International Journal of Gynecology and Obstetrics 120 (2013) 275–278

Contents lists available at SciVerse ScienceDirect

International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo

CLINICAL ARTICLE

Impact of the complete ban on female genital cutting on the attitude of educated women from Upper Egypt toward the practice

Ibrahim M.A. Hassanin [a], Omar M. Shaaban [b,*]

[a] Department of Obstetrics and Gynecology, Faculty of Medicine, Sohag University, Sohag, Egypt
[b] Department of Obstetrics and Gynecology, Faculty of Medicine, Assiut University, Asyut, Egypt

ARTICLE INFO

Article history:
Received 27 June 2012
Received in revised form 28 September 2012
Accepted 20 November 2012

Keywords:
Egypt
Female circumcision
Female genital cutting

ABSTRACT

Objective: To compare the prevalence of female genital cutting (FGC) before and 5 years after the law completely banned the practice in Egypt, and evaluate the attitude of educated mothers of girls toward FGC in Upper Egypt. *Methods:* All women attending 2 outpatient clinics in Upper Egypt were approached from January 1 through November 30, 2011. A trained nurse interviewed those who had daughters, and factors influencing their attitude toward FGC were evaluated. The participants in a previous study done in the same locality acted a historical comparison group. *Results:* The percentage of women who had FGC performed on at least 1 daughter was significantly lower in 2011 than in 2006 (71.6% vs 77.8%, $P=0.04$). The main reason for performing FGC, given by 42.6% of the participants, was family pressure. The percentage of FGC procedures practiced by physicians was significantly lower in 2011 than it was in 2006 (34.6% vs 39.3%, $P=0.04$). *Conclusion:* The decrease in prevalence of FGC after its complete ban was small after 5 years, with little change in attitude among educated families in Upper Egypt. In addition to the current law, a change in attitude will be needed to wipe out this custom.

1. Introduction

Female genital cutting (FGC), also referred to as female genital mutilation or circumcision, is a prevalent sociocultural practice in Egypt. Usually performed in prepubertal girls, it is prevalent in most of the Nile countries, in some parts of Sub-Saharan Africa and the Middle East, and in countries of immigration [1–6]. According to the WHO, the number of women and girls who live with genital mutilation ranges from 100 to 140 million, with 92 million in Africa alone [7]. In Egypt, the overall prevalence of genitally mutilated girls is 84.2%, and it is 89.2% in rural areas of Upper Egypt [8].

The WHO defined FGC as the excision and/or wounding of parts or all of the external genital area for reasons other than medical. It also provided a classification for FGC: type I is the least extensive; type III is the most extensive; and type IV includes all other harmful procedures to the female genitalia (e.g. "pricking, piercing, incising, scraping and cauterization") [7]. It was reported that, in 30.9% of cases, FGC was done to lessen sexual desire and, thus, promote chastity before and after marriage [9]. Other studies have reported religious beliefs, although with no basis in the Quran or the Bible, as well as custom and tradition, as reasons for performing FGC [10]. A statement from Al-Azhar Supreme Council of Islamic Research, the highest religious authority in Egypt, that a belief in the necessity of FGC was not part of the core Islamic faith enabled the government to outlaw the practice.

Educational level is a major independent factor of change in attitude toward FGC [11]. Dalal et al. [12] found that, in approximately 68% of cases, FGC was performed in girls whose parents had a primary education or less and resided in an urban area.

Although FGC was made illegal in Egypt in 1997, the law was not implemented owing to opposition from society and some radical Islamic groups. In 2000, a media campaign resulted in a ban on performing FGC outside medical facilities. The campaign was triggered by the broadcast of a photograph of a 10 year old undergoing FGC at the hands of a barber in Cairo.

The prevalence of FGC was approximately 95% in 1997 and started to decline after the law began to be applied [13]. It reached 84.9% in 2002, as reported by El-Gibaly et al. [10]. However, in a 2006 study that included secondary school girls from both urban and rural areas, Hassanin et al. [14] also reported an 84.9% prevalence of FGC and concluded that the implementation of the law had not affected attitudes toward the practice. In 2007, the Ministry of Health released an amendment to the law banning FGC at all medical facilities, whether public or private, which made the ban complete. This action was probably secondary to the death of a 12-year-old girl from an overdose of anesthesia for FGC at an illegal clinic (her mother had paid a physician the equivalent of $9.00 to perform the procedure) [15,16]. In 2010, the prevalence of FGC in Upper Egypt was approximately 89%, indicating that the decrease was lagging behind expectations [8].

* Corresponding author at: Department of Obstetrics and Gynecology, Women's Health Center, Assiut University, PO Box 174 Assiut, Egypt. Tel.: +20 88 2314927; fax: +20 88 2327254.
E-mail address: omshaaban2000@yahoo.com (O.M. Shaaban).

0020-7292/$ – see front matter
http://dx.doi.org/10.1016/j.ijgo.2012.10.010

The present study assessed the prevalence for the year 2011, 5 years after the law was extended to ban FGC at all medical facilities, and compares the rate with that reported for 2006 (the baseline rate) by Hassanin et al. [14] for the same locality.

2. Materials and methods

Data collection for the present cross-sectional observational survey was carried out from January 1 through November 30, 2011, at the outpatient clinics of 2 Upper Egypt hospitals: Sohag University Hospital and Assiut University Hospital. All women attending the clinics for gynecological complaints were approached and were solicited for participation if they had 1 or more daughters aged 8–14 years. The other eligibility criteria were having completed at least preparatory education (grade 9 of primary education) and admitting to have known at the time of the procedures that the law prohibited FGC. The women who participated were all living in urban areas of Upper Egypt and their children were attending school.

A trained clinic nurse conducted a questionnaire interview in private with each potential participant and helped her understand the information sheet. Verbal consent was necessary for participation, and complete confidentiality was ensured by means of anonymous, successively numbered data collection sheets. Recruitment ceased when the study group (group 1) reached 500 participants.

The historical comparison group (group 2) consisted of 500 women who were from the same locality and of similar age and education level as the women in group 1. The women in group 2 had participated in a study carried out by Hassanin et al. [14] in 2006: that is, just before the law against FGC was extended to ban the practice even at medical facilities. The questionnaires used in the 2 studies were almost identical. The Ethical Review Board of Assiut Medical School approved the study.

In both groups, all participants were asked whether they had FGC performed on 1 or more of their daughters and, if yes, where, when, and by whom. Those who answered "yes" were then asked: (1) about the reasons that motivated them to have FGC done to their daughters; (2) about their husbands' influence regarding the decision; (3) whether they knew about the potential complications of FGC; and (4) whether they had any regrets having it done. Those who answered "no" were asked: (1) why they did not have the FGC done to their daughters; (2) how family and friends reacted to their decision; and (3) whether they had any regrets not having it done.

Data were recorded and analyzed using SPSS version 18 (IBM, Armonk, NY, USA). Findings are presented as number (percentage) and mean ± SD. The t test was used to compare differences between means, and $P<0.05$ was considered significant.

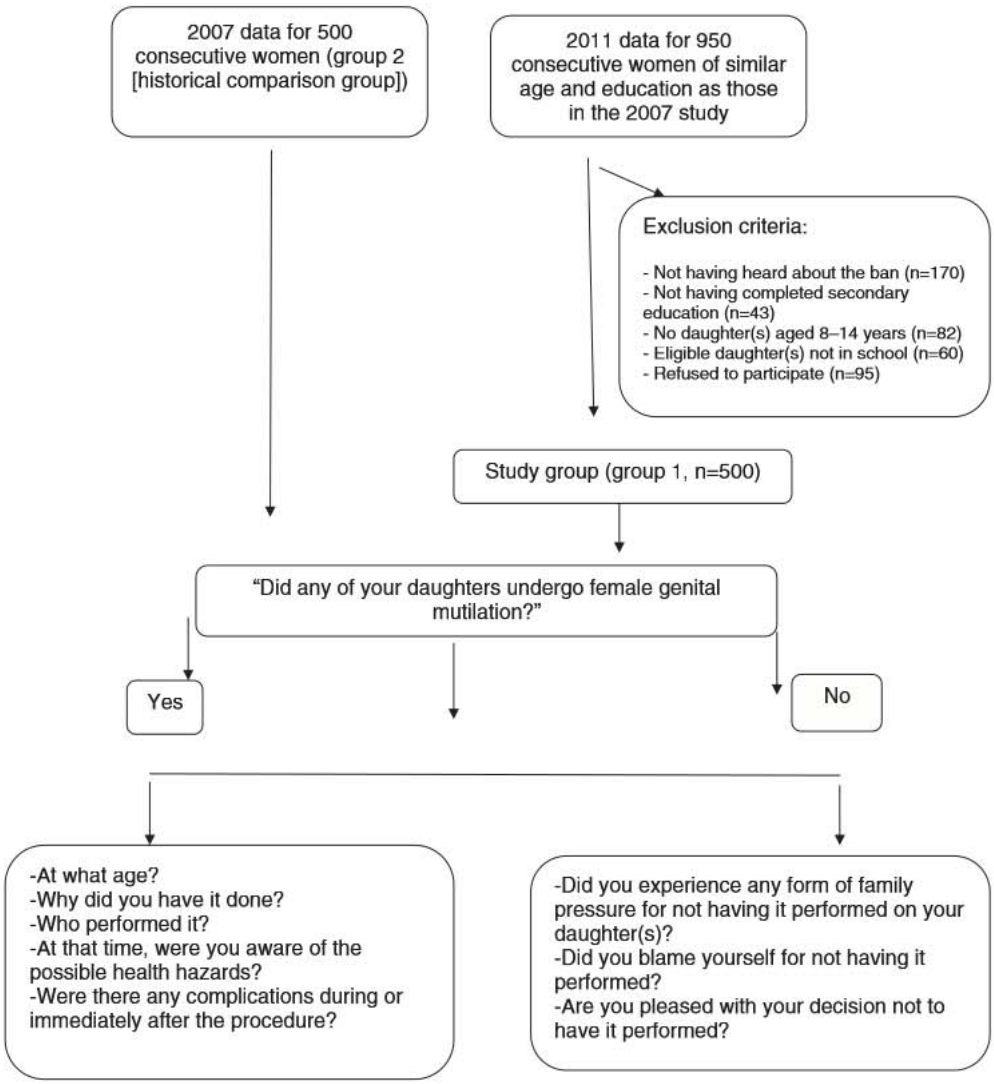

Fig. 1. Study flowchart.

Table 1
Sociodemographic characteristics of the participants in both groups.[a]

Characteristic	Group 1 (n=500)	Group 2 (n=500)	*P* value
Age, y	32.3±5.4	33.9±4.7	0.08
≤25	137 (27.4)	124 (24.8)	
26–35	291 (58.2)	283 (56.6)	0.07
≥36	72 (14.4)	93 (18.6)	
Education level			
Secondary or equivalent	387 (77.4)	399 (79.8)	0.07
University degree	113 (22.6)	101 (20.2)	0.10
No. of daughters			
1 or 2	321 (64.2)	356 (71.2)	0.04
>2	179 (35.8)	144 (28.6)	
Has at least 1 daughter with FGC	357 (71.6)	388 (77.8)	0.04

Abbreviation: FGC, female genital cutting.
[a] Values are given as mean ± SD or number (percentage) unless otherwise indicated.

3. Results

Of 950 consecutive women approached in 2011, 500 were eligible and accepted to participate (group 1). Their answers to the questionnaire were compared with those of 500 women of similar age and education level who answered an almost identical questionnaire almost 5 years earlier, just before the ban against FGC became complete (group 2) (Fig. 1).

Table 1 gives the characteristics of the participants in both groups. There was no statistically significant difference between the groups regarding education level, but the percentage of participants who had at least 1 daughter undergo FGC was significantly lower in group 1 than in group 2 (71.6% vs 77.8%, $P=0.04$).

The reasons the participants gave for having their daughters undergo FGC are shown in Table 2. The most common reason was family pressure (the rate was 42.6% in group 1, with no significant difference between the groups). The most common answer (given by 58.7% of participants in group 1), however, was having "more than 1 reason."

Table 2
Responses of the participants who had FGC performed in at least 1 daughter.[a]

Interview question	Group 1 (n=358)	Group 2 (n=389)	*P* value
Age of daughter at FGC procedure, y			
≤8	92 (25.7)	105 (26.9)	0.05
8–9	118 (32.9)	134 (34.4)	
9–10	69 (19.3)	84 (21.6)	
≥11	79 (22.1)	66 (16.9)	
Reason given for FGC[b]			
More than 1 reason	210 (58.7)	235 (60.4)	0.07
Family pressure	152 (42.6)	175 (44.9)	
Religious obligation	137 (38.3)	156 (40.1)	
To decrease daughter's sexual desire	68 (19.0)	58 (14.9)	
Who performed FGC			
Physician	124 (34.6)	68 (39.3)	0.04
Nurse	50 (13.9)	68 (17.7)	
No answer	184 (51.4)	167 (42.9)	
Knew of any possible complications at the time of FGC			
Yes	79 (22.1)	68 (17.4)	0.08
No	198 (55.3)	213 (54.7)	
No answer	81 (22.6)	108 (27.7)	
Difficulties during or after the procedure			
Problem finding a willing physician	115 (32.1)	144 (37.0)	0.09
Fear of legal prosecution	190 (53.1)	218 (56.0)	0.12
Fear of unclean instruments	79 (19.6)	27 (6.9)	0.05
More than 1 of the above	301 (84.0)	340 (87.4)	0.15

Abbreviation: FGC, female genital cutting.
[a] Values are given as number (percentage) unless otherwise indicated.
[b] The percentages add up to more than 100% because participants could give more than 1 reason.

Table 3
Feelings of participants who did not have FGC performed in any of their daughters.[a]

Feeling	Group 1 (n=142)	Group 2 (n=111)	*P* value
Experiences family pressure	33 (23.4)	30 (27.0)	0.04
Blames herself	25 (17.6)	18 (16.2)	0.12
Both of the above	57 (40.0)	45 (40.2)	0.15
Feels good about the decision	67 (47.2)	39 (35.1)	0.03
No answer	17 (12.0)	24 (21.6)	0.03

Abbreviation: FGC, female genital cutting.
[a] Values are given as number (percentage) unless otherwise indicated.

The percentage of girls in whom physicians performed FGC was significantly lower in 2011 than in 2006 (34.6% vs 39.3%, $P=0.04$).

The feelings of women regarding their decision of not having FGC performed on their daughters, as well as the feelings of family members, are reported in Table 3. The percentage of families pressured to have the procedure done was significantly lower in 2011 than in 2006 (23.4% vs 27.0%, $P=0.04$). In 2011, 17.6% of the women who had not had FGC performed on their daughters blamed themselves for it, with no significant difference with the 2006 percentage.

4. Discussion

Female genital cutting is a deeply rooted social practice within the Egyptian population, and its prevalence in Upper Egypt is among the highest worldwide [1,2]. The present study was carried out in 2011 to assess the effect, among educated families in Upper Egypt, of a 2007 law completely banning the performance FGC. Its findings demonstrate that, after 5 years, the law had not succeeded in adequately decreasing (let alone eradicating) the prevalence of FGC even in this socioeconomic group.

A study by Rasheed et al. [8] in 2007 reported an 89.2% FGC prevalence among young girls. Conducted in the same setting, the present study found a statistically significant 5-year decrease in prevalence among the daughters of educated women, from 77.8% to 71.6%. However, the lower prevalence is probably more attributable to the higher education level of the 2011 participants, who all had at least a secondary education and whose daughters were all attending school, than to an overall change in attitude toward FGC. It is likely that the prevalence was higher among uneducated families living in the same area. Regardless, the 5-year decrease reported in the present study is not proportionate to the work accomplished in the community by both governmental and nongovernmental organizations, and did not meet expectations.

In the closed and highly religious communities of Upper Egypt, and in many other parts of Egypt, a girl losing her chastity before marriage brings shame to her family. Consequently, families do all they can to prevent such scenarios, and a chief concern among mothers is to diminish sexual desire in their daughters [12,17]. This explains why girls can be pushed into very early marriage, sometimes before puberty, as reported for Upper Egypt [8,14,18]. In the present study, family pressure (42.6%), religious obligations (38.3%), and the preservation of their daughters' chastity (19.0%) were the reasons the participants cited the most for their decision to have FGC performed on their daughters. Regarding religion, the highest Egyptian Islamic and Coptic authorities both announced that the practice of FGC was not grounded in religious texts. However, approximately 40% of the participants still thought that this practice was a religious duty, or at least that it helped their daughters maintain the religious obligation of preserving their chastity before marriage. This attitude may reflect a lack of communication and education in these communities. Five years after a law completely banned FGC, there were no significant differences in the reasons given by educated women for having their daughters undergo the procedure—a clear demonstration that the law alone is not sufficient to reduce the problem of FGC.

Educating women could be a solution if it were combined with empowerment. The education level of women has increased in Upper Egypt in the past decade but it has not affected the prevalence of FGC among girls. A 2009 study was conducted in Egypt by Afifi et al. [19] to study the intention of married women to pursue the FGC tradition among their daughters. The authors compared groups of poorly educated, disempowered women with groups of educated women who were empowered within their communities and/or families, and concluded that the women who were the most empowered culturally were 8.06 times more likely not to consider FGC for their daughters.

Banning FGC at all health facilities without a concomitant education program may have merely resulted in a change in the venues at which it is performed and, therefore, the ways in which it is performed. The present study showed a significant reduction in the percentage of procedures performed by physicians, from 39.3% in 2006 to 34.9% in 2011. This reduction may indicate a shift toward hiring paramedical and nonmedical personnel, such as barbers and traditional birth attendants, with all that the shift may carry in terms of FGC complications. Approximately half of the participants refused to reveal who performed the procedure.

Specific campaigns should be urgently started to educate families about the health hazards of FGC. Door-to-door programs, with in-depth interviews that would include religious leaders and health educators, are much needed to convince families to change their attitude, and television programs would also be of assistance. Rather than be forced to forgo FGC for their daughters, families should be helped to the point that they choose to let go of this custom.

In conclusion, the decrease in FGC prevalence was slim in Upper Egypt 5 years after its complete prohibition by law, as there was little change even among educated families. In addition to the law, a change in attitude is needed to eradicate the practice.

Conflict of interest

The authors have no conflicts of interest.

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