

Female Genital Mutilation: Impact on Knowledge, Attitude, Sexual Score Domains and Intention of Females in Northern Upper Egypt

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Abstract

Background: Female genital mutilation/cutting is extensively done in societies where it is believed to promote marriageability. As a result, the practice of FGM/C will continue because parents believe it will provide a better future for their daughters, and some girls may even desire to be mutilated to find a husband.

Aim: The aim of this study was Estimate effect of FGM on Females' knowledge, Attitude, Sexual Score Domains, and Intention 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.

Tool: A Structured Interviewing Questionnaire sheet was used to collect data related females' knowledge, attitude, and intention. Female Sexual Function Index (FSFI) to assess female sexual function.

Results: The prevalence of Female Genital Mutilation (FGM/C) among total participants at Beni-Suef is 71.4%. Good knowledge score (27%) was more prevalent among non-mutilated females. Unfavorable and neutral attitude score (49.3%) was more prevalent among females with FGM. that there was a significantly higher Desire domain (5.8±1.8), Arousal domain (13.7±2.9), Lubrication domain (16±3.4), Orgasm domain (11.7±2.6), Satisfaction domain (13.3±2.4), and Total score among not circumcised married participants than circumcised ones but the Pain domain didn't differ significantly between circumcised (9.7±3.3), and not circumcised (9.3±2.2). About 79.4% of females who experienced FGM/C had the intention to mutilate their daughters in the future.

Conclusion: Good knowledge score was more prevalent among non-mutilated females. There was a significant relationship between FGM and knowledge, attitude, Sexual Score Domains, and intention to mutilate their daughters in the future (p-value <0.001).

Key words: female genital mutilation; knowledge; attitude; intention; sexual domains

1. Introduction

More than 31 countries in Africa, a few in Asia, and the Middle East all practice female genital mutilation or circumcision [1-5]. According to UNICEF, FGM/C global databases (February 2020), the prevalence of FGM/C in Uganda became 0% compared to a quarter within the update on February 2018. The prevalence of FGM/C among females aged

15 - 49 years ranged from 1% in Cameroon to 98% in Somalia, while among girls aged 0 - 14 years it has ranged between 0.1% in Benin and 83% in Mali. The prevalence of FGM/C exceeds 90% in Guinea, Djibouti, and Mali, while it is about 10% in Niger, Ghana, Togo, and Benin [6].

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 [7-10]. The prevalence of FGM/C among adolescent girls and women has dropped from 94% in 2008 to 88% in 2014 [10-15].

Female genital mutilation/cutting has complicated social and cultural foundations that outweigh the requirements and ideas of individuals. Female genital mutilation/cutting is seen as a normal part of female socialization in societies that practice it. The reasons for continuing FGM/C in these societies include religious obligations, beauty in the form of smooth and small genitalia, delighting future families and sexual partners, having social significance, and being accepted for marriage [16-18].

Female genital mutilation/cutting is extensively done in societies where it is believed to promote marriageability. As a result, the practice of FGM/C will continue because parents believe it will provide a better future for their daughters, and some girls may even desire to be mutilated to find a husband. The hypothesis also suggests that in places where FGM/C is a part of the culture, no one will want to stop doing it because families are afraid of deviating from community norms [19-22].

2. AIM OF THE STUDY

The present study was carried out to find out about FGM in Beni-Suef Governorate through:

1. Estimate effect of FGM on Females' knowledge in Northern upper Egypt
2. Estimate effect of FGM on Females' Attitude in Northern upper Egypt
3. Estimate effect of FGM on Females' Sexual Score Domains in Northern upper Egypt
4. Estimate effect of FGM on Females' Intention in Northern upper Egypt

2.1. Research Questions

1. Does exposure to FGM can affect Females' knowledge in Northern Upper Egypt?
2. Does exposure to FGM can affect Females' Attitude in Northern Upper Egypt?
3. Does exposure to FGM can affect Females' Sexual Score Domains in Northern Upper Egypt?
4. Does exposure to FGM can affect Females' Intention in Northern Upper Egypt?

3. Subjects and Methods

3.1. Research Design: A Descriptive Cross-sectional study was used to achieve the aim of 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:

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

3.2.2. Sample:

3.2.2.1. Sample Type:

A Convenient sample was used. The study sample was selected according to the following Inclusion criteria: 18-60 years old women. Can read and write

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 six 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: Knowledge of females regarding FGM/C: Females' knowledge was assessed using both single-response and multiple-response questions.

a. Single response questions:

They included knowledge of females about the spread, types, and procedures of FGM/C, side effects, and health consequences of FGM/C and FGM/C in Egyptian law.

Scoring system

- It received (0) if the answers were wrong or don't know
- It received (1) if the answers were incomplete correct
- It received (2) if the answers were complete correct

b. Multiple response questions:

They included knowledge of females regarding the immediate and long-term health consequences of FGM/C. Participants were expected to select the right responses and not select the wrong responses.

Scoring system

- It received (0) if less than 25% of the answers were correct.
- It received (1) if ≥ 25 percent to less than 50% of the responses were correct.
- It received (2) if $\geq 50\%$ of the answers were correct.

The scores are then turned into percentages, and the overall score is divided into the following categories:

- Good level of knowledge $\geq 75\%$.
- A fair level of knowledge is $\geq 50\%$ to $< 75\%$.
- Poor level of knowledge $< 50\%$.

Section III: Attitudes of females regarding FGM/C:

A Likert scale was used to assess attitudes, ranging from agree to disagree. FGM/C from a social standpoint; FGM/C and its effect on female genitalia; FGM/C violation and disability; FGM/C from a religious standpoint; FGM/C practice encouragement in society; FGM/C and marriage; and finally, FGM/C law were all included.

Scoring system

- It received (1) if participants have bad attitude
- It received (2) if participants have neutral attitude
- It received (3) if participants have favorable attitude

The scores are then turned into percentages, and the overall score is divided into the following categories:

- Favorable attitude $\geq 75\%$.
- Neutral attitude $\geq 50\%$ to $< 75\%$.
- Unfavorable attitude $< 50\%$.

Section IV: 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 V: Reasons for practicing FGM/C and reasons for refusing FGM Section

VI: Female Sexual Function Index (FSFI).

A four-week self-reported questionnaire that examines the key characteristics of female sexual function. It consists of 19 multiple-choice

questions that assess six domains. Each dimension was rated on a scale of 0/1 (no sexual activity or sexual dysfunction) to 5 (complete sexual activity).

Researchers used the Arabic version of the FSFI, which was translated by (Anis, et al., 2011), to determine the full-scale score. The domain score is calculated by summing the scores of the domain's questions and multiplying the total by the domain factor. (=2 to 36). It was approved for use among Egyptians [38].

For the Arabic version of the FSFI, a total score of 28.1 was used as the cutoff point to distinguish between women with FSD and those with normal functions (sensitivity 96.7%, specificity 93.2%). The scale has been translated into Arabic.

Scoring system for (Female Sexual Function Index) (FSFI):

A formula can be used to calculate the FSFI's individual domain scores and full-scale (overall) scores. Add the scores of the individual items that make up the domain and multiply the total by the domain factor.

For the Arabic version of the FSFI, a total score of 28.1 was used to discriminate between women with FSD and those with normal functions. A domain score of 0 implies that the subject reported no sexual activity in the previous month within the specific domains.

Doman	Questions	Score Rang	Factor	Minimum Score	Maximum Score	Score
Desire	1,2	1-5	0.6	1.2	6.0	
Arousal	3,4,5,6	0-5	0.3	0.0	6.0	
Lubrication	7,8,9,10	0-5	0.3	0.0	6.0	
Orgasm	11,12,13	0-5	0.4	0.0	6.0	
Satisfaction	14,15,16	0 (or 1) - 5	0.4	0.8	6.0	
Pain	17,18,19	0-5	0.4	0	6.0	
Full Scale Score Rang				2.0	36.0	

3.4. Validity of the Tool

All tools were tested for content validity by a jury of five experts in the obstetrics and gynecological nursing, pediatric nursing professor and one from biostatistics field.

3.6. Reliability of the Tool

Reliability of tools was tested by using Cronbach's Alpha coefficient test. Consisted of relatively homogenous items as indicated by high reliability which was (0.405) for knowledge and (0.764) for attitude.

3.7. Ethical Considerations:

Informed consent was taken from each female to participate in the study after explaining the purpose of the study, and its importance for her, it will haven't any harmful effect on them, the information will be confidential and they can withdraw from the study at any time.

3.8. Administrative Considerations:

Official permission was obtained by submission of an official letters from the Faculty of Nursing, Beni-Suef University to the responsible authorities of the study setting (family health centers (FHCs)) to obtain their permission for data collection for our study. These letters provided the study's goal as well as photocopies of data collecting materials to obtain their consent and assistance with data collection.

3.9. Pilot Study

The pilot study was conducted on 10.0% of the total sample to test the feasibility & the applicability of the tool, find out the possible obstacles or problems that might face the researchers and interfere with data collection, detect any problems peculiar to the statements as sequence of questions, clarity and estimate the time needed for data collection. The samples of the women included in the pilot study were excluded from the main study sample

3.10. Field Work

The process of data collection was carried out in the period from November 2021 and completed by April 2022, 3 days/week Saturday, Tuesday and Thursday from 9am to 2pm in three phases: The researcher begins filling out the interviewing questionnaire to assess women's demographic characteristics, knowledge of FGM/C, attitudes toward FGM/C, intention to practice FGM/C, reasons for practicing FGM/C, and reasons for refusing FGM/C, and Female Sexual Function Index (FSDI). The instruction was given to each woman individually for 3 sessions each session ranging from 15-20 minutes on an individual.

3.11. 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.

3.11.1. Descriptive Statistics data were expressed as:

- **Count and percentage:** Used for describing and summarizing categorical data

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

3.11.2. Analytical Statistics:

- **Cronbach alpha and Spearman-Brown coefficients:** The internal consistency of the generated tools was measured to assess their reliability.
- **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.

3.11.3. Graphical presentation:

Data visualization was done with graphs:

- Colum chart
- Bie in 3D chart

4. Results

Figure (1): Presents Female Genital Mutilation Experience among Participant Study Sample. The prevalence of Female Genital Mutilation (FGM/C) among total participants (2837) at Beni-Suef is 71.4%.

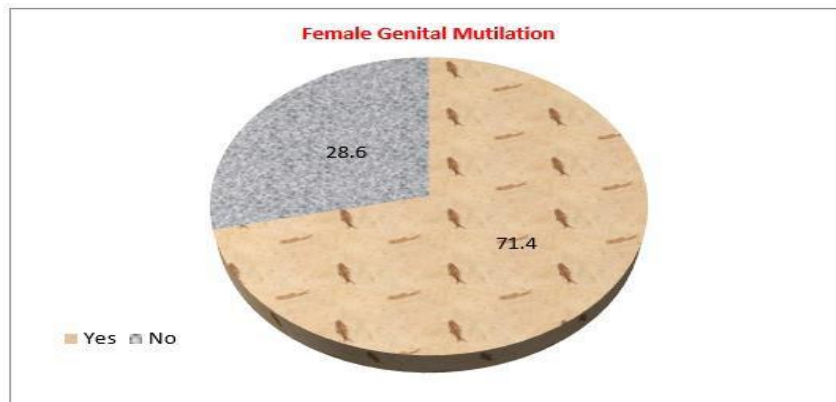


Figure (1): Female Genital Mutilation Experience among Participant Study Sample

Figure (2) showed an association between participants' total knowledge and their exposure to FGM. Good knowledge score (27%) was more prevalent among non-mutilated females. Also, fair knowledge was more prevalent (51.9%) among un-circumcised ones. While poor knowledge score (37.1%)

was more prevalent among females with FGM There was a significant relationship between circumcision and participant knowledge (p-value <0.001).

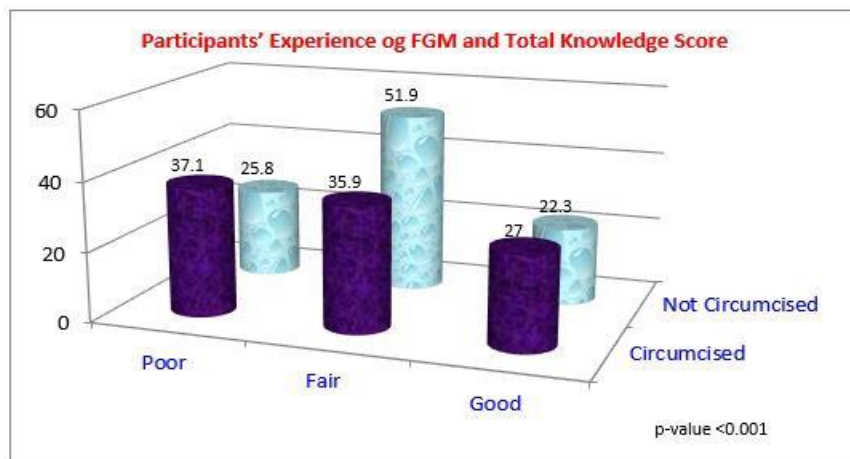


Figure (2): Participants' Experience of FGM and Total Knowledge Score

Figure (3): Presents Association between Participants' Experience of FGM and their Total Attitude score. It showed an association between experience of FGM and total Attitude score among participant females. Unfavorable and neutral attitude score (49.3%) was more prevalent among females with FGM,

while the favorable attitude (52%) was associated with the absence of FGM. There was a significant relationship between FGM and the participant's attitude.

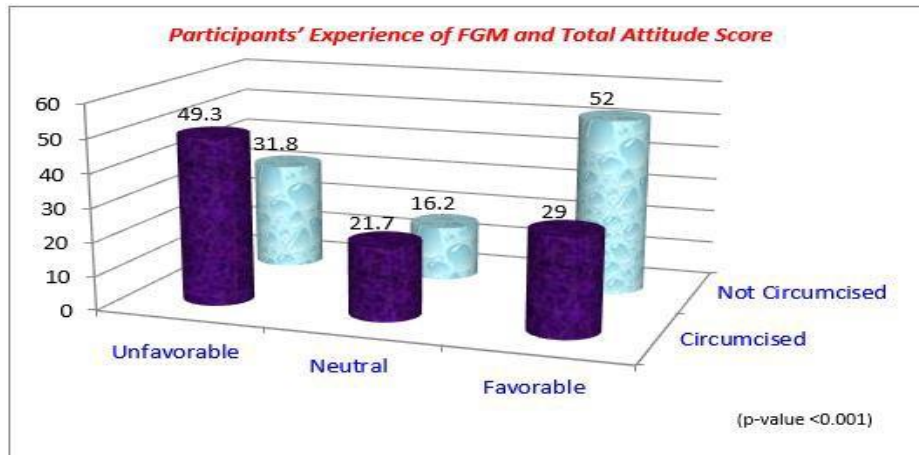


Figure (3): Participants' Experience of FGM and Total Attitude Score

Table (1) Presents the Association between FGM and the Sexual Score Domains and Total Score. It showed that there was a significantly higher Desire domain (5.8±1.8), Arousal domain (13.7±2.9), Lubrication domain (16±3.4), Orgasm domain (11.7±2.6), Satisfaction domain (13.3±2.4),

and Total score among not circumcised married participants than circumcised ones but the Pain domain didn't differ significantly between circumcised (9.7±3.3), and not circumcised (9.3±2.2).

Variables	Not Circumcised (no=291)	Circumcised (no=899)	P-value
Desire domain	5.8±1.8	5.1±1.7	<0.001*
Arousal domain	13.7±2.9	12.3±3.6	<0.001*
Lubrication domain	16±3.4	13.6±4.3	<0.001*
Orgasm domain	11.7±2.6	10.6±3.1	<0.001*
Satisfaction domain	13.3±2.4	11.8±3.6	<0.001*
Pain domain	9.3±2.2	9.7±3.3	0.052
Total score	64.3±10.8	58.3±14.6	<0.001*

*P-value is significant (p<0.001)

Figure (4): Presents Participants' Experience of FGM and Intention of Mutilating their Daughters. An association between females' intention of

mutilating their daughters and their mutilation experience was found. About 79.4% of females who experienced FGM/C had the intention to mutilate their daughters in the future, while only 20.6% of females who did not experience FGM/C had the intention to mutilate their daughters in the future.



Figure (4): Participants' Experience of FGM and Intention of Mutilating their Daughters

5. Discussion

The results of the current study revealed that the prevalence of Female Genital Mutilation (FGM/C) among total participants was 71.4%. This result is in accordance with other researches. In Nigeria, according to a 2013 Department of Health (DHS) report, one in every four women aged 15 to 49 has had FGM, with 82% of the procedures occurring before the age of five. The prevalence of FGM in Nigerian women aged 15 to 49 has been steadily decreasing, from 30% in 2008 to 25% in 2013 [23-26]. According to a study conducted in 2020 in the southern-eastern part of Nigeria, FGM was found to be 13.4% prevalent [27].

A study of Iraqi Kurdish females indicated that 70.3 percent of the participants had undergone FGM/C, but only 58.6 percent of them had been mutilated when clinically assessed. Female genital mutilation was most common in Erbil (62.9%) and Sulaimany (55.8%) governorates in Iraq's Kurdistan Region [28]. According to a study conducted in Iran, FGM was found to be prevalent in 50.5% of the population between the ages of 21 and 30 [29].

Several nations, including Sudan, Ethiopia, and Nigeria, have conducted studies on females' knowledge of FGM. FGM is viewed differently by girls and women in different countries. Mali, Sierra Leone, Guinea, and Somalia had the highest levels of support for FGM, with more than half of the female population believing the practice should continue [30].

Significant statistical relationship between participants' experiences to FGM and their total score of knowledge was revealed (p-value <0.001). It showed an association between good knowledge and circumcision. Good knowledge score was more prevalent among mutilated females. This may be due to their exposure to that experience give and encourage them to read and find out information related circumcision.

The understanding of females, males, midwives, and health care practitioners regarding FGM/C was the subject of much of the research, which was largely conducted in African countries. They intended to look at their participants' basic knowledge and attitudes about FGM/C, as well as its determinants, to see whether any intervention strategies could assist abolish the practice [31-34]. Other research was conducted in the Eastern Mediterranean region, Europe, and the United States [35-37].

Regarding the association between attitudes and FGM, the result of the current study revealed that unfavorable attitude score was more prevalent among mutilated females, while the favorable attitude was associated with the absence of FGM. There was a significant relationship between FGM and the participant's attitude (p-value <0.001). This may attributed to their exposure to complications after FGM which affect them and left bad personal experiences.

FGM/C is extensively done in societies where it is believed to promote marriageability. As a result, the practice of FGM/C will continue because parents believe it will provide a better future for their daughters, and some girls may even desire to be mutilated to find a husband. The hypothesis also suggests that in places where FGM/C is a part of the culture, no one will want to stop doing it because families are afraid of deviating from community norms [19].

Regarding the effect of FGM/C on Female Sexual Function there was a significantly significant total score of among not mutilated married participants than mutilated ones. This is agreeing with other studies that reported that un-mutilated subjects scored considerably higher on desire,

arousal, lubrication, orgasm, and satisfaction than the mutilated participants. Regarding the sexual pain domain, no apparent difference between the two groups was reported [38-39]. According to a study conducted by *KHEIR, et al., (2017)*; the study suggests that FSFI domains were significantly lower in women with FGM: for desire, arousal, lubrication, orgasm, satisfaction, and pain [40]. In contrast, in a study conducted in Sudan, there were no discernible differences between mutilated and non-mutilated women in terms of desire arousal, orgasm, or pain. This lack of discernible changes could be attributed to the traditional obligation of most women to conceal these experiences [41].

Concerning participants' experience of FGM and intention of mutilating their daughters; an association between females' intention of mutilating their daughters and their mutilation experience was found. Most of females who experienced FGM/C had the intention to mutilate their daughters in the future, while females who did not experience FGM/C had the intention to mutilate their daughters in the future. This may attribute to that culture, education, and residence play a curial role in individual intention. This is close to a study conducted in Iran that revealed that intention decrease with an increased level of education [41].

6. Conclusion

Good knowledge score was more prevalent among non-mutilated females. There was a significant relationship between FGM and knowledge, attitude, Sexual Score Domains, and intention to mutilate their daughters in the future (p-value <0.001).

7. Recommendations

1. Study Knowledge, attitude, and practice of medical care providers regarding FGM/C.
2. Inter-sectorial cooperation is being used by the MOHP, the Ministry of Justice, and the National Counsel for Women, the Egyptian Medical Syndicate, and the media to carry out a national program aimed at stopping FGM/C by healthcare professionals.

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