

Final Report

Clinic-based Investigation of the Typology and
Self-reporting of FGM in Egypt

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Executive Summary

Recent studies of female genital mutilation in Egypt have provided varying rates of prevalence among different types of populations. Although most studies found high rates of FGM it was not until 1995 Demographic and Health Survey in Egypt (EDHS) that a nationally representative survey measured FGM among women of reproductive age. The 1995 EDHS results indicate an FGM prevalence of 97%. Although the 1995 Egypt DHS included an extensive module on the attitudes and practice of FGM, only limited information could be obtained from the women themselves on the severity of the FGM procedure. Since it was considered important to have more detailed information on the types of FGM practiced in Egypt, a clinic-based study of FGM was designed and carried out by the Egypt Fertility Care Society.

The study involved interviews with clinic clients to elicit information about their experience and attitudes concerning FGM, and gynecological examinations by specially trained OB/GYN physicians. The information collected in the clinical examinations on the range of the severity of the FGM practice represented the first time that information on the typology of FGM has been systematically recorded in Egypt. By comparing the women's reporting of their FGM status in the interviews using the EDHS questions with the results of the physical examination, the study also allowed for an assessment of the accuracy of self-reporting of FGM in interview situations like that of the 1995 EDHS.

This study's sample of 1,339 women was drawn from the out-patient services at eleven clinics providing gynecological and family planning services. Five of the sites are University hospitals (from which the preponderance of the sample was drawn), four are Ministry of Health and Population rural hospitals, and two are Clinical Services Improvement clinics. Data was collected during June 24 - August 8, 1996.

The self-report findings indicate an FGM prevalence of 97%. Agreement between self-reporting and examination findings (either negative or positive reports) occurred in approximately 94% of the cases. Conversely, about 6% of the cases revealed a discordance between the self-report and the examination. In all, 93% of the women in this study were found to have some type of FGM.

Regarding the range of FGM practices, the partial or total removal of both the clitoris and labia minora was found in approximately 60% of the women examined. This is the most common type FGM practice observed in the study. Approximately 9% of the women in the study were found to have had the tissue of the labia majora excised.

The study's findings have been incorporated in the final report of the 1995 Egyptian Demographic and Health Survey, and are meant to contribute to the scientific understanding of the practice of female genital mutilation in Egypt.

Abbreviations

ANE OR/TA	Asia and The Neat East Operations Research and Technical Assistance Project, The Population Council
CSI	Clinical Services Improvement Project
DHS	Demographic and Health Survey, Macro International
EDHS	Egyptian Demographic and Health Survey
EFCS	Egyptian Fertility Care Society
FGM	Female Genital Mutilation
MOHP	Ministry of Health & Population
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

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I. Background

Female genital mutilation (FGM) which is performed mainly on pre-adolescent girls involves the partial or total excision of external parts of the genital tract (labia minora, labia majora and clitoris). Use of the term "female circumcision" incorrectly implies that male and female circumcision have parallel medical implications, when in fact the latter has severe adverse health effects to females.

A widely recognized report on FGM (Africa News, 1980) lists both the immediate and the long-term adverse effects of the mutilation of female genital organs. The most severe complications include death from uncontrollable bleeding or from shock due to overwhelming pain and blood loss. Organs near the vaginal opening, including the vagina, rectum, bladder and urethra are often injured leading to persistent disabilities such as incontinence (or the inability to control urination or bowel movements). Infections of the wound are common when the procedure is done by lay practitioners resulting in infertility or in the case of tetanus, death. Complete closure of the wound in the case of infibulation may cause urinary retention. Debilitating menstrual pain is brought about by the difficulties of passing urine and menstrual blood after infibulation. Malformation of the genital area, including cysts and hardening of scar tissue also occurs. Painful urination is common after the operation even with milder forms of FGM. Clitoridectomy can result in recurrent long-term health problem such as urinary disturbances and infertility. Scientific research has also shown that in some cases, displacement of the nerve endings in the area makes sexual intercourse very painful (dyspareunia). Childbirth difficulties are another consequence. The hardened scars dilate insufficiently, tearing instead of stretching which can cause damage to the baby, especially with the first child as well complicating the postpartum recovery of the woman. Rupturing of the vagina (vaginal fistulae) is sometimes caused by obstructed labor, bringing on incontinence and turning the woman into a social outcast. Unassisted delivery is impossible for an infibulated woman and both mother and baby risk dying if there is no one to cut open the vagina to allow passage of the baby.

Gilbert (1993) cites that in countries where FGM is practiced, it is done by local women (mainly dayas) on babies just a few days old, girls just before marriage or young women pregnant with their first child. The mutilation in its severe forms can result in the accumulation of menstrual blood and pelvic inflammatory disease often leading to infertility, urinary tract infections and calculus formations. Between 20 and 25% of the cases of infertility in Sudan (where infibulation is widely practiced) have been attributed to female genital mutilation. FGM prevalence is more than 80% in north and central Sudan. In Somalia almost 100% of the women are infibulated. In Ethiopia/Eritrea, Mali and Sierra Leone 90% of the women have undergone some form of genital mutilation. The rate reaches 70% in Burkina Faso, 60% in Kenya, Gambia and the Ivory Coast and 50% in Senegal, Guinea Bissau and Nigeria (Gilbert, 1993). Although FGM is mainly done in Moslem regions the practice is not necessarily associated with a religion. For example, in many Muslim countries the practice is unknown, (e.g., in Saudi Arabia, Iraq, Syria and Tunisia), whereas in Egypt Christians also practice it. It is important to consider FGM as an embedded cultural practice that serves a "functional" role for women within their society. Often the excision is part of a larger cultural ritual that mark a young girl's transition to womanhood or her preparation for marriage. Women's attitudes towards FGM are deeply affected by the ritual's seeming inevitability and by the fear of social consequences should the operation not be performed. Women readily acknowledge that the practice is a cruel prerequisite for marriage. When marriage is the only acceptable vehicle for childbearing, by which women acquire their status in many societies where FGM prevails, to be husbandless is to be a social outcast. The physical pain of the FGM practice is thus viewed less of a burden than the social sanctions of being unmarriageable. There seems to be no incentive to dispense with the custom since no alternative is offered in terms of women's self - and community identity. Hence, women themselves are often the strongest advocates of an admittedly painful custom as it represents to them a social and psychological reality. Young girls are consequently taught to accept the FGM procedure a necessary step towards womanhood and marriage (UNICEF, 1981).

II. Problem Identification and Study Justification

FGM in Egypt persists despite a history of efforts to discourage the practice. While the milder forms of partial or total excision of the clitoris are thought to be usually performed, adverse health effects (physical and psychological) are frequently reported by the Egyptian medical community.

Prior to the 1995 EDHS it was believed that FGM was on the decline, prevailing mainly among illiterate populations and the lower and middle classes. However, results from the EDHS --which included for the first time questions on FGM-- show that FGM is virtually universal among ever-married women in Egypt; the prevalence rate is 97 percent (EDHS, 1996). Most procedures took place during childhood (the median age at time of the FGM is around 10 years), and were performed by untrained providers (mainly dayas). Doctors performed only about 10% of the procedures reported by ever-married women. Information collected from women about their daughters suggest that FGM practices may be changing. For example, doctors are currently more likely to perform an FGM practice today than they were in the past. Women's attitudes about FGM may be changing, but very slowly. Currently, 82% of ever-married women 15-49 years of age believe that FGM should be continued.

The 1995 EDHS prevalence estimate of FGM in Egypt is comparable to the results of a number of other, smaller scale studies. These studies have shown that FGM is quite common, especially in rural areas and urban slum areas where residents are of rural origin. For example, in a 1978 survey commissioned by the Cairo Family Planning Association (CFPA), at least 80% of rural and urban Egyptian women living in the areas covered by the survey were found to have undergone FGM (cited in Hussein, 1993).

In a more recent survey carried out in Lower Egypt to study the prevalence of maternal morbidity in Menoufeya Governorate (EFCS, 1995), a sub-group of the study sample was gynecologically examined. Results from the exam show that among 1,243 women, 93% had some type of FGM. Varying degrees of FGM were observed in the study sample. Among 68% of all women examined both the clitoris

and labia minora removed; only the clitoris was removed in 14% of the cases, and in 5%, only the labia minora was removed. It is of interest to note that in this sample of women residing in a Lower Egypt governorate, 6% had undergone infibulation (removal of labia majora among other parts), whereas only 88 women (7%) had no evidence of FGM.¹

As the literature review suggests, comparatively little information has been systematically obtained on the practice of FGM in Egypt and particularly on the degree of severity of the procedures which women undergo. This study was undertaken to contribute to a greater understanding of the nature of FGM practices in Egypt. In addition, the study offered the opportunity to assess the extent to which women accurately report their FGM status during interviews such as that conducted in the 1995 EDHS survey.

III. Study Objectives

In summary, the major objectives of this study are:

1. To obtain descriptive information about the range of FGM practices in Egypt from a clinic based population.
2. To investigate the accuracy of self-reporting of FGM.

IV. Research Design

A cross-sectional design was used to compare results from the same questions used in the 1995 EDHS on FGM with results from a physical examination

¹ A pilot study involving the subset of women with no FGM and their controls (matched on age and place of residence) is currently underway using qualitative research methods to investigate the cultural and social determinants of this practice. This study (carried out by EFCS and funded by the Population Council's ME Awards) will develop a questionnaire that will examine the effects of FGM on women's lives, physiological and psychological health. The questionnaire will be fielded in subsequent studies.

performed by a specially trained OB/GYN specialists. The study was carried out in a total of eleven clinics providing gynecological and family planning services located in seven Governorates (Alexandria, Assiut, Behira, Cairo, Dakahlia, Giza, and Minia). The participating sites included five university hospitals (Al Hussein, Al Minia, Al Shatby, Assiut, and Mansoura); four MOHP rural hospitals (Al Baramoun, Mousha, Nahya and Mansoureira) and two Clinical Services Improvement Project (CSI) clinics (Agouza and Sidi Bishr) during the period from June 24 to August 8, 1996. These sites were purposively selected on the basis of the following criteria;

1. High caseload allowing for recruitment of 1,000-1,500 women of varying socio-economic backgrounds and diverse age groups within a relatively short period of time (approximately one month);
2. Availability of skilled gynecologists to undertake the physical examinations;
3. Presence of research-oriented clinic staff to facilitate patient interviews.

Women accepting to participate in the study were first interviewed by female interviewers in private, using a standardized questionnaire composed of the 1995 EDHS questions on FGM and respondent characteristics. They next underwent a gynecological examination to assess the physical evidence of FGM. Standardized procedures for conducting the gynecological examination were adhered to by the largely female OB/GYN physicians collecting this information.

V. Study Implementation

A. The Study Questionnaire

The study questionnaire was limited to the exact same items on FGM utilized in the 1995 EDHS, including questions on both the women's and daughter's experience of FGM. In addition, the same questions used in the 1995 EDHS relating to the background information of the respondents were also included. Clinical information (recorded by the examining physician) was limited to information on the presence or absence (partial or total) of female genitalia excised during FGM.

Clinical data was recorded on a separate sheet that identified the woman's only by a serial number. The sheet was later clipped to the woman's interview questionnaire (which also did not contain the woman's name) after the interview was complete). Thus, physicians and interviewers were both unaware of the results of the interviews or clinical exams.

The necessity of maintaining the confidentiality of study findings had a number of implications for the training of researchers, including limiting the number at each site. At least one supervisor was appointed in each site to monitor the flow of activities, ensure that informed consent was properly obtained prior to the conduct of the interviews, transfer the coded serial number of each interviewed women onto the clinical sheets, check that the results of the clinical examination were fully recorded and the clinical sheet was returned and clipped to interview questionnaire of the same woman, while respecting the procedures to ensure the confidentiality of the data collection procedures.

B. Training of the Research Team

1. Training of Interviewers

Selection was made of 35 female interviewers from those who previously worked on the 1995 EDHS. A training session was held that provided theoretical training on the medical component of the study, the purpose of the study; and the need for obtaining informed consent from study participants. This was followed by extensive training on the conduct of interviews in a clinical setting, (which is to a great extent different from the interviewers' previous experience with home interviews).

2. Training of Physician

It is widely acknowledged that most physicians in Egypt lack the training (both theoretical and practical) on the anatomy of the external parts of the female genitalia removed during FGM. Thus all of the physicians conducting the clinical examinations received specialized training. University hospitals were requested to select a senior staff physician to conduct the clinical training of other hospital staff who carried out gynecological examinations. These university faculty were trained theoretically by the study's principal investigator and were instructed to clinically train and then supervise their colleagues during the data collection. Physicians working in MOH rural hospitals were subsequently trained by the faculty from the university hospital in their area.

VI. Results

Data on 50 women recruited into the study at one of the MOH Rural Hospitals (Mansoureya) was excluded from the study because of the attending physician's failure to comply with the prescribed data collection procedures. A total of 1,348 women were interviewed in the study at the other ten sites. Of those, nine cases were excluded from analysis for the following reasons. Accordingly, a total of 1,339 women are included in the present analysis.

<u>No. of cases</u>	<u>Reason for Exclusion</u>
1	Woman's age outside studied age group (55 years)
5	Examination findings were inconclusive on circumcision status (physician unable to state presence/absence of examined part)
3	Woman claimed a natural FGM status e.g.; congenital absence or atrophy of part(s).

It should be noted that results reported here are based on information collected from clients of gynecological and family planning services in university hospitals and, to a lesser extent, MOH rural hospitals and CSI clinics. These women are predominantly from the lower socio-economic segments of Egyptian Society. Representation of the higher socio-economic classes (i.e.; women who do not utilize public health services for their health care) was not possible due to the difficulty/impossibility of studying the patients of the private physicians. Overall, the study's sampling procedures and size do not permit it to be considered as being representative of Egyptian society. However, the results are revealing of FGM practices that took place 20 - 30 years ago (50% of respondents are 20 - 35 years of age) among women who currently seek care at the country's university hospitals. The findings with regard to the accuracy of self-reporting of FGM are also indicative of the level of misreporting that occurs in studies of FGM like the 1995 EDHS survey.

A. Characteristics of Studied Women

Table 1
Selected socio-demographic characteristics of respondents and their families

Background characteristics	% (n = 1,339)
<u>Age</u>	
15-19	5.9
20-24	17.8
25-29	21.5
30-34	20.5
35-39	15.3
40-44	11.8
45-49	7.2
<u>Age at marriage</u>	
15-19	64.0
20-24	26.4
25-29	7.8
30-34	1.3
35-39	0.5
<u>Number of living children</u>	
None	19.8
1	12.9
2	17.1
3	15.8
4	13.0
5	9.6
6+	11.8
<u>Family type</u>	
Nuclear	81.9
Extended nuclear	12.8
Extended	5.2
<u>Current marital status</u>	
Married	98.0
Widowed	1.4
Divorced	0.6
<u>Schooling</u>	
None	43.8
Some primary	15.9
Completed primary-some secondary	20.5
Completed secondary and higher	19.7
<u>Religion</u>	
Muslim	95.4
Christian	4.6

Table 1
Selected socio-demographic characteristics of respondents and their families (Cont.)

Background characteristics	% (n = 1,339)
<u>Rural/Urban residence</u>	
Urban	45.3
Rural	54.7
<u>Place of residence</u>	
Urban Governorates	28.2
Lower Egypt	33.8
Upper Egypt	37.5
<u>Husband education</u>	
None	30.8
Some primary	7.8
Completed primary-some secondary	29.0
Completed secondary and higher	30.8
Don't know	1.6
<u>Working for cash</u>	
Worked before marriage	
Yes	24.3
No	75.7
Working for cash now	
Yes	14.6
No	85.4
<u>Father's education</u>	
None	67.7
Primary-preparatory	20.5
Secondary and higher	6.7
Do not know	5.2
<u>Mother's education</u>	
None	82.3
Primary-preparatory	12.3
Secondary and higher	3.4
Don't know	1.9

As Table 1 presents, the majority of women interviewed in this study are young (66% were below age 35), and only 10% were aged 45-49 years. The vast majority are Muslim (95%); all are ever married (either currently married, widowed or separated). The majority of these women were married below age 20 (64%), and currently live in a nuclear family setting (82%). Almost 35% of the women have four or more children; 44% had no formal education and only 20% completed secondary or higher education. Educational attainment of the women's husbands was higher: only 31% had no formal education while 31% completed secondary or higher

education. Women were asked about the educational attainment of both parents in their family of orientation (as one of the correlates of their FGM status). The vast majority of their mothers were illiterate (82%), whereas their fathers were more likely to be educated (an illiteracy rate of 68%; 21% completed primary/preparatory education and 7% completed secondary or higher education). As regards the women's place of residence, a higher proportion live in rural areas (54.7%) compared to urban areas (45.3%). Geographical distribution of the sample covered Upper and Lower Egypt (37.5% and 33.8%, respectively), Urban Governorates (28.2%) and Frontier areas (0.5%).

B. Accuracy of the Self-Reporting of FGM

The accuracy of women's self-reported FGM status is examined in this study by comparing women's own reports of their FGM status (obtained from the interview conducted prior to the

gynecological

examination) to the

findings of the

examination. In the

interview, 97% of the

women indicated some

type of FGM, whereas

during the gynecological

examinations physical

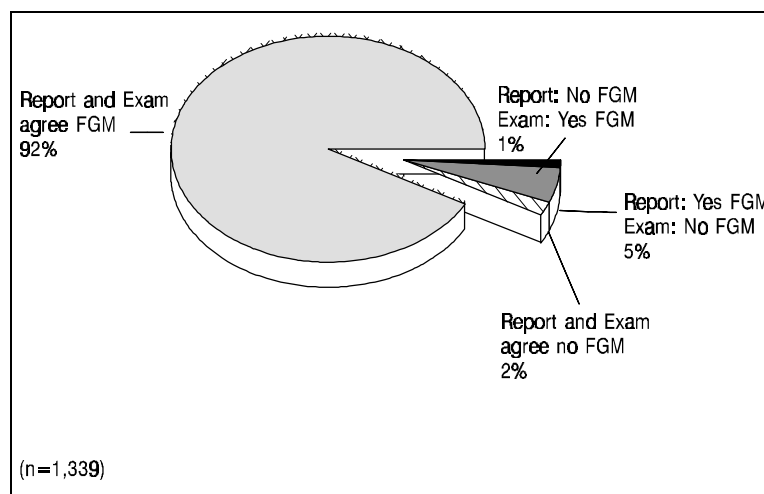
evidence of FGM was

noted in 93% of the women. Agreement between self-reporting and examination

findings (either negative or positive reports) occurred in 1,258 out of the 1,339

cases examined (94%). Among the remaining cases, 5% of the women reported

that they had been circumcising but were found not to have any evidence of FGM on examination, while 1% of the women had reported that they were not circumcised



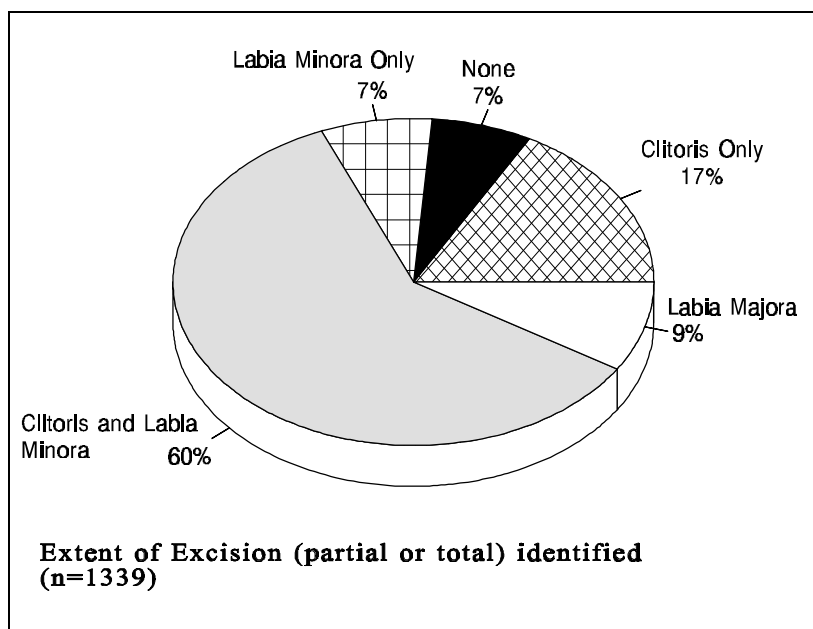
but some evidence of FGM was found during the examination.²

C. Typology of FGM

Although the World Health Organization has suggested a classification scheme for the severity of FGM (WHO, 1996), it has not been widely adopted or agreed upon. Therefore

for this study the following typology was developed based on the results of the physical examinations:

1) no evidence of FGM (all external genital parts were found intact); 2) partial/ total excision of clitoris only; 3) partial / total excision of labia minora only; 4) partial / total excision of both clitoris and labia minora and 5) any excision in labia majora.



Of all women examined, 7% showed no evidence of FGM. Partial or total excision of the clitoris only was noted in approximately 17% of the cases, whereas partial or total excision of the labia minora only was found in approximately 7% of the cases. The partial or total removal of both clitoris and labia minora was the most frequently identified type of FGM, being present in approximately 60% of the 1,339 women examined. A comparatively small group (9%) of the women exhibited evidence of a more severe form of FGM in which tissue of the labia majora is excised.

² Approximately one third of the discordant cases came from one clinic.

D. FGM Status by Background Characteristics

Table 2

Percent distribution of women for whom evidence of FGM was found during the physical examination by the type of FGM performed according to selected background characteristics *

Type of FGM	Partial/total excision of clitoris	Partial/total excision of labia minora only	Partial/total excision of clitoris and labia minora	Any excision of labia majora	Total Percent
<u>Age</u> (n = 1,249)					
15-24	23.4	7.4	60.2	9.0	100%
25-34	17.0	8.5	65.8	8.7	100%
35-49	17.6	7.4	64.4	10.6	100%
<u>Urban-rural residence</u> (n = 1,249)					
Urban	13.8	9.7	68.5	8.0	100%
Rural	22.5	6.5	60.5	10.5	100%
<u>Education</u> (n = 1,249)					
No education	19.0	6.0	64.9	10.1	100%
Some primary	21.8	7.9	62.4	7.9	100%
Completed primary some secondary	19.8	8.4	63.4	8.4	100%
Completed secondary/higher	14.0	11.8	63.8	10.4	100%
<u>Person performing circumcision</u> (n = 1,225)					
Trained medical provider					
Traditional pract.	15.4	10.8	64.6	9.3	100%
Missing	18.9	7.2	64.4	9.6	100%
	35.5	6.5	48.4	9.6	100%

* Based on FGM cases as confirmed by physical examination.

Partial/total excision of both labia minora and clitoris was the form of FGM most prevalent among all the women studied, irrespective of the background characteristics or person performing the operation (around 65%). However, partial or total excision of only the clitoris was more prevalent in the younger age groups (15-24 years) and in rural areas (23%). This finding is suggestive of a shift away from the more severe forms of FGM (excision of both clitoris and labia minora) to what is commonly thought of as a type of FGM with a reduced risk of complications (as fewer parts of the genitalia are effected). However, the accuracy of this belief can be questioned since the excision of part/all of the clitoris carries with it the hazards of severe hemorrhage and the long-term physiological morbidities and psychological trauma.

Table 3
Presence of any type of FGM (as determined by physical examination)
and selected socio-demographic characteristics of the
women's spouse and parents

Characteristics	Physical Evidence of FGM (%)	No Physical Evidence of FGM (%)
<u>Husband Schooling</u> (n = 1,339)		
None	96.1	3.9
Completed some primary	95.2	4.8
Primary-some secondary	94.6	5.4
Secondary and higher	88.6	11.4
Do not know	95.5	4.5
<u>Husband profession (occupation)</u> (n = 1,339)		
Professional	83.3	16.7
Administrative	87.0	13.0
Clerical	93.0	7.0
Salesman	95.7	4.3
Services	94.7	5.3
Agriculture	97.4	2.6
Production	93.2	6.8
Others	100.0	0
<u>Father education</u> * (n = 1,339)		
None	95.3	4.7
Primary-preparatory	95.6	4.4
Secondary and higher	68.9	31.1
Do not know	89.9	10.1
<u>Mother education</u> * (n = 1,339)		
None	95.4	4.6
Primary-preparatory	89.1	10.9
Secondary and higher	54.3	45.7
Do not know	100.0	0.0

* P < 0.05 Significant Association Because of the very large proportion of women who were found to have some type of FGM, statistical analysis to determine significant associations was problematic (given the skewed distributions of the response). However, the findings in Table 3 indicate that the likelihood that the woman has some type of FGM decreases if her husband or either of her parents (particularly her mother) have a higher education.

E. FGM Status and Intention to Circumcise Daughters

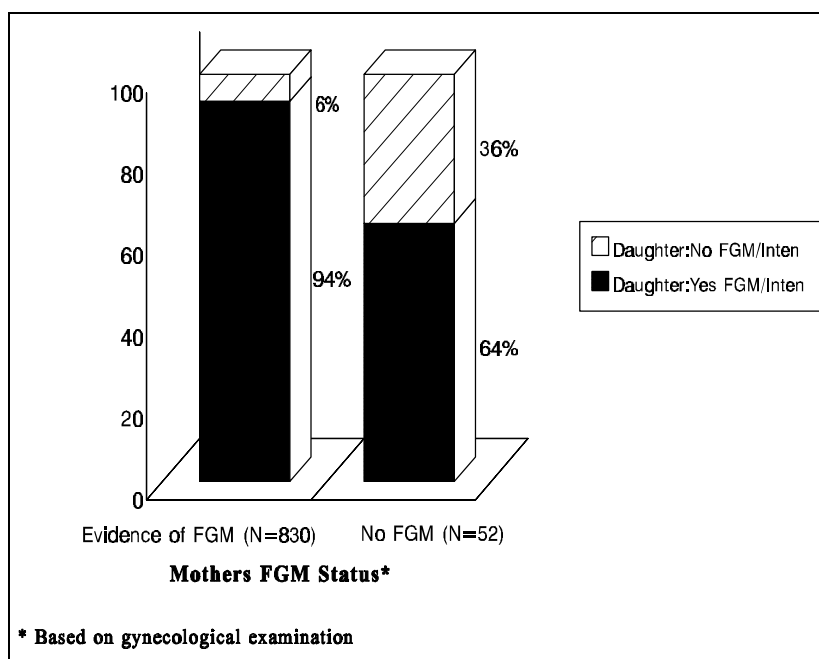
Table 4
FGM status and intention for daughters among all women

Status of the daughter(s)	No.	%
Have no daughter	457	34.1
FGM	405	30.2
No FGM but intend to circumcise	404	30.2
No FGM nor intend to circumcise	73	5.5
Total	1339	100

Women were asked about the FGM status of their daughters and, in cases where the daughter(s) has not yet undergone FGM, whether the woman intends to have the daughter undergo the procedure in the future. Table 4 shows that of all women interviewed, 34% had no daughters; an equal proportion (30% each) either had a daughter with FGM or indicated she intended to have a daughter undergo an FGM procedure. Only 6% of the women did not intend to have FGM practiced on their daughter(s).

F. FGM Status of Mothers and Daughters

Analysis of the reports on actual FGM practice or intentions for her daughter (among women with daughters) by the woman's own FGM status showed that women with FGM themselves are more likely to have practiced FGM or intend to do so on their daughters, than women who have no FGM, (94% and 64%,



respectively). However, the fact that 64% of the women with no indication of FGM have already performed FGM on their daughter(s) or intend to do so in the future is indicative of the social pressure to perpetuate the practice even where the mother herself is not circumcised.

G. Why not Practice FGM on Your Daughter?

Table 5
Reasons given for no FGM practice or intentions for their daughters by all women

Reason*	% of women citing the reason
Unacceptable	58.9
Fear of complications	39.7
Against religion	19.2
Better marriage	4.1
More satisfaction to woman	8.2
Others	2.7

* n = 73 women who gave multiple reasons

When asked about the reason(s) underlying the woman's decision not practice FGM on her daughter, the major reason given is that the practice is unacceptable (59%), whereas fear of complications accounted for 40% of the responses. Also of note is the fact that 19% of the women who decided not to have FGM practiced on their daughters stated that they believed that FGM is against religion (See Table 5, above).

H. Persons/Factors Influencing Decision for Daughter's FGM

Table 6
Factors or persons influencing the mother's decision about her daughter's FGM

Factor/Person **	% (n = 882)*
Husband	10.0
Mother	15.4
Mother-in-law	10.0
Relatives of mother	10.5
Relatives of husband	5.9
Neighbors	7.5
Girl herself	1.0
Customs	39.1
Others	1.1
No body	33.9

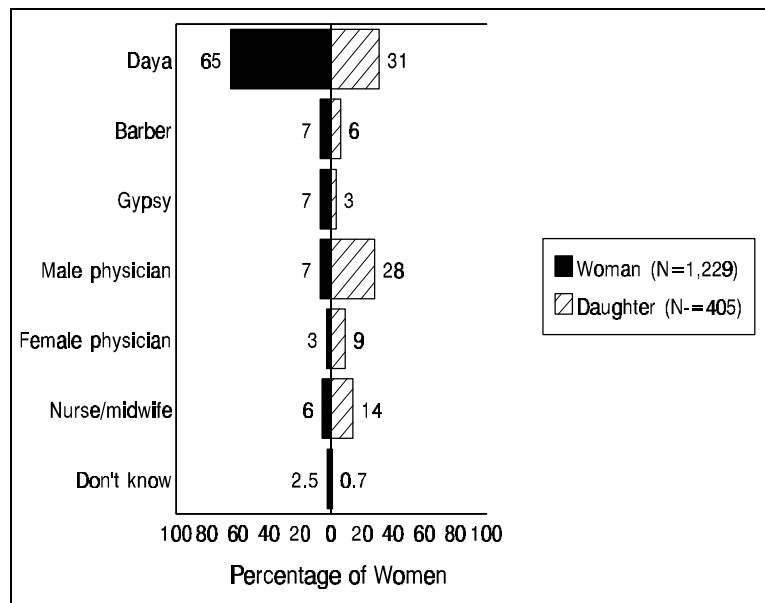
* Based on women with daughter only (n=882)

** More than one reason may be given by each participant

When asked about the most influential person(s) or factors in the woman's decision or intention to have her daughter practice FGM, the majority of women (39%) cited it being a custom as the main factor. Husbands have a marginal role to play in this decision (cited by only 10% of the women). The proportions citing other relatives vary between 10 and 15%, with mothers mentioned most often. Contrary to anecdotal reports that the girls themselves want to be circumcised, only 1% of the women cited the daughter's wish as factor in their decision (see Table 6).

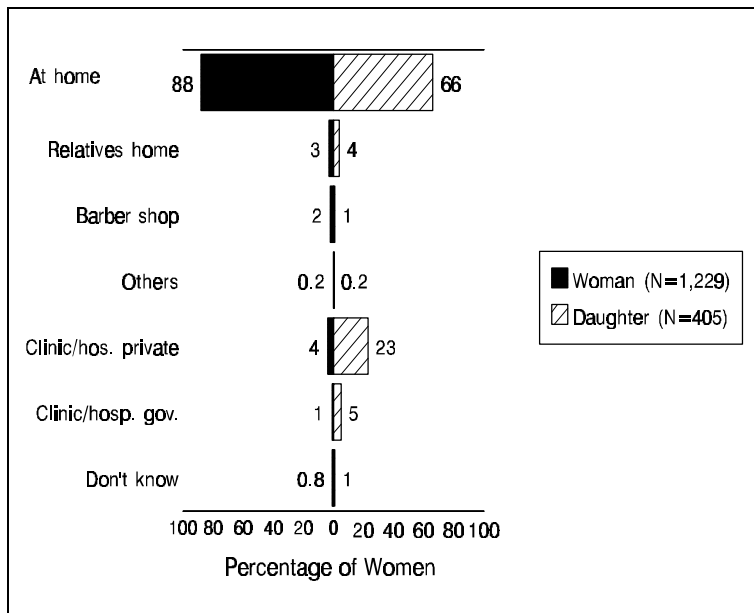
I. Daughter's and Mother's FGM Experience

Figure 4 presents results comparing the type of person who performed the FGM procedure for the woman and her daughter (among those groups who had some type of FGM). There clearly appears to be a shift away from the use of dayas towards medical personnel between the two generations. Among daughters, however, the proportion who resorted to a daya is important.



Corresponding to the

changes in the providers of FGM there appears to be a shift in the place where the FGM procedure is performed (Figure 5). Whereas both the women and their daughters are more likely to have had the FGM procedure performed at home, their daughters have a greater likelihood to have had the FGM procedure performed at a health care facility.

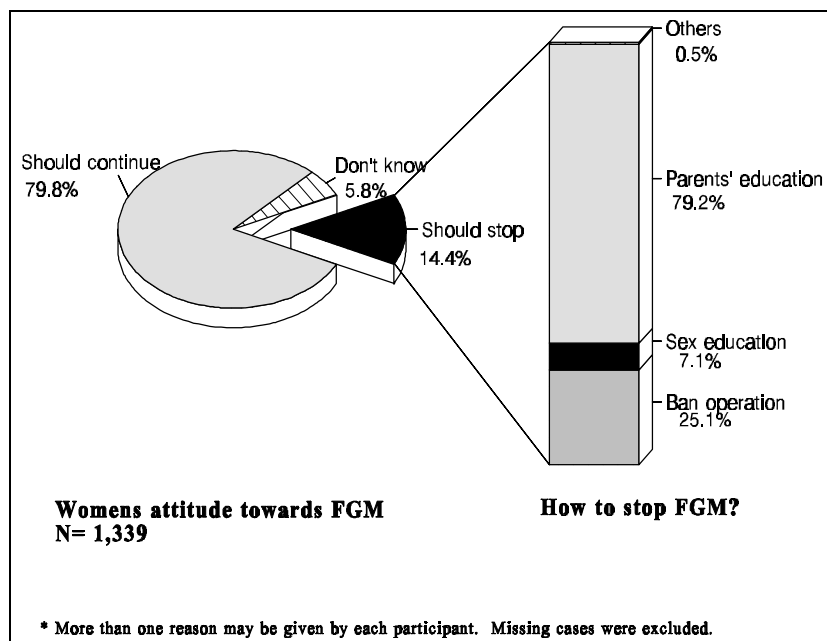


J. Women's Attitudes on FGM

Among the 1,339 women interviewed approximately 80% think that the practice of FGM should continue. Another 6% are undecided or feel they did not have an opinion on the subject. Approximately, 14% stated that FGM should be stopped.

Women who thought FGM should be stopped (193 women) were asked to give the reasons for this opinion. 43% view it as a bad custom, 42% fear the risk of complications, and 22% confirmed that it prevents satisfaction with marital relations. Remembering their own experience, 19% of the women said it was a bad experience. An additional 17% believe it is against religion.

Women who felt FGM should end were asked about the means to eradicate the practice. Among the women who offered suggestions, 79% emphasized the importance of educating parents on the hazards of the operation and 25% indicated that passage of a law to stop practitioners from performing FGM and sex education was suggested by 7%.



K. Women's Attitudes Towards FGM Practices

Table 7
Women's attitude towards FGM practices *

Attitude	Agree %	Do not agree %	Do not know %
FGM is a religious practice	60.3	18.5	21.2
Husband prefer FGM	71.5	11.5	17.0
FGM causes complications & death	27.0	67.7	5.3
FGM prevents adultery	45.0	38.5	16.5
FGM causes pregnancy problems	8.3	79.2	12.5
FGM decrease sexual satisfaction	27.8	47.0	25.2
FGM causes difficult labor	6.9	79.3	13.7

* Based on all women (n=1,339)

A scale was used to measure women's opinions or attitudes on the practice of FGM and knowledge about its harmful effects. As Table 7 shows, a sizeable proportion of the women (60%) believed FGM is a religious practice, that husbands prefer a wife with FGM (72%), and that it prevents adultery (45%). As for the statements addressing the medical complications of FGM, 68% of respondents did not agree that it causes complications leading to death, 79% did not agree that it causes problems for conception or pregnancy, 79% did not believe FGM can cause difficult labor and 47% did not think it decreases sexual satisfaction. Overall, an almost constant proportion of 15% - 20% preferred not to express an opinion on the subject of FGM.

VII. Discussion of Major Study Findings

One of the principal contributions of this study is an assessment of the accuracy of women's self-reporting of FGM status. Using questions identical to those employed in the 1995 Egypt DHS, the women in this study were asked about their FGM status. The level of agreement between their responses and the results of gynecological examinations was quite high -- 94 percent. Although some differences were found between the women's self-reporting and the findings of the physical examinations, this study clearly shows that the vast majority of women accurately report their FGM status in response to survey questions like those used in the 1995 Egypt DHS.

The second contribution of this study relates to the measurement of FGM severity. The majority of cases (64%) of the FGM involved the removal of the clitoris and labia minora. There is very little variation in the type of FGM across the different sub-groupings of the study population (age, education, place of residence, etc), suggesting that the correlates of the type of FGM must be found using different measures than the standard socio-demographic indicators.

The remaining findings from this study, although revealing of FGM practices around 20 years ago amongst the population of (largely) University Medical Centers, are similar to the 1995 Egyptian DHS results on FGM.

VIII. Conclusions

These findings strongly suggest that additional efforts are required to alert women, their families, and the medical profession on issues related to FGM. There is a need to re-think strategies employed in reaching target populations and to address the cultural reasons underlying the continued practice of FGM, as a means of diminishing the practice. As the study findings indicate there has been an increased role of medical staff in performing FGM. Consequently more attention should be given to the institution of ethical concerns associated with their practice of an operation they were not trained to perform. The recently passed Ministerial decree may discourage some practitioners from performing the operation. However, it also may lead to some reluctance on the part of both provider and family to refer complicated cases to receive timely and proper medical attention. Clearly families need to understand the implications of the newly passed law otherwise fewer complications may be brought to the attention of medical personnel. As well, more effort is needed on the part of health educators to inform mothers and the public at large of the problems associated with FGM, especially the cases of severe complications/mortality, addressing the underlying causes in each. The present strategy should include a frank approach towards dealing with reports of adverse experiences and mortality and to openly use these cases to discourage families from risking the health and lives of their daughters.

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