

Female Genital Mutilation: Females' Related Knowledge

Hanan Elzeblawy Hassan^{1*}, Rasha El-Syed Ebrahim¹, Momen Zakria Mohammed² and Fatima Hosny Abd-ELhakam¹

¹Maternal and Newborn Health Nursing, Faculty of Nursing, Beni-Suef University, Egypt

²Lecturer of Obstetrics and Gynecology, Faculty of Medicine, Beni-Suef University, Egypt

***Corresponding Author:** Hanan Elzeblawy Hassan, Maternal and Newborn Health Nursing, Faculty of Nursing, Beni-Suef University, Egypt.

Received: February 13, 2023; **Published:** March 10, 2023

Abstract

Background: According to a representative from the United Nations Population Fund in Cairo, Egypt's rate is so high that it accounts for one-fourth of all cases worldwide. Female genital cutting roots are unknown, but it is supposed to predate all religions, including Judaism, Christianity, and Islam, and to have been performed within all of these religions.

Aim: It was conducted to assess the level of total knowledge of females toward the practice of female genital mutilation (FGM).

Subject and 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. A Structured Interviewing Questionnaire sheet was used to collect data.

Results: The most of studied participants (71.2%) their age was 15 - 30 years old. The majority of studied participants (90.2%) were highly educated. More than half (57.5%) of studied participants were single, round two-thirds (65.4%) of studied participants were students. Only 25.7% of females had good knowledge regarding FGM/C, while 40.5% and 33.8% had poor and fair levels of knowledge, 71.3% of females mentioned that the source of their information about FGM/C was their personal experience. Poor knowledge score (37.1%) was more prevalent among females with circumcision (p-value < 0.001).

Conclusion: Knowledge score regarding FGM was poor for the most of participants. The main source of females' information was their personal experience. Poor knowledge score was more prevalent among mutilated females.

Recommendations: Development of an educational programs and brochures for mothers about FGM is required to increase their awareness.

Keywords: Female Genital Mutilation; Knowledge

Introduction

The expression of "female genital mutilation" began to gain support within the late 1970s because it established a transparent distinction from male circumcision. The word mutilation gave a lightweight to the violation of the act and thus gained national and international support for its elimination [1-6].

According to a representative from the United Nations Population Fund in Cairo, Egypt's rate is so high that it accounts for one-fourth of all cases worldwide [7-13]. Female genital cutting roots are unknown, but it is supposed to predate all religions, including Judaism, Christianity, and Islam, and to have been performed within all of these religions [14-19]. The practice's earliest traces in Africa can be traced back to ancient Egyptian Pharaohs, but some say that FGC has long existed in African cultures as a significant rite of passage from childhood to adolescence and maturity [20-23].

Female genital mutilation/cutting Female genital mutilation/cutting Female genital mutilation/cutting Female genital mutilation/cutting is also seen as a technique for cleaning girls in some societies. They consider that FGM/C should continue in order to preserve virginity and serve as a source of femininity [24]. Attitudes towards the continuation of FGM/C are influenced by the idea that the girl is a source of shame. People believe that because FGM/C decreases female libido, it lessens premarital sex and other forms of sexual activity [25-29].

The procedure of FGM/C is typically applied by knives, scissors, scalpels, glass, or razor blades. Additional damage occurs as a result of poor lighting, non-sterile equipment, and aseptic conditions. The procedure is typically administered by traditional healers, traditional birth attendants, barbers, or health care providers like midwives, nurses, and physicians. Members of the family help the performer by holding the girls to stop their movements and also the procedure usually takes from 15 to 20 minutes depending on the experience of the performer and the resistance of the girls. The age at which FGM/C is completed varies but it's usually done between the age of 4 and 14 years [30-32].

Aim of the Study

Study was conducted to assess the level of total knowledge of females toward the practice of female genital mutilation (FGM). This goal will be achieved through:

1. Assess the level of total knowledge of females toward the practice of FGM.
2. Assess participants' sources of knowledge related to FGM.
3. Assess the effect of female genital mutilation on females' related knowledge.

Research questions

1. How much do females in Beni-Suef know about the practise of FGM?
2. What are the FGM-related knowledge sources?
3. Is there relationship between female genital mutilation and females' related knowledge?

Subjects and Methods

Research design: The current study's objective was accomplished via a descriptive cross-sectional study.

Subjects and setting

Setting: The study was carried out at various Beni-Suef Governorate family health clinics (FHCs). The governorate of Beni-Suef is divided into seven sectors. The MCH was chosen at random from each region to reflect it geographically.

Sample

Sample type

A practical sample was employed. The following inclusion criteria were used to choose the study sample: women from 18 to 60 and reading and writing.

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.

Tools of data collection

Information was gathered using a pre-designed structured questionnaire. Data were gathered using in-person interviews. Six sections make up the questionnaire:

- Section I: Age, place of residence, amount of education, marital status, job, and history of mutilation are all included on a structured interviewing questionnaire sheet.
- Section II: Females' understanding of FGM/C Single-response and multiple-response questions was used to gauge the knowledge of the female population.
 - a) Single response questions: These covered women's awareness of FGM/prevalence, C's types, and methods, as well as its side effects, health impacts, and legal status in Egypt.

Scoring system

- If the responses were incorrect or unclear, it received a score of (0).
 - If the answers were accurate but incomplete, it received (1).
 - If all of the answers were accurate, it was given a score of (2).
- b) Multiple response questions: They included knowledge of females regarding the immediate and long-term health consequences of FGM/C. The correct responses and avoiding the incorrect ones were expected of the participants.

Scoring system

- If fewer than 25% of the responses were accurate, it was given a score of (0).
- If 25% to fewer than 50% of the responses were accurate, it received (1).
- If 50% of the responses were accurate, it received (2).

Following the conversion of the scores into percentages, the following categories are created from the overall score:

- Good level of knowledge $\geq 75\%$.

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

Validity of the tool

A jury of four women's health nursing experts and one from the field of biostatistics evaluated each tool's content validity to ensure its relevance and thoroughness.

Reliability of the tool

The knowledge evaluation sheet's reliability was assessed using the Cronbach's Alpha coefficient test. The high reliability indicated that the tool's pieces were reasonably homogeneous.

Ethical and administrative considerations

An official letter was sent from the nursing college to the director of the MCH Centers at Beni-Suef to obtain his authority to carry out the study after it had been approved by the nursing college and Beni-Suef University. Following an explanation of the purpose of the study and the interventions, each participant gave their oral consent. Each participant received assurances regarding the privacy of her data, the freedom to decline participation, and the right to leave from the study without facing any repercussions.

Pilot study

10.0% of the total subjects participated in pilot research to evaluate the usability and clarity of the study tools. The subjects of the study were not participants in the pilot trial.

Field work

The six-month data gathering period ran from the beginning of November 2021 through the end of April 2022. The sample was collected on Saturday, Tuesday, and Thursday between the hours of 9 a.m. and 2 p.m.

Statistical analysis

Using IBM SPSS 25, all data were gathered, tabulated, and statistically examined. Data were provided, and based on the type of data gathered; the proper analysis was done for each parameter.

Descriptive Statistics data were expressed as:

- The terms "count" and "percentage" are used to define and summaries categorical data.
- For quantitative data that is normally distributed, the arithmetic mean (\bar{X}) and standard deviation (SD) are utilized as measures of central tendency and dispersion.

Analytical statistics:

- Spearman-Brown and Cronbach's alpha coefficients: The internal consistency of the created tools was assessed to determine the dependability of them.

- Chi-square (2): used to determine if two or more proportions differ or if there is a relationship between two category variables. Wherever 2 were present, the Monte Carlo exact probability was applied to the Race tables.

Graphical presentation:

- Using a 3D graphic, Bie was used to visualize the data.

Results

The majority of the participants in the study (71.2%) were between the ages of 15 and 30 (Figure 1). Furthermore, the majority of the participants in the study (90.2%) had a high level of education (Figure 2). More than half (57.5%) of studied participants were single (Figure 3). About two-thirds (65.4%) of them were students (Figure 4). Regarding distribution of women based on their overall knowledge score: Only 25.7% of females had strong understanding about FGM/C, compared to 40.5% who had low awareness and 33.8% who had fair knowledge (Table 1). 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, 22% from TV or radio, 22.1% from the internet, 5.1% mentioned religious leaders, 10.3% from doctors and nurse, 8% from the lecture about FGM and 0.03% of females read about FGM/C health consequences in books (Figure 5). There was a link between ignorance and circumcision. Females who have undergone circumcision were more likely to have low knowledge scores (37.1%). Fair knowledge, however, was more common (51.9%) among the uncircumcised. The correlation between participant knowledge and circumcision was significant (p-value 0.001) (Table 2).

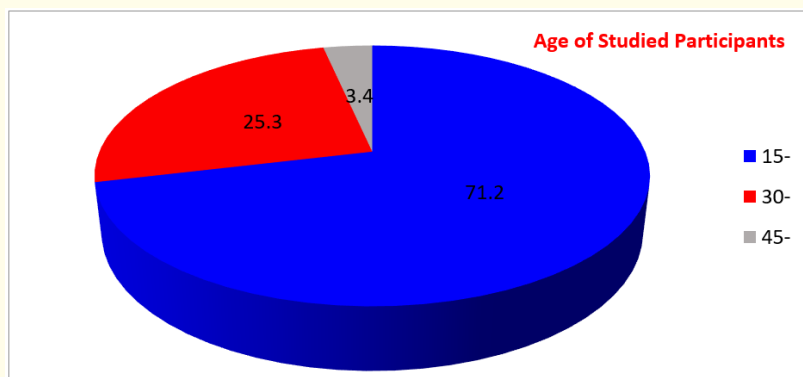


Figure 1: Age of the studied participants.

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

Table 1: Total knowledge score categories among the studied participants.

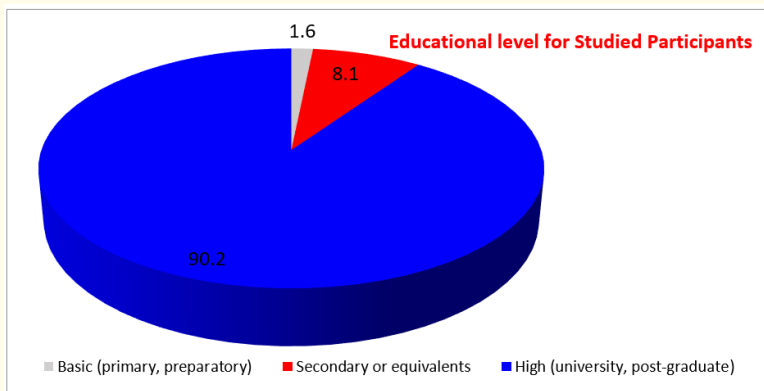


Figure 2: Educational status of the studied participants.

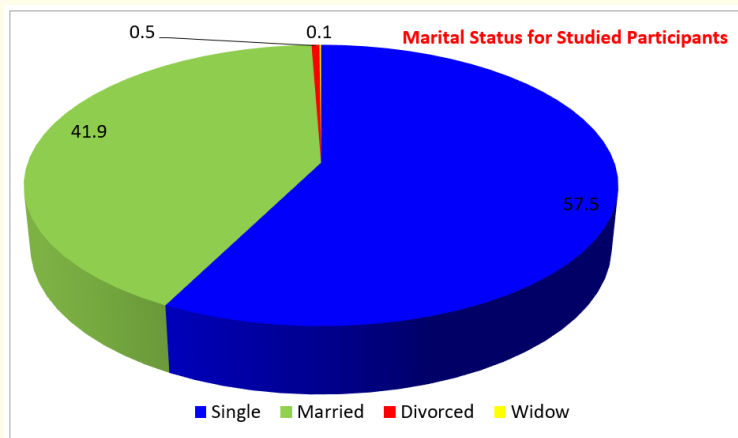


Figure 3: Marital status of the studied participants.

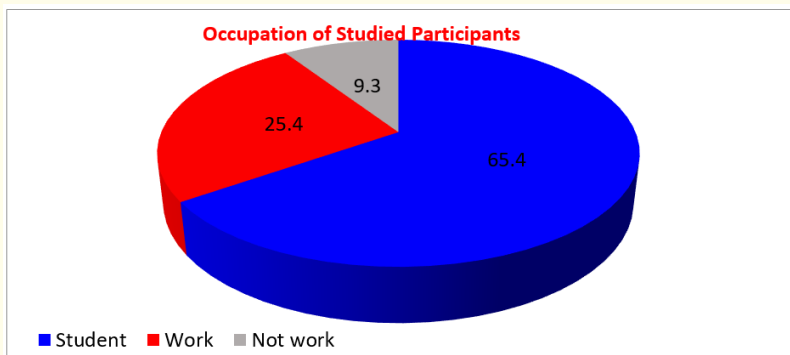


Figure 4: Occupation of the studied participants.

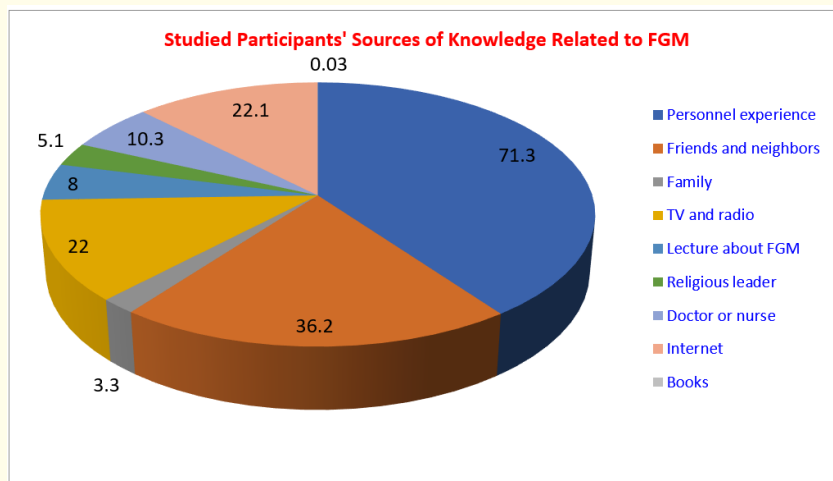


Figure 4: Occupation of the studied participants.

Knowledge score categories	Are you circumcised				Total		
	Yes (n = 2021)		No (n = 816)				
	No	%	No	%			
Poor knowledge	750	37.1	210	25.8	960	33.8	
Fair knowledge	725	35.9	424	51.9	1149	40.5	
Good knowledge	546	27	182	22.3	728	25.7	
Total	2021	100.0	816	100.0	2837	100.0	
P-value	<0.001*						

Table 2: Association between the participants' knowledge and their circumcision.

*P-value is significant.

Discussion

The current study was conducted to assess the level of total knowledge of females toward the practice of FGM, and assess participants' sources of knowledge related to FGM. Less than one-third of the female participants in the study had good understanding of FGM/C. This may attribute to that the most of the studied females were young aged and rural residents. This result was much lower than results reported in Sudan and Nigeria which reported that most females had a good level of knowledge relating to FGM/C [33,34].

WHO reported that Female genital mutilation/cutting has no benefits; on the contrary, it has both physiological and psychological consequences, including short- and long-term effects. The approach used to perform the procedure may influence the severity of the short-term consequences [22]. Circumcision deprives the woman from her right in healthy sexual life through cutting the most sensitive organs such the clitoris that is necessary for good sexual sensation and satisfaction not only for the wife but also for her partner. The complications include disfigurement of the external genitalia as well as hemorrhage that might be fatal and lead to loss of female life [35,36].

Several countries, including Sudan, Ethiopia, and Nigeria, have carried out research on the awareness of FGM among females. Girls and women in various nations have diverse perspectives on FGM. The highest rates of FGM support were seen in Mali, Sierra Leone, Guinea, and Somalia, where more than half of the female population thought the procedure should continue [37].

In Mauritania, Ouldzeidoune (2013) discovered that 91.7 percent of females had heard about FGM/C and 64.4 percent of them wanted the practice to continue (had an unfavorable attitude) [38]. Whereas in Somalia, Adigüzel., *et al.* 2019 discovered that the majority of females had a good level of knowledge about FGM/C, 92.1 percent of them saw FGM/C as a health problem, and 91 percent wanted the practice to be In Ethiopia, females' knowledge and attitudes toward FGM/C varied by area and ethnicity of the interviewees [39].

Additionally, it was lower than Mohammed., *et al.* (2018) studies' findings, which showed that more than half of the female participants had a good level of understanding. The fact that the present study covered a wide range of FGM/C knowledge topics, including names, occurrence, types, complications, and legalization of FGM/C in Egyptian law, as opposed to other studies that focused primarily on the health issues related to FGM/C, may help to explain the difference in knowledge levels [40].

Participants' experiences with FGM and their overall knowledge score were found to have a statistically significant relationship (p -value 0.001). It demonstrated a connection between wisdom and circumcision. Females who had been mutilated were more likely to have high knowledge scores. This might be as a result of their exposure to that experience, which encouraged them to read and learn more about circumcision.

Conclusion

Most participants had inadequate knowledge scores on FGM. Females' personal experiences served as their primary information source. Females who had been mutilated were more likely to have low knowledge scores.

Recommendation

1. To raise mothers' awareness of FGM, educational programmes and pamphlets must be developed.

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