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Prevalence of Female Genital Mutilation in Northern Upper Egypt

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Abstract **Background:** The utilization of the word "mutilation" reinforces the very fact that the practice may be a serious violation of girls' and women's rights. This term also establishes a transparent distinction from male circumcision and emphasizes the gravity and harmfulness of the act. Although FGM is practiced in some communities within the belief that it's a religious requirement, research shows that FGM predates Islam and Christianity. **Aim:** the study was conducted to assess Prevalence of Female Genital Mutilation in Northern Upper Egypt. **Subject & Methods:** A descriptive cross-sectional study was used. The study population consisted of 2837 females in family health centers (FHCs) in different sitting at Beni-Suef. A Structured Interviewing Questionnaire sheet was used to collect data. **Results:** Most of the studied participants were rural residents (70.4%). Non-mutilated females constituted 28.6% of the studied females. About 81.3% and 44.5% of circumcised females are from rural and married females. There was a significant association between the illiteracy of father and mother and rural residence and the FGM by barber and dayah. **Conclusion:** The prevalence of FGM/C is still high despite the health consequences of the procedure. **Recommendations:** Design and disseminate brochures work on the health effect of female genital mutilation in health centers and hospitals.

Keywords: *prevalence, female genital mutilation, Upper Egypt*

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1. Introduction

The term female genital mutilation (FGM) is employed by World Health Organization (WHO) [1]. The utilization of the word "mutilation" reinforces the fact that the practice may be a serious violation of girls' and women's rights. This term also establishes a transparent distinction from male circumcision and emphasizes the gravity and harmfulness of the act [1-6].

Although FGM is practiced in some communities within the belief that it's a religious requirement, research shows that FGM predates Islam and Christianity. Some anthropologists trace the practice to 5th century BC Egypt, with infibulations being mentioned as Pharaonic circumcision. Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young female herders, as a custom among stone-age people in Equatorial Africa, or as an outgrowth of human sacrificial practices, or some early attempt at population control. There have been also reporting within the early 1600s of the practice in Somalia as a way of extracting higher prices for female slaves, and within the late 1700s in Egypt to stop pregnancy in women and slaves [7-11].

Female genital mutilation is taken into account as a deep-rooted inequality between boys and girls and is seen as gender discrimination against girls and women [8-12]. Female genital mutilation/cutting may be a global concern. Worldwide; the precise number of women and girls who experienced FGM/C isn't known, but UNICEF reported in 2016 that quite 200 million females had undergone FGM/C [1,13,14]. Approximately 6,000 girls are circumcised every day [15,16,17].

Female genital mutilation (FGM/C) is also prevalent in Europe, North America, New Zealand, and Australia [18]. Young girls in Western countries are at a high risk of undergoing FGM/C as their families tend to keep up their cultural beliefs in their new communes, although it's forbidden by the law [19,20,21].

In Egypt, although the prevalence of FGM/C among females aged 15- 49 declined from 97% in 1985 to 87% in 2015, the prevalence remains high despite governmental efforts. The prevalence of FGM/C among adolescent girls and women has dropped from 94% in 2008 to 88% in 2014 [22].

2. Aim of the Study

The aims of the study are to:

1. Assess Prevalence of Female Genital Mutilation in Northern Upper Egypt
2. Assess Relationship between Socio Demographic Data and Female Genital Mutilation in Northern Upper Egypt

2.1. Research Questions

1. What is the prevalence of FGM in Northern Upper Egypt?
2. Is there Relationship between Socio Demographic Data and Female Genital Mutilation in Northern Upper Egypt?

3. Subjects and Methods

3.1. Research Design

A Descriptive Cross-sectional study.

3.2. Subjects & Setting

3.2.1. Setting

The study was conducted different Settings in Beni-Suef govern as the following mention:

Salah Salem, Eastern, Taha Bosh, Beba Medical Center, Tarshoup, Bani Saleh, Al-shantour, El- Mamalik, Elnouira, and Kamen El-Arouse.

3.2.2. Sample

3.2.2.1. Sample Type

A Convenient sample was used.

3.2.2.2. Sample Size

The study population consisted of all females who were accepted to participate in the study at the time of data collection (A period of six months from the start of data collection).

3.2.3. Tools of Data Collection

A pre-designed structured questionnaire was used to collect data. Data were collected through personal interviews. The questionnaire is divided into:

a. A Structured Interviewing Questionnaire sheet which includes the following parts: age, residence, level of education, marital status, occupation and experience with mutilation, etc……
b. Question regarding if exposure to Female Genital Mutilation (FGM/C) among total participant women
c. Data regarding Female Genital Mutilation as: Age at circumcision, Who took the decision? Place at which performed, Medical examination before the procedure, Who perform it?, Types of circumcision, among the participant women.

3.3.4. Ethical & Administrative Considerations

Researchers took approval from setting directors before starting the research. An informed consent to conduct the study was taken from each studied.

3.3.5. Field Work

The researcher identified herself to the subjects and explained to them the nature of the study, and its importance. Data were gathered over six months beginning in November 2021 and ending in April 2022. Data collection took about 45 minutes for each participant to fill a questionnaire on the scheduled days: Saturday, Monday, and Wednesday from 9:00 Am until 12:00 Pm.

3.3.6. Statistical Analysis

All data were collected, tabulated and statistically analyzed using IBM SPSS 25. Data was supplied, and appropriate analysis was performed for each parameter based on the type of data obtained.

3.3.6.1. Descriptive Statistics Data

Descriptive Statistics data were expressed as:

- **Count and percentage:** Used for describing and summarizing categorical data
- **Arithmetic mean ($\bar{X}$), Standard deviation (SD):** Used for normally distributed quantitative data, these are used as measurements of central tendency and dispersion.

3.3.6.2. Analytical Statistics

- **Chi-square (χ^2):** used to see if there's a link between two category variables or to see if two or more proportions differ.

3.3.6.3. Graphical presentation:

- Data visualization was done with Bar chart graphs.

4. Results

Figure 1 showed that the most of the studied participants was were rural residents (70.4%), 57.5% were single, 96.8% were Muslims, and most of their mothers were educated (72.8%), and most of their fathers were educated (83.2%). About two-thirds of the participants were a student (65.4%).

The distribution of females aged 18-60 years according to their mutilation information is shown in Figure 2. Non-mutilated females constituted 28.6% of the studied females. Among them, 39.9% were medically examined by physicians or other mutilators to know whether they needed to be mutilated or not. The percentage of those who had been mutilated was 15.8% over 15 years. More than half of mutilation cases (51%), the mother was the person responsible for the mutilation decision. Doctors were the most common person performing the mutilation (55.6%). The procedure of FGM is usually performed at home (62.3%).

Figure 3 showed that there were significant association between rural residence, mother and father education,

marriage, and the presence of circumcision. About 81.3% and 44.5% of circumcised females are from rural and married females. While 94.4% of those not circumcised were high educated females with educated mothers and fathers (82.2% & 90.7%), respectively.

Figure 4 showed that there were significant association between the illiteracy of father and mother and rural residence and the FGM by barber and dayah. About 98.8% of FGM is done by dayah from rural area, while 94.7% and 34.1% of FGM are done by dayah with illiterate mothers and fathers.

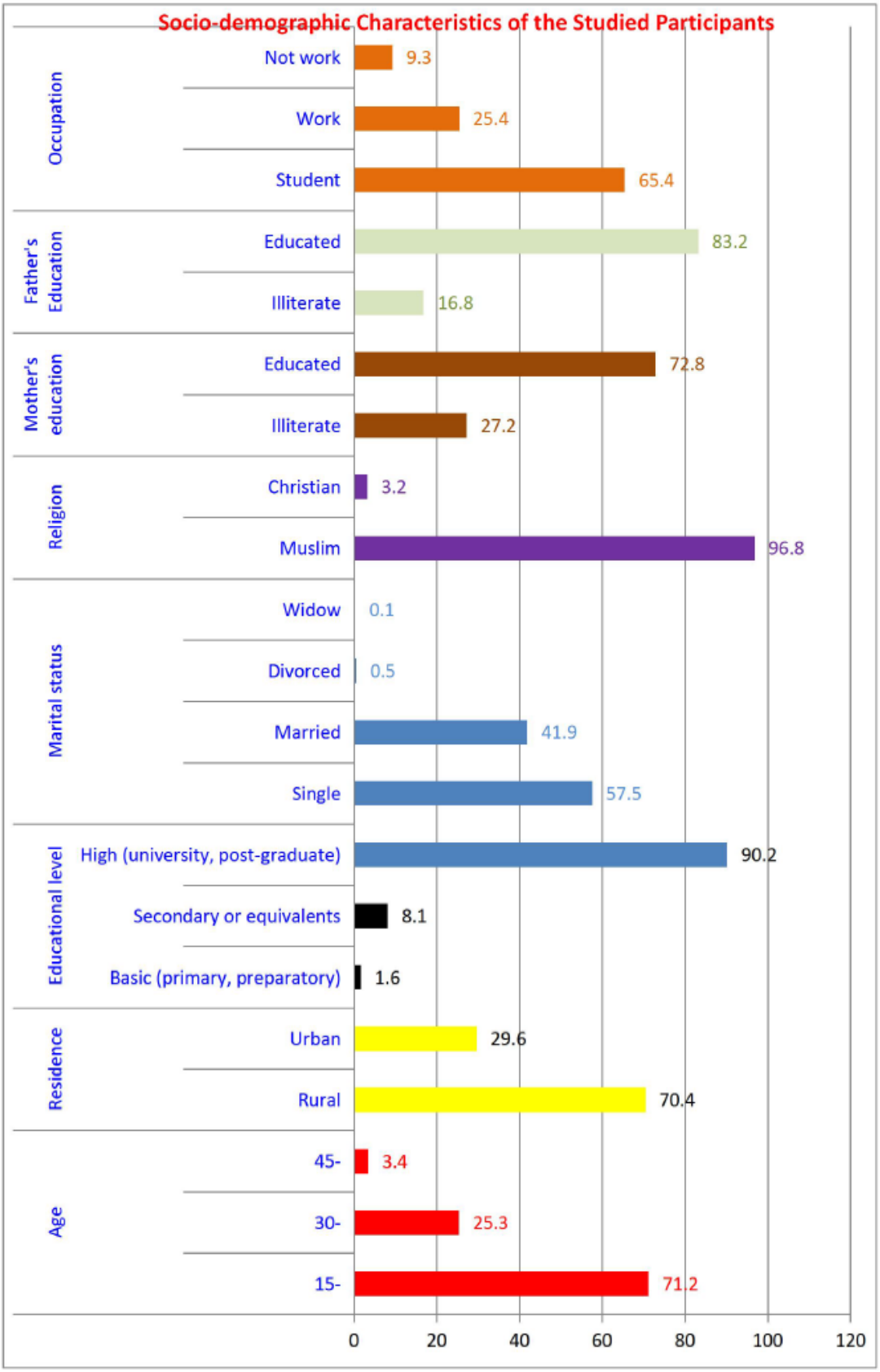


Figure 1. Socio-demographic Characteristics of the Studied Participants

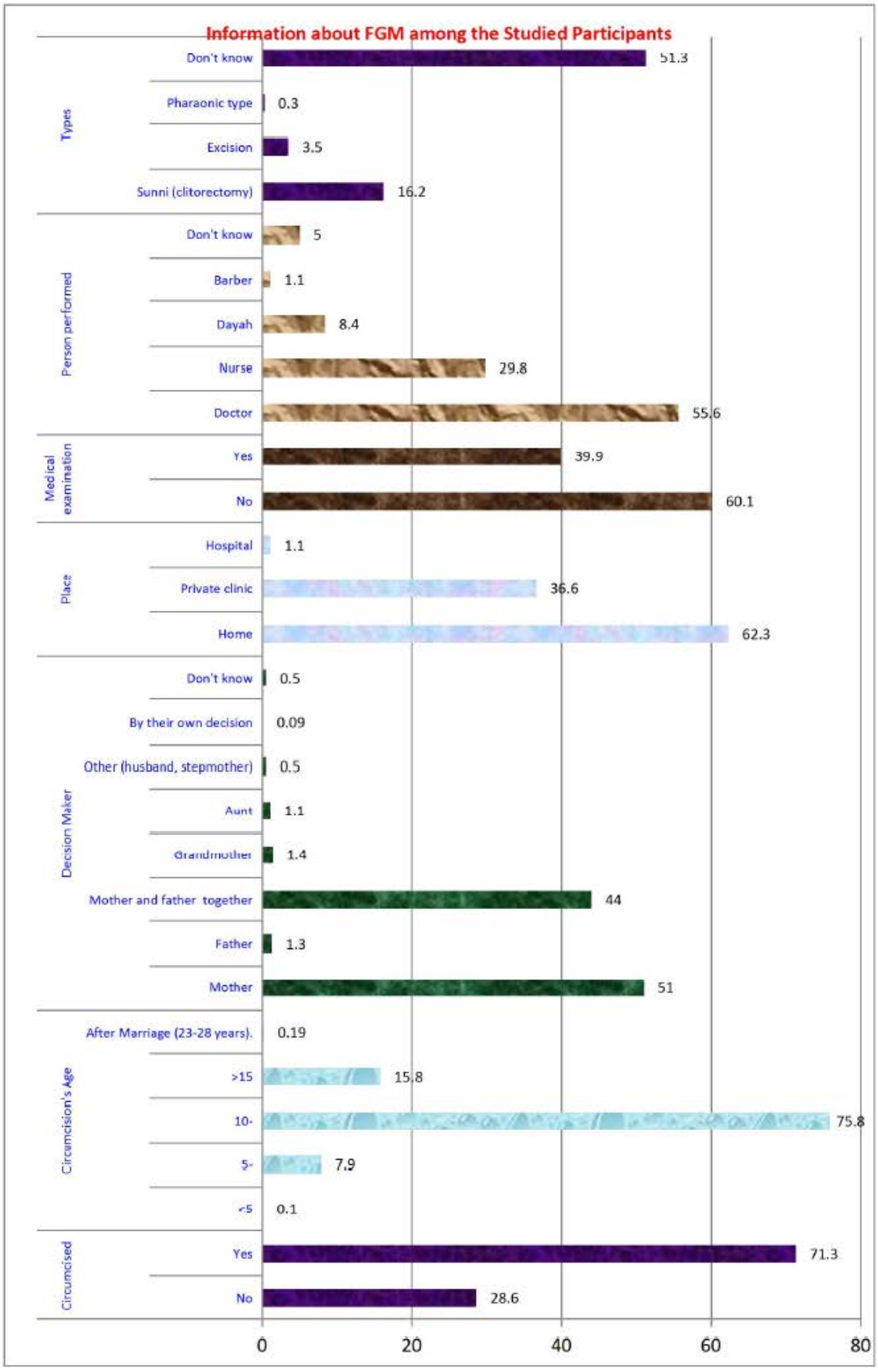
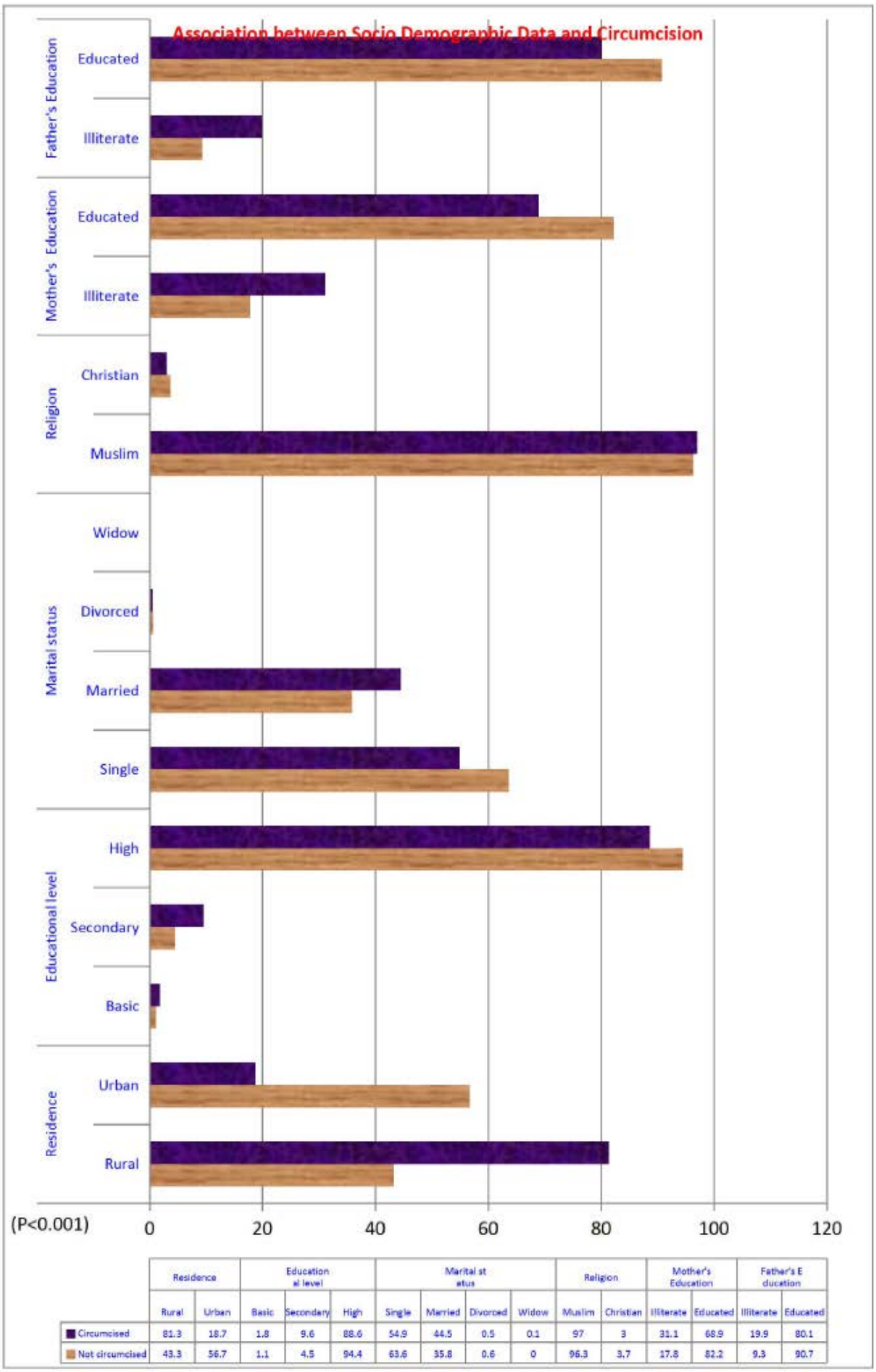
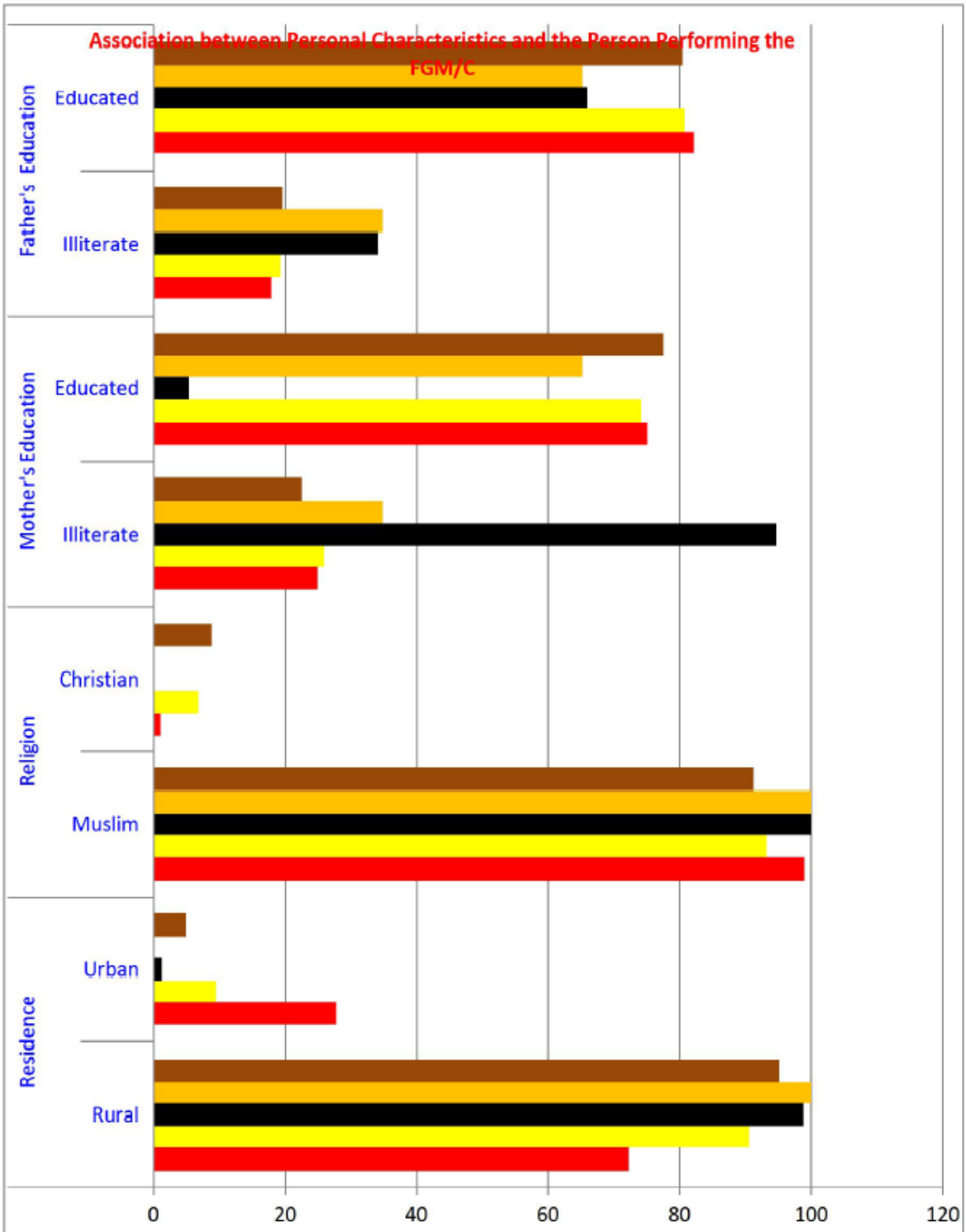


Figure 2. Information about FGM among the Studied Participants



	Residence		Educational level			Marital status				Religion		Mother's Education		Father's Education	
	Rural	Urban	Basic	Secondary	High	Single	Married	Divorced	Widow	Muslim	Christian	Illiterate	Educated	Illiterate	Educated
Circumcised	81.3	18.7	1.8	9.6	88.6	54.9	44.5	0.5	0.1	97	3	31.1	68.9	19.9	80.1
Not circumcised	43.3	56.7	1.1	4.5	94.4	63.6	35.8	0.6	0	96.3	3.7	17.8	82.2	9.3	90.7

Figure 3. Association between Socio Demographic Data and FGM among the Studied Participants



(P<0.001)

	Residence		Religion		Mother's Education		Father's Education	
	Rural	Urban	Muslim	Christian	Illiterate	Educated	Illiterate	Educated
Don't Know	95.1	4.9	91.2	8.8	22.5	77.5	19.6	80.4
Barber	100	0	100	0	34.8	65.2	34.8	65.2
Dayah	98.8	1.2	100	0	94.7	5.3	34.1	65.9
Nurse	90.5	9.5	93.2	6.8	25.9	74.1	19.3	80.7
Doctor	72.2	27.8	99	1	24.9	75.1	17.9	82.1

Figure 4. Association between Demographic & Personal Characteristics and the Person Performing the FGM/C

5. Discussion

According to the United Nations Educational, Scientific, and Cultural Organization (UNESCO), gender-based discrimination is founded on gender disparities and power imbalances between males and females, and it prevents women from fully exercising their human rights. International law guarantees the right to participate in social life as well as religious freedom. However, the ability to express one's faith or convictions may be constrained by the need to protect others' basic rights and freedoms. As a result, societal and cultural arguments cannot be used to justify FGM/C [22,23].

The results of the current study revealed that the most of the studied participants were rural residents, highly educated, Muslims, about two-thirds of the participants were a student, and most of their parents were educated. The prevalence of Female Genital Mutilation (FGM/C) among total participants was 71.4%. This result is in accordance with other researches. The prevalence of FGM/C is ranging from 61% in Lower Egypt to 97% in Upper Egypt. It is practically common in Upper Egypt, with highs of 73.9%, 75.5%, and 85.5% in Beni-Suef, Assiut, and Luxor, respectively [24]. A study conducted among Suhag University students (2015) institute that the prevalence of FGM/C among female students was 86.87% [25].

A survey of young women living in Beni-Suef City revealed that the prevalence was more than half of the studied participants were circumcised. Another research among university students in Beni-Suef found that near to half of the participants had been circumcised [23]. This may be accounted for by the variations in research settings and times. Despite the lesser incidence, a mutilation performer examined roughly more than one third of non- mutilated girls to determine whether they need mutilation. The prevalence of FGM/C would have been higher if these females had been mutilated.

On the other hand, according to a survey conducted among students at Beni-Suef University (2018), FGM/C is prevalent among female students. FGM was performed on slightly less than half of our students (47.3%). FGM/C was more common in students who lived in rural regions or had illiterate parents [23]. According to a study conducted on 860 preparatory school female students attending two public According to a study conducted on 860 preparatory school female students attending two public schools in the rural area of Beni-Suef city the prevalence of FGM was 78.8% [23]. According to research conducted among schoolgirls in El-Dakahlia Governorate in 2014, the prevalence of FGM was 53.7%. Rural areas had a frequency of 65.6%, while urban areas had a prevalence of 42.3% [26]. According to the United Nations Children's Fund (2020) about Eighty- seven percent of women and girls aged 15 to 49 years have undergone FGM; levels are high throughout most of the country [27].

The results of the current study reveals that non acceptable percentage of mutilated females did not medically examined by physicians or other mutilators to know whether they needed to be mutilated or not. This may attributed to that most of studied participants were from rural areas where traditions and customs cannot allow gynecological examination for their daughters. This may explain the high prevalence of FGM among them.

The mean age at the time of mutilation was greater in the current study compared to studies in conducted El-Mansoura Center, El-Dakahlia among school girls [26]. About three fourths of those had been mutilated between the ages of 10 and 15 years. According to the Survey of young people in Egypt (SYPE), mutilation was performed at a younger age in Upper Egypt compared to the urban governorates and Lower Egypt for females [28]. However, data demonstrates that most Egyptian females are mutilated before puberty [29].

A glans clitoris is the externally visible portion of the clitoris. Its average length is about 1–1.5 cm (0.5 inch) and it's about 0.5 cm in diameter. However, there is a lot of diversity in clitoral size between people. A shaft and glans make up this cylindrical structure (enlarged end). It shares some similarities with the penis (erectile function). The clitoral shaft comprises a pair of corpora cavernosa, spongy cylinders of tissue that fill with blood and cause the clitoris to erect somewhat during sexual stimulation [30]. The clitoral glans is partially covered by the clitoral prepuce, which is homologous to an identical structure covering the glans of the penis. The clitoris is rich in sensory receptors [31]. It is worth mentioning that some participants were mutilated after her marriage; their ages ranged between 23-28 years. This may attributed to that they found that they are not accepted from their husbands; as clitoris corresponds penis in erection that is why they decide by themselves or forced by their husbands to perform FGM after their marriage.

More than half of mutilation cases, their mother was the person responsible for the mutilation decision. This support that the decision maker in Upper Egypt almost in mother's hand especially in this issues related to daughters' circumcision. This was lower than the results of Yasin, (2014) who reported that mothers were responsible for FGM/C decisions. The procedure of FGM is usually performed by physician or nurse but it should be at home as it is not allowed to expose daughters to gynecological clinic especially before marriage [26]. This was in line with UNICEF, 2018 [18]. These are the nations with the highest frequency of medicalized FGM/C. Egypt (78%), Sudan (77%), Guinea (31%), Djibouti (21%), Kenya (20%), Iraq (14%), Yemen (13%), and Nigeria (12%) [32]. Moreover, UNICEF reported that FGM is most commonly performed by health care providers in Egypt and Sudan, with doctors doing the procedure in Egypt and midwives performing the procedure in Sudan. In Egypt alone, 1.5 million girls and women have had their hair cut by health care providers, 1.2 million of whom have had their hair trimmed by doctors [18].

Significant association between FGM and their socio-demographic characteristics (residences, education, and marital status) was found. The prevalence of FGM/C in the present study was higher in rural areas. It is similar to the results of EHIS which reported that the highest prevalence of FGM/C was in rural areas. Moreover, the prevalence of FGM/C was found to be lowest among highly educated females, most of their parents were educated. This finding was at odds with the Survey of young people in Egypt, SYPE findings, and the EHIS, which indicated that the prevalence of FGM/C reduced as

educational attainment rose. The findings of the current study agreed with those of a study carried out in Alexandria, which revealed that mutilated females were more likely to be illiterate or have limited reading and writing skills than non-mutilated females [33-39].

6. Conclusion and Recommendations

The prevalence of FGM/C is still high despite the health consequences of the procedure. There were significant association between socio-demographic characteristics and circumcision. So, research questions were answered. Based on research's results, Increase awareness about FGM/C law against all parties; whether parents seeking to perform FGM/C or health care workers or other persons participating in performing FGM/C should be recommended.

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