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Abusing female children by circumcision is continued in Egypt

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SUMMARY

Female circumcision is a frank picture of female child abuse that is practised widely in many countries especially in Africa. This procedure is considered a fundamental violation of human rights. The procedure is expected to be declining in Egypt in response to the recent medicolegal litigation in 2007. The aim of this study is to record the prevalence of female circumcision in 2010, in the region of Cairo and Giza, seeking to show if there is difference in the practice after the change in the law and banning of the procedure. A formatted questionnaire for 244 female volunteers was conducted. Statistical analysis revealed that 63.9% of the sample had been victimised by circumcision. The mean age of circumcision was 10.846 ± 1.98 years. Circumcision took place at victim's home in 56.5%, private clinics in 38.5% or at hospitals in 5%. The procedure was performed by medical personnel in the majority of cases. The motivation behind the practice was primarily traditional beliefs (64.1%) followed by religious considerations (35.9%). Experienced complications were emotional trauma in 94.9%, haemorrhage in 33.3% and dysuria in 7.7%. Sexual problems were exclusively reported by the victimised subjects in 72.7% of sexually experienced subjects.

1. Introduction

Female circumcision is the partial or total removal of the female external genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons.[1]

The practice is often referred to as female circumcision /genital mutilation/cutting (FGM/C). Practitioners commonly prefer the term 'female circumcision' (FC), yet many people object to the use of this term which, they argue, suggests that the practice is analogous to male circumcision. 'Female genital mutilation', is the term adopted in the mid-1990s by the World Health Organisation (WHO), which emphasises the permanent physical damage done to the female genitalia. 'Female genital cutting' is a term chosen for its neutrality. However, all terms are currently still actively used.[2]

Female circumcision is traditionally practised in more than 28 African countries, plus some countries in the Middle East and Asia. As for the entire Islamic world, the WHO reports state that there are almost no cases of women undergoing the practice in Saudi Arabia, Iraq or Iran, though African immigrants to the gulf may or may not practice the procedure.[3] However, Amnesty International in 2010 has been documented FGM/c in a few countries in the Middle East (e.g., Yemen, Kurdish communities and Saudi Arabia), Asia and among certain ethnic groups in Central and South America.[4]

The WHO estimates that between 100 million and 140 million girls and women alive today have experienced some form of the practice.[3] It is further estimated that up to 3 million girls in sub-Saharan Africa, Egypt and Sudan are at risk of genital mutilation annually.[5]

It is a deeply rooted popular practice throughout Egypt, directly coined to certain cultural relativism that ranges from habitual customs to religious beliefs.[6] Yet, the traditional cultural practice of FGM predates both Islam and Christianity. A Greek papyrus from 163 B.C. mentions girls in Egypt undergoing circumcision and it is widely accepted to have originated in Egypt and the Nile valley at the time of the Pharaohs. Evidence from mummies has shown the presence of FGM. [7]

It is traditionally fuelled with certain consideration, that are not evidence based, such as ensuring the chastity of the woman, better marriage prospects, healthier menarche, hygiene and cosmetic appearance, fertility of the women and better sexual performance.[8]

Female circumcision is not recommended in any religion. In Egypt, both Christian and Muslim families have chosen to have their adolescent daughters circumcised throughout the history.[9] In 1995, a survey conducted by the WHO in Egypt revealed that the percentage of circumcised females is 97% in Muslims and 87.8% in Christians.[10]

Female circumcision is a fundamental violation of human rights. Among those rights violated is the right to the highest attainable

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standard of health and to bodily integrity, besides the fact that girls (under 18) cannot be said to give informed consent to such a harmful practice to their minds and bodies.[1] The girls are deceived, assaulted, chased and violently immobilised to be forced to have their genitals mutilated. Others are misinformed, and misled to the imminent danger of physical violation and genital mutilation. Their 'consent' was not 'informed' in any legal sense.[9]

In the absence of any perceived medical necessity, circumcision subjects the girls to health risks and life-threatening consequences. These consequences vary according to the type and severity of the procedure performed. The most common procedure done in Egypt, accounting for up to 80% of all cases, is clitoridictomy. The most extreme form of FGM/C practised in areas of southern Egypt closer to Sudan is infibulation. It constitutes about 15% of all procedures.[8]

Reported physical health problems may occur immediately in the form of severe pain, shock, haemorrhage, dysuria and urine retention. Late complications include cysts, abscesses, keloid formation and damage to the urethra that may result in urinary incontinence. Genital mutilation may leave a lasting mark on the life and mind of the woman who has undergone it. In the longer term, women may suffer feelings of incompleteness, anxiety and depression.[11]

Sexual problems are commonly encountered in the form of dyspareunia, frigidity, sexual dysfunction and inorgasmia during sexual connection.[12] Also, reproductive sequelae may occur as infertility, difficulties with childbirth – due to excessive scarring and tissue inelasticity – in the form of obstructed labour, tight introitus, increased incidence of episiotomy and caesarean section and vulnerability to perineal tears and vesico-vaginal fistula. In the post-partum period there may be increased incidence of haemorrhage, asphyxia neonatorum or infant mortality.[13]

Considered to be a sensitive issue, it has been widely viewed as a private act that is carried out by individuals and family members rather than state actors. Governments have sometimes been reluctant to address female circumcision. However, the health and psychological consequences of the practice itself, as well as the underlying causes that reinforce it, make it imperative for societies, governments and the entire international community to take actions towards ending this practice.[1]

The Egyptian Health Ministry issued a decree on 28 June 2007, which officially banned female circumcision. A similar order was already in place to prevent hospitals and medical doctors from carrying out the procedure; yet, it is still widely performed in the community.[14]

The new law stipulates a fine of 1000 Egyptian pounds ($185) to 5000 Egyptian pounds ($900) and a prison term of 3 months up to 2 years if the person is caught performing FGM. The first doctor in Egypt, who was being charged under the new Egyptian law that forbids the controversial practice of FGM, was in El Minya Governorate in 2009.[15]

2. Aim

The objective of this study is to record the prevalence of female circumcision in 2010, in the region of Cairo and Giza, seeking to show if there is difference in the practice after the change in the law and banning of the procedure.

3. Subjects and methods

The survey was conducted in Cairo, Giza and their suburbs. The total number of the participants was 244 female volunteers. The sample was randomly chosen between the ages of 5 and 30 years. They were classified into three groups according to age

G (1): ≤10 years;
G (2): >10–20 years; and
G(3): >20–30 years.

A structured questionnaire developed by the authors was used to obtain information in the following areas: personal data (age, residence, religion, education and marital status) and circumstances of circumcision if happened (motivation, place, operator and effects upon physical and psychosexual functioning). The data were collected during a single interview with each female participant after taking her consent.

The data collected were coded and edited with no references to the identity of the participants. The included candidates were further classified into victimised and non-victimised groups according to the exposure to circumcision. Sexual dysfunctioning problems were traced as consequences of the practice in sexually experienced candidates only.

Statistical analysis was done using the SPSS version 17. Numeric values were expressed as mean ± SD and categorical values were expressed as percentages. The 'Student's *t*-test' was used to compare the ages of the subjects in any two given groups. The 'chi squared test' was used to compare percentages of categorical variables. *P* value of 0.05 was considered to be statistically significant.

4. Results

The majority of the members of the study live in Giza (73.8%) and the rest live in Cairo (26.2%). According to age, G1 included 4.9%, G2 included 32.8% and G3 included 62.3%. Educated members represented 65.6% while non-educated ones represented 34.4%. All of them were found to be Muslims. A percentage of 45.9 of the candidates were unmarried, while 49.2% were married and 4.9% were divorced. A sector of 63.9% of the total sample was victimised by circumcision. The previous data are detailed in Table 1.

There were no significant differences between circumcised and non-circumcised candidates regarding residence, age, education and marital status as detailed in Table 2. The mean age of circumcision was (10.846 ± 1.98) years and ranged between 8 and 15 years as shown in Table 3.

Table 4 shows that the event of circumcision took place at the home of the victim in 56.5%, in private clinics in 38.5% or at hospitals in 5%. The procedure was performed by a doctor in 53.8%, a housewife in 33.3%, a nurse in 10.3% and other personnel in 2.6%. The motivation for doing the practice was primarily traditional beliefs (64.1%) followed by religious considerations (35.9%).

Table 5 shows that there was a highly significant relation between residence of the victim and the place and the operator of circumcision, while the motivation for the practice differed significantly with residence.

Table 1
Characteristics of the total sample.

Variable		No.	%
Residence	Cairo	64	26.2
	Giza	180	73.8
Religion	Muslim	244	100.0
	Christians	0	0
Age	G1 (<10)	12	4.9
	G2 (10–20)	80	32.8
	G3 (>20)	152	62.3
Education	Educated	160	65.6
	Non	84	34.4
Marital status	Single	112	45.9
	Married	120	49.2
	Divorced	12	4.9
Circumcision	Circumcised	156	63.9
	Non-circumcised	88	36.1
Total		244	100

Table 2
Characteristics of the circumcised versus non-circumcised candidates.

Variable		Circumcised		Non-circumcised		*P* value
		No.	%	No.	%	
Residence	Cairo	40	62.5	24	37.5	0.781
	Giza	116	64.4	46	35.6	
Age	G1 (<10)	4	33.3	8	66.7	0.004
	G2 (10–20)	44	55	36	45	
	G3 (>20)	108	71.1	44	28.9	
Education	Educated	96	60	64	40	0.077
	Non	60	71.4	24	28.6	
Marital status	Single	68	60.7	44	39.3	0.628
	Married	80	66.7	40	33.3	
	Divorced	8	66.7	4	33.3	
Total		156	63.9	88	36.1	

Table 6 shows that the place and the motivation of circumcision did not differ significantly with the victim being educated or not, yet there was a highly significant difference between the victim's education and the operator.

There was a highly significant difference between the three described age groups and the place together with the operator of circumcision, while there was no significant difference regarding the motivation as shown in Table 7.

Many types of complications were experienced by the victims following the event as emotional trauma in 94.9%, haemorrhage in 33.3% and dysuria in 7.7%. These are shown in Table 8.

Sexual experience was assessed in sexually experienced group (married and divorced) and showed a highly significant relation with respect to circumcision as. Table 9 shows that sexual problems were exclusively reported by the victimised subjects in 72.7%.

5. Discussion

Estimates of FGC obtained from the past Demographic Health Surveys (DHS) in 1995, 2000, 2003 and 2005 were 97%, 97%, 97% and 96%, respectively. These are virtually constant, indicating the possibility of no change over the past decade.[1]

The current results revealed that about 64% of the total sample was victimised by circumcision. Thus, we may assume that the current legalisation might have a positive effect upon retraction of the catastrophe of female circumcision. This is affirmed by the recent 2008 Demographic Health Survey in Egypt (EDHS) which reported that the FGM/C prevalence rate among women aged 15–49 is 91.1%, but 74% among girls aged 15–17 (UNFPA, 2008).[16]

There is no significant difference between the three age groups regarding the incidence of circumcision, indicating that there is no generational trend towards ending the practice as if it is a matter of 'self-mutilation' passing from our mothers to our sisters and daughters. Lower FGC prevalence levels in the first age group (≤10 years) may be misleading as the candidates may be subjected to the issue later on especially that the mean age of circumcision is above 10 years and the range is between 8 and 15 years as reported in our results. On the contrary, the United Nations Children's Fund (UNICEF) report in 2005 stated that Egyptian girls undergo FGM/C between 7 and 11 years and hence at least one generation is needed for any decline to be detected.

There were no significant differences between circumcised and non-circumcised candidates regarding residence or education. However, these results could be misleading taking into consideration that the study was conducted in the area of Cairo and Giza where the incidence of urbanisation and education is much higher and incomparable with that in the total Egyptian population.

Because almost all girls in Egypt undergo FGM/C, few differences in prevalence rates can be observed at the regional or educational levels. For example, 95% of women living in urban areas have undergone genital mutilation/cutting, compared to 99% of women living in rural areas.[17]

In general, considerations establishing a relationship between a woman's FGM/C status and her educational level can often be misleading, as FGM/C usually takes place before education is completed and may be before it commences. However, FGM/C prevalence levels are generally lower among women with higher education, indicating that circumcised girls are also likely to grow up with lower levels of education attainment.[1]

An analysis of the identity of the practitioner provides important insights into the context and circumstances surrounding the practice. The current study revealed that the procedure was performed by a doctor in 53.8%, a housewife in 33.3 %, a nurse in 10.3% and other personnel in 2.6%.

When comparing the results with data from statistical analysis in Cairo (1985), we notice that the identity of the persons who do the cutting changes by time, as the primary person who inflicts the cutting was the midwife (Daya) in 60.9%, followed by physicians in 22.9% and then barbers in 16.2%.[9]

Table 3
Age of the circumcision in the victimised candidates.

Variable		Range of circumcision age (years)	Mean ± SD
Residance	Cairo	9–15	11.50 ± 2.136
	Giza	8–15	10.62 ± 1.89
Education	Educated	9–15	11.54 ± 1.76
	Non-educated	8–15	9.73 ± 1.82
Age groups	G1	8	8
	G2	8–15	10.909 ± 2.3
	G3	8–15	10.925 ± 1.8
Total		8–15	10.846 ± 1.98

Table 4
Circumstances of circumcision in the victimised candidates.

Variable		No.	%
Place of circumcision	Home	88	56.5
	Clinic	60	38.5
	Hospital	8	5
Operator	House wife	52	33.3
	Nurse	16	10.3
	Doctor	84	53.8
	Others	4	2.6
Motivation	Religion	56	35.9
	Tradition	100	64.1
Total		156	100

Table 5
Circumstances of circumcision with respect to residence.

Variable		Cairo	Giza	Total	*P* value
Place of circumcision	Home	16	72	88	0.003**
	Clinic	24	36	60	
	Hospital	0	8	8	
	Total	40	116	156	
Operator	House wife	4	48	52	0.000**
	Nurse	4	12	16	
	Doctor	28	56	84	
	Others	4	0	4	
	Total	40	116	156	
Motivation	Religion	20	36	56	0.031*
	Tradition	20	80	100	
	Total	40	116	156	

*$P < 0.05$ is significant.
**$P < 0.005$ is highly significant.

Table 6
Circumstances of circumcision with respect to education.

Variable		Educated	Non-educated	Total	*P* value
Place of circumcision	Home	52	36	88	0.071
	Clinic	36	24	60	
	Hospital	8	0	8	
	Total	96	60	156	
Operator	House wife	20	32	52	0.000**
	Nurse	12	4	16	
	Doctor	60	24	84	
	Others	4	0	4	
	Total	96	60	156	
Motivation	Religion	32	24	56	0.398
	Tradition	64	36	100	
	Total	96	60	156	

**$P < 0.005$ is highly significant.

The involvement of medical professionals in the practice, in fact, undermines the targeted message that FGM/C remains a discriminatory act of violence that denies women and girls their right to the standard of health and physical integrity.[18] It must be emphasised that physicians who perform these procedures are violating their medical oath and ethics that prohibit unnecessary medical practices.[9]

The event of circumcision took place at the home of the victim in 56.5%, in private clinics in 38.5% or at hospitals in 5%. Retraction of the practice in hospitals rather than clinics may be referred to the legal banning of the issue conducted in 2007.

Badawi (1989)[9] stated that the home of the girl is the primary place for genital mutilations where 79.3% of genital mutilations occur, 13.5% occur in clinics, 4.1% in street booths and 3.0% in hospitals.

The deviation towards practising in private clinics supports medicalisation of the habit, that is, the involvement of health professionals in any form of female genital mutilation in any setting, including hospitals or other health establishments.[10]

The shift towards medicalisation can be attributed to early advocacy efforts aimed at ending FGM/C that placed a strong emphasis on the health consequences of the procedure. These initiatives undeniably played an important role in raising public awareness of female genital mutilation and the attendant health risks. However, their overemphasis on the health implications – at the expense of placing the practice in the context of a larger human rights violation – has led to a misconception that medicalisation decreases the negative health consequences of the procedure, and is therefore a more 'benign' form of the practice.[11]

The UNICEF's position is that medicalisation obscures the human rights issues surrounding FGM/C, preventing the development of effective and long-term solutions for ending it. Besides endangering advocacy efforts, the medicalisation of FGM/C has served to legitimise and perpetuate the practice in some countries such as Egypt and Sudan.[1]

Other organisations throughout the world also actively decry medicalisation. They base their position on the grounds that FGM/C is an irreversible procedure that exposes girls to unnecessary health risks with no perceived medical necessity.[6]

Hence, we could consider that there are two main anti-FGC frameworks: the health model and the human rights-based model. The health model is against FGC and the adverse effects associated; it often rejects methods to provide medical support to minimise FGC health risks (i.e., medicalisation). The human rights-based model has to replace the health-based model in recent times as the preferred approach in anti-FGC campaigns. Also, the health model could be expanded through the health workers to contribute to the change process by integrating education and counselling against FGM into day-to-day nursing and midwifery practice, visiting individuals or groups in the community and assisting the people to think about FGM and its effects not only as a health issue but also as a gender and human rights issue.[19]

The present study revealed that psychosexual dysfunction was exclusively reported in 72.7% of the circumcised. This result is a fair justification for us to consider female circumcision as a typical cause of 'permanent infirmity'.

Badawi,[9] in his epidemiological survey in 1989, found that 7.7 times as many normal women experienced sexual excitement to stimulation of the clitoris/clitoral area than did the genitally mutilated women.

It is clear that FGC has a major negative impact on females' sexual pleasure and orgasm attainment. Therefore, this irreversible psycho-physical damage to her body is enough reason to ban the practice.[12]

Using FGM/C as a way to control women's sexuality is a main manifestation of gender inequality and discrimination related to the historical suppression and subjugation of women, denying girls and women the full enjoyment of their rights and liberties.[20]

The motivations for carrying on the practice in our results were primarily traditional beliefs (64.1%) followed by religious considerations (35.9%).

Table 8
Complications of circumcision in the victimised candidates.

Complication	No.	%
Emotional	148	94.9
Haemorrhage	52	33.3
Dysuria	12	7.7
Total	156	100

Table 7
Circumstances of circumcision with respect to age groups.

Variable		G1		G2		G3		Total		*P* value
		No.	%	No.	%	No.	%	No.	%	
Place of circumcision	Home	0	0	16	12.2	72	81.8	88	56.5	0.000**
	Clinic	4	6.7	28	46.7	28	46.7	60	38.5	
	Hospital	0	0	0	0	8	100	8	5	
	Total	4	2.6	44	29.2	108	68.2	156	100	
Operator	House wife	0	0	8	15.4	44	84.6	52	33.3	0.000**
	Nurse	0	0	0	0	16	100	16	10.2	
	Doctor	4	4.8	36	42.9	44	52.4	84	54	
	Others	0	0	0	0	4	100	4	2.5	
	Total	4	2.6	44	28.2	108	69.2	156	100	
Motivation	Religion	0	0	16	28.6	40	71.4	56	35.8	0.316
	Tradition	4	4	28	28	68	68	100	64.2	
	Total	4	2.6	44	28.2	108	69.2	156	100	

**$P < 0.005$ is highly significant.

Table 9
Sexual complaints in sexually experienced candidates (married and divorced).

Subjects	Sexual complaints present		Sexual complaints absent		Total		*P* value
	No.	%	No.	%	No.	%	
Circumcised $n=88$	64	72.7	24	27.3	88	100	0.000**
Non-circumised $n=44$	0	0	44	100	44	100	
Total $n=132$	64	48.5	68	51.5	132	100	

**$P<0.005$ is highly significant.

Circumcision is practised by people of many ethnicities and various religious backgrounds, including Muslims, Christians and Jews, as well as followers of traditional African religions. For some it is a rite of passage, for others it is not. Some consider it aesthetically pleasing; for others, it is mostly related to morality or sexuality.[6]

Egypt's top religious scholars are taking a stand. AL Azhar Supreme Council of Islamic Research, the highest religious authority in Egypt, issued a statement saying that "FGM/C has no basis in core Islamic law or any of its partial provisions and that it is harmful and should not be practised." [21] Dr. Ali Guma, the Grand Mufti of Egypt, announced in 2007 that "This custom is prohibited."[14] Al-Qaradawi, the president of the International Union for Muslim Scholars, considered the conduction of female circumcision banned according to Islamic law. He affirmed in a fatwa (an Islamic edict) published on his website the absence of any legal evidence in the Islamic religion which obliges female circumcision or makes it a preferable act adding that if a certain action is proven by specialists to cause harmful results, stopping this act would be obliged in order to block any route to corruption and to prevent harm.[22]

6. Conclusion and recommendation

- Female circumcision is a psychosexual cultural disease, passed from one mutilated generation to the next and not significantly related to residence, age or education.
- Overemphasis on physical complication of the practice directs the public towards medicalisation.
- Recent legalisation towards banning of female circumcision in Egypt in 2007 is a positive step towards retraction of the practice.
- We recommend considering the practice legally a 'permanent infirmity'.

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