Article

Prevalence of female genital cutting in Upper Egypt: 6 years after enforcement of prohibition law

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Abstract

The objective of this study was to evaluate the prevalence of female genital cutting (FGC) in Upper Egypt, after 6 years of putting prohibition law into action. A total number of 3730 girls between the ages of 10–14 years were recruited to participate in this study. They were mainly preparatory school students (three urban and three rural areas). Social workers interviewed them as to whether they had undergone circumcision within the last 6 years or not. Subsequently, a questionnaire was sent to parents of girls who were positive for circumcision as to the circumstances surrounding the procedure. The prohibition law of FGC seems not to have altered the prevalence of this procedure. The majority of girls (84.9%) had had circumcision within the last 6 years with high prevalence in rural areas (92.5%). Circumcision was done for a combination of reasons, according to parents, with high rates of non-medical personnel participation (64.15%). This study's results indicate that the practice of FGC in Upper Egypt remains high despite enforcement of law. Extensive efforts are needed both to revise public awareness and to change attitudes regarding FGC.

Keywords: *female circumcision, female genital cutting, female genital mutilation*

Introduction

Egypt has recently announced that it is imposing a complete ban on female genital cutting (FGC) following a public outcry after a young girl died during the operation (BBC News, 2007). However, this is not the first time the Egyptian authorities have made this announcement. A similar ban was introduced in 1995, almost a decade ago, but the practice continued to be allowed in exceptional circumstances. However, the recent ban declared that no member of the medical profession would be allowed to perform the operation in public or private establishments (BBC news).

The practice of female genital cutting is long-standing in some communities, although the origin is lost (Cook *et al*., 2002). The practice of FGC remains prevalent in Egypt and is shared with countries of Nile Valley and part of sub-Saharan Africa (Egypt Demographic and Health Survey, 1997). Over 25 African countries in the sub-Saharan and northeastern regions share in this practice; however, the prevalence varies widely from country to country and has spread to nontraditional countries by immigration (Fathalla, 1997; Rahman and Toubia, 2000). It ranges from nearly 90% or higher in Egypt, Eritrea, Mali and Sudan to less than 50% in central Africa and Côte d'Ivoire and 5% in Congo and Uganda (Rahman and Toubia, 2000). The World Health Organization (WHO) observed in the year 2000 that 130 million girls worldwide have undergone FGC. At least 2 million girls a year are at risk

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of undergoing some form of FGC with nearly 5500 cases a day (WHO, 1996, 2000; Fathalla, 1997; Vissandjee *et al.*, 2003).

In Egypt, FGC is usually performed by traditional health providers at home. However, there is evidence of increasing medicalization of the practice by physicians in clinics and hospitals. It is usually performed before a girl reaches puberty and with one or more sisters, neighbours or female cousins undergoing the procedure at the same time (Egypt Demographic and Health Survey, 1997). Previous research in Egypt suggested that the practice persists because of a belief that circumcision will moderate female sexuality, assure a girl's purity, femininity and marriage ability, and that it is recommended by religion (Assaad, 1980).

The demographic and health survey in Egypt in 1995 found the prevalence of FGC among all married women aged 15–49 years to be 97%, and among younger women aged 15–19 years to be 98%. Furthermore, about 88% of mothers who were asked about their intentions to circumcise their daughters responded affirmatively, and there was a negative association between FGC and education and urban residence (El-Gibaly *et al.*, 2002).

From a legal perspective, FGC, even with personal consent, has long been considered a crime called 'maim' or 'mayhem' in Anglo-Saxon customary law, with only a few exceptions (*R. v. Brown*, 1993). In Egypt, if a qualified physician performed FGC, he was considered to have inflected a simple wound, and subjected to punishment under Article 242, paragraph one of Penal Code. In addition, he had to pay compensation under civil liability (Shaaban, 2002). In the year 2000, Egyptian law considered FGC as a permanent infirmity and any physician or other healthcare provider accused of performing the procedure was subjected to arrest for up to 3 years even if consent had been obtained from the parents (Rahman and Toubia, 2000). Currently, no data are available as to the effectiveness of such strict Egyptian law in reducing the practice of FGC in Egypt. The objective of this study was to evaluate the impact of the prohibition law on the practice of FGC in Upper Egypt after 6 years of putting law into action.

Materials and methods

The study was conducted at the beginning of the education year 2006/2007 by interviewing female students in preparatory schools (aged 10–14 years) as to whether they had had circumcision within the last 6 years or not. Three schools were selected from Sohag city representing urban areas and three schools from villages around the city representing rural areas. A questionnaire was sent to parents of girls who were positive for circumcision asking the following: (i) the year at which the girl was circumcised; (ii) why the procedure was done; (iii) who performed the procedure; (iv) level of education of the parents; and (v) whether the parents knew about the law that forbids FGC or not. Data were recorded with Statistics Package for Social Sciences (SPSS) 9 program (SPSS Inc., Chicago, IL, USA) for data entry and analysis. Data were recorded as mean ± SD and percentages where appropriate. Student's *t*-test compared differences in distribution of frequencies among various groups, with *P*-values of less than 0.05 being considered significant.

Results

A total of 3730 girls were interviewed. Out of them, 2007 girls (53.8%) were from urban areas, and 1723 (46.2%) were from rural areas. The mean (± SD) age of girls included in the study was 12.4(± 1.2) years. 3168 girls (84.9%) reported that they had had circumcision within the last 6 years. The mean (± SD) age of girls at the time of circumcision was 7.1 (± 1.2) years.

Prevalence of circumcision was significantly higher in female students from rural areas as compared with urban areas (92.6% versus 78.4%, $P < 0.05$). The response to the letters that were sent for the direct interviews was high among girls from urban areas 55.5% (873/1573) compared with 44.1% (703/1595) of the rural areas, with an overall response rate of 49.7%. No significant differences were found in the pattern of distribution of female circumcision over the years from 2001 to 2006 (**Table 1**).

The majority of parents (71.5%) reported that they had subjected their girls to circumcision due to a number of reasons including religious and traditional beliefs and concerns regarding attenuation of sexual desire (**Table 2**). Non-medical personnel performed most cases of female circumcision in both urban and rural areas, as shown in **Table 3**. The distribution of girls according to the level of parental education showed that the majority of cases of FGC are among those for whom both parents attended only up to preparatory school (level 1) while the lowest rates were among those girls for whom both parents were highly educated (level 3) as shown in **Table 4**. The majority of parents (81.6%) from urban areas reported that they knew about the law forbidding female circumcision compared with 55.6% of parents in rural areas.

Table 1. Distribution of female genital cutting according to the year in which circumcision was done.

Year	*Urban* (n = *873*)	*Rural* (n = *703*)	*Total* (n = *1576*)
2000/2001	173	105	278
2001/2002	146	124	270
2002/2003	153	122	275
2003/2004	147	137	284
2004/2005	152	97	249
2005/2006	102	118	220

There were no statistically significant differences between the years.

Table 2. Main reason for performing female circumcision in urban and rural areas in Upper Egypt.

Reason	*Urban* n *(%)*	*Rural* n *(%)*	*Total* n *(%)*
Total number	873	703	1576
Religion	322 (36.9)	256 (36.4)	578 (36.7)
Custom/tradition	291 (33.3)	226 (32.2)	517 (32.8)
Attenuation of sexual desire	260 (29.8)	227 (32.3)	487 (30.9)
More than one reason	608 (69.6)	519 (73.8)	1127 (71.5)

Table 3. Personnel performing female genital cutting.

	Urban n *(%)*	*Rural* n *(%)*	*Total* n *(%)*
Medical and paramedical			
Specialized doctors	67 (7.7)	47 (6.7)	114 (7.2)
Residents and GPs	137 (15.7)	185 (26.3)	322 (20.4)
Nurses	87 (10.0)	42 (6.0)	129 (8.2)
Total number	219 (33.3)	274 (39.0)	565 (35.9)
Non-medical			
Midwives and barbers	582 (66.7)	429 (61.0)	1011 (64.2)

Table 4. Distribution of circumcised girls according to the level of education of parents.

Level	*Education of one or both parents*	*Urban* n *(%)*	*Rural* n *(%)*	*Total* n *(%)*
I	Up to the end of preparatory school	591 (67.7)	567 (80.7)	1158 (73.5)
II	Less than university degree	213 (24.4)	97 (13.8)	310 (19.7)
III	University degree	69 (7.9)	39 (5.6)	108 (6.9)

Discussion

Demographic reports and health surveys indicate that FGC is widely practiced in African countries. About nine in 10 women in Egypt, Eritrea, Mali and northern Sudan have had at least some part of their external genitalia removed, while in Côte d'Ivoire and the Central African Republic the practice is less common (Demographic and Health Surveys, 1999). A report in 1995 indicated that 97% of Egyptian women who had ever been married had been subjected to FGC (Yount, 2002). Egypt has tried to solve the problem of FGC practice using different methods, including media information and the law.

The prevalence of circumcised girls in this study is 84.9%, which indicates that the practice of FGC is declining in Egypt, and this is in agreement with the earlier report by El-Gibaly *et al*. (2002). Their study showed that approximately 84.2% of girls in Egypt would be circumcised, and the figures are lower than the report in 1995 in Egypt, which reported the prevalence of FGC to be about 98.1% for women aged 15–19 years (Egypt Demographic and Health Survey, 1997). This decline is also supported by a study conducted in Minia governorate, Upper Egypt, which concluded that age-specific probabilities of genital cutting are lower among daughters than mothers, and among younger rather than older daughters (Yount, 2002). Another study was conducted in nulliparous females admitted for childbirth in Assuit, Upper Egypt in 2003 and showed that 51% had type-I cutting and 49% had type-II cutting, with 100% prevalence (Al-Hussaini, 2003). This variation may also be due to the lower reliability of self-reported forms of FGC with which there is considerable under-reporting (Elmusharaf *et al*., 2006).

The goal of abolishing FGC requires that the sociocultural dynamics of it should be well understood. In the study present here, many people (36.7%) think that FGC is performed for religious reasons. However, there is no religious basis for this practice either in the Quran or the Bible (Gruenbaum, 2001; Shell-Duncan and Hernlund, 2000). In addition, some predominantly Muslim countries, such as Senegal, have a lower prevalence rate of FGC (5%) than countries with a Christian religion base such as Côte d'Ivoire (50%) (Rahman and Toubia, 2000). Therefore, religious basis is not the only cause for FGC, and inherited customs and tradition form a sizable cause (32.8%) of FGC (Shell-Duncan and Hernlund, 2000). Also, another study has reported adherence to tradition as the most common motive for the operation (46.5%) (Al-Hussaini, 2003). Among other reasons, parents reported 30.9% of FGC was done to decrease sexual desire as a prevention of promiscuity, to be chaste and remain a virgin before marriage, and to remain faithful to her husband after marriage; in this way, it intends to serve as a means of social control of the daughters (Cook *et al*., 2002).

The education level of parents is an important factor in the practice of FGC as evident by high prevalence of FGC among daughters with parents with a low education level. This is also reported by Yount (2002), who showed that a mother's education is negatively associated with, and her circumcision status positively associated with, her intent and decision to circumcise a daughter. Overall, increasing girls' access to higher education may contribute to further declines in FGC (Shell-Duncan and Hernlund, 2000). In addition, multimedia communication programmes have been proven to be effective in changing FGC-related attitudes and promoting the intention not to perform FGC (Babalola *et al*., 2006). Some support for modernization theories, which argue that economic development leads to gradual erosion of the practice of FGC, was found. However, more community-level variation is explained by the convention hypothesis, which proposes that the prevalence of female circumcision will decline rapidly once parents see that a critical mass of other parents have stopped circumcising their daughters (Hayford, 2005).

It was reported that 35.9% of FGC was performed by medical personnel, 'specialized doctors, residents, GPs and nurses', and there was a marked increase in specialized doctors and residents performing FGC compared with previous years. The argument favouring medical involvement for FGC says that there are less injuries and a lower risk of bleeding with the use of skilled medical management of FGC rather than unskilled traditional practitioners (British Medical Association Staff, 1992). Increasing reliance on doctors to perform the procedure is positively associated with urban residence and father's education (Yount, 2002). This reflects medicalization of the procedure after putting law into action. However medical professionals should not engage in the practice of FGC. Furthermore, the majority of female circumcision in both rural and urban areas is still performed by non-medical personnel.

The elimination of FGC by enforcement of criminal laws has not had a significant impact on rates of FGC in Upper Egypt over the past 6 years. Instead, perhaps counselling and education of patients and communities by caring healthcare professionals will lead to less practice of FGC and thereby advance women's health and human rights. Involving community education, improvements in women's socioeconomic status, and traditional and religious leaders will be critical for FGC eradication. Indeed, recent reports raise the hope that a shift in public opinion and leadership is afoot: after the highly publicized and tragic death of a 12-year-old girl from an overdose of anaesthesia during circumcision, both government leaders and the religious cleric of Egypt have publicly denounced the practice and tightened the ban on FGC (Meleigy, 2007).

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