

Female Genital Mutilation: Females' Intention in Northern Upper Egypt

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Abstract:

Background: Female Genital Mutilation/Cutting is an ancient cultural practice, predating the Bible and therefore the Koran, and has no basis in any religion. It is related to deep social and cultural ideas impeded in several societies regarding femininity and modesty because it is viewed as girls clean and delightful only after being genitally cut. FGM/C is additionally viewed as a protection of virginity, and it prevents premarital sex.

Aim: The present study was carried out to assess Females' Intention in Northern Upper Egypt regarding Female Genital Mutilation.

Subject & Methods: A Descriptive Cross-sectional study was used. The study was conducted in family health centers (FHCs) in different sitting at Beni-Suef Governorate. A Convenient sample was used. A Structured Interviewing Questionnaire sheet which includes three sections: Socio-demographic data, Intention to practice FGM/C, and Causes for intention or not to practicing FGM/C.

Results: The mean age of the studied participants was 22.6±5. Prevalence of Female Genital Mutilation is 71.4%, 29.7% of participants are suffering from complications after FGM. About 28.6% of females who had mutilated their daughters were planning to mutilate their other daughters in the future. More than one-third of females (35.5%) had an unfavorable attitude and 40.5% had poor levels of knowledge regarding FGM/C. 71.3% of females mentioned that the source of their information about FGM/C was their personal experience.

Conclusion: Northern Upper Egyptian Females' Intention regarding intention of mutilating their daughters was significantly affected by demographic characteristics, level of knowledge, and level of attitude, source information, exposure to complications or pressure from family and neighbors.

Recommendations: Alleviate females' intention toward Female Genital Mutilation should be improving their awareness regarding complications and Egyptian law against FGM, established by improve females' resistance toward family or neighbor regarding bad and harmful traditions.

Keywords: female genital mutilation; intention; northern upper Egypt

1. Introduction

The terms female genital cutting (FGC) and female genital mutilation/cutting (FGM/C) are often used among practicing communities and individuals. These concepts emphasize the significance of adopting nonjudgmental vocabulary when working with practitioners. When

discussing the matter in practice communities, terms like excision or genital cutting are also acceptable [1-7].

The FGM/C is an ancient cultural practice, predating the Bible and therefore the Koran, and has no basis in any religion [8-10]. FGM/C is related to deep social and cultural ideas impeded in several societies regarding femininity and modesty because it is viewed as girls clean and delightful only after being genitally cut. FGM/C is additionally viewed as a protection of virginity, and it prevents premarital sex [11-15].

Sociological causes include what's called "rite de passage" which suggests a transition within the stage of life from girlhood to womanhood and the entrance of the females to the wedding age. These traditions and social norms pass between generations resulting in the continuation of the practice. Psychological causes involve the thought of danger. Some tribes consider the clitoris to be a dangerous organ that has got to be removed. Others see that the removal of the sensitive genital tissues curbs sexual pleasure which successively preserves virginity and chastity and maintains the fidelity of females [16-20].

In Belgium, a study conducted to estimate the number of females who had experienced FGM/C found that 27.4% of immigrant females living in Belgium had undergone FGM/C and 8.7% of the females were in danger of experiencing FGM/C [21-23].

In Germany, 30% of immigrant females from Sub-Saharan Africa had experienced FGM/C before moving to Europe [24-26].

Preventive Strategies of FGM/C:

The eradication of FGM/C necessitates, so WHO reported preventive strategies through three diminutions [28]. (1) Multi-sector: addressing a wide range of issues at multiple levels, including education, justice, finance, women's issues, and health. (2) Sustained: have a long-term impact because progress can be slow. (3) Community-directed projects: have projects driven by communities to assist them in identifying problems, issues, and interventions. These projects aimed at ending FGM/C are non-judgmental and enable people to make their own decisions about whether or not to continue with the practice.

Seven things can be done to assist communities to abandon FGM/C: [29]

1. Bring to light the discriminatory motivations for FGM/C.
2. Change customs with the assistance of older generations.
3. Teach girls that they have the right to control what happens to their bodies.
4. Raise awareness about the risks and realities of female genital mutilation (FGM/C).
5. Raise awareness that FGM/C is not a religious requirement.
6. Address the secrecy that enables the cutting to take place.
7. Continue to advocate for the prohibition of FGM/C

Egyptian Strategies & Law for FGM/C prohibition:

First: - the laws:

In 1996, the Ministry of Health issued a decree-law prohibiting the practice of female circumcision, based on the criminal law, which prohibits harm to the body of humans except under medical controls. It should be noted that the criminalization of FGM officially began in 2008 when the Egyptian People's Assembly (currently the House of Representatives) passed a law

punishing the perpetrators of the crime with a fine and imprisonment ranging from three months to two years.

Second: The Legislative Position on Female Genital Mutilation

When the Child Law was amended by Law No. 126 of 2008, the text of Article 242 was added to the Penal Code to toughen the punishment for an intentional wound if it occurred through "female circumcision".

The new law contains two important articles

Article One: A number of recent legal amendments to the article of the Penal Code relating to female genital mutilation were approved in accordance with Law No. 78 of 2016, which was published in the Official Gazette on September 26, 2016. Article 242 of the Penal Code reads: "A penalty of imprisonment for a period of no less than five Years and not more than seven years for anyone who performs female circumcision by partially or completely removing any of the external genitalia or inflicting injuries on those organs without medical justification".

The penalty shall be hard labor for a period of no less than five years if the person who performs the circumcision referred to in the previous paragraph is a doctor or a practitioner of the profession of nursing. If his crime results in a permanent disability, the penalty shall be aggravated imprisonment for a period of no less than ten years; Temporary imprisonment for a period of no less than fifteen years and not more than twenty years.

In addition to the aforementioned penalties, the court shall decide to deprive its perpetrator, doctors and nurses, of practicing the profession for a period of no less than three years and not more than five years, beginning after the end of the period of execution of the penalty, and the closure of the private facility where the circumcision was performed.

**Replaced by Law No. 10 of 2021 published in the Official Gazette on 4/28/2021

As for the second article, it added to the Penal Code an updated text for the first time, which is the text of Article 242 (a). Anyone who requests female circumcision and it was circumcised at his request, as stipulated in Article 242 of this law, shall be punished with imprisonment.

Anyone who promotes or encourages, or calls in one of the ways set forth in Article (171) of this law to commit the crime of female circumcision, even if there is no effect from his action, shall be punished by imprisonment.

**Replaced by Law No. 10 of 2021 published in the Official Gazette on 4/28/2021

2. Aim of the Study

The present study was carried find out to assess Females' Intention in Northern Upper Egypt regarding Female Genital Mutilation

3. Subjects and Methods

3.1. Research Design: A Descriptive Cross-sectional study was used in the current study.

3.2. Subjects & Setting:

3.2.1. Setting: The study was conducted in family health centers (FHCs) in different sitting at Beni-Suef Governorate. Beni-Suef governorate is

divided into seven sectors. From every sector the MCH was randomly selected to geographically represent the sector. As the following mention:

At Beni-Suef sector Salah Salem MCH and Eastern MCH. At Nasser sector Taha Bosh MCH was selected, Beba sector Beba Medical Center and Tarshoup MCH was selected. While Fashen sector Bani Saleh MCH was selected. At Somesta sector Al-shantour MCH was selected. Ehnasia sector EL- Mamalik MCH and Elnouira MCH. While Elwasta sector Kamen El-Arouse MCH was selected.

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) and will be included in the study.

3.3 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 three sections:

Section I: A Structured Interviewing Questionnaire sheet which includes the following parts: age, residence, level of education, marital status, occupation and experience with mutilation, etc.....

Section II: Intention to practice FGM/C: It included questions about the following:

- Planning to mutilate their daughter(s).
- Supporting the practice of FGM/C.
- Confiscating information about mutilating daughters (age of the daughter, any health consequences, who perform mutilation, intention for mutilation of daughters in future).
- Facing social pressure from family or neighbors to have their daughter undergo FGM/C.
- Is there anyone in the area who does or wants to conduct FGM/C?

Section III: Females' Causes for Intention or not to Practicing FGM/C

3.5 Validity & Reliability of the Tool

A panel of 3 experts in the field of maternity, Obstetrics and Gynecologic Nursing reviewed the tool to test its content validity. Modifications were done accordingly based on their judgment. The reliabilities of the tool were biased on of Cronbach Alpha.

3.6. Administrative & Ethical Considerations:

Official permission was obtained by submission of an official letter from the Faculty of Nursing, Beni-Suef University, to the responsible authorities of the study setting to obtain their permission for data collection for the study. All ethical issues were taken into consideration during all the phases of the study; the researcher maintained the anonymity/confidentiality of the women.

The researcher introduced herself to every woman and briefly explained the nature, and the objectives of the study before participation. Participant women were enrolled voluntarily after the oral informed consent.

3.7. Pilot Study

The pilot study was carried out on 10% of the studied women in the study setting (that were excluded from)

3.8. Field Work

Data were gathered over six months beginning in November 2021 and ending in April 2022.

3.9. 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.

3.9.1. Descriptive Statistics data were expressed as:

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

3.9.2. Analytical Statistics:

- a. **Cronbach alpha and Spearman-Brown coefficients:** The internal consistency of the generated tools was measured to assess their reliability.
- b. **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. For Race tables, Monte Carlo exact probability was used wherever 2 was present.

3.9.3. Graphical presentation:

- C. Data visualization was done with graphs:
 - Bie in 3D chart
 - Bar chart

4. Results

Table (1) showed that the mean age of the studied participants was 22.6 ± 5 , most of them were rural residents (70.4%), 90.2% were highly educated, 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%).

Variables	Values (no=2837)	
	No.	%
Age		
18-	2020	71.2
30-	719	25.3
45-60	98	3.4
Age (Mean ± SD)	22.6±5	
Residence		
Rural	1997	70.4
Urban	840	29.6
Educational level		
Basic (primary, preparatory)	46	1.6
Secondary or equivalents	231	8.1
High (university, post-graduate)	2560	90.2
Marital status		
Single	1630	57.5
Married	1190	41.9
Divorced	15	0.5
Widow	2	0.1
Religion		
Muslim	2746	96.8
Christian	91	3.2
Mother's education		
Illiterate	773	27.2
Educated	2064	72.8
Father's Education		
Illiterate	478	16.8
Educated	2359	83.2
Occupation		
Student	1854	65.4
Work	720	25.4
Not work	263	9.3

Table (1): Socio-Demographic Characteristics & of the Studied Participants.

Figure (1) presents that the prevalence of Female Genital Mutilation (FGM/C) among total participants (2837) at Beni-Suef is 71.4%.

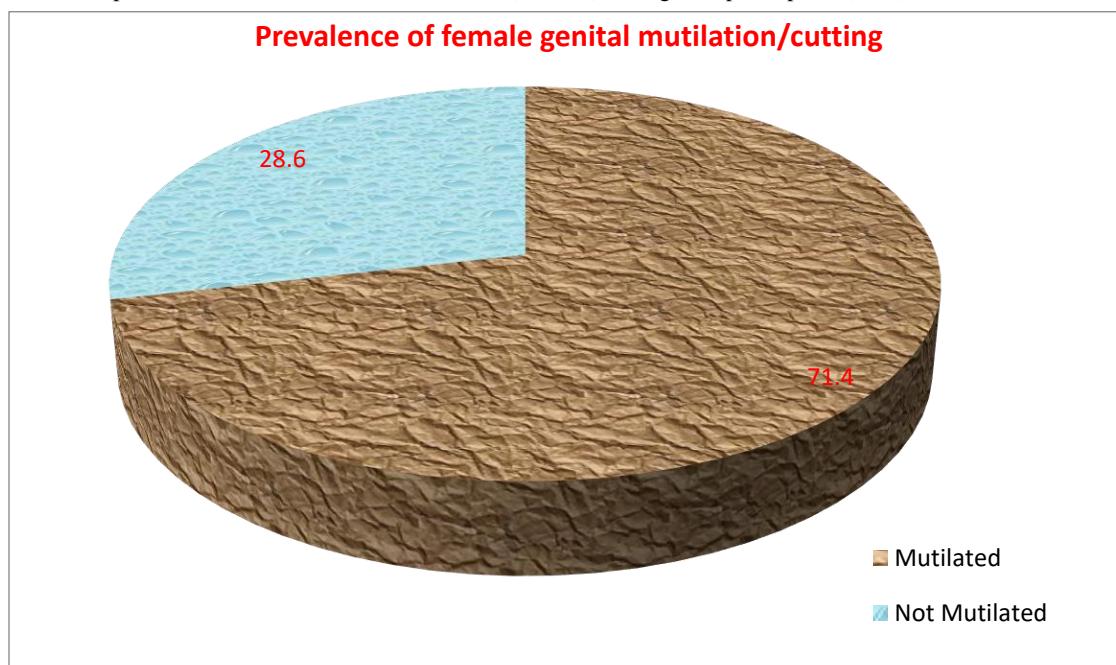


Figure (1): Prevalence of female genital mutilation/cutting.

Figure (2) Presents participants' intention to perform FGM for their sister or daughter. About 28.6% of females who had mutilated their daughters were planning to mutilate their other daughters in the future.

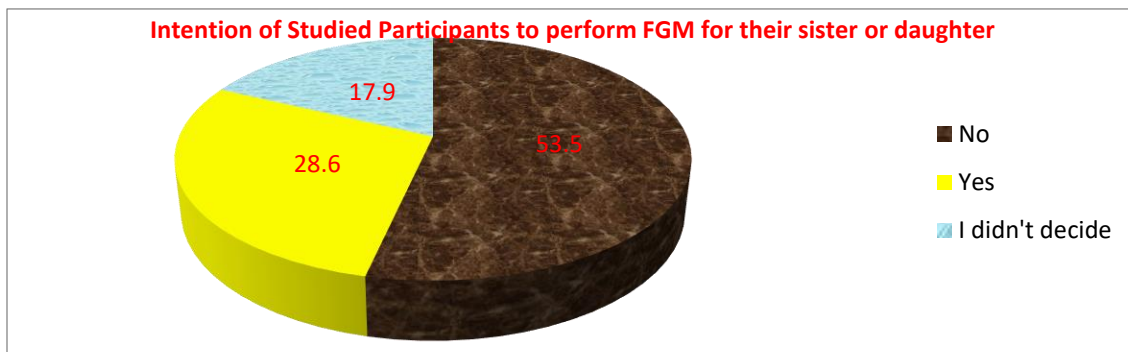


Figure (2): Participants' Intention to perform FGM for their sister or daughter.

Table (2) showed Significant statistical relationship between participants' intention of mutilating their daughters and demographic & personal characteristics (p<0.001).

Variables	Intention to Mutilate						Total
	Yes (n=811)		No (n= 1519)		I didn't decide (n= 507)		
	No	%	No	%	No	%	
Age (in years)							
15-	354	43.6	1272	83.7	347	68.4	2020
30-	367	45.2	240	15.7	159	31.3	719
45-	90	11.2	7	0.6	1	0.3	98
Residence							
Rural	479	59.1	1118	73.6	400	78.9	1997
Urban	332	40.9	401	26.4	107	21.1	840
Educational level							
Basic (primary, preparatory) Secondary or equivalents	33	4.1	10	0.7	3	0.6	46
High (university, post-graduate)	168	20.7	44	2.9	19	3.7	231
	610	75.2	1465	96.4	485	95.7	2560
Marital status							
Single	258	31.8	1050	69.2	321	63.3	1629
Married	539	66.5	467	30.7	185	36.5	1191
Divorced	12	1.5	2	0.1	1	0.2	15
Widow	2	0.2	0	0.0	0	0.0	2
Religion							
Muslim	793	97.8	1480	97.4	473	93.3	2746
Christian	18	2.2	39	2.6	34	6.7	91
Occupation							
Student	333	41.1	1112	73.2	409	80.7	1854
Work	317	39.1	333	21.9	70	13.8	720
Not work	161	19.9	74	4.9	28	5.5	263
P- value	<0.001*						

Table (2): Relationship between Females' Intention of Mutilating their daughters and Demographic & Personal Characteristics

*P-value is significant (p<0.001)

Table (3) presents the distribution of sample according to their total knowledge score. Only 25.7% of females had good knowledge regarding FGM/C, while 40.5% and 33.8% had poor and fair levels of knowledge.

Categories	Frequency	Percent
Poor knowledge	960	33.8
Fair knowledge	1149	40.5
Good knowledge	728	25.7
Total	2837	100.0

Table (3): Total Knowledge Scores among the Studied Participants.

Table (4) describes the percent of the distribution of females according to their total attitude score towards FGM/C. More than one-third of females (35.5%) had an unfavorable attitude towards (supporting) FGM/C and 44.3 % of them had a favorable attitude towards (refusing) FGM/C while 20. 2% had a neutral attitude.

Categories	Frequency	Percent
Unfavorable attitude	1007	35.5
Neutral attitude	573	20.2
Favorable attitude	1257	44.3
Total	2837	100.0

Table (4): Attitude categories among the studied participants.

Table (5) presents significant statistical relationship between females' intention of mutilating their daughters and their mutilation experience, level of knowledge, and level of attitude (p<0.001).

Variables	Intention to Mutilate						Total
	Yes (n=811)		No (n=1519)		I didn't decide (n=507)		
	No	%	No	%	No	%	
Mutilation experience:							
Mutilated	644	79.4	940	61.9	437	86.2	2021
Non-mutilated	167	20.6	579	38.1	70	13.8	816
Level of knowledge:							
Poor knowledge	520	64.1	250	16.4	170	33.5	960
Fair knowledge	280	34.5	570	37.5	299	59	1149
Good knowledge	11	1.4	699	46.1	38	17.5	728
Level of attitude:							
Favorable	30	3.7	960	63.1	80	15.7	1007
Neutral	143	17.6	291	19.2	139	27.45	573
Unfavorable	638	78.7	268	17.7	288	6.9	1257
P-value	<0.001*						

Table (5): Relationship between Females' Intention of Mutilating their daughters and their Mutilation Experience, Level of Knowledge, and Level of Attitude
*P-value is significant (p<0.001)

Figure (3) portrays the distribution of females according to their source of information regarding FGM/C. About 71.3% of females mentioned that the source of their information about FGM/C was their personal experience, 36.2% from friends or neighbors, and 22% from TV or radio.

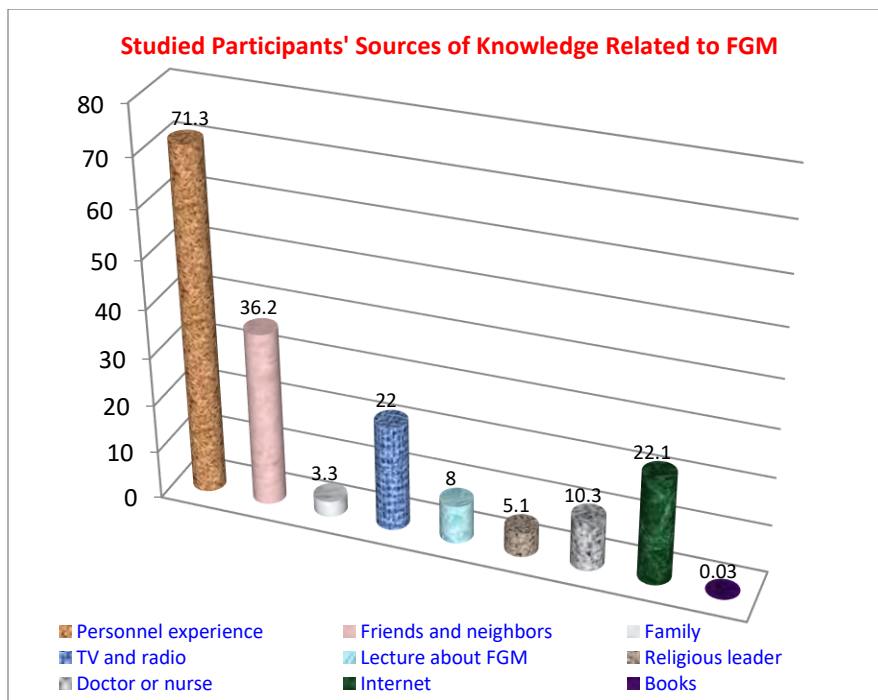


Figure (3): Sources of information regarding FGM among the Studied Participants.

Table (6) shows a significant statistical relationship between women's intention to circumcise their daughters and their source information (p<0.001).

Sources of Information #	Intention for circumcision						Total		
	Yes (n=811)		No (n=1519)		I didn't decide (n=507)				
	No	%	No	%	No	%	No	%	
Personnel experience	406	50	1205	79.3	310	61.1	2021	71.3	
Friends and neighbors	70	8.6	900	59.2	58	11.4	1028	36.2	
Family	12	1.4	41	2.6	42	8.2	95	3.3	
TV and radio	50	6.1	410	26.9	166	32.7	626	22	
Lecture about FGM	33	4	154	10.1	42	8.2	229	8	
Religious leader	77	9.4	22	1.4	47	9.2	146	5.1	
Doctor or nurse	10	1.2	110	7.2	174	34.3	294	10.3	
Internet	2	0.24	500	32.9	127	25	629	21.3	
Books	0	0.0	0	0.0	1	0.1	1	0.03	
P-value	<0.001*								

Table (6): Relationship between Source of Information and their Intention to Mutilate their daughters. (*P-value is significant (p<0.001) (# more than one answer).

Table (7) reveals that about 29.7% of participants are suffering from complications after FGM. About 82.1% of them suffered from pain after the surgery. About 79.9% of females were facing pressure from a family member to perform FGM/C, and 5.9% were facing pressure from a neighbor.

Variables	No.	%
Did you have complications from the mutilation? (1130)		
Yes	602	29.7
No	1419	70.3
If yes, mention the complication you have (602)		
Pain	290	82.1
Bleeding	120	33.9
Difficult urination	110	31.1
Keloids and scar	66	18.6
Inflammation	20	5.6
Are you pressured by a family member to do an FGM again?		
No	2268	79.9
Yes	569	20.1
Are you under pressure from your neighbors?		
No	2670	94.1
Yes	167	5.9

Table (7): Females' exposure to Pressure, and Complication.

Table (8) showed statistically significant relationship between women's intention for mutilation and their exposure to complications or pressure from family and neighbors (p<0.001).

Variables	Intention for Circumcision						Total	
	Yes (n=811)		No (n=1519)		I didn't decide (n=507)			
Did you have complications from the mutilation?	No	%	No	%	No	%	No	
Yes	180	22.2	230	15.1	192	37.9	602	
No	631	77.8	511	33.6	277	54.6	1419	
If yes, mention the complication did you have #								
Pain	85	10.4	131	8.6	74	14.5	290	
Bleeding	8	1	70	4.6	42	8.2	120	
Difficult urination	34	4.1	46	3.0	50	5.9	110	
Keloids and scar	22	2.8	34	2.2	10	2	66	
Inflammation	2	0.3	12	0.7	8	1.6	20	
pressure by family member to do an FGM again?								
Yes	254	31.3	215	14.1	100	19.7	569	
No	557	68.7	1304	85.9	407	79.3	2268	
Are you under pressure from your neighbors?								
Yes	75	9.2	50	3.3	42	8.2	167	
No	769	94.8	1469	96.7	432	91.8	2670	
P-value	<0.001*							

Table (8): Relationship between Women's Intention for Mutilation, Exposed to Pressure, And Complication.

*P-value is significant (p<0.001) (# more than one answer).

Figure (4) shows the distribution of females according to their reasons for performing and reasons for refusing FGM/C. Traditions and culture was the main reason for performing FGM/C as stated by females (77.4%), followed by religious requirements 21.7 %, decrease the sexual desire of females

(14.4%). Health consequences of FGM/C were the main reason stated by females for refusing the procedure (47.3%), followed by 10.3% of females who stated that FGM/C is not necessary.

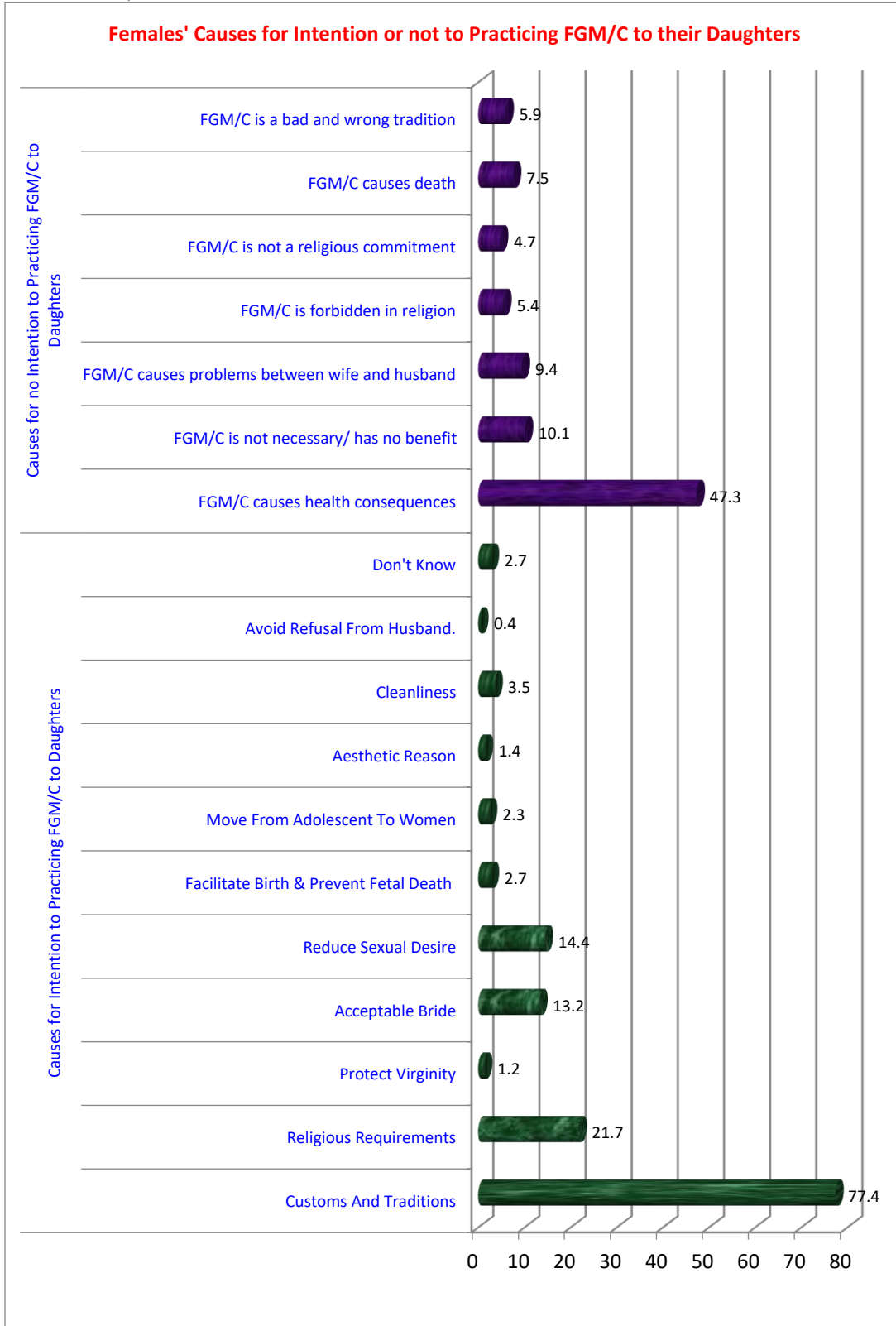


Figure (4): Distribution of Females According to their Causes for Intention or not to Practicing FGM/C.

5. Discussion

According to the 2015 Egypt Health Issue Survey (EHIS), the prevalence of FGM/C among females aged 15-19 years was 70%, while 80% of females aged 20 - 24 had endured FGM/C compared to 89%-97% of females aged 25-49 who were mutilated. Quite half of the girls aged 1 -14 are probable to experience FGM/C in the future. The prevalence of FGM/C is lower among non-married females compared to ever-married females (68% and 93%, respectively) [30].

Regarding prevalence of FGM, the presents study revealed that the prevalence of Female Genital Mutilation (FGM/C) at Beni-Suef is 71.4%. This result is in accordance with other studies in Upper Egypt that reported that the prevalence of FGC 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 [31]. A study conducted among Suhag University students (2015) institute that the prevalence of FGM/C among female students was 86.87% [32].

Concerning females' intention in Upper Egypt to perform FGM for their sister or daughter; the results of the current study reveal that, near to one third of females aged 18-60 had the intention to mutilate their daughters. The EHIS statistics showed that two fifth intended to mutilate their daughters, which was higher than the results above [30]. The difference shows advancements in female attitudes, beliefs, and opinions regarding the ending of FGM/C in Egyptian society.

Significant relationships were found between women's intention to practice FGM/C and their level of education, and occupation (p-value <0.001). The results of the present study revealed that their intention decreased with the increase in the level of education. This is close to a study conducted in Iran that revealed that intention decrease with an increased level of education [33]. Moreover, about two fifth of employed female has the intention to practice FGM, while the highest proportion of females who had no intention to practice FGM/C was among student females. This is at odds with a study conducted in UAE that revealed that employed and educated women were less likely to have undergone FGM/C. highlighting the crucial role that women's education plays in efforts to end FGM/C [34].

Female genital mutilation/cutting is seen as a normal part of female socialization in societies that practice it [35]. Regarding statistical relationship between females' intention of mutilating their daughters and their mutilation experience, level of knowledge, and level of attitude, significant statistical relationship was found. About 79.4% of females who experienced FGM/C had the intention to mutilate their daughters in the future. This result agrees with a study conducted in Ethiopia, which revealed that the circumcised respondents were nearly three times more likely to intend the continuation of FGM than uncircumcised respondents [36].

Females' intentions to continue performing FGM/C on their daughters were significantly predicted by their prior experience with mutilation, lack of knowledge, an unfavorable attitude, rural residence, and pressure from their families. This was in line with a study conducted in Egypt, which discovered that the desire of females to continue performing FGM/C on their daughters was significantly predicted by the experience of mutilation, lack of education, an unfavorable attitude, and pressure from the spouse [11,37]. In Ethiopia, lack of access to mass media, degree of education, and age all had an impact on women's intentions to undergo FGM or C [38].

The primary sources of information for study's sample regarding FGM were personal experience, friends or neighbors. This is contradicted [39] who conducted research in rural Egypt, found results that contrasted with the findings of the current study because their participants' primary sources of information were radio and television. A significant statistical relationship between women's intention to circumcise their daughters and their source information was found. This highlights the idea that media had an impact on participants' awareness and may be used in delivering the eradication messages required to stop FGM/C practices in Egypt.

A proportional slid of participants are suffering from complications after FGM. They suffered from pain after the surgery, severe bleeding, difficult micturition and keloid and scar from the mutilation. There was an association between women's intention for mutilation and type of complication they have exposed. This expected as bleeding is life threaten. Shabila, et al., (2019) reported that hemorrhage occurs when the arterial blood supply to the genital organs is severed. The hemorrhage can happen right after the procedure or later as a result of a clot sloughing over the blood supply due to the infection [40]. Berg, R. C, 2018 added that severe bleeding after an FGM/C operation can result in a decrease in the volume of circulating blood in the body, leading to hemorrhagic shock. If the female does not receive the emergency help, she requires, she may die soon [41].

Females who were intended to mutilate their daughters in the current study were facing pressure from a family member to perform FGM/C, from their own family or their husband's family, and neighbors. There was an association between women's intention for mutilation and they're exposed to pressure from family as found by results of the current study. In the present study, about one fifth of females were facing pressure from a family member to perform FGM/C, from their own family or their husband's family, and the minority was facing pressure from a neighbor. One of the main causes of the intention to mutilate daughters was family pressure, according to research done in Upper Egypt to assess how women felt about the prohibition on FGM/C [42,43].

6. Conclusion

Northern Upper Egyptian Females' Intention regarding intention of mutilating their daughters was significantly affected by demographic characteristics, level of knowledge, and level of attitude, source information, exposure to complications or pressure from family and neighbors

7. Recommendations

1. The development of an educational program for mothers about FGM is required to increase their awareness.
2. Alleviate females' intention toward Female Genital Mutilation should be improving their awareness regarding complications and Egyptian law against FGM, established by improve females' resistance toward family or neighbor regarding bad and harmful traditions.
3. Further studies are needed to assess Knowledge, attitude, and practice of medical care providers regarding FGM/C

Conflict of interest: The authors have no conflicts of interest to disclose.

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8. References

1. Abdou, M. S., Wahdan, I. M., & El-Nimr, N. A. (2020). Prevalence of Female Genital Mutilation, and Women's Knowledge, Attitude, and Intention to Practice in Egypt: A Nationwide Survey. *Journal of High Institute of Public Health*, 50(3): 139-145.
2. Adinew, Y. M., & Mekete, B. T. (2017). I knew how it feels but couldn't save my daughter; testimony of an Ethiopian mother on female genital mutilation/cutting. *Reproductive health*, 14(1): 1-5.
3. Al Awar, S., Al-Jefout, M., Osman, N., Balayah, Z., Al Kindi, N., & Ucenic, T. (2020). Prevalence, knowledge, attitude, and practices of female genital mutilation and cutting (FGM/C) among the United Arab Emirates population. *BMC women's health*, 20(1): 1-12.
4. Berg, R. C., Taraldsen, S., Said, M. A., Sørbye, I. K., & Vangen, S. (2018). The effectiveness of surgical interventions for women with FGM/C: a systematic review. *BJOG: An International Journal of Obstetrics & Gynaecology*, 125(3): 278-287.
5. Bogale, D., Markos, D., & Kaso, M. (2015). Intention toward the continuation of female genital mutilation in Bale Zone, Ethiopia. *International Journal of Women's Health*, 7, 85.
6. Chukwuka, O. O. A. (2018). Female genital mutilation in Nigeria; a brief sociological review. *World*, 6(1): 1-5.
7. Cottler-Casanova, S., Horowicz, M., Gieszl, S., Johnson-Agbakwu, C., & Abdulcadir, J. (2020). Coding female genital mutilation/cutting and its complications using the International Classification of Diseases: a commentary. *BJOG: An International Journal of Obstetrics & Gynaecology*, 127(6): 660-664.
8. EL-Gharib, M. N. (2019). Female genital cutting: A persistent African health challenge. *Gyne and Obste Open an Open J*, 1(1): 1-6.
9. Hassanin, I. M., & Shaaban, O. M. (2013). Impact of the complete ban on female genital cutting on the attitude of educated women from Upper Egypt toward the practice. *International Journal of Gynecology & Obstetrics*, 120(3): 275-278.
10. Matanda, D., Okondo, C., Kabiru, C. W., & Shell-Duncan, B. (2018). Tracing change in female genital mutilation/cutting: Shifting norms and practices among communities in Narok and Kisii counties, *Kenya*: 1-57.
11. Ministry of Health and Population [Egypt] (MOHP) (2015). El-Zanaty and Associates [Egypt], and ICF International. Egypt Health Issues Survey. Cairo and Rockville: *Ministry of Health and Population and ICF International*.
12. Mitwaly, A., Abd El Aal, D., Aziz, P., Hassanin, A., & Abbas, A. (2017). A recent look for the implication and attitude of practicing female genital mutilation in Upper Egypt: a cross sectional study. *International Journal of Reproduction, Contraception Obstetrics and Gynecology*, 6: 4224-4249.
13. Mohammed, E. S., Seedhom, A. E., & Mahfouz, E. M. (2018). Female genital mutilation: current awareness, beliefs and future intention in rural Egypt. *Reproductive Health*, 15(1): 1-10.
14. Njoku, D. C., Heba, A., & Njoku, U. (2020). The History, Sexual, And Reproductive Consequences of Female Genital Mutilation on Women: A Focus on Sub-Saharan Africa. *Sapientia Foundation Journal of Education, Sciences and Gender Studies*, 2(4):1-12
15. Pashaei, T., Ponnet, K., Moeeni, M., Khazae-pool, M., & Majlessi, F. (2016). Daughters at risk of female genital mutilation: Examining the determinants of mothers' intentions to allow their daughters to undergo female genital mutilation. *PLoS One*, 11(3), e0151630.
16. Pashaei, T., Rahimi, A., Ardalan, A., Felah, A., & Majlessi, F. (2012). Related factors of female genital mutilation (FGM) in Ravansar (Iran). *J Women's Health Care*, 1(2), 1000108.
17. Sabry, H. A., & Elamir, R. Y. (2020). Knowledge, Attitude and Intention to Future Practice of Female Genital Mutilation among Medical Students, Egypt. *The Egyptian Family Medicine Journal*, 4(2): 7-21.
18. Shabila, N. (2019). Geographical variation in the prevalence of female genital mutilation in the Kurdistan region of Iraq. *Eastern Mediterranean Health Journal*, 25(9): 630-636.
19. UNICEF Data. (2020). Female Genital Mutilation: A New Generation Calls for Ending an Old Practice.
20. UNICEF, (2016). Female genital mutilation/cutting: a global concern. Geneva.
21. World Health Organization (WHO). (2018). Care of girls and women living with female genital mutilation: A clinical handbook. *Geneva: WHO*.
22. Yousef, F., Hamed, A., & Mostafa, N. (2017). Female genital cutting: prevalence, knowledge, and attitudes of Sohag University level students, Upper Egypt. *Egyptian Journal of Community Medicine*, 35(1):1.



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