.2 Respondent's knowledge of FGM

Variable	Frequency (%)	Variable	Frequency (%)	Variable	Frequency (%)
		Reasons of FGM			
FGM Known		FGM reduces sexual feelings		Reason FGM is religious	
Yes	277 (95.2)	Yes	203 (69.8)	Yes	228 (78.4)
No	14 (4.8)	No	88 (30.2)	No	63 (21.6)
Types of FGM known		FGM is a rite of passage for girls into womanhood		Reason of FGM is cultural	
Clitoridectomy	44 (15.1)	Yes	223 (76.6)	Yes	282 (96.9)
Excision	164 (56.4)	No	68 (23.4)	No	9 (3.1)
Infibulations	67 (23.0)	FGM helps to maintain their virginity		FGM reduces Prostitution	

Other harmful procedures	2 (.7)	Yes	218 (74.9)	Yes	174 (59.8)
		No	73 (25.1)	No	117 (40.2)
Affects and Complications of FGM					
Hemorrhage		Difficult Labour		Genital tears	
Yes	82 (28.2)	Yes	60 (20.6)	Yes	61 (21)
No	209 (71.8)	No	231 (79.4)	No	230 (79)
Infection		HIV transmission		Infertility	
Yes	93 (32.9)	Yes	97 (33.3)	Yes	100 (34.4)
No	198 (68)	No	194 (66.7)	No	191 (65.6)
Genital scar					
Yes	73 (25)				
No	218 (75)				
Knowledge scores					
High		23 (7.9%)			
Moderate		126 (43.2%)			
Low		142 (48.7%)			

4.1.3 Attitude of TBAs towards FGM

Majority of respondents 123(42.3%) strongly disagree to stop FGM. 83 out of 291 of respondent disagree to discriminate uncircumcised girls from marriage. 117 out of 291 agree that TBAs have a role FGM continuation. 117 out of 291 respondents agree that medicalization makes FGM practice safer.

123 out of 291 respondents agree that medicalization is a way of encouraging FGM practice. 86 out of 291 respondents disagree that medicalization should be stopped. Most of respondents 116(39.9%) agree believe that FGM is good practice.

Majority of the respondents 111(38.1%) agree that they should encourage FGM practice. Whilst 79 out of 291 respondents strongly disagree that FGM should be legislated against with similar number 79(27.1%) of respondents were disagree.

Table 4.3 Respondent's attitude towards FGM

Variable	Frequency (%)	Variable	Frequency (%)	Variable	Frequency (%)
FGM Practice should be stopped		Uncircumcised girls should not be discriminated from marriage		FGM practice should be eliminated	
Strongly agree	17 (5.8)	strongly agree	49 (16.8)	strongly agree	33 (11.3)
Agree	29 (10.0)	Agree	83 (28.5)	Agree	54 (18.6)
Neutral	34 (11.7)	Neutral	48 (16.5)	Neutral	61 (21.0)
Disagree	88 (30.2)	Disagree	60 (20.6)	Disagree	70 (24.1)
Strongly disagree	123 (42.3)	Strongly disagree	51 (17.5)	strongly disagree	73 (25.1)
TBAs have a role for FGM continuation		Medicalizing FGM makes the practice safer		Medicalizing FGM is a way of encouraging FGM/C	
Strongly agree	90 (30.9)	Strongly agree	104 (35.7)	Strongly agree	84 (28.9)
Agree	117 (40.2)	Agree	117 (40.2)	Agree	123 (42.3)
Neutral	43 (14.8)	Neutral	27 (9.3)	Neutral	41 (14.1)
Disagree	29 (10.0)	Disagree	34 (11.7)	Disagree	31 (10.7)
Strongly disagree	12 (4.1)	Strongly disagree	9 (3.1)	Strongly disagree	12 (4.1)
Medicalizing FGM should be stopped		FGM is a good Practice		You should encourage FGM	
Strongly agree	37 (12.7)	Strongly agree	112 (38.5)	Strongly agree	80 (27.5)
Agree	51 (17.5)	Agree	116 (39.9)	Agree	111 (38.1)
Neutral	56 (19.2)	Neutral	27 (9.3)	Neutral	41 (14.1)
Disagree	86 (29.6)	Disagree	25 (8.6)	Disagree	39 (13.4)
Strongly disagree	61 (21.0)	Strongly disagree	11 (3.8)	Strongly disagree	20 (6.9)
FGM should be legislated against		Attitude scores			
Strongly agree	24 (8.2)				
Agree	43 (14.8)	Positive		61(21%)	
Neutral	66 (22.7)	Neutral		173(59.4%)	
Disagree	79 (27.1)	Negative		57 (19.6%)	
Strongly disagree	79 (27.1)				

4.1.4 Practice of TBAs towards FGM

Majority of respondents 283(97.3%) responded that FGM practiced in their household. Almost of respondents 287(98.6%) mentioned that they had undergone FGM.

Nearly two third of respondents mentioned that had ever performed FGM. Among these respondents 145(49.8%) mentioned that they routinely perform FGM. 85 out of 192 of respondents declared that they were practicing FGM more than 10 years. Among these respondents 98(33.7%) mostly practice type 1(clitoridectomy).

Majority of respondents 174(59.85%) mentioned that they will practice FGM in the future and more than two third of respondents 229 (78.7%) are planning to perform FGM for their daughter.

Table 4.4 Respondent's practice of FGM

Variable	Frequency (%)	Variable	Frequency (%)
Household circumcised		Self circumcised	
Yes	283 (97.3)	Yes	287 (98.6)
No	8 (2.7)	No	4 (1.4)
Routinely perform FGM		Duration of practicing FGM	
Yes	145 (49.8)	Less than 1 year	25 (8.6)
No	47 (16.2)	1-10 years	82 (28.2)
Future willing to perform FGM under certain circumstances		More than 10 years	85 (29.2)
Yes	174 (59.8)	Future intention to perform FGM	
No	117 (40.2)	Yes	229 (78.7)
		No	62 (21.3)
Type of FGM most practiced		Has ever performed FGM in the past	
Type 1	98 (33.7)	Yes	192 (66.0)
Type 2	62 (21.3)	No	99 (34.0)
Type 3	28 (9.6)		
Type 4	4 (1.4)		
FGM practice scores			
High level		218(74.9%)	
Moderate		65 (22.3%)	
Low		8 (2.7%)	

Socio-demographic characteristics associated with knowledge level

Among variables used include bi-variate analysis, respondent's age and educational level showed significant association. Traditional birth attendants who are old age and those are Illiterate have almost low level of education with p-value (0.024 and 0.02) respectively, in addition respondents attended primary or secondary has moderate level knowledge and high level knowledge with p-value (0.04 and 0.001) respectively, furthermore respondents who was single demonstrated high level knowledge with p-value (0.055) as shown (table 4.4).

Table 4.4 Association between socio-demographic characteristics and knowledge level

		Knowledge of FGM			
		High level	Moderate level	Low level	
Variable	N	n (%)	n (%)	n (%)	p-value
Age					
20-25 yrs (Ref)	5	1 (20)	2 (40)	2 (40)	
26-30 yrs	28	2 (7.1)	13(46.4)	13(46.4)	
31-35 yrs	36	4(11.1)	21(58.3)	11(30.5)	0.019
36-40 yrs	59	6(10.2)	23(39)	30(50.8)	
41-45 yrs	49	6(12.2)	22(44.9)	21(42.9)	
Above 46 yrs	114	4(3.5)	45(39.5)	65(57)	0.024
Educational level					
None/ Illiterate	142	7(4.9)	60(42.3)	75(52.8)	0.02
Informal (Ref)	76	5(6.6)	26(34.2)	45(59.2)	
Primary	35	4(11.4)	22(62.9)	9(25.7)	0.04
Secondary	38	7(18.4)	18(47.4)	13(34.2)	0.001
Marital status					
Single	14	3(21.4)	7(50)	4(28.6)	0.055
Married	179	16(8.9)	80(44.7)	83(46.3)	
Divorced	38	3(7.9)	14(36.8)	21(55.2)	
Widowed (Ref)	60	1(1.7)	25(41.7)	34(56.6)	
Occupational status					
Employed	15	0(0)	8(53.3)	7(46.7)	0.244
Unemployed	1	0(0)	0(0)	1(100)	0.381
Traditional birth attendants	220	21(9.6)	94(42.7)	105(47.7)	
Housewife	50	2(4)	22(44)	26(52)	
health staff (Ref)	5	00(0)	2(40)	3(60)	

Socio-demographic characteristics related with attitude towards FGM

Association between socio demographic characteristics and the attitude towards FGM showed that respondents aged (41-45years) and those above 46 years demonstrated positive attitude towards practice of FGM with p-value (0.01 and 0.03) respectively which means old age traditional birth attendants prefer practice of FGM. Moreover those who had no educational background (illiterate) had positive attitude to FGM with p-value (0.033), in addition those who attended secondary school showed negative attitude towards FGM. Furthermore those whose occupation was traditional birth attendants and housewives showed positive attitude towards FGM practice with p-value (0.000 and 0.02) respectively, while other variables had no significant association to the attitude as shown (table 4.5).

Table 4.5 Association between socio-demographic characteristics and attitude of FGM

		Attitude of FGM			
		Positive	Neutral	Negative	
Variable	N	n (%)	n (%)	n (%)	p-value
Age					
20-25 yrs (Ref)	5	4(80)	1(20)	0(0)	
26-30 yrs	28	20(71.4)	5(17.9)	3(10.7)	0.494
31-35 yrs	36	22(61.1)	9(25)	5(13.9)	0.260
36-40 yrs	59	39(66.1)	11(18.6)	9(15.3)	0.974
41-45 yrs	49	34(69.4)	8(16.3)	7(14.3)	.01
Above 46 yrs	114	75(65.8)	19(16.7)	20(17.5)	.03
Educational level					
None/ Illiterate	142	88(62)	26(18.3)	28(19.7)	.033
Informal (Ref)	76	56(73.7)	12(15.8)	8(10.5)	
Primary	35	22(62.9)	7(20)	6(17.1)	0.722
Secondary	38	28(73.7)	8(21)	2(5.3)	0.041
Marital status					
Single	14	9(64.3)	3(21.4)	2(14.3)	0.749
Married	179	123(68.7)	33(18.4)	23(12.9)	0.172
Divorced	38	23(60.5)	7(18.4)	8(21)	0.274
Widowed (Ref)	60	39(65)	10(16.7)	11(18.3)	
Occupational status					
Employed	15	13(8.6)	1(6.7)	1(6.7)	0.093
Unemployed	1	1(100)	0(0)	0(0)	0.672
Traditional birth attendants	220	141(64)	43(19.6)	36(16.4)	.000
Housewife	50	35(70)	9(18)	6(12)	.02
health staff (Ref)	5	4(80)	0(0)	1(20)	

Association between socio-demographic characteristics and FGM practice

Association between socio demographic characteristics and the practice of FGM showed that respondents aged (41-45years) and those above 46 years and those who had no educational background demonstrated high practice of FGM. Moreover those whose occupational status was traditional birth attendants showed high FGM practice while other variables had no significant association with practice (table 4.6)

Table 4.6 Socio-demographic characteristics related with FGM practice

		Practice of FGM			
		High level	Moderate level	Low level	
Variable	N	n (%)	n (%)	n (%)	p-value
Age					
20-25 yrs(Ref)	5	4(80)	1(20)	0(0)	
26-30 yrs	28	22(78.6)	5(17.8)	1(3.6)	0.639
31-35 yrs	36	25(69.4)	10(27.8)	1(2.8)	0.419
36-40 yrs	59	46(78)	11(18.6)	2(3.4)	0.446
41-45 yrs	49	38(77.5)	10(20.4)	1(2.0)	.05
Above 46 yrs	114	83(72.8)	28(24.6)	3(2.6)	.04
Educational level					
None/ Illiterate	142	109(76.8)	27(19.0)	6(4.2)	.001
Informal (Ref)	76	52(68.4)	22(28.9)	2(2.6)	0.133
Primary	35	26(74.3)	9(25.7)	0(0)	0.289
Secondary	38	31(81.6)	7(18.4)	0(0)	
Marital status					
Single	14	11(78.6)	3(21.4)	0(0)	0.594
Married	179	134(74.9)	42(23.5)	3(1.7)	0.157
Divorced	38	24(63.1)	12(31.6)	2(5.3)	0.073
Widowed(Ref)	60	49(81.7)	8(13.3)	3(5)	
Occupational status					
Employed	15	13(86.7)	2(13.3)	0(0)	0.390
Unemployed	1	1(100)	0(0)	0(0)	0.562
Traditional birth attendants	220	163(74.1)	50(22.7)	7(3.2)	.01
Housewife	50	37(74)	12(24)	1(2)	0.722
health staff (Ref)	5	4(80)	1(20)	0(0)	

Association between knowledge and attitude with FGM practice

Respondents who have high or moderate knowledge level demonstrated low practice of FGM and those who have moderate knowledge about FGM showed high practice of FGM with p-value (0.03 and 0.05) respectively. Moreover those who had positive attitude for FGM showed high practice with p-value (**0.000**) and those who had negative attitude that against FGM had low practice with p-value (**0.02**) (table 4.7).

Table 4.7 Association between knowledge and attitude with FGM practice

		Practice of FGM					
		High level		Moderate level		Low level	
Variable	N	n(%)	p-value	n(%)	p-value	n(%)	p-value
Knowledge level of FGM							
High level	23	16(69.6)	.759	4(17.4)	.915	3(13.1)	.03*
Moderate level	126	84(66.7)	.080	24(19.1)	.747	18(14.3)	.05*
Low level	142	94(66.2)	.000*	25(17.6)	.793	23(16.2)	
Attitude towards FGM							
Positive attitude	194	142(73.2)	.000*	49(25.3)	.091	3(1.5)	
Neutral attitude	53	42(79.2)	.074	7(13.2)	.078	4(7.5)	.018
Negative attitude	44	34(77.2)	.069	9(20.4)	.745	1(2.3)	.02*

5. Discussion

In this study, the overall KAPs about female genital mutilation among traditional birth attendants showed the majority of respondents had low level of knowledge, neutral attitude and high level of practice.

Almost of the respondents aged above 46 years old were illiterate and working as traditional birth attendants.

According to the knowledge of FGM, most of the respondents have an idea about FGM and the most common form they know is type II (excision) as they reported. Moreover more than two third of respondents mentioned the reasons behind FGM are religious, culture, reduction of sexual feelings, passage for girls into women status and also to maintain virginity of the girls.

A study done in Gambia although their populations were health care professionals yet again reasons behind FGM practice were similar to the result of this research.

According the traditional birth attendants' knowledge on complications, evidentially it is inadequate; the majority of them believe that FGM doesn't cause Hemorrhage, difficult labor birth, tears on female genitals during labour, infections, HIV, scars and keloid formation on reproductive organs. In addition most of respondents 191(65.6%) responded that FGM experienced women did not complain infertility. Complications during childbirth among women with FGM have been documented in a multicounty prospective study in six African countries, and were consistent with all of the above mentioned obstetric complications in women with FGM (29).

On the other hand, according to the attitude of traditional birth attendants towards FGM; majority of respondents strongly disagree to stop FGM and believe to marry uncircumcised girls. Moreover, most of respondents strongly disagree that FGM can ever be eliminated in Mogadishu and also believe that TBAs have a role the continuation of FGM. This indicates that TBAs still believe FGM

Furthermore, most of respondents agreed that medicalisation makes FGM practice safer and 123 out of 291 respondents agreed that medicalisation is a way of encouraging FGM practice. 86 out of 291 respondents disagreed that medicalisation should be stopped.

116(39.9%) mentioned that they agreed FGM is a good practice, 111(38.1%) agreed that they should encourage FGM practice. 79 out of 291 respondents strongly disagreed that FGM should be legislated against with similar number 79(27.1%) of respondents disagreed.

More than two third of respondents 283(97.3%) reported that their household females have undergone FGM. Almost, all respondents 287(98.6%) mentioned that they had circumcised.

According to the practice of FGM, nearly two third of surveyed TBAs mentioned that had ever practiced FGM and among these respondents 145(49.8%) mentioned that they do routinely perform FGM while 47(16.2%) of respondents responded that they did not perform FGM routinely. And also among those who perform FGM declared that they were practicing FGM more than 10 years. Majority of respondents 98(33.7%) who mostly perform circumcision responded that they mostly practice type 1. This indicated that the most FGM practitioners are TBAs which perform long time and this needs intensive interventions to change this harmful practice. Moreover, according to this study results, there is still willing to perform FGM since majority of respondents 174(59.85) mentioned that they will practice FGM and more than two third of respondents 229 (78.7%) said that their daughters will be circumcised in FGM type.

6. Conclusion and recommendation

6.0 Conclusion

Female genital mutilation (FGM) is one of the worst types of violence against little girls and women and is practice that has in reflexion to religion, tradition and culture. The overall KAPs about female genital mutilation among traditional birth attendants showed the majority of respondents had low level of knowledge, neutral attitude and high level of practice and the most common type of FGM they perform is type 1 which seems that there is a shift from the most severe form (type3) which Somali people mostly practice. And there is a willing to continue this culture in the future.

6.1 Recommendation

To eliminate FGM practice requires many integrated interventions.

1. Develop strategic plans to change the attitudes, values and norms through providing information, education and communication as well as empowerment of women.
2. To enhance the awareness of TBAs about FGM complications on girls and women lives, change their attitudes and to stop its practice through legislation against FGM.
3. Skills transfer to mitigate negative cultural norms requires awareness-raising programs by community mobilization and education in order to bring up a new generation that does not accept to continue this harmful practice.
4. To create an alternative occupation for the practitioners of FGM, such as traditional birth attendants
5. To implement interventions for the reduction of physical and psychological violence against children, in the form of harmful traditional practices

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ANNEXES 1: Consent form

Questionnaire

Informed Consent form

Read the following paragraph for the selected person.

My name is -----, I am working as data collector in a survey conducted by Benadir University. To conduct our study, I would like to ask you some questions which may take about 30 minutes. As your participation is very important to the outcome of the study, we kindly request you to give us your sincere and truthful answer. All the information that you and other respondents are going to provide us will remain confidential and you don't need to mention your name and you are also free to withdraw at any time and if you have question during interview you can ask and discuss with the interviewer.

Are you willing to participate in the interview? Yes, _____ (continue the interview if the respondent says, "Yes") No, _____ (Thank and stop here if respondent says "No")

Signature_____ Date_____

(Signature of the interviewer certifying that consent has been obtained verbally)

Instruction: - The following are interview questions in order to identify knowledge, attitude and practice of FGM. Please give your honest and truthful answer to each question from the indicated choices.

Contact Address:-

Mobile: - 252 615938152

Email: - sahramire27@gmail.com

ANNEXES 2: Questionnaire

Study on knowledge, attitude and practice of female genital mutilation among traditional birth attendants in Mogadishu

Instructions to the respondents

- ❖ Do not write your name on the questionnaires
- ❖ The research is for academic purpose and not for money
- ❖ All information will be confidential.
- ❖ Please fill in the space provided to the best of your knowledge.
- ❖ You are free to choose not to fill it

To response these questions please use a tick (✓)

Section (A): SOCIO -DEMOGRAPHIC DATA

1. Age -----
2. Address -----
3. **Marital status:**
 - a) Single ()
 - b) Married ()
 - c) Divorced ()
 - d) Widow
4. **Level of education:-**
 - a) Informal ()
 - b) Primary ()
 - c) Secondary ()
5. **Occupations:-**
 - a) Employed ()
 - b) Unemployed ()
 - c) Traditional midwife ()
 - d) House wife ()
 - e) Health staff ()

Section (B): knowledge of traditional midwives towards female genital mutilation

1. Do you know female genital cutting (circumcision)?

- a. Yes () b. No ()

2. How many forms of FGM/ do you know?

3. Do you think the reason behind FGM practice is mandatory religious practice

- a) Yes () b) No ()

4. Do you belief FGM is deeply rooted cultural practice?

- a) Yes () b) No ()

5. Do think FGM reduces sexual feelings?

- a. yes () b) No ()

6. Is FGM a rite of passage for girls into womanhood?

- a) Yes () b) No ()

7. Does it helps to maintain their virginity for their husband ()

- a. Yes () b) No ()

8. Do you belief, If girls are circumcised the rate of prostitution reduces?

- a) Yes () b) No ()

9. Does FGM cause Haemorrhage?

- a. Yes () b) No ()

10. Does FGM cause difficult labour /childbirth?

- a. Yes () b) No ()

11. Can Genital tears occur to the circumcised females during childbirth?

- a) Yes () b) No ()

12. Does Infection occur to the circumcised girls and women?

- a) Yes () b) No ()

13. Can FGM causes HIV transmission?

- a) Yes () b) No ()

14. Do female genital mutilated women complain Infertility?

- a) Yes () b) No ()

15. Does FGM causes scar and keloid formation on reproductive organs?

- a) Yes () b) No ()

Section (C): attitude of traditional midwives towards female genital mutilation

Please tick one of the numbers below that corresponds to your best answer.

1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree

No	Questions	Answer				
1	The practice of FGM/C should be stopped	1	2	3	4	5
2	Girls that have not undergone FGM/C should be discriminated at the marriage	1	2	3	4	5
3	The practice of FGM/C can ever be eliminated in The Mogadishu city	1	2	3	4	5
4	Traditional birth attendants have a role in continuing to perform FGM/C	1	2	3	4	5
5	Medicalizing FGM make the practice safer	1	2	3	4	5
6	Medicalizing FGM is a way of encouraging FGM/C	1	2	3	4	5
7	Medicalizing FGM should be stopped at all levels	1	2	3	4	5
8	FGM is a good practice	1	2	3	4	5
9	You should encourage FGM	1	2	3	4	5
10	FGM should be legislated against	1	2	3	4	5

Section (D): practice of traditional midwives towards female genital mutilation

1. Is FGM practiced your family/ household?

- a. Yes () b. No ()

2. Are you circumcised?

- a. Yes () b. No ()

3. Have you ever performed FGM in the past?

- a. Yes () b. No ()

4. If yes Q3, do you routinely perform FGM?
a. Yes () b. No ()
5. If yes Q3, How long you are practicing FGM
a. Less than One year() b. 1-10 years () c. > 10 years()
6. If yes Q3, Which type of FGM do you most practice?

7. Will you perform FGM in future when compelled/forced by certain circumstances?
a. Yes () b. No ()
8. If you have a daughter in the future, do you intend to circumcise her?
a. Yes () b. No ()

Thanks for your participation

Somali Republic
Benadir University
Postgraduate Office



جمهورية الصومال
جامعة بنادر
مكتب الدراسات العليا

School of Postgraduate Studies and Research Center

Ref No: ~~BUPST/Res/~~ 2017/01

Date: 05, Nov, 2017

Att: Dr. Sahra Mire Mohamed

Subject: Ethical Approval

Protocol Title: "Knowledge, Attitude and practice of female genital mutilation (FGM) among traditional birth attendants (TBAs) in Mogadishu- Somalia".

Dear Sahara Mire Mohamed

The Research committee of Benadir University has reviewed your application and related documents of above mentioned protocol in which you are the Principal investigator. Accordingly, the committee is hereby confirm approval of your proposal and authorize to be conducted in the manner it has been presented. Further, the committee expects to be informed about the progress of the study, any amendment occurring or revision in the protocol in the course of the study. In this connection, a copy of the final study report is to be provided to the committee as well.

The Research committee is working accordance to Benadir University guidelines and other applicable international regulation

Yours Sincerely,

Prf. Dr. Mohamed Mohamud Ali (Dr. Fuje)
Chairman Benadir University Research Committee





Somali Federal Republic
Ministry of Health & Human Services

RESEARCH & ETHICS REVIEW COMMITTEE

ETHICAL APPROVAL

This is to certify that the proposal submitted by:

Investigators: Sahra Mire Mohamed

Reference No:

MOH&HS/DGO/0795/Nov/2017

Title:

Knowledge, attitude and practice of female genital mutilation among traditional birth attendances in Mogadishu- Somalia.

To be undertaken in

Mogadishu, Somalia

For the proposed period of research

Has been approved by the Research & ethics committee at the Ministry of Health

On the 05th day of Nov 2017

Chairman



Secretary

Ministry of health, Somalia

Tell: +252612375800 Email: hashi4@hotmail.com /P.O BOX 22

