

## Research Article

# Gender Equity & Its Relation to Female Genital Mutilation in Rural Minia, Egypt

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**\*Corresponding author:** Seedhom AE, Department of Public Health and Preventive Medicine, Minia University, Minia 61111, Egypt**Received:** December 26, 2016; **Accepted:** February 28, 2017; **Published:** March 02, 2017**Abstract****Objectives:** To measure and relate Gender Equity Score (GES) to FGM future intentions.**Methods:** A cross-sectional community-based study. An interview administered questionnaire was used to measure GES. A systematic random sample was taken from the village. 578 males and females were included in the period from October to December 2016.**Results:** Men were more supportive of FGM. 78.03% of rural dwellers had low GES, 17.3% had medium and 4.67% had high GES. There was a significant relation between GES, supporting attitude towards FGM ( $p=0.001$ ), Knowledge that FGM is harmful ( $p=0.03$ ) and future intention to undergo to their daughters ( $p=0.0001$ ).**Conclusion:** The association between low GES, education, social pressure and intentions to carry out FGM to their daughters means that could help to fight FGM increasing importance of values as personal wellbeing and women empowerment.**Keywords:** Female genital mutilation; Gender equity; Egypt**Abbreviations**

FGM: Female Genital Mutilation; GES: Gender Equity Score; EHIS: Egyptian Health Issues Survey; EDHS: Egypt Demographic Health Survey

**Introduction**

World bodies have defined gender equality in terms of human rights, especially women's rights, and economic development [1]. UNICEF describes that gender equality "means that women and men", and girls and boys, enjoy the same rights, resources, opportunities and protections. It does not require that girls and boys, or women and men, be the same, or that they be treated exactly alike [2].

The United Nations Population Fund stated that, "despite many international agreements affirming their human rights, women are still much more likely than men to be poor and illiterate. They have less access to property ownership, credit, training and employment. They are far less likely than men to be politically active and far more likely to be victims of domestic violence [3].

Thus, promoting gender equality is seen as an encouragement to greater economic prosperity. For example, nations of the Arab world that deny equality of opportunity to women were warned in a 2008 United Nations-sponsored report that this disempowerment is a critical factor crippling these nations' return to the first rank of global leaders in commerce, learning, and culture [4].

A large and growing body of research has shown how gender inequality undermines health and development. To overcome gender inequality the United Nations Population Fund states that, "Women's empowerment and gender equality" requires strategic interventions

at all levels of programming and policy-making. These levels include reproductive health, economic empowerment, educational empowerment and political empowerment [5].

Female genital mutilation is mostly carried out on girls between the ages of 0 and 15 years. However, occasionally, adult and married women are also subjected to the procedure. The age at which female genital mutilation is performed varies with local traditions and circumstances, but is decreasing in some countries [6].

In every society in which it is practiced, female genital mutilation is a manifestation of gender inequality that is deeply entrenched in social, economic and political structures. Such practice has the effect of perpetuating normative gender roles that are unequal and harm women. Analysis of international health data shows a close link between women's ability to exercise control over their lives and their belief that female genital mutilation should be ended [7].

**Subjects and Methods**

A cross-sectional community-based study was conducted to measure gender equity score and identify its association with FGM in a rural area in Minia governorate that was chosen randomly then a systematic random sample was taken from the village (the 1<sup>st</sup> house was chosen randomly then every 5<sup>th</sup> house).

The questionnaires were administered, face to face. The sample size was calculated using EP Info version 2000. A total of 578 male and female rural dwellers, aged >18 years were participated in this study.

The study was conducted in the period from October to December, 2016. A pilot study was performed on 50 persons and the

questionnaire was further validated through a review panel process where each item was considered for appropriateness.

GES was used. The 2006 Victorian Survey identified that the strongest predictor for holding violence-supportive views about violence against women was an individual's 'gender equity score' [17]. This gender equity score or GES was constructed by asking respondents a series of attitudinal statements about women and their role in society. As with the 2006 Victorian Survey, the 2009 National Survey asked participants to respond to the same series of attitudinal statements relating to gender equity adapted from [18]. Responses to these statements were based on a likert scale where 1 = 'strongly agree' and 5 = 'strongly disagree'. The questions were:

On the whole, men make better political leaders than women.

When jobs are scarce men should have more right to a job than women.

1. A university education is more important for a boy than a girl
2. A woman has to have children to be fulfilled
3. It's OK for a woman to have a child as a single parent and not want a stable relationship with a man (reversed scored)
4. In the 2009 survey additional three statements were included:
5. Discrimination against women is no longer a problem in the workplace
6. Men should take control in relationships and be the head of the household
7. Women prefer a man to be in charge of the relationship

The gender equity scale and associated scores were calculated and summed to give a score out of 100. Participants were required to respond to eight statements on a scale of 1 (strongly agree) to 5 (strongly disagree).

The eight statements were summed to give the respondent a score out of 40. The score was then multiplied by 2.5 to give the respondent a score out of 100. The score out of 100 was then categorized as 'high GES' (>90), 'medium GES' (75-90) or 'low GES' (<75).

Those who scored closest to 100 gave answers to the statements which indicated they supported gender equity – women should not only have equal rights and opportunities but be treated fairly and justly in the distribution of benefits and responsibilities between women and men. Those who scored lower on the gender equity scale expressed views that indicated less support for women being treated equally and fairly [8].

### Statistical analysis

The Statistical Program SPSS for windows version 20 had been used in data analysis. Statistical significance was set at  $p < 0.05$ .

### Ethical considerations

The study protocol had been approved by the standard ethics of Minia University ethical committee for human studies. Interviews were held in strict privacy, mainly in the respondents' homes, with

no one able to overhear the conversation. The participants were informed about their possibility to withdraw at any point during the research phase and gave written informed consent to participate.

## Results

The study highlighted the key characteristics that either foster or discourage the continuation of the practice. A total of 578 rural dwellers were included in the present study with only 0.1% non response rate. Respondents' average age was  $30.7 \pm 12.4$  years. 89.6% were moslems in religion and 68.9% were women. 59.2% were married (Table 1).

Table 2 showed that 451 (78.03%) of rural dwellers had low GES, 100 (17.3%) had medium and 27 (4.67) had high GES.

Table 3 showed that there was a significant relation between GES and sex, marital status and education. Also, there was a significant relation between GES and attitude that FGM is a good practice ( $p=0.0001$ ), Knowledge that FGM is harmful ( $p=0.02$ ) and agreement with FGM performance to daughter in the future ( $p=0.0001$ ).

## Discussion

FGM has gained increased attention in policy and research over the last decades due to its impact on women's health, including severe violation of human rights [9,10]. Studies on FGM in the general population in Egypt have reported that almost all Egyptian women (97%) have been subjected to FGM [11,12].

About 78.03% of rural dwellers had low GES, this result was less than what was found by Hassan et al. who found that 90.5% of respondents' scores fell within the low range of support for gender

**Table 1:** Socio-demographic profile of studied population, rural Minia, Egypt.

Percentage	Frequency	Socio-demographic variables
<b>Sex</b>		
31.1	180	Male
68.9	398	Female
<b>Age</b>		
18-74 (30.7±12.4)		<b>Range (Mean±SD)</b>
<b>Educational level</b>		
17.3	100	Illiterate
9.3	54	Read and write
10.7	62	1ry education
28.4	164	2 <sup>nd</sup> education
34.3	198	University
<b>Religion</b>		
89.6	518	Moslem
10.4	60	Christian
<b>Marital status</b>		
36.7	212	Single
59.2	342	Married
0.6	4	Divorced
3.5	20	Widow
100	578	Total

**Table 2:** Gender equity score among the studied sample.

GES	No.	%
Low	451	78.03
Middle	100	17.3
High	27	4.67

**Table 3:** Relation between GES and socio-demographic variables and some factors related to FGM, rural Minia, Egypt.

X <sup>2</sup>	Total (n=578)	Low GES (n=451)	High and medium GES (n=127)	
				Sex
24.3	398 (67.6)	333 (72.8)	65 (51)	Females
0.0001	180 (32.4)	118 (27.2)	62 (49)	Males
				Age
2.4	286 (49.5)	215 (47.8)	71 (55.1)	Less than 25 year
0.1	292 (50.5)	236 (52.2)	56 (44.9)	More than 25 year
				Marital status
8.4	232 (40.8)	167 (37.6)	65 (51)	Never married
0.004	346 (59.2)	19 (62.4)	62 (49)	Ever married
				Education
48.4	218 (38.5)	137 (31.2)	81 (61.9)	University
0.0001	144 (26.5)	136 (31)	8 (12.2)	Secondary education
	32 (8.4)	30 (8.5)	2 (8.2)	Primary education
	44 (10.4)	42 (11)	2 (8.2)	Read and write
	100 (16.2)	86 (18.3)	14 (9.5)	Illiterate
				Attitude that FGM is a good practice
17.5	262 (45.6)	227 (50.3)	35 (30.6)	Yes
0.0001	316 (54.4)	224 (49.7)	92 (69.4)	No
				Knowledge that FGM is harmful
5.1	304 (52.4)	225 (49.9)	79 (60.5)	Yes
0.02	274 (47.6)	226 (50.1)	48 (39.5)	No
				Agree to perform FGM to his daughter in the future
				Yes
31.7	315 (54.2)	275 (60.5)	40 (34)	No
0.0001	263 (45.8)	176 (39.5)	87 (66)	

equity, 8.6% fell within the medium range of support. This difference may be explained by that, our study sample included males and females, while in the other study, the participants were males only and this emphasize that women in poor agricultural villages in Upper Egypt were still considered to be inferior to males and to their husbands [13].

Behaviour change will become more likely when people are not only ready to change, but willing and able as well. Such interpretation is consistent with social convention theory. Social conventions require social support. To change social conventions, role models (such as individuals or families in good social standing) may introduce new behaviours [14].

In an analysis to EDHS, 2008 in Egypt, unlike mother's education; father's education as well as father employment status had no association with FGM. In addition, the parent's preference for daughter circumcision decreased over time [15].

According to the results of a previous study, higher educated mothers were less likely to have circumcised daughters than for medium and low educated women when other factors as family and community factors were held constant. Past experience of women about FGM was also consistently related to decision to mutilate their daughters since mutilated women were more likely to have their daughters circumcised too. Women who believed that hygiene and cleanness were benefits for girls who undergo FGM were more likely to mutilate daughter. Family approval, achievement of community status and tradition and sexual control, assurance of eligibility for marriage and male pleasure were other factors that might contribute to fostering the FGM practice [16].

### Limitations of the Study

1. This cross-sectional study allowed studying associations but not causality.
2. Some women and men refused to participate in the study. Applying patience and diplomacy the researchers had to work for long hours.
3. The possibility of recall bias or reporting bias.

### Conclusion and Recommendations

The overall results gave important inputs to policy makers. Educating and protecting girls and increasing importance of values as personal wellbeing, health care and women empowerment which could help to fight acceptance of FGM.

### Acknowledgement

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### Ethical Consideration

This research took approval from the research ethical committee of the university. All participants gave consent to participate in the study.

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