FEMALE GENITAL MUTILATION/CUTTING IS A CONTINUED PROBLEM

Heba H Rohym[1], Hoda Sayed Mahmoud [2], Amal R. Saleh[1]
[1] Department of Forensic Medicine and Clinical Toxicology, Fayoum University, Egypt
[2] Department of Forensic Medicine and Clinical Toxicology, Beni suefUniversity, Egypt
Heba H Rohym, E mail: arabieid@yahoo.com Mobil phone : +201013355112
Submit Date 2023-02-10
Revise Date 2023-09-04
Accept Date 2023-09-07

ABSTRACT

Background: Female Genital Mutilation/Cutting (FGM/C) refers to the partial or complete removal of the external female genitalia or other forms of injury to the female genital organs for cultural or other non-therapeutic reasons**. Aim:** the present study aims to assess the prevalence, frequency, and complications associated with FGM/C, as well as the level of awareness among women and healthcare providers. **Methods:** The survey was carried out at Fayoum General Hospital, involving 235 female volunteers and 100 health office providers. To gather data, the authors designed a questionnaire that included personal information about the subjects, such as age, place of residence, religion, education level, marital status, and specific details regarding circumcision**. Results:** The study findings revealed that approximately 140 (59.6%) of the female participants in Group I had undergone circumcision. 72.8% of the female participants were married. Among the participants, 199 (84.7%) were Muslims, while 36 (15.3%) were Christians. Rural areas were the predominant locations where circumcision took place. A negative correlation was observed between education level and female circumcision. The majority of female circumcision cases occurred after the age of 10, with an average age of 12.5 ± 1.3 years. Midwives were predominantly responsible for performing the procedure. The most common complications of circumcision were psychological and sexual problems. Out study's females examined, 107 (76.4%) had type II circumcision, while 33 (23.6%) had type I. Among the participants in Group I, 112 (80%) stated that circumcision was performed for social and cultural reasons, while 28 (20%) mentioned religious reasons. Among healthcare providers, 9 (18%) reported practicing circumcision for medical reasons, while 41 (82%) stated social and cultural reasons as the primary motivations. All 100 (100%) healthcare providers surveyed did not receive formal training or have any references for performing circumcision operations. Most healthcare providers practiced Type I circumcision. **Conclusion**: Female genital mutilation /cutting (circumcision) is a continued problem. To achieve the best results for the abolition of FGM/C in Egypt, rules and legislation that forbid it must be supplemented with culturally relevant education and public awareness-raising initiatives.

Keywords: Egypt, Female genital mutilation, Type of circumcision, Complications

INTRODUCTION

Female Genital Mutilation/n/Cutting (FGM/C) all around the world is considered a harmful practice. It became more medicalized to lessen its adverse health consequences **(Leye, et al., 2019).**

In 30 countries, 200 million women and children have undergone female genital mutilation or cutting (FGM/C) **(UNICEF, 2016).**

FGM/C is defined as "all operations involving part or total removal of external female genitalia or harm to it for reasons other than medical necessity"**. (WHO, 2007).**

FGM/C is progressively being "medicalized" by healthcare professionals. FGM/C is made by any category of healthcare practitioner in a public clinic or a private clinic, at home or elsewhere" **(WHO, 2010).** The healthcare professionals can be doctors, nurses, or midwives. Medicalization has expanded dramatically in Egypt, Sudan, Kenya, Nigeria, Guinea, Yemen, and, more recently, Indonesia,

According to statistics from the Demographic and Health Surveys (DHS), In many of these countries, at least one-third of women said that their daughters had FGM/C performed by a licenced medical expert**. (Serour ,2013) and (Abdulcadir, et al. 2017).**

Although more nations are passing laws banning the practice, the medicalization of FGM/C continues to rise in many of them.

According to Shell-Duncan and colleagues' analysis of data from the Demographic and Health Survey (DHS) in 25 countries, 26% of women aged 15 to 49, or roughly 16 million women, had FGM/C performed by a medical professional. **(Kimani and Shell-Duncan, 2018).**

The following nations have high medicalization rates as a percentage of FGM/C performed by medical personnel: Guinea (15%), Kenya also (15%), Nigeria (13%), Sudan (67%), and Egypt (38%), all have rising rates, except Nigeria **(Abdulcadir, et al. 2017).**

In Egypt, where the frequency of FGM/C among women and girls between the ages of 15 and 49 was 87% in 2015, the practice is firmly ingrained (Ministry of Health and Population, Egypt. 2015). Regarding age, FGM/C is done slightly before or at puberty **(El-Gibaly, et al., 2002).**

Egypt has experienced a dramatic increase in FGM/C medicalization over the past 20 years, contributing to the nation's high rate of medicalization**.**

The procedure was made illegal in 2008. Data from the Egypt Demographic and Health Survey (EDHS) show that the proportion of girls and young women aged 19 or younger who had FGM/C has increased from 55% in 1995 to 74% in 2014 **(EI-Zanaty, et al., 2019).** This rise could be attributed to a 1994 medical instruction noted by the Ministry of Health and the population that permits FGM/C to be performed by doctors only in specified institutions at set times, and costs may be to blame for this increase. **(Shell-Duncan. 2001).**

PARTICPANTS & METHOD

The study employed a prospective cross-sectional design and was conducted between January 1 and December 31, 2022, at the outpatient gynecology and obstetrics clinics of Fayoum General Hospital in Egypt. Fayoum Governorate, situated in the central region of the country, was chosen as the study location. The governorate has a population of approximately 3,848,708 individuals as of 2020. According to the Central Agency for Public Mobilization and Statistics, the population distribution consists of 77.5% rural inhabitants and 22.5% urban inhabitants.

Ethical considerations:

The research project received approval from the Research Ethics Committee of Fayoum University Faculty of Medicine, with reference number R 363. Before participation, verbal informed consent was obtained from everyone after providing a clear and comprehensible explanation of the study's purpose and procedures.

Study design

The study population comprised two groups: Group I, consisting of 235 female participants, and Group II, consisting of 100 health office providers. Both groups were invited to take part in the study and were administered a structured, pre-tested questionnaire through face-to-face interviews conducted by the author.

Following the pilot phase, the questionnaire underwent modifications to align with cultural norms and traditions. This included revising the wording of the questions to ensure clarity, simplicity, and an improved understanding for the participants. The questionnaire was refined to provide sufficient detail and enhance the overall comprehensibility of the survey.

The initial section of the study encompassed gathering basic sociodemographic information, assessing participants' awareness of the practice of FGM, exploring personal experiences with the procedure, and identifying any associated complications or concerns. In group I, before undergoing a private gynecological examination to evaluate the presence of FGM and related genital issues, each study participant provided informed consent. According to the WHO classification, female genital mutilation (FGM) is categorized into four types:

Type I: This involves the partial or total removal of the clitoral hood or clitoris itself (clitoridectomy).

Type II: It refers to the partial or total removal of the clitoris and the labia minora, with or without the excision of the labia majora as well.

Type III: Also known as infibulation, this type involves the narrowing of the vaginal opening through the excision of the clitoris, labia minora, and labia majora. The remaining tissue is then stitched together to create a seal, leaving a small opening for urine and menstrual flow.

Type IV: This category includes any other harmful procedures performed on the female genitalia for non-medical reasons. These

procedures may involve cauterization, piercing, scraping, incising, or pricking.

The second phase of the study focused on administering a questionnaire to group II participants, which comprised health office providers. The questionnaire included inquiries related to their basic demographic characteristics, level of awareness regarding the practice of FGM, personal experiences with the procedure, and knowledge about the potential complications associated with female genital mutilation or cutting (circumcision).

Statistical analysis: data was collected and coded to facilitate data manipulation, and double entered into Microsoft Access, and data analysis was performed using the Statistical Package of Social Science (SPSS) software version 22 in Windows 7 (SPSS Inc., Chicago, IL, USA). Simple descriptive analysis in the form of numbers and percentages of qualitative data, arithmetic means as central tendency measurement and standard deviations as a measure of the dispersion of quantitative parametric data.

The Chi-square test is used to compare two or more qualitative groups. The P-value of 0.05 was considered statistically significant **(Altman, 1991).**

RESLUTS

Table 1 shows the demographic information of the female participants in group I. Throughout the one-year duration of the study, a total of 235 females were randomly selected and enrolled, with ages ranging from 15 to 45 years. Among the participants, approximately 140 (59.6%) had previously undergone circumcision. Of the female participants, 72.8% were married. In terms of religious affiliation, 199 (84.7%) were Muslims, while 36 (15.3%) were Christians. Circumcision was found to be more prevalent in rural areas, with 167 (71.1%) participants residing in rural locations, while 68 (28.9%) participants hail from urban areas.

The findings of the present study revealed that out of the total participants, 114 (48.5%) parents had received an education, while 121 (51.4%) parents were non-educated. Among the female participants, 143 (60.9%) had received an education, while 92 (39.1%) were non-educated. In terms of awareness, 127 (54%) females were aware that circumcision is illegal, while 108 (46%) lacked this knowledge.

Table (1): Description of demographic characteristics among female participants group I.

Variables		
Number (n=235)		
Age	**15-45**	
	No.	**%**
Marital status		
Married	171	72.8%
Single	64	27.2%
Religious		
Muslim	199	84.7%
Christian	36	15.3%
Residence		
Rural	167	71.1%
Urban	68	28.9%
Education		
Educated	143	60.9%
Non educated	92	39.1%
Parents education		
Educated	114	48.5%
Non educated	121	51.4%
Incidence of circumcision		
Circumcised	140	59.6%
Non circumcised	95	40.4%
Knowledge that circumcision is illegal.		
Yes	127	54%
No	108	46%

Table 2 demonstrates that most females underwent circumcision after the age of 10, with an average age of 12.5 ± 1.3 years.

The findings of the current study indicated that most circumcision procedures, 111 (79.3%), were performed by midwives. 22 (15.7%) were conducted by gynecological doctors, and only 7 (5%) were performed by surgeons. In Table 2 and Fig. 1, the study demonstrated that 107 (76.4%) of the females underwent type II circumcision based on examination, while the remaining 33 (23.6%) underwent type I circumcision. Regarding complications of circumcision, the study findings indicated that 76 (54.3%) of the females experienced psychological problems, 49 (35%) reported sexual problems, and 15 (10.7%) reported a combination of both sexual and psychological problems. These results are presented in Table 2 and Fig. 2. Additionally, the study showed that 16 (11.4%) of the females had complications in the form of scars or keloids, while the majority, 124 (88.6%), did not exhibit any scars or keloids.

According to the study findings, the majority of circumcisions, 99 (70.7%), took

place at home, while 31 (22.1%) were performed in hospitals, and 9 (6.4%) were conducted in private clinics. This information is presented in Table 2 and Fig. 3. Furthermore, the study revealed that 54 (38.6%) of the female participants in group I reported cleanliness as the perceived benefit of circumcision, while 86 (61.4%) reported social acceptance as the main reason.

The study found that 112 (80%) of the female participants in group I underwent the procedure for social and cultural reasons, while 28 (20%) cited religious reasons.

Table 2: Circumstances of circumcision in the victimized females

Circumcised female	**140**
Age of circumcision	**12.5 ±1.3**
Who perform (for circumcised)	
Gynecological doctor	22(15.7%)
Surgeon	7(5%)
Midwife	111(79.3%)
Barber	0(0%)
Place of circumcision performance (for circumcised)	
Home	99(70.7%)
Hospital	31(22.1%)
Private	9 (6.4%)
Complication of circumcision by examination	
Menstrual problem	0(0%)
Sexual problem	49 (35%)
Fertility problem	0(0%)
Labor problem	0(0%)
Psychological problem	76 (54.3%)
Combination Sexual and Psychological problem	15 (10.7%)
Type of circumcision by examination	
I	33(23.6%)
II	107 (76.4%)
III	0(0%)
IV	0(0%)
V	0(0%)
Complication as scar or keloid	
Yes	16(11.4%)
No	124(88.6%)
Benefits of circumcision	
Cleanliness	54(38.6%)
Social acceptance	86(61.4%)
Motivation	
Religious reasons	28(20%)
Social and Cultural reasons	112(80%)
Sexual reasons	0(0%)
Combination	0(0%)

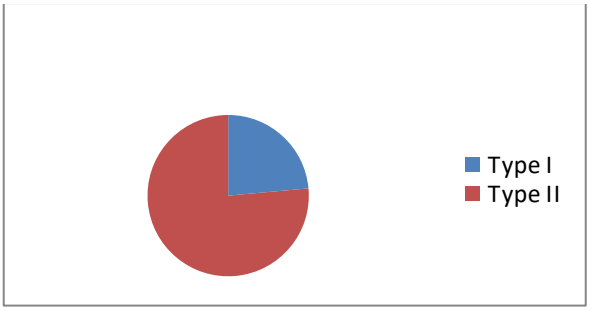

Figure (1): Types of circumcision found in female participants.

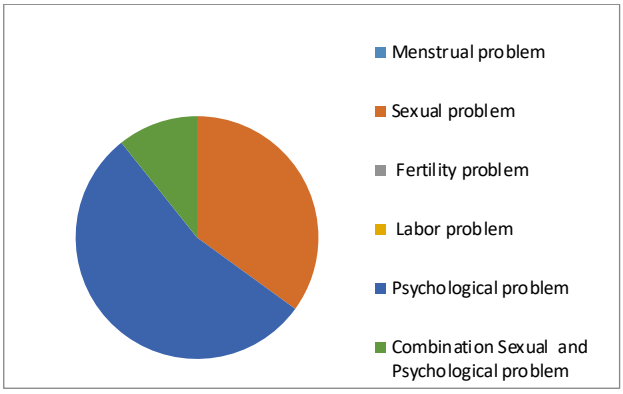

Figure (2): Complication of circumcision by examination

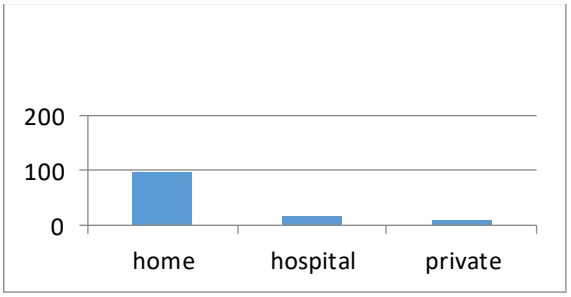

Figure (3) Place of doing circumcision.

There was a statistically significant higher percentage of circumcised females among married cases, Muslims, women in rural areas, not educated, and women who did not know the illegibility of circumcision, with a p-value of 0.05.

On the other hand, there was no statistically significant difference with a p-value >0.05 as regards age, or patent education, as shown in Table (3).

Table (3): Comparisons of characteristics between circumcision groups.

Variables	Circumcised (N=140)		Non-Circumcised (N=95)		P-value
Age (years)	27.8±4.2		28.02±6.3		0.740
Marital status					
Married	**109**	**77.9%**	61	64.2%	
Unmarried	31	22.1	3	35.8%	**0.026***
Religious					
Muslim	117	**83.6%**	67	70.5%	
Christian	23	16.4%	28	29.5	**0.024***
Residence					
Rural	**119**	**85** %	48	50.5%	
Urban	21	15%	47	49.5%	**<0.001***
Education level					
Educated	65	46.4%	73	76.8%	
Non educated	**75**	**53.6%**	22	23.2%	**0.001***
Education of parents					
Educated	61	43.6%	53	55.8%	
Not educated	79	56.4%	42	44.2%	0.084
Knowledge that circumcision is illegal.					
Yes	58	41.4%	64	67.4%	
No	**82**	**58.6%**	31	32.6%	**<0.001***

In Table 4, the participants in Group II were health care providers, 60 (60%) physicians and 40 (40%) nurses. Their age distribution was within the range of 25 to 45 years. There were 48 male participants (48%) and 52 female participants (52%). It was noteworthy that a significant majority of health care providers, 81 individuals (81%), possessed knowledge regarding the illegality of circumcision. This finding underscores the awareness among healthcare providers regarding the legal implications associated with this practice. 50 per cent of health care providers do circumcision. The analysis of healthcare providers' practises in circumcision revealed interesting results. Among the participants, 9 individuals (18%) reported performing circumcision for medical reasons, whereas the majority, 41 individuals (82%), cited social and cultural reasons. Notably, no participants mentioned religious reasons for performing circumcision. This finding highlights the prevailing motivations behind healthcare providers' involvement in circumcision procedures and suggests a stronger influence of social and cultural factors than medical or religious justifications. Understanding these underlying reasons is essential for comprehensive discussions and decision-making regarding circumcision practices within the healthcare field.

Regarding complications associated with circumcision, 33 healthcare providers (33%) reported sexual problems as complications, while a larger proportion of 52 healthcare providers (52%) mentioned psychological problems. Additionally, 11 healthcare providers (11%) experienced a combination of sexual and psychological problems, and 4 individuals (4%) reported complications related to scarring and keloid formation. Importantly, this emphasizes the diverse range of complications that healthcare providers encounter with circumcision procedures.

Furthermore, it is noteworthy that 100% of the healthcare providers surveyed admitted to lacking formal education or references regarding circumcision operations. 42

Healthcare providers (80%) reported performing Type I circumcision, while 8 providers (20%) stated that they perform Type II circumcision.

Table (4): Health care provider and the medicalization of female genital mutilation or cutting.

Health care provider	
Physician	60(60%)
Nurse	40 (40%)
Sex	
Male	48(48%)
Female	52(52%)
Knowledge that circumcision is illegal	
Yes	81(81%)
No	19(19%)
Circumcision complication	
Menstrual problem	0(0%)
Sexual problem	33 (33%)
Fertility problem	0(0%)
Labor problem	0(0%)
Psychological problem	52 (52%)
Scar and keloid	4(4%)
Combination Sexual and Psychological problem	11 (11%)
None of above	0(0%)
IF they do circumcision	
Yes	50(50 %)
No	50(50 %)
Cause of doing circumcision operation	
Social and Cultural reasons	41(82%)
Medical reason	9(18%)
Religious reasons	0(0%)
if they studied circumcision operation or have reference for circumcision operation	
Yes	0(0%)
No	100(100%)
Type of circumcision done	
I	42(80%)
II	8(20%)
III	0(0%)
IV	0(0%)
V	0(0%)

DISCUSSION

FGM/C is now widely recognized as a violation of girls' and women's rights, an expression of gendered violence, and having a demonstrable negative impact on women's sexual and reproductive health, whether it is still practiced traditionally or has been medicalized**. (Leye. et al., 2019)**

The present study, which surveyed 235 female participants and 100 health providers, showed that 59.6% of these females had FGM/C. The study found that FGM was less common than in previous studies conducted in Egypt. These findings are in line with those of **Modrek and Liu (2013),** who looked at data from the Egypt Demographic and Health Survey's 2005 and 2008 waves. They found that among the youngest generation of high-risk girls in Egypt, declines in female circumcision are likewise correlated with increases in women's educational attainment at the community level.

The results showed that most of the females doing circumcision above the age of 10 agree with **Elbendarya. et al. (2020)** noted that 62% of participants had undergone circumcision at an average age of 13.2±2.2.

These results agree with **Zayed and Ali. 2012,** they claimed that the age range for circumcision was between 8 and 15 years and that the mean age was 10.84 ±1.98 years.

There were 72.8% of participants married, which agrees with **the Egyptian Demographic Health Survey (EDHS) from 2014,** which reported that 91% of women who have ever been married have been circumcised.

This study revealed that 71.1% of participants were from rural areas, while 28.9% were from urban areas. These results disagree with **Shabila (2021)** who observed that the study from 2011 to 2018 in the Iraqi Kurdistan Region found that the prevalence of FGM was relatively similar in urban and rural areas. The larger drop in FGM in rural areas identified by his study may be due to rural-urban migration as well as greater access to technology, education, and awareness in rural areas.

The current study showed that 56.5% of circumcised female parents were non-educated, while 43.5% were educated. These results coincide with **Elbendarya, et al. 2020;** according to their findings, a large percentage of circumcised females were from illiterate homes, with a substantial difference between them and those who did not.

These findings conflict with an Egyptian study by **Refaat, 2009** that found that FGM incidence was unaffected by participants' socioeconomic status, religious affiliation, and educational attainment.

The present study revealed that 79.3% of cases were performed by midwives, 15.7% by gynecological doctors, and only 5% by surgeons.

These results disagree with **Zayed and Ali (2012),** who claimed that a doctor performed the FGM operation in 53.8% of cases, a housewife in 33.3%, a nurse in 10.3% of cases, and other professionals in 2.6% of

cases.

Regarding the place of circumcision, the results showed that 70.7% were at home, 22.1% were at a hospital, and 6.4% were at a private clinic.

These findings agree with those of **Zayed and Ali. 2012** found that 56.5% of circumcisions occurred at the victim's home, 38.5% occurred in private clinics, and 5% occurred in hospitals. These results were inconsistent with **Refaat, 2009** stated that the place of practice of FGM by physicians was the clinic (64.9%), hospital (21.6%), and home (13.5%).

This contradiction may be caused by the fact that, according to a nurse, FGM/C was more frequently carried out at home in rural areas after parents picked her up to go carry out the cutting on their daughters there. While it was more frequently performed in private clinics in urban areas, according to the opinions of a clinical officer from Nairobi, Kenya**. (Kimani, et al.2020).**

Regarding complications of circumcision, the study revealed that (54.3%) had psychological problems, 35% had sexual problems, (10.7%) combination of sexual and psychological problems.

These results agree with a study by **Knipscheer, et al. (2015)** that showed that a significant number of FGM/C survivors reported having severe sadness, anxiety, and post-traumatic stress disorder (PTSD).

Regarding the type of circumcision, the study showed that 76.4 per cent of the females were type II, while the others were (23.6%) type I.

This result agrees with **Al-Hussaini (2003),** who reported that Type I and Type II are the most common forms of FGC in Egypt**.**

80% of cases were for social and cultural reasons, and 20% were due to religious reasons**.**

This result coincides with **Martinelli and Ollé-Goig (2012).** According to a survey conducted in Djibouti, tradition/culture (34%), religion (30%), income (15%), and familial pressure (11%) were the main drivers behind the persistence of this practice.

The study showed that 80 per cent of healthcare providers know that circumcision is illegal. 50 per cent of healthcare providers practise circumcision. The study showed that healthcare providers practise circumcision for 41 (82%) social and cultural reasons and 0 (0%) religious reasons that agree with **El-Gibaly et al. (2019).** According to his study results, most nurses and some doctors continue to be heavily impacted by the cultural beliefs of their ethnic groups, reporting engaging in FGM/C in their own families because they still view it as a traditional obligation to which they must adhere.

100 per cent didn't study circumcision operations or have a reference for circumcision operations. This agrees with **Abdulcadir, et al. (2017),** who studied the knowledge, attitude, and practice (KAP) of healthcare students and providers about FGM.

42 (80%) of healthcare providers do Type I, and 8 (20%) of them do Type II circumcision. This result agrees with **Al-Hussaini's 2003 study,** which reported that Type I and Type II are the most common forms of FGC in Egypt.

Conclusion and recommendation: a negative correlation was observed between education level and female circumcision. Improving women's education and literacy and empowering them with more health education and awareness about FGM complications, can help in prevention the FGM practice.

Ethical Clearance: Faculty of Medicine, Fayoum University, Research Ethical Committee Permission Number.R363

Conflict of Interest: Nil

Source of Funding: Self-Funding**.**

REFERENCE

Abdulcadir, J., Say, L., & Pallitto, C. (2017). What do we know about assessing healthcare students and professionals' knowledge, attitude, and practice regarding female genital mutilation? A systematic review. Reproductive health, 14(1), 64.

Al-Hussaini T. K. (2003). Female genital cutting: types, motives, and perineal damage in laboring Egyptian women. Medical principles and practice: international journal of the Kuwait University, Health Science Centre, 12(2), 123–128.

Altman GA, (1991): Practical statistics for Medical Research: Chapman &Hall, London.

Egypt Demographic and Health Survey (2014), Cairo, Egypt and Rockville, Maryland,

EI-Zanaty F, Hussein EM, Shawky GA, Way AA& Kishor S (2019). Egypt

Demographic and Health Survey 1995. Calverton: National Population Council [Egypt] and Macro International Inc; 1996.

El-Gibaly, O., Aziz, M., & Abou Hussein, S. (2019). Health care providers' and mothers' perceptions about the medicalization of female genital mutilation or cutting in Egypt: a cross-sectional qualitative study. BMC international health and human rights, 19(1), 26.

El-Gibaly, O., Ibrahim, B., Mensch, B. S., & Clark, W. H. (2002). The decline of female circumcision in Egypt: evidence and interpretation. Soc Sci Med.; 54:205–20.

Kimani S& Shell-Duncan B.(2018). Medicalized female genital mutilation/cutting: contentious practices and persistent debates. Curr Sex Health Rep.10(1):25–34

Kimani, S., Kabiru, C. W., Muteshi, J., & Guyo, J. (2020). Female genital mutilation/cutting: Emerging factors sustaining medicalization related changes in selected Kenyan communities. PloS one, 15(3), e0228410.

Knipscheer, J., Vloeberghs, E., van der Kwaak, A., & van den Muijsenbergh, M. (2015). Mental health problems **a**ssociated with female genital mutilation. BJPsych bulletin, 39(6), 273–277**.**

Leye, E., Van Eekert, N., Shamu, S., Esho, T., Barrett, H., & ANSER (2019). Debating medicalization of Female Genital Mutilation/Cutting (FGM/C): learning from (policy) experiences across countries. Reproductive health, 16(1), 158.

Martinelli, M., & Ollé-Goig, J. E. (2012). Female genital mutilation in Djibouti. African health sciences, 12(4), 412–415.

Modrek, S., Liu, J.X. (2013). Exploration of pathways related to the decline in female circumcision in Egypt. BMC Public Health 13, 921 (2013).

Refaat A. (2009). Medicalization of female genital cutting in Egypt. Eastern Mediterranean health journal = La revue de sante de la Mediterranee orientale = al-Majallah al-sihhiyah li-sharq al-mutawassit, 15(6), 1379–1388.

Serour G.(2013). Medicalization of female genital cutting/mutilation. Afr J Urol.19(3):145–9.

Shabila, N.P.(2021) Changes in the prevalence and trends of female genital mutilation in Iraqi Kurdistan Region between 2011 and 2018. BMC Women's Health 21, 137 (2021).

Shell-Duncan B. (2001). The medicalization of female "circumcision": harm reduction or promotion of a dangerous practice? Soc Sci Med. 2001;52(7):1013–1028.

UNICEF. Female genital mutilation and cutting. UNICEF data. (2016).

WHO. Classification of female genital mutilation.(2007).

WHO. Global strategy to stop health-care providers from performing female genital mutilation.(2010) .

Zayed, A. A., & Ali, A. A. (2012). Abusing female children by circumcision is continued in Egypt. Journal of forensic and legal medicine, 19(4), 196–200.

الملخص العربي

ختان الاناث مشكلة مستمرة

هبه رحيم ١ هدى السيد محمد٢ امل رؤوف صالح١
قسم الطب الشرعي والسموم كلية الطب البشري جامعة الفيوم١
قسم الطب الشرعي والسموم كلية الطب البشري جامعةبني سويف٢

ختان الاناث هو الإزالة الجزئية أو الكلية للأعضاء التناسلية الخارجية للأنثى أو أي إصابة أخرى بالأعضاء التناسلية الأنثوية لأسباب ثقافية أو لأسباب أخرى غير علاجية.

تهدف الدراسة الحالية إلى تقييم مدى انتشار وتواتر ومضاعفات تشويه الأعضاء التناسلية الأنثوية(الختان) بالإضافة إلى تقييم وعي النساء ومقدمي الخدمات الصحية بالفيوم.

وقد تم إجراء الدراسة بمستشفى الفيوم العام. حيث بلغ العدد الإجمالي للمشاركين 235 متطوعة و 100 من مقدمي الخدمات الصحية. وقد أنشأ المؤلفون استبيانًا لجمع معلومات حول المعلومات الشخصية للمشاركين في الدراسة ، بما في ذلك العمر ومكان الإقامة والدين ومستوى التعليم والحالة الاجتماعية ، بالإضافة إلى أي تفاصيل متعلقة بالختان.

أوضحت الدراسة أن حوالي 140 (59.6٪) من المشاركات الإناث قد خضعن للختان .

72.8٪ من المشاركات كن متزوجات. حوالي 199 (84.7٪) من المشاركات مسلمات ، 36 (15.3٪) مسيحيات. وكانت المناطق الريفية هي المنطقة الرئيسية للختان.

يوجد ارتباط سلبي بين التعليم وختان الإناث. وقدعرفت 127 (54٪) من الإناث أن الختان غير قانوني بينما 108 (46٪) لم يعرفن بأنه غيرقانوني.

وقد تم ختان معظم الإناث فوق سن 10 سنوات ، بمتوسط سن 12.5 ± 1.33 ، معظم الحالات التي أجريت بواسطة المولدة ، وكشفت الدراسة أن معظم مضاعفات الختان هي مشاكل نفسية وجنسية.

107 (76.4٪) من الإناث كانت من النوع الثاني للختان عن طريق الفحص بينما كانت الأخريات 33 (23.6٪) من النوع الأول.

وقد تبين من الدراسة أن 112 (80٪) من المشاركات كان الختان لأسباب اجتماعية وثقافية ، 28 (20٪) لأسباب دينية.

ويمارس مقدمو الرعاية الصحية الختان لـ 9 (18٪) لأسباب طبية ، 41 (82٪) لأسباب اجتماعية وثقافية و 0 (0٪) لأسباب دينية .100 (100٪) لم يدرسوا عملية الختان أو لديهم مرجع لعملية الختان. ويمارس معظم مقدمي الرعاية الصحية النوع الأول من الختان.

وقد كشفت الدراسة أن تشويه / بتر الأعضاء التناسلية الأنثوية (الختان) مشكلة مستمرة. ولتحقيق أفضل النتائج لإلغاء ختان الإناث في مصر ، يجب استكمال القواعد والتشريعات التي تمنعه بمبادرات تثقيفية ذات صلة ثقافية وتوعية عامة.